CURAMERICAS GLOBAL

ENVISIONING FIVE YEARS OF GROWTH, EXPANDED IMPACT AND INCREASED ORGANIZATIONAL STRENGTH
January 2022 – December 2026

Hope through Health: A World Free of Preventable Suffering

For Approval

Curamericas Global, Inc. Five-Year Strategic Plan
January 2022 – December 2026

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The Curamericas Global Community. 29

Cover photos not final. Beneficiaries in Liberia and Kenya

I. Vision, Mission and Core Values

Vision Statement:

Hope through Health: A World Free of Suffering from Preventable Causes.

Mission Statement:

Curamericas Global partners with underserved communities to make measurable and sustainable improvements in their health and wellbeing.

Core Values:

Empowerment of individuals and communities

Focus on preventable and treatable conditions

Commitment to evidence-based interventions and measurable outcomes

Sustainability through education, technical support, and community focused partners

Equity of health access and outcomes, eliminating disparities especially for indigenous, rural, and non-white communities.

Respect for the dignity of all

Compassion for those who are suffering

Passion, Integrity, and Excellence in all actions

II. Curamericas Global At-A-Glance: Who, What, Where and How

Curamericas Global is a long-standing international nonprofit organization committed to empowering underserved communities worldwide to provide basic life-saving community-based public health services to mothers, children, and their families. We say this most succinctly by stating our commitment to provide Hope Through Health to all the communities we serve. We deploy postgraduate public health professionals to partner with communities in developing and implementing community-based life-saving public health programs and interventions, particularly those focused upon helping mothers and children survive.

Curamericas Global functions as a responsible global development partner, consciously aligning our work with global initiatives such as the United Nation's Sustainable Development Goals (SDGs), USAID's A Promise Renewed, Every Mother Every Child, and Ending Preventable Maternal and Child Death. These initiatives provide roadmaps for organizations such as ours for just and lasting change, allowing us to work in harmony with the global public health community. For example, our work explicitly furthers the SDGs for 1) ending all forms of malnutrition by 2030; 2) reducing the global maternal mortality ratio to less than 70 per 100,000 births; 3) ending preventable deaths of newborns and under-5 children; 4) ending the epidemics of AIDS and malaria; 5) ensuring universal access to sexual and reproductive health-care services; 6) achieving universal access to quality healthcare services; and 7) supporting the participation of local communities in improving water and sanitation management. The goals of Ending Preventable Maternal and Child Death embody our Vision and Mission Statements and its recommended evidence-based interventions are included in our standard project "toolkit." Our work counting and reviewing every birth and death and promoting exclusive breastfeeding as a keystone of young child health are two of the key strategies promoted by Every Woman Every Child, a massive global alliance to confront major health challenges facing women, children, and adolescents.

Our work began nearly 40 years ago through the efforts of Dr. Henry Perry and Dr. Alice Weldon working with Duke University, the Bolivian Methodist Church, and the Bolivian Ministry of Health to bring community public health services to indigenous Aymara villagers living at over 13,500 feet on the Northern Altiplano in Bolivia. Early in our history, Dr. Perry teamed with Dr. John Wyon, a Harvard professor, to develop an innovative methodology for working with communities to improve health. The census-based impact-oriented methodology (CBIO) they developed focuses on building a partnership with communities, completing a census of all households, regularly visiting every household, and using routine surveillance data to guide programs to achieve maximum impact.

Using CBIO as a methodology in our projects, we have been able to determine the major health problems in our partner communities, to implement interventions to address those most in need (particularly, mothers and children), and to provide essential health services and education requested by those communities. By tracking all the births and deaths that occur, CBIO allows us to measure mortality rates and to monitor changes in these rates. It gives us the ability to demonstrate actual measurable impacts of our work, a unique and powerful aspect of the CBIO methodology. The work of Curamericas Global in Bolivia achieved over a 50% reduction in the deaths of children in partner communities during their first five years of life.

Curamericas Global has also employed CBIO in conjunction with the Care Group model developed by World Relief and introduced to Curamericas Global by Tom Davis, among others. This combination of methodologies quickly empowers communities to improve their health and to demonstrate the success of their efforts in tangible ways. We also have added education and volunteer work components to our programs. These approaches expand knowledge domestically about the communities we serve and enable us to share our data and experience with others.

Another key methodology Curamericas Global employs is the Community Birthing Centers (in Spanish, Casa Maternas or just Casas), which are built with volunteer community labor; our partners manage the clinical side of the facility while the communities manage construction, repair, and maintenance. Casas are strategically located within an hour drive of their communities; are open 24/7; and integrate traditional birthing practices with WHO and Ministry of Health protocols for clinical care. They are staffed by intensively trained Auxiliary Nurses rather than scarce Registered Nurses, a task-shifting innovation with an enormous return on investment. Casas provide culturally appropriate, respectful care in the local

language, and feature aspects of local homes (such as the traditional sweat lodge). Traditional midwives are integrated into Casa services, bringing women there to deliver instead of attending unsafe home deliveries. Casa services are free of charge or low-cost (determined by the local partner). Ministry ambulances and a network of on-call drivers ensure emergency transport. To foster a culture of health and women's empowerment, mother peer educators are trained to deliver life-saving health education to every doorstep. These women, as well as project staff, also go door to door to collect the vital events data- all births and maternal and child deaths – that allow us to demonstrate actual reductions in mortality rates.

Communities we have served include:

- Isolated Guatemalan villages inhabited by indigenous Mayan people working with local groups under the leadership and guidance of Dr. Mario Valdez (population served of 208,000);

- Communities in the Nimba County, Liberia working with the Ganta United Methodist Hospital (population served of 288,000);

- One of the largest slums in the world, Kibera in Nairobi, Kenya, an intensely dense community that compounds the issues of poverty, working through a partnership with Carolina for Kibera to implement CBIO and Care Groups through Train the Trainer (serving 150 Community Health Workers who in turn provide health education and outreach to 11,000 households with a population of 37,000);

- The western highlands of Kenya, in Kisii County, where our partners are the Ministry of Health of Kenya to test our methodology in a new context, adding the Community Birthing Center model to serve a population of 35,960, reducing maternal mortality by 91% and neonatal deaths by 41%;

- An indigenous population in the rural Altiplano area of Bolivia, serving over 250,000 people at elevations more than 13,500 feet above sea level, now served by Andean Rural Health Care, a Bolivian based nonprofit that grew out of our early work;

- The border community of Rio Bravo, Mexico where, in partnership with Rotary International and various local Rotary Clubs, Curamericas Global worked to establish a nonprofit organization and build its

capacity to implement community health services in a high-needs poor community to serve more than 11,000 people.

- Rural communities in Bo District, Sierra Leone in partnership with the General Board of Global Ministries of the United Methodist Church, Helping Children Worldwide, the United Methodist Women and the Methodist Church in Sierra Leone (currently in the pilot program stage serving over 4,000 people).

- Communities across the rural mountains of the southern claw of Haiti before, during and after the earthquake of 2010 serving over 214,000 people.

- In Cite Soleil, we provide technical assistance and program oversight in an urban area of Port-au-Prince, Haiti since 2020.

- Over 3,000 U.S. citizens through international education, cultural and service exchanges with participants from over 16 states and 5 countries.

- Over 167,000 residents of North Carolina in partnership with 19 nonprofits or university affiliates in response to the COVID19 pandemic.

Curamericas Global reached the One Million Lives Served threshold in 2013 establishing the successful scalability of our methodologies and work.

In the early days of Curamericas Global, we were funded in substantial part by churches and private donations. In later years, we benefited from government grants, particularly the United States Agency for International Development (USAID) Child Survival and Health Program grants, managing over $13 million in grants since 1990. During this period, a tremendous amount of good work was accomplished. Yet the organization became vulnerable to shifting government priorities, which occurred in 2010. Since 2010, Curamericas Global has been transitioning away from dependence upon government grants and over the next five years, we envision a continued healthy diversification of our funding sources to eliminate dependence upon institutional or government grants for our core operations and for baseline funding of our public health professionals. This approach will allow more of the government and institutional funds we receive to go toward capacity building and program implementation in our partner communities and enable us to partner with other organizations in pilot and proof of

concept programs in preparation for and to justify institutional funding to benefit our communities. It will also allow our professionals to work on programs that are community, rather than funding, centric.

With this history of achievement, Curamericas Global looks to a future in which we continue this critical lifesaving and life changing work. As we turn to the future in this Strategic Plan, we pause to re-affirm the who, what, where and how of Curamericas Global:

What we do: Curamericas Global provides underserved communities with public health expertise, professional knowledge, and technical support services to implement effective and sustainable community health programs.

Who do we serve: We provide services to support development of community-based primary health care for mothers, children, their families, and their communities at large.

Who we work with: We partner our community-focused public health professionals with passionate local healthcare leaders in underserved communities around the world.

How do we work: Working with our partners, we implement effective and efficient interventions based on local epidemiological and community priorities and measure the results to guide our programs. Engagement with local and mother-centered services is a crucial part of our culture and approach.

Where do we work: Over the past 39 years, we have worked in Bolivia, Guatemala, Haiti, Kenya, Liberia, Mexico, Sierra Leone, Haiti, and the United States. We are expanding our current work in Guatemala, Kenya, and Haiti and are in planning phases for new programs in Liberia and the United States.

How is our work funded: Our financial strategy is to reliably fund our public health professionals to provide needed critical services, expertise, and technical support. We are transitioning from dependence upon government and institutional-driven funding by implementing an annual unified fundraising campaign and by building an endowment to sustainably fund our core operations and our full-time graduate level or higher professional staff. We further seek to focus additional donations as well as government and institutional grants on building local community capacity and implementing local community driven public health programs.

Our domestic program: In 2015 our strategic planned called for implementation of programs and partnerships in the United States. We began with the Guatemalan Consulate and a group in Philadelphia known as CCATE. By identifying partners and communities who shared our vision, we introduced CBIO and Care Groups. When COVID-19 hit, we sprang into action to reach people of color in NC, first through the Guatemalan Consulate. We mobilized 500+ volunteers to call 10,000 families and provide education. We were then asked to lead a contract bid to the North Carolina Department of Health and Human Services that focused on building up Community Health Workers. Our strategy mirrored our international work, to find local partners who already had trust and were from communities that were often without access to health. Since March of 2020, we have reached over 189,000 people, more than 12,000 vaccinations and 800+ education events across 26 counties in North Carolina and more than 13 states (through phone calls). We were also asked to lead a coalition of partners in Durham County, NC with a focus on vaccine equity.

As Curamericas Global heads into its 40th year, we have surveyed our community of longtime supporters, institutional partners, staff, volunteer Board Members and others to set the course for the future. This Strategic Plan is our effort to articulate that course.

III. Strategies

A. Focus on the Public Health Professional to Deliver Critical Foundational Technical Support to Partners serving Partner Communities.

Implementing effective public health interventions in underserved communities requires building health foundations such as Prevention, Home and Self Care, Practical Access to Best Available Facility-Based Care, Community Ownership and Commitment, Long-Term Sustainability at the Community Level, and timely Capacity Expansion at the Community Level. Programs to build these foundational elements require local implementation capacity and critical know-how. Our experience and history demonstrate that achieving long-term success in these efforts requires local implementation by local partners with high credibility in the communities served. Often a missing element however is institutional know-how, program management best practices, financial management best practices, program design and monitoring capacity, and access to international resources available to support public health capacity and infrastructure building efforts. Our programming strategy is to fill this gap by providing the public health professionals and the institutional knowledge necessary for effective technical support for the work of our local partners. A part of this strategy is to avoid

expending limited resources on short-term efforts or vertical health interventions that are not part of our broader integrated community-based efforts in our partner communities.

B. Listen to Our Partner Communities and Build Relationships with These Communities.

A critical teaching from the CBIO methodology is assessment of community needs first and development of the program interventions second. A corollary premise is that the community should be actively involved in the decisions about approaches to undertake and how to define success. Community commitment, both conceptually, as well as through actual provision of community resources, is an important element of successful programs. To accomplish the necessary level of community involvement requires continuous and deep communication as well as development of trusting relationships. In addition to the structured information and data gathering used in implementing and monitoring our programs, fact finding trips and volunteer work trips to our communities facilitate deeper communication by creating an atmosphere of exchange and by building trust and understanding through shared experiences. Our strategy here is to build in opportunities for our communities and our partners to share with us at every stage of program development, implementation, and assessment.

C. Focus Our Work on Mothers and Children.

With an overarching aspiration to provide "Hope Through Health" to all members of our partner communities, we strategically focus our work on mothers and children. Helping to prepare women from adolescence to have healthy babies and to properly provide for the health of those babies through age five builds a public health foundation in communities that is readily understood as important and that can be readily expanded to other adolescents and other adults. Starting with other groups does not seem to offer as universal an opportunity to spread healthy practices and healthcare capacity beyond the initially targeted populations. Women and children are the most vulnerable to preventable illness, suffering and death; and interventions during these life stages have the most impact in terms of saving lives and improving quality of life in the long term. For these reasons, we have chosen to focus our limited resources on mothers and children, including those women who would or could become mothers.

D. Play the Long Game Building Long Term Relationships with Our Partners and Partner Communities.

As we have demonstrated in Bolivia and are demonstrating in Guatemala, we will stay with our partners and partner communities when times get tough. We are committed to long-term partnerships that last beyond any one funding stream or grant and that lead to long-term and sustainable change. We see behavior change and improved health impacts as readily achieved and sustained through concentrated and clear long-term commitment to our partners and partner communities. These commitments empower our professionals to achieve sustained and sustainable outcomes that improve lives and advance our vision, mission, values, and goals to improve health. These commitments also empower our partners, improve our credibility with partner communities and position us to address health needs that others with shorter-term focus cannot reach.

E. Measure All We Do for Transparency and Accountability.

Curamericas Global has a rich history of gathering and relying upon data to make decisions about community health needs and interventions. We seek to expand upon that history and the know-how we have developed to use data-driven and evidence-based approaches to guide all aspects of our work. The strategy here is to provide transparency and accountability to our partners and to ourselves so that we may continuously improve our work and outcomes and so that we may share our data and information with the larger public health community including our donors, partner agencies and sponsoring institutions. By doing so, our partner communities should reap the benefits of improved information and improved access to critical services and support.

F. Contribute to the Development of the U.S.-based International Public Health Workforce.

Through our domestic programs, we spread knowledge and information to students and public health professionals alike both at our headquarters offices, through our work teams, as well as through collaboration with other professionals pursuing similar work and goals including academic communities. We advocate for change in support of our communities and feed the body of knowledge to answer the question “what is sustainable development?” We also aim to assist underserved communities here in the United States that have demonstrated needs that are readily preventable using our experience in community-based health care.

G. Build Sustainable Funding.

In 2016, it was time to end the organizational dependency a limited number of donor sources for revenue and put our words into action for a diverse revenue stream that will sustain the critical work for another 40 years and beyond. We have established long-term funding sources that allow us to maintain our commitment to our partners and partner communities. We will continue to shape programs based on the actual needs of our partner communities and not the priorities of the donors. Sometimes funding organizations will want the Technical Assistance to be tied to the funding for accounting and control purposes. Other times they will want the funding provided directly to the on the ground implementing entity to flatten the structure. And other times they may want to handle the funding through a different NGO that they rely on for control of funding and reporting. The funding does not have to be through Curamericas Global and we expect that often up to 100% of funding to be directly spent in the field.

IV. Priorities: Goals, Objectives, and Indicators

GOAL: ESTABLISH SUSTAINABLE COMMUNITY DRIVEN PUBLIC HEALTH PROGRAMS ALIGNED WITH INTERNATIONALLY ACCEPTED STANDARDS AND LONG-TERM PUBLIC HEALTH GOALS

Objective 1: To empower public health professionals to focus on community health and well-being.

Indicators of success:
Maintain our current level (3) of professional staffing and expand to four fully supported professionals by Fiscal Year Ending (FYE) 2022 with the addition of one additional fully supported professional at least every other year (2024, 2026).

Provide annual professional development opportunities for each member of the professional staff and assist the professional staff in securing at least two speaking/teaching opportunities annually. (Distinguish teaching opportunities which are externally focused and are not part of program implementation from training work that is part of the technical support we provide for programs.)

Objective 2: To deliver best available technical services to our partners for the benefit of our partner communities.

Indicators of success:
Validate the results of our programs and technical services by publishing an average of at least one article in peer reviewed journals annually.

Objective 3: To foster existing and create new, mutually beneficial partnerships with partners and committed partner communities who share the organization's core values and complement its resources and expertise.

Indicators of success:
By FYE 2022, have in place agreements with existing and new partners describing five-year goals, objectives and performance goals for mutually agreeable public health and organizational capacity efforts in each of the following countries: Bolivia, Guatemala, Haiti, Kenya, and Liberia and within six months for new partners.

By FYE 2022 implement a written partnership discovery process that continually assesses opportunities for new partnerships of all types, producing quarterly and annual reports to the Board regarding priority prospects and defining decisional criteria.

Objective 4: To strengthen domestic (U.S. communities) programs.

Indicators of success:
Prioritize and deepen relationships with existing domestic partners (of which there are 23 we have worked with in the past 18 months) through formal Memorandum of Understandings (MOUs) and community-based program support.

Recruit and deploy 100 volunteers/interns/practicum students per year.

Ensure alignment with and contributions of intern and volunteer programs with achieving technical program goals and effectiveness in building long-term relationships among our partner communities through an established process.

Develop criteria and goals for an advocacy initiative by FYE2022 that advocates for global development goals related to community-based primary healthcare, with a primary emphasis on care for mothers and children in resource-constrained settings.

GOAL: STRENGTHEN AND POSITION CURAMERICAS GLOBAL TO CONTRIBUTE LONG TERM TO GLOBAL HEALTH

Objective 5: To achieve financial sustainability through a stable, diverse, and growing resource base.

Indicators of success:

Raise at least $500,000 annually from a recurring annual campaign, thereafter, increase funds raised by 15% annually. In 2020 we raised about $400,000.

Increase direct investment in marketing and fundraising to 5% of annual budget with two Full Time Equivalent ("FTE") staff member to manage these efforts by FYE 2022. In 2020, we invested about 3% with 1 FTE between the Executive Director, Church Relationship Manager and Marketing Contractors)

Maintain cash reserves greater than six months of operating overhead. In 2020, that number was $180,000.

Obtain documented planned giving bequests of at least $7,500,000 by FYE 2026. In 2021, documented planned giving was $800,000 to the Foundation.

Pilot the deployment of Software as a Service (SaaS) initiative, globally and domestically, with a feasibility study and subsidiary in place as well as 12 partner agencies actively using the software by FYE 2022.

Objective 6: To strengthen the Curamericas brand.

Indicators of success:
Add an average of at least one Board member per year, for 2022-2025, reaching and maintaining a total of at least nine Board members.

Obtain a professional review of current name/brand, marketing, development and planned giving programs with recommendations to the Board by FYE 2022 regarding brand expansion and recognition. Implement approved recommendations beginning no later than FYE 2023.

Enhance visibility locally and globally by regularly (at least twice a year)

disseminating achievements at global health conferences and in global health publications using data obtained from program and organization assessments.

V. Strategic Planning Process

In the spring of 2020, the Curamericas Global reactivated its strategic planning committee and tasked the Committee with preparing a five-year strategic plan to be presented for vote at the December 2021 Curamericas Global meeting of the Board of Directors. The Committee began work in the fourth quarter of 2020 and executed a strategic planning process that included the following:

- Recruiting additional committee members with expertise in relevant programs and strategic planning/business development,
- Conducting committee meetings to review the 2016 Strategic Plan process, and determine if any changes were needed to deadlines and end product,
- Building off the expert work done in 2016 and replicating the process,
- Identifying key stakeholders around the world to integrate partners, supporters, staff, board members, and other experts in the planning process,
- Preparing a questionnaire for the identified key stakeholders,
- Implementing the questionnaire process and assimilating the data, including conducting one-on-one interviews in Spanish and in English,
- Preparing a draft strategic plan to include specific: I. Goals (what is to be accomplished), II. Objectives and indictors for success (the metric and quantity indicative of accomplishing the objective), and III. Strategies (statement of how the objective is to be delivered),
- Vetting the draft plan via in-person meetings with Curamericas staff and Board of Directors,
- Finalizing the proposed plan,
- Presenting the plan for Board approval and hand-off to staff for annual implementation plan.

The Strategic Planning Committee is comprised of the following members:

Michelle Richter, Vice-Chair Curamericas Global Board of Directors (Committee Chair)
Jordan Jones, Curamericas Global Board of Directors (Committee Co-Chair)

Andrew Herrera, Executive Director, Curamericas Global

Tina Jones – Chair of the Curamericas Global Board of Directors

Henry Perry – Co-Founder of Curamericas Global

David Shanklin – former Executive Director of Curamericas Global

Gladys Shanklin – former staff of Curamericas Global

Reed Altman – de Facto Chair of the Curamericas Global Board of Advisors

Stacie Arechavala – Chair of the Curamericas Global Young Professionals Board

VI. Glossary

CBIO (Community-Based, Impact Oriented): *Community-Based* – because it empowers communities as full partners in improving their own health; *Impact-Oriented* – because of its unique ability to show actual reduction in child and maternal mortality. Originally known as Census-Based Impact-Oriented.

Communities: Curamericas works with different types of communities around the world. While we commonly think of communities as having a common geographical location, communities can also be defined by a common identity or interest, patterned social interactions or in their potential for unified action to meet needs.

Domestic Programs: Working with existing community leaders to build up capacity for community health programs, specifically using CBIO, Care Groups and Community Health Worker strategies.

Fiscal Year ("FY") and Fiscal Year End ("FYE"): The Curamericas Global fiscal year is from January 1 – December 31. The Fiscal Year End 12.2022 is the twelve months ending December 31, 2022. Since 1983, the fiscal year has changed twice,

most recently in 2018 from ending 30Sept to ending 31Dec. Since then and still today, our fiscal year follows the calendar year.

Mother: Women of reproductive age who may or may not have children.

Partners: Curamericas Global forms mutually beneficial relationships with NGOs, clinics, Ministries of Health, and agencies to address the health needs of the communities where we work. Partnership involves the full empowerment of our community partners to de- sign, implement, monitor, and sustain their health programs.

Public Health Professionals Vs. Health Care Professionals: Health Care Professionals refers to a licensed practitioner who is qualified to provide medical services. Public Health Professionals prevent disease and injury by promoting healthy lifestyles and behaviors. Public Health Professionals are not necessarily qualified to provide medical care directly.

Underserved: Underserved refers to populations and communities experiencing obstacles to maintaining their health and thus have poorer health outcomes. Obstacles stem from social conditions as well as a history of political, social, and financial marginalization.

INTERNAL USE ONLY APPENDIX TO CURAMERICAS GLOBAL

Curamericas Global- Strategic Planning
Data Collection Summary
September 9, 2021
Andrew Herrera with review by Hilary Moshman*, Dave Heiser, Michelle Richter*** and Alyssa Rosenfeld******

*** Volunteer**
**** Volunteer member of the Board of Advisors**
***** Board of Directors Vice Chair and Strategic Planning Committee Co-Chair**
****** Volunteer Member of the Young Professionals Board**

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Summary

We have received 19 survey responses and 15 individual interviews.

Of 5 staff and key contractors, two have completed the survey and interview and one is on this committee.
Of 8 board of directors' members, two have completed the survey and interview and four are on this committee.
We have surveys, interviews, or both from partners in Bolivia, Guatemala, Haiti Kenya, Liberia, and the US.
From our Young Professionals Board and Board of Advisors we have 7 responses, mostly from the YPB.

Still needed: Key Staff, Board of Director Written Feedback, Board of Advisors, Board of Trustees, and subject matter experts.

Below you will find details of interviews and survey responses broken up by group. Here is a summary of the responses.

- Opportunities
  - Publish
  - Be active in global organizations
  - Marketing improvements (social media, Website improvement, fundraising)
  - Highlight program achievements, individual stories of people/families that have been helped

- **What was Curamericas Worst at?**
  - Having a larger programmatic vision.
  - End of NCDHHS project
  - Marketing

- **What was it good at?**

Good social media

Model of CBO/community empowerment/deployment of CHWs and showing that it can work in the US

There were 9 questions. Here is a summary of the results.

1. **What could Curamericas do to improve its impact? (Please provide three ranked suggestions)**
    1. More funds for our programs. Mentioned Multiple times by Board and Staff
    2. Focus on quality rather than quantity Mentioned Multiple times by Board and Staff. Including ensuring that we are utilizing the last evidence-based methods and approaches
    3. Ensure more and stronger partners provide consistent and standardized administrative support, as well as consistent, regular communication
    4. Integrate Bolivia more as a strategic partner.
    5. Continue focus on CBIO. It leads to understanding/knowing and being in relationship with communities that is critical in public health
        1. Consider doing case studies on projects with best results to figure out what went right and how those strategies/approaches can be leveraged elsewhere
    6. How we can utilize technology (mobile data collection platforms, etc.)
    7. Expand internship and volunteer programs, strengthen relationships with schools/universities
2. **What is the most useful metric that we should be tracking?**
    1. Mortality (mentioned by all stakeholder groups)
        1. How does Curamericas' work directly tie to Mortality rates?
    2. Teen pregnancy
    3. Level and type of participation of partners
    4. Fundraising measures "Including Return-on-Investment" and Volunteer #s
    5. Other metrics mentioned include clinical measures, lives impacted, success of interventions and Community Satisfaction.
3. **What is happening in Global Health today that should inform our work?**
    1. Climate Change mentioned multiple times
    2. Pandemic's impact on public health
    3. Inequity, health as a human right, advocacy
    4. CBIO data could be used across larger populations (i.e., One Health)
    5. Integrating our programs across interventions (water and sanitation, HIV, girls' empowerment, mental health, tuberculosis, dengue, influenza, chronic diseases, malnutrition)
4. **Do you think the name Curamericas Global is the best name for our organization? Why or why not? If Curamericas Global were to change its name, do you think it would be worth the effort? Include thoughts on color/branding, tagline/mission statement?**
    1. Very mixed
    2. Staff
        1. It is not the best name. Changing the name is risky, it is more about our branding than the name itself. While it does not reflect our current work, changing the name could take years to recoup recognition. Changing as part of a bigger change would make sense (Does not reflect the focus of current work but may take a long time to recoup loss of recognition. Change could help reflect and assist with new direction.
        1.
    3. Board
        1. **Three of four board members were proponent of changing the name** It is worth the effort, taking the name "Cure" out is important. It does not represent our work. If we were bigger, it would be worth it, but at our scale it is not.

4. Partners
    1. Name is well known, don't change it, "out of the question" Recognition helps with funding.
    2. It "Causes America-centrism"
    3. Think about sub-branding or positing the existing brand instead of changing

5. **How could we expand the brand awareness of Curamericas?**
    1. Demonstrate impact through Conference presentations and publications
    2. Website improvement
    3. Campaigns to clarify who we are and what we do (clearer branding overall in terms of clarifying mission, values, etc., including on website, social media, in communications with potential partners etc. Ensure consistency in branding/messaging)
    4. Generally, we are doing ok, it is slow and steady work and hard if different people are doing this, having dedicated effort would be useful.
    5. Need more effort of this, events to celebrate with partners. Need good marketing to link results to our name. (More professional support for marketing/fundraising)
    6. In an institution, the director, staff, and board should be responsible for expanding the organization's brand. The board of directors must become transmitters of the vision, mission, and values of Curamericas in a sustained manner to achieve more significant resources.

6. **From your perspective, what is the ideal breakdown between US and international programs that Curamericas should support? Why?**
    1. 60 to 70% international
    2. US programs are good but can distract from international programs. US supporters can learn about the work and be interested in Curamericas. There is still need in low- and middle-income countries where Curamericas Global can have a significant impact and work with indigenous communities responding to inequalities.
    3. CG Staff should have the best sense of what it should be given opportunities and needs. We should resist modifying our models to meet limited domestic programming opportunities. We need to be careful and judicious about where and with whom we work. Ensure that domestic aspect still aligns with mission (i.e.- maternal health, supporting marginalized communities)
    4. We are not specialists in domestic health. Did we get new donors because of the domestic health work? One staff member would vote zero domestic. One key staff said domestic work is vital.

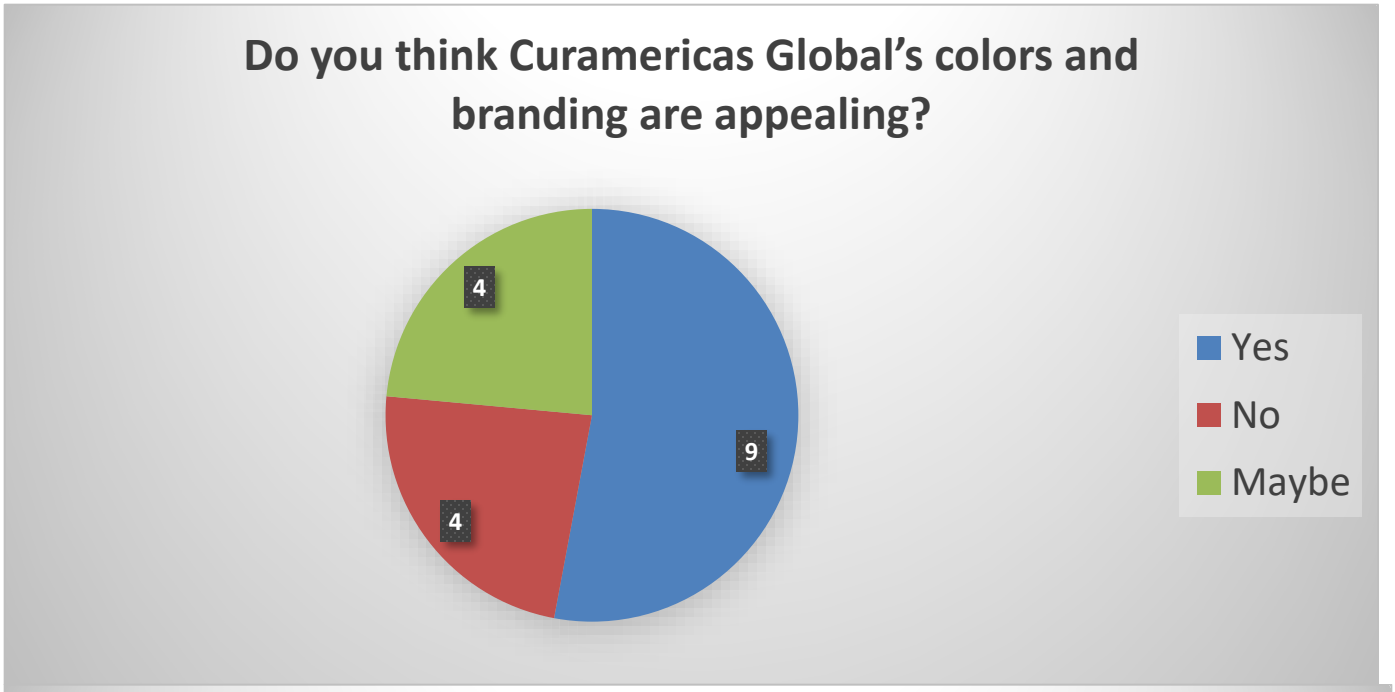
7. **In which communities or populations should we work?**
    1. Fairly universal agreement on where to go.
    2. Where we are already working, marginalized populations who suffer inequities.
    3. Communities in need is critical.
    4. Where can we make an impact?
    5. Where we have strong partners
    6. Peri-urban areas where migration is causing overpopulation and public health problems, especially related to sanitation

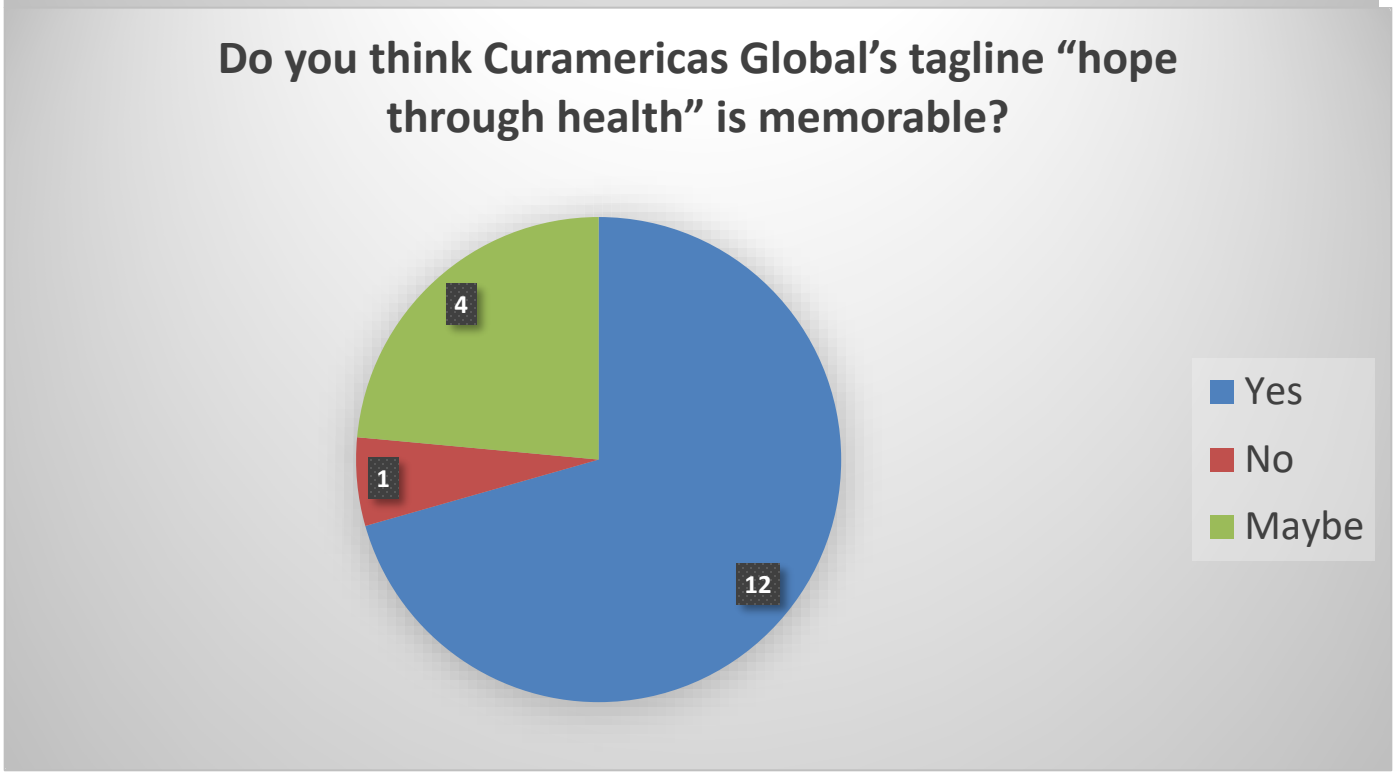
8. **How can we further enhance CG's credibility and trust among its partners?**
    1. This is very important. MOUs/Contracts are where we start, joint long-term plans create more trust. CG is already asking for feedback from government and communities themselves.
    2. Continuity of projects ensures impact, at least 3-year commitments
    3. We can work more closely with Bolivia partners
    4. Must select partners carefully
    5. Partnership symposium is a good way to communicate with partners.
    6. More funding with more PH Professionals towards shared goals.

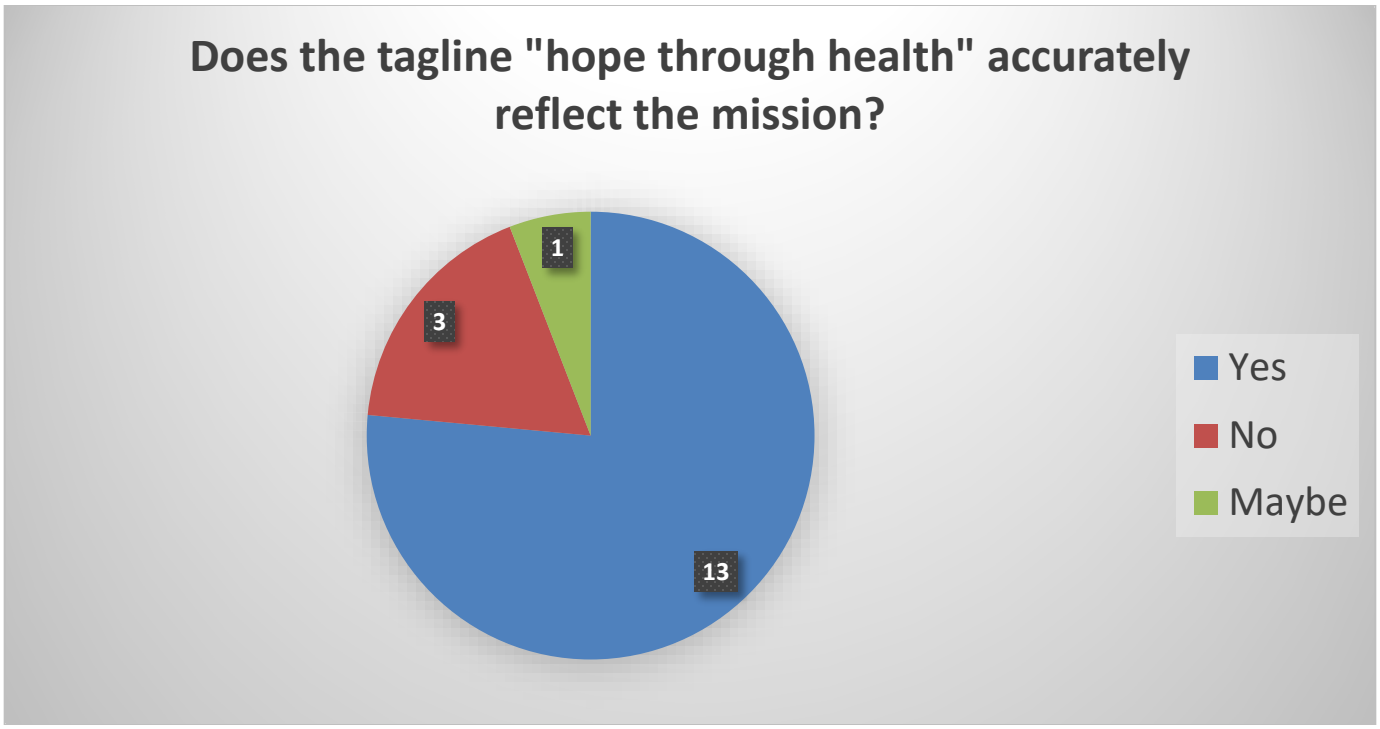
7. Do fewer things better. Keep our promises on existing commitments,
8. Leadership on both sides giving the necessary time to follow-up and make sure plans are on course.
9. A lot of emphasis on communication- more face-to-face time with and among partners; get stakeholders' input in planning and throughout projects; scheduled meetings at regular intervals; communication after project finished to maintain partnership; ensure transparency- how we spend money, etc. (I guess this fall into the next section)

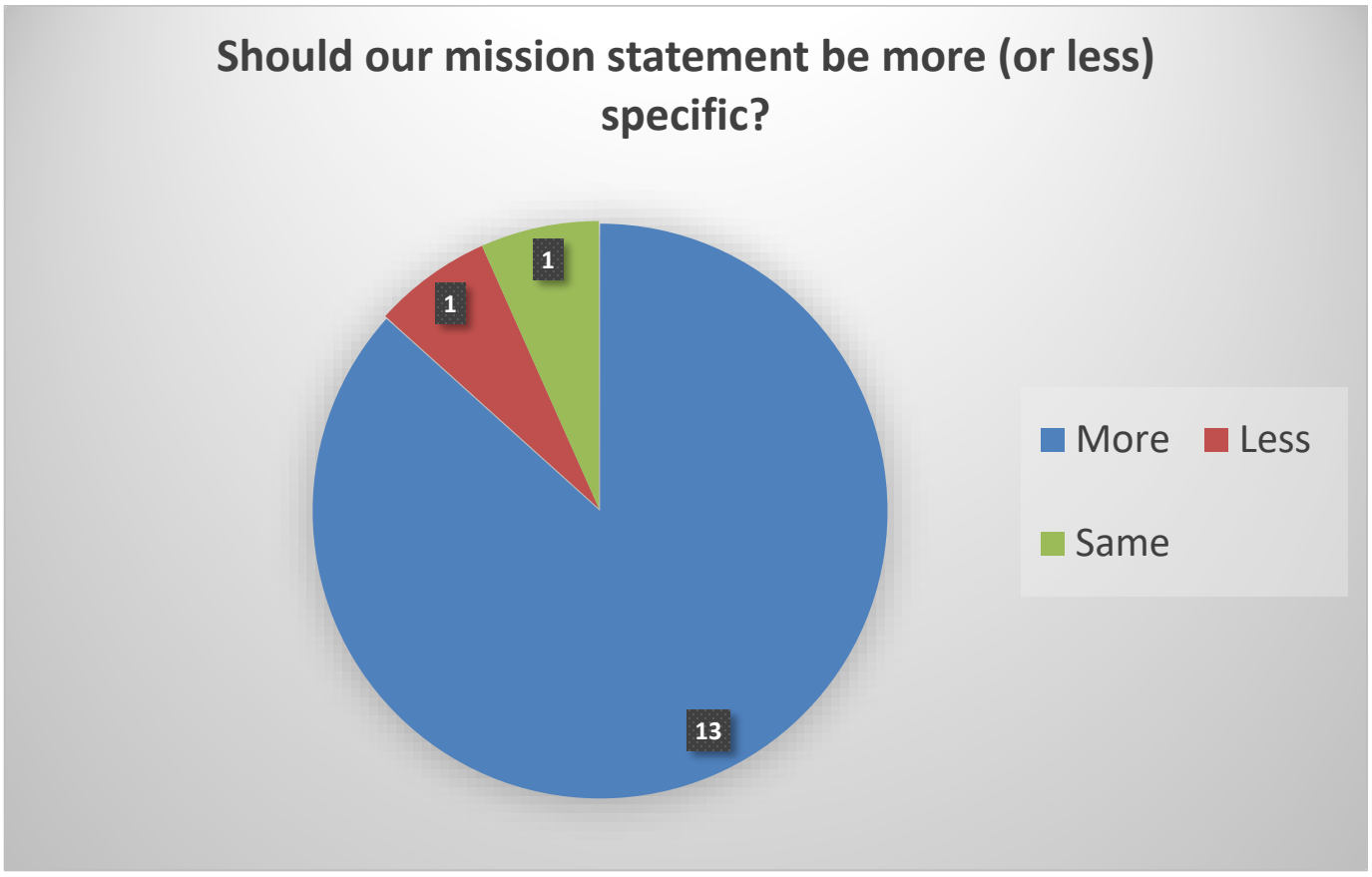
9. How can we improve communications?

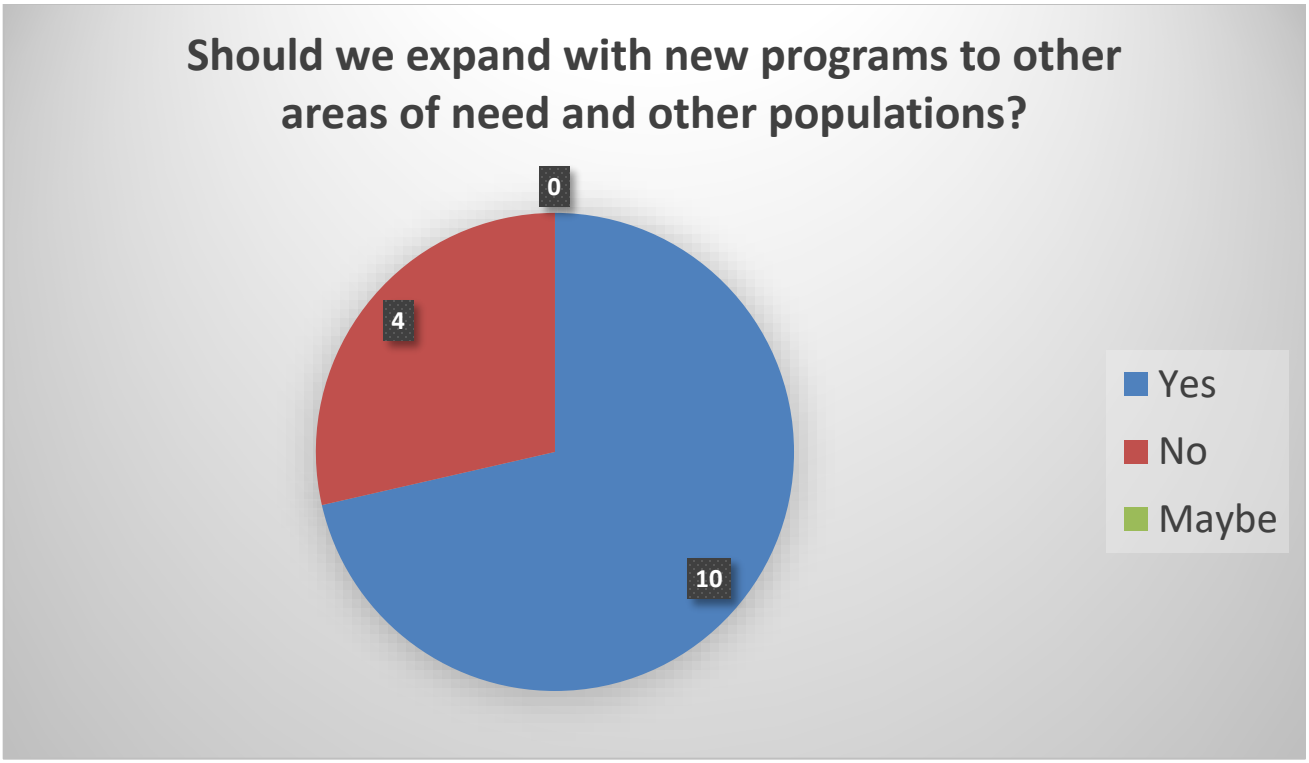
Questionnaires

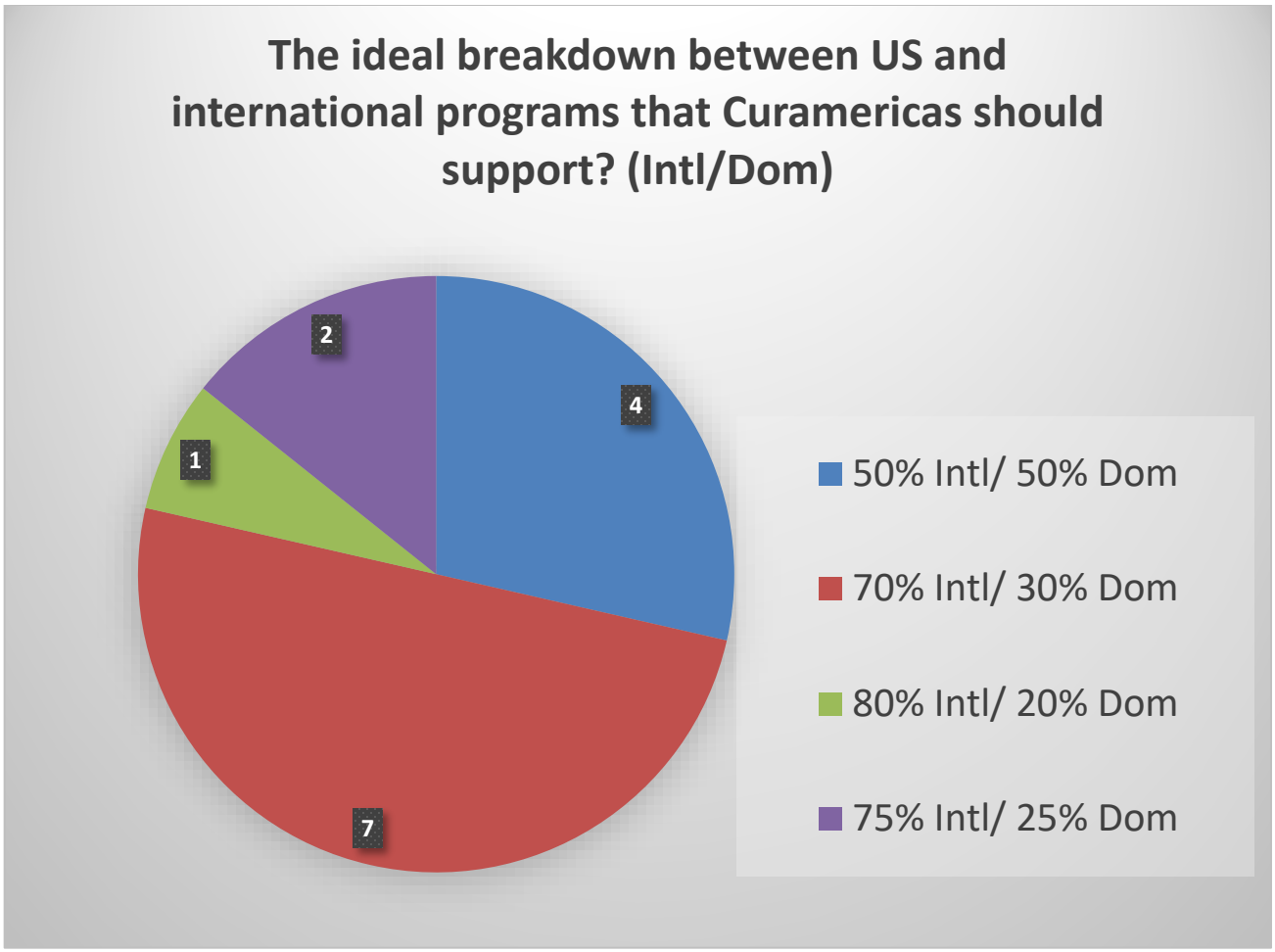





Does the tagline "hope through health" accurately reflect the mission?
1
3
13
Yes
No
Maybe


Should our mission statement be more (or less) specific?
1
1
13
More
Less
Same


Should we expand with new programs to other areas of need and other populations?
0
4
10
Yes
No
Maybe


The ideal breakdown between US and international programs that Curamericas should support? (Intl/Dom)
4
1
2
7
50% Intl/ 50% Dom
70% Intl/ 30% Dom
80% Intl/ 20% Dom
75% Intl/ 25% Dom

Appendix B – Yearly Financial Data Spreadsheet

LINK TO FULL DOCUMENT HERE ON OUR GOOGLE DRIVE

FYE 9/30	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	12.2019	2020
Income															
Contributions	$ 968,180	$ 826,533	$ 642,455	$ 586,128	$ 796,463	$ 781,362	$1,789,955	$1,043,125	$ 804,864	$ 857,775	$1,045,981	$ 1,070,658	$ 1,683,785	$1,604,495	$1,375,640
Board	$ 325,785	$ 301,800	$ 244,000	$ 162,680	$ 249,113	$ 142,950	$ 300,400	$ 395,741	$ 110,039	$ 150,010	$ 188,147				
Government Grants	$ 520,770	$ 555,913	$ -	$ 522,828	$1,181,869	$ 630,065		$ 888,725	$ 598,131	$ 525,379		$ 3,062			
In-kind	$ 322,359	$ 195,340	$ 29,532	$ 28,623	$ 182,200	$ 229,540	$ 189,245	$ 121,692	$ 116,539	$ 132,039	$ 288,405	$ 203,377	$ 292,702	$ 296,143	$ 130,280
Other Revenue	$ 1,545	$ 2,028	$ (3,123)	$ 1,068	$ 13,490	$ 5,345	$ 7,682	$ 6,880	$ 10,537	$ 15,513	$ 43,385	$ 58,190	$ 30,675	$ 30,797	$ 37,276
Investment Income												$ 3,966	$ 8,191	$ 18,622	$ 22,336
Program Service															$5,546,866
Total	**$1,490,495**	**$1,384,474**	**$ 639,332**	**$1,110,024**	**$1,991,822**	**$1,416,772**	**$1,797,637**	**$1,938,730**	**$1,413,532**	**$1,398,667**	**$1,377,771**	**$ 1,135,876**	**$ 1,722,651**	**$ 1,653,914**	**$ 6,982,118**
Expesnes															
Programs	$1,171,110	$1,121,496	$ 571,185	$ 897,945	$1,630,730	$1,188,033	$1,291,911	$1,495,877	$1,149,727	$1,131,147	$1,168,520	$1,004,644	$1,236,671	$1,316,107	$5,983,359
Salaries	$ 190,642							$ 481,692	$ 356,983	$ 396,987					
Management	$ 214,600	$ 192,927	$ 196,051	$ 193,264	$ 192,384	$ 214,343	$ 410,985	$ 337,111	$ 202,550	$ 203,550	$ 227,200	$ 70,879	$ 106,808	$ 82,684	$ 421,111
Salaries	$ 54,469							$ 128,458	$ 47,688	$ 77,542					
Fundraising	$ 34,378	$ 35,942	$ 39,882	$ 35,585	$ 37,386	$ 44,964	$ 24,663	$ 24,257	$ 14,916	$ 14,890	$ 17,283	$ 62,539	$ 39,370	$ 45,673	$ 58,884
Salaries	$ 27,235							$ 16,016	$ 6,088	$ 9,899					
Total	**$1,420,088**	**$1,350,365**	**$ 807,118**	**$1,126,794**	**$1,860,500**	**$1,447,340**	**$1,727,559**	**$1,857,245**	**$1,367,193**	**$1,349,587**	**$1,413,003**	**$ 1,138,062**	**$ 1,382,849**	**$ 1,444,464**	**$ 6,463,354**
Excess or Defecit for the Year	$ 70,407	$ 34,109	$(167,786)	$ (16,770)	$ 131,322	$ (30,568)	$ 70,078	$ 81,485	$ 46,339	$ 49,080	$ (35,232)	$ (2,186)	$ 339,802	$ 209,450	$ 518,764
Net Assets at end of year	$ 42,387	$ 76,496	$ (91,290)	$ (108,060)	$ 23,262	$ (7,306)	$ 62,772	$ 149,799	$ 196,138	$ 245,218	$ 214,898	$ 218,496	$ 559,177	$1,001,091	$1,581,524
Debt other than AP or Accrued Expenses according to Balance Sheet	$ 65,250	$ 10,000	$153,809	$ 207,448	$ 48,394	$ 44,769	$ 18,380	$ -	$ -	$ -	$ 500,732	$ 487,562	$ 474,126	$ 456,949	$ 442,896
Endowment (permanently Restricted)	25457	27957	27957	27957	27957	27957	27957	$ 27,957	$ 27,957	$ 27,957	$ 134,016	$ 134,016	$ 524,196	$ 930,678	$ -
Executive Director Compensation	$ 64,400	$ 66,500	$ 66,500	$ 70,000	$ 70,000	$ 60,000	$ 90,000	$ 90,000	$ 62,500	$ 70,000	$ 70,000	$ 70,000	$ 70,000	$ 90,000	$ 152,104

Appendix C – Curamericas Global Volunteer Program 2001 - 2020

APPENDIX II - VOLUNTEER PROGRAM HISTORY

	International							Domestic Volunteers		
	Teams	# Vols on tean	Individuals	Hours	FTE	Value of time	In-kind Value	# Vols	Hours	Value of Time
2001		149			0.00					
2007		53			0.00					
2008		50			0.00					
2009		50			0.00					
2010	5	51	3	5164	2.48	$ 93,468.40		12	2315.5	$ 41,643.86
2011	6	51	10	6972	3.35	$ 123,217.84		20	2480.5	$ 46,388.76
2012	5	53	5	4574	2.20	$ 99,433.54		24	3762.75	$ 80,811.90
2013	1	11	7	2506	1.20	$ 54,605.74		10	1659.5	$ 36,160.51
2014	3	35	1	3646	1.75	$ 59,441.80	$ 18,133.00	14	878.5	$ 19,810.18
2015	3	18	5	2720.25	1.31	$ 61,341.64	$ 9,805.83	27	2605.75	$ 58,697.41
2016	5	63	1	4270	2.05	$100,601.20	$ 7,120.00	28	2665	$ 60,325.38
2017	6	39	1	4344	2.09	0	$24,909.17	29	2655.50	$ 62,563.58
2018	4	43	3	6759	3.25	$ 163,162.26	$11,906.42	49	4299.50	$ 103,789.93
2019	4	58	3	6879	3.31	166403.01		81	5363.37	$ 124,680.50
2020	0	No International Volunteers - COVID19						242	5385.7	$ 130,280.08
2021	0									
TOTAL	42	724	39	47834.25	23.00	$ 921,675.43	$ 71,874.42	536	34071.6	$ 765,152.08

Appendix D – The Curamericas Global Community

The purpose of this Appendix is to show the complex, interrelated individuals and groups who form the Curamericas Global Community.

The Curamericas Global Community.

CGI is founded in partnership and development of forgotten communities around the world. One community we have not yet identified and discussed is our own. Who is part of the Curamericas Community?

A common vocabulary challenge for us is the use of the word "Partner". Our community is the aggregate of our partners.

LOCAL: Community members (i.e., partners) include Board of Directors, staff, contractors, domestic and international volunteers, individual donors including faith-based groups and small-family foundations;

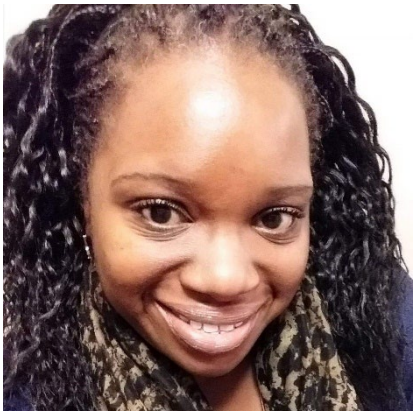
NATIONAL: individuals, and churches around the US, Professional Associations such as the CORE GROUP and the American Public Health Association, and institutional donors (e. g. USAID, CDC, Ronald McDonald House Chari- ties, Rotary International, the United Methodist Church);

INTERNATIONAL: Partners in the Field include implementing partners such as Andean Rural Health Care, Curamericas Guatemala, the Liberian Annual Conference of the United Methodist Church, Haiti Outreach Ministries, and the Ministry of Health in each country we work, other international development NGOs (FHI360, IntraHealth,) universities such as Johns Hopkins University Bloomberg School of Public Health, The University of North Carolina, and others.


Local
•Board of Directors
•Staff
•Domestic Partners
•Local Champions
•Universities
•Volunteers
CGI Community
International
•CGI Heroes
•Implementing Partners
•Multi-lateral Donors
National
•Churches and individuals around the country
•Foundations
•Professional Groups

Andrew Herrera, MPH, MBA - Before joining Curamericas Global in 2009, Andrew served with the City of Raleigh Parks and Recreation for four summers and spent a year studying in Ecuador. In 2004 Andrew was a State Department Ambassador to Jiaonan, China through the American Field Service. He has a B.A. in Hispanic Studies and Religious Studies from East Carolina University and an MPH from the University of North Carolina Gillings School of Global Public Health in Public Health Leadership and a concentration in Field Epidemiology. He finished his MBA at the University of Chicago Booth School of Business. As Executive Director of Curamericas Global since December 2013, Andrew has been responsible for leading strategic initiatives, development of the Board of Directors and the day-to-day operations of an international Nongovernmental Organization.

Barbara Muffoletto, MPH - Barbara joined the Curamericas Global team in December 2013. Barbara holds an MPH in Health Behavior from UNC Chapel Hill and a BA in both Political Science and Spanish from UNC Asheville. Before coming to Curamericas Global, Barbara worked with AmeriCorps VISTA, triangle-based nonprofit organizations a nonprofit organization in El Salvador focused on improving critical thinking and decision-making abilities through literacy. Barbara has also completed program management, capacity-building, and research with global health projects in Guatemala, Haiti, Kenya, and Sierra Leone, and with Latinx populations in the US.



Catrina Lloyd, MPA – Before joining Curamericas Global in March of 2021, Catrina worked in a variety of positions across triangle-based nonprofits with a focus on Human Resources, Operations, and Compliance. She also spearheaded a community health program in Durham. Before working in the nonprofit sector, Catrina worked in the private sector as a Certified Financial Counselor. Catrina's passion for excellence and supporting her team aligns well with the Curamericas Global values. In her spare time, she volunteers as an English as a Second Language Instructor. She has travelled internationally and served as a leader on international volunteer experiences, including supporting Spanish interpretation for volunteers.

Born in Ghana, Donna is the youngest child in a family of 6 children. She completed her primary and secondary education in Ghana, and her bachelor's degree at Claflin University, a United Methodist affiliated college in South Carolina. In 2011, Donna received her Juris Doctor from Duke University. Donna remains a dedicated advocate for human rights worldwide.

Ira Stollak, MPH, MA – Senior Technical Advisor. Ira came to international public health work via a life-transforming two years as a middle-aged Peace Corps Volunteer in Guatemala and Belize, where he designed and implemented projects to combat the spread of HIV/AIDS. Prior to this, he had parallel careers directing educational programs for at-risk youth and teaching college English and Literature. He returned to grad school at the University of Washington School of Public Health and Community Medicine, where he earned an MPH in International Health; his thesis work, funded by the Gates Foundation, examined the HIV dissemination risk of Mexican truckers in the Yuca- tan. He then worked for a year in Alaska for the Alaska Center for Rural Health, doing research on inequities in health care provision in rural Alaska, and then joined the team at Curamericas Global, initiating two new projects in Liberia and Haiti, before becoming Program Manager for Latin America, supporting CGI's Guatemala project in partnership with Curamericas Guatemala.

Dr. Henry Perry, MD, PhD, MPH – Founder and Director Emeritus of Curamericas Global. Henry currently serves as Senior Associate in the Health Systems Program of the Department of International Health at the Johns Hopkins Bloomberg School of Public Health in Balti- more, MD. He has a formal background in medicine including general surgery, public health, sociology, and anthropology. Henry has lived and worked in Bangladesh and Haiti in maternal and child health issues, primary care, hospital care, and community development.

Alma Dominguez - Alma is the head nurse for the Casa Materna in Calhuitz and is a founding member of Curamericas Guatemala.

Dr. Mario Valdéz – MD, PhD, MPH – Founder of Curamericas Guatemala. Dr. Valdéz was trained as an OBGYN and first worked in the Western Highlands as a resident. Twenty years later, Dr. Valdéz continues to drive systemic change among the most vulnerable populations. A world-class public health professional in the highlands of Guatemala, Dr. Valdéz has worked on various community-based efforts throughout his entire career.

Ramiro Llanque - Ramiro graduated from the faculty of medicine at the Universidad de San Francisco Xavier de Chuquisaca, Sucre in 1993. He received his Master's in Public Health from the James P. Grant School of Public Health in Bangladesh in 2007 and studied Project Monitoring and Evaluation at the University of North Carolina. After working for several years in the Ministry of Health he started working for Andean Rural Health Care (Consejo de Salud Rural Andino (CSRA)) in 1997. At first, he was responsible for heading project implementation in the field and then went on to become a manager in the main office in 2002. He currently manages funding from external sources by designing projects and doing consultancy work. He specializes in designing, monitoring, and evaluating projects and programs, infant nutrition, systematization, and social research.

Nat Robison served as Executive Director of Curamericas Global's partner organization in Bolivia (*Consejo de Salud Rural Andino)* for 27 years until his retirement from that position in 2013. He has extensive knowledge about and

experience with community health programming and community development more broadly. In addition to his work with CSRA, Nat has a long experience working with many other development organizations in Bolivia. He currently serves on the boards of directors of several Bolivian NGOs, including CRECER, a successful micro-credit lending institution; PROCOSI, a network of 26 nonprofit organizations providing integrated health services in Bolivia; and SEMTA, which provides technical and financial assistance to families and communities in in- come generation and social development. Nat was born in Bolivia and is the son of life-long Methodist missionaries who served there.

Ann Kerubo Bitengo, MPH is the Co-Director of the Kisii Konya Oroiboro Project (KIKOP). Ann is a result-driven professional with aspiring progressive career. She is able to relate well with people at all levels with the flexibility of working well as part of a team or individually. She is able to work in a fast paced, growth orientated work environment and possessing a proven ability to ensure that and communication is understood and implemented effectively. She has training in HIV Counseling, Reproductive Health and Palliative Care and is responsible for training, supervision of the field officers as well as supporting financial management of the project.

Kevin Kayando, MPH - is the Co-Director of the Kisii Konya Oroiboro Project (KIKOP). Kevin is a leading public health professional and researcher applying the theoretical and scientific knowledge, work experience and skills, for better service delivery with humanitarian organization in tough and challenging environments. He works to protect human health and create environmental sustainability among the world's most vulnerable and poorest. Kevin has training in GIS mapping and analysis, report writing, statistical packages including SPSS and in conflict resolution and environmental health.

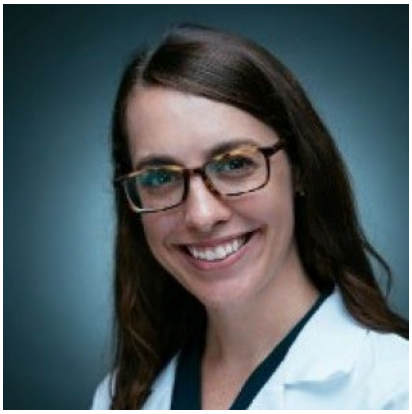
Tina Jones – Immediate Past Chair of the Board of Directors. Tina received a B.A. degree in History from Fairmont State College and a J.D. degree from West Virginia University College of Law. She has over seventeen years of experience in complex health care litigation working with Womble Carlyle Sandridge & Rice, LLP. She joined the board to combine her experience as a healthcare attorney with her interest in the human rights of all women and girls. She believes that educating and training community members and collecting long-term data empowers the girls and women of tomorrow.

Rob Fields – Former Chair of the Board of Directors. Rob received a B.A. degree in Economics from Davidson College and a J.D. degree from Wake Forest University. He has over thirty years of experience representing businesses in litigation, dispute resolution and other matters. Rob's practice experience spans every region of the United States. Rob's commitment to Curamericas grew out of the experiences of his daughters with Curamericas in Bolivia.

Jordan Jones is a development advisor for DFI where he supports the mission through providing his real estate expertise through consulting and teaching. He has focused his career on reactivating communities, particularly downtowns, through transformative real estate development projects. He has specialized in creative financing (including historic and new markets tax credits) and public private partnerships to deliver curated developments, particularly in lower wealth communities. With DFI, Jones has advised on more than 20 projects representing more than $600m of development potential.

Jones is also the principal of JA Jones Ventures, his development company that has active projects in North Carolina, South Carolina, and Virginia. Through JA Jones Ventures, Jones is one of the lead partners behind $65m of private development in his hometown of Fayetteville, NC. These Fayetteville projects include the historic renovation of the Prince Charles ($17m), acquisition/re-positioning of the Festival Park Plaza office building ($6m) as well as new construction of a public parking garage ($17m), upscale select service hotel ($22m), and Class A office building ($20m). These projects are part of the $110m public private partnership with the City of Fayetteville that also includes the delivery of a minor league baseball stadium. JA Jones Ventures has an additional $55m of projects in its pipeline.

Jones received a dual master's degree from UNC in public administration and city & regional planning. He completed his undergraduate studies from Wake Forest University in business and enterprise management.



Lauren Eberly earned her BS in Biology and BA in Spanish from the University of North Carolina at Chapel Hill in 2010, and her MD from University of New Mexico in 2015. She was an intern with Curamericas Global during her undergraduate studies. After college, her work with Curamericas Global brought her to the northwest highlands of Guatemala where she spent several months working to improve health capacity at the Casa Materna. She returned after her first year of medical school to help with the implementation of a USAID Child Survival and Heath Grant. During medical school, she volunteered at Clinica One Hope, a community-run health center serving primarily undocumented immigrants. Here, she was involved in a project to integrate community health workers into the clinic and to diminish language and cultural barriers to care. She is currently at Brigham and Women's Hospital in Boston completing a combined Internal Medicine and Global Health Equity residency. As a Global Health Equity resident, she has spent much of her time in rural Rwanda, engaging local partners to find innovative strategies to decentralize and integrate care for non-communicable diseases.

Rev. Dr. Amy McCullough has served as the Lead Pastor at Grace United Methodist Church since July 2011. Ordained in the Baltimore-Washington Conference in 2000, she has served previously at Glenelg United Methodist Church and as the Associate Minister at Metropolitan Memorial (now National) United Methodist Church in Washington, DC. She is a graduate of Wellesley College (B.A.) and Duke Divinity School (M.Div.). She holds a Ph.D. in Homiletics and Liturgics from Vanderbilt University and is the author of Her Preaching Body: Conversations in Identity, Agency, and Embodiment in Contemporary Female Preachers (2018). She is an avid reader and runner. Along with

her husband, Chris McCullough, she is the proud parent of two children.

Michelle received a BS in Chemical Engineering from NC State in 2011. She works in project management for labs, CROs and clinical trial implementing institutions. Michelle has served as the Chair of the Young Women in Bio organization. committed to promoting careers, leadership, and entrepreneurship of women in the life sciences. She has traveled with Curamericas Global to Guatemala and Bolivia to see firsthand our work. She has also supported the Strategic Planning process. As vice-chair, she will now lead our next Strategic Planning process. Michelle has been an independent, voting member of the Board since February 2017.

Board of Advisors – Founded in 2016, Curamericas Global has a Board of Advisors that works on special projects and meets quarterly. By recruiting subject matter experts with shared vision and values, Curamericas Global has access to committed volunteers to move forward special projects. For example, Advisors fundraise for Curamericas Global, host international guests, connect Curamericas Global to their professional network, support in office tasks, deliver PPE locally to partners, and generally use their skills and interests to support Curamericas Global. Today there are 19 active members of the Board of Advisors.

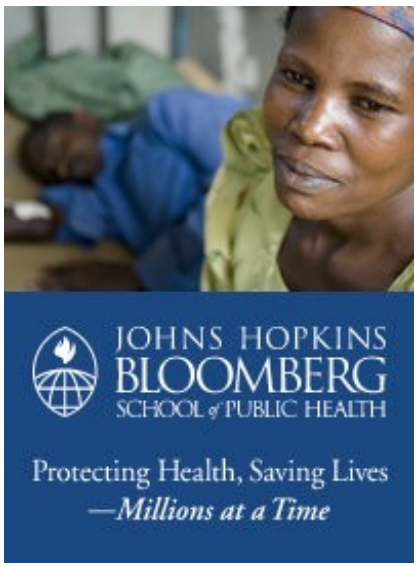
Young Professionals Board – Founded in 2020, right before the pandemic, the YPB quickly pivoted to all virtual activities and have found great success. The Young Professionals Board members are located around the country and support outreach by telling the Curamericas Global story and raising funds. Their operations committee supports international projects through data cleaning. With eight active members in 2021, their goal is to support the Solar Panel Installation in Kenya through their fundraising efforts.

Since 1983, Curamericas Global has partnered with Andean Rural Health Care (*Consejo de Salud Rural Andino*) to provide life-saving community-health to the most underserved in Bolivia. First working on the Altiplano with the Aymara people, ARHC work expanded to the lowlands into Montero. Today, ARHC has operated for over 20 years as a fully independent Bolivian NGO serving Bolivian People.

Curamericas Guatemala is a non-governmental organization and not-for-profit, dedicated to the Integrated Community Development through action in the form of projects and programs in Health, Education, Production, Employment, Income, Equity, and the Environment. Curamericas Global has been in partnership with Curamericas Guatemala since 1999 and serve forgotten communities across Guatemala. Curamericas Guatemala also partners with the Guatemala Ministry of Health (MSPAS) and the University of San Carlos.

The MASTAS Project of Rapatriye is a maternal and child health project paid for by Haiti Outreach Ministries and where Curamericas Global is providing technical assistance for implementation of CBIO and other core methodologies to reduce maternal and child mortality.

The Ministry of Health of Kisii County is a partner of Curamericas Global with three Community Birthing Centers established since 2016. The KIKOP Project is now an independent partner of the MOH and provides community-based primary care for mothers and children in the highlands of Western Kenya.



As the largest school of public health in the world and ranked number 1 by the U.S. News and World Report since 1994, the Johns Hopkins Bloomberg School of Public Health has partnered with Curamericas Global on research projects and through practicum experiences for graduate students.

coregroup

Advancing community health worldwide.

Curamericas Global is a founding member of the CORE Group, which emerged organically, in 1997, when a group of health professionals from non-governmental development organizations saw the value of sharing knowledge and ideas about how to best help children survive.

CORE Group works to fulfill their vision by working with its 70+ Member and Associate organizations and a network of partners to generate collaborative action and learning to improve and expand community-focused public health practices for underserved populations around the world. We give particular emphasis to women of reproductive age and children under five because they are the most vulnerable to death and illness from poverty and disease.

The Triangle Global Health Consortium is a nonprofit member organization representing institutions and individuals from the pharmaceutical and biotechnology industry, the international health development NGO community, and academia.

The Consortium includes 18 institutional members and numerous individual members, representing some of the best and brightest in the field of global health. Our members include major pharmaceutical companies including GlaxoSmithKline, leading global health development organizations including founding members RTI International, FHI360 and IntraHealth, and major academic institutions, including Duke University, NC State University, and UNC Chapel Hill.

In partnership since 1983, Curamericas Global and the United Methodist women have supported initiatives surrounding clean water, family planning and maternal and child health in Bolivia, Guatemala, Liberia, and Sierra Leone.

In partnership since 1983, Curamericas Global and the General Board of Global Ministries of the United Methodist Church have worked together to build partnerships and implement programs around the world. Recent partnerships have been to develop the Community-Based Primary Health Care Nehnwaa project at Ganta United Methodist Hospital and the Kuiemi program in Bo District, Sierra Leone.

Liberia

LAC and Curamericas Global have partnered since 2008 to provide Community-Based Primary Healthcare and Health System Strengthening