

PIH Change Narrative: 1984- 2010

The PIH Change Narrative, written by Ophelia Dhal in 2010, talks about where we have come as an organization and where we are going. It addresses the importance each of you will play as current students of, and professionals working towards, global health equity. You will hear common PIH terms—MDRTB, Multidrug-resistant tuberculosis, and O for the P, the preferential option for the poor. As you read, think about the importance of your role this summer—supporting our Monitoring, Evaluation, and Quality team, fundraising with the Development team, assisting with research or helping to build the movement for the right to health.

Cange, 1984

In 1984, a young woman collapsed on a soccer field in Cange, a squatter settlement in Haiti's Central Plateau. She eventually lapsed into a coma, and was diagnosed with cerebral malaria. There followed a struggle over who would care for her—the newly-introduced practitioners of biomedicine, or the traditional practitioners who for two centuries were the only people offering care to the rural poor—and, for us, the first of many complicated and challenging questions about how best to serve the poor. The woman—and her unborn child—both survived, and their story contains PIH's.

Our partnership began in Cange. We were very young, we had very few resources, and we were surrounded by great need. We were fortunate to meet, almost immediately, Pere and Mme Lafontant (Manmito), who became our first teachers and our first partners in health—and in education, and in the other socioeconomic needs we saw. We learned quickly that community health workers were central to addressing all of these needs, and that we would need their help to reach the patients we sought to serve. As we identified additional needs and funding, we added services and programs—many of them successful, like Sante Fanm, building houses, bringing drinking water to Cange, creating schools in the communities we served—and others less so. An early bakery project funded by Tom White, about which we were particularly enthused, consumed huge volumes of firewood—not a great way to increase food security in a country already facing rampant deforestation. A similarly well-intentioned but poorly-conceived scheme to raise pigs and distribute them to poor families failed because we didn't do enough homework. But both ventures taught us important things about acting quickly to address the needs of the community, and about delivering visible results as a way of building trust and momentum. They also encouraged our native and complementary appetite for taking risks, which has largely served us in good stead as we have navigated PIH's growth and the shifting political, economic and scientific landscapes around us. We have been extremely fortunate to always have supporters, starting with Tom, who encouraged us to take these risks and accepted that some failures would come alongside.

As Zanmi Lasante grew, both upwards in Cange and outwards to other communities in Haiti's Central Plateau, we did a few important things right: we maintained our focus on individual patients, even as we pursued new strategies to strengthen systems; we continued to rely on the strategy of accompaniment, mainly by the community health workers who served the ill and vulnerable in their own communities; we sought to address the full spectrum of our patients' needs. One of Paul's first research projects in Haiti showed that TB patients who were given money for transport to the clinic and to buy milk had much better outcomes than those given the same treatment but not the financial support. This confirmed for us that providing healthcare in settings of entrenched poverty would require more than a medical clinic, and

clinicians to staff it; we would need to find ways to accompany patients through their illnesses and beyond. This crucial lesson of accompaniment has informed almost all of the work we've done since, and guided our expansion into new places and new areas of work: to the poorest areas of Tomsk oblast and inner-city Boston, for example, to accompany TB and HIV patients falling through the cracks of the health care system, or to the rugged highlands of Lesotho, where we reach isolated rural communities that have rarely seen a doctor.

Peru, 1994

So when we were invited to Peru a few years later, we already had some experience with community-based projects. However, the crisis presented by MDRTB included a new set of strategic and logistical challenges. We knew that we could successfully treat MDRTB in poor communities, and we believed that we could influence the international community toward the same conclusion. But we needed cash to buy the drugs to treat a first cohort of patients. We turned again to Tom White, who, like us, trusted that if we could prove that patients could be cured, then eventually the cost of the necessary drugs could be lowered. We relied again on the system of paying community health workers to deliver the difficult and painful treatment.

After we had shown that a significant portion of the patients we treated for MDRTB were cured, we secured a very large grant—\$44 million from the Gates Foundation, one of the biggest early grants for global health—as part of a partnership that included Harvard Medical School, WHO, the Stop TB Initiative and the CDC. It was this consortium, working closely with the Peruvian ministry of health, which ultimately brought MDRTB under control in Lima's slums. Changes in national and international treatment policy followed, as did massive reductions in drug prices. The accompaniment we had learned in Haiti was at the heart of this successful endeavor: accompaniment of patients, of ministries, of pharmaceutical companies, and of one another. From this experience, which affirmed for us the possibility and necessity of creating change with the largest levers of international policy-making and financing, we have continued to expand our work in that sphere, working closely with colleagues in standards-setting bodies (and joining those bodies ourselves); using Paul's MacArthur award to found the IHSJ; writing about, talking about and teaching what we do and how we do it.

Rwanda, 2005

After twenty years of expanding our work within Haiti and to Peru, the U.S., Mexico, Guatemala, and Russia, moving into Africa presented another set of challenges and difficult decisions. At the request of the Government of Rwanda, in partnership with CHAI, and with the blessing of our Board, we launched Inshuti Mu Buzima in 2005. It was an opportunity to apply everything we'd learned in twenty years' work in Haiti to a completely new setting: delivering care, rebuilding infrastructure, and training local people, all within the ministry of health system. This "public-sector strategy" of restoring or creating a sense of basic social and economic rights for the poor, which we had first proposed in Haiti after the democratic elections there in 1990, has been our M.O. in all our work since. Now that the understanding of access to services—health care, water, education, housing, jobs—as a human right is broadening, we must turn our attention to improving the quality of the services we offer. Increasing our focus on research is one way to do this, and another is to improve the quality of infrastructure. In Rwanda, five years after we got to work in what was left of Rwinkwavu District Hospital, we will shortly inaugurate, in Butaro, what must be central Africa's finest teaching hospital. In the intervening years, we have expanded into three districts in Rwanda,

forging, there, our closest partnership yet with a government, and seeing our work reflected in national policy changes. We also launched programs in Lesotho and Malawi, leaning heavily, as we did in Rwanda, on ZL staff who traveled from Haiti to Africa to help get the programs off the ground and guide their growth.

Taking on a new continent of concern, new communities, millions more individual patients—and, significantly, new government partners—required a major expansion of our base of financial and logistical support in the U.S. Our work in Rwanda, Lesotho and Malawi has stretched us in every sense of the word, and taught us lessons about, among other things, strengthening the public sector, working in true partnership with governments, and that sometimes it snows in sub-Saharan Africa. We have learned to work with pilots—who get our doctors up Lesotho’s mountains, and our patients down them—and the optimal time to plant crops in Malawi, and how a genocide can inscribe itself on peoples’ bodies and minds.

Boston, 2010

Now, nearly three decades after we first met in Haiti, we have faced many difficult decisions together, and shared these burdens with many of you. Some of these have been small and poignant—involving, say, an individual patient. Some of these are major in one country and less so in another. But some difficult decisions involve, or should involve, almost all of us engaged in the joint enterprise of trying to break the cycle of poverty and disease. After decades of rapid growth, we were, even before the earthquake, seeking to chart a course for our collective future. This includes both considering our broad strategy for fulfilling our mission and the internal work of looking hard at the ways PIH’s organizational and management structure serves that mission, and the ways that it doesn’t.

Our work now spans a dozen countries, involves more than twenty institutions, and engages over 11,000 people in diverse forms of direct service to many millions of people living in poverty. The communities of concern we have engendered comprise hundreds of thousands of individuals who donate and advocate and engage with the principles and places and people we serve. In this year of loss and destruction, of the crisis upon catastrophe in Haiti, and concomitant explosion of interest in our work—in the rapid expansion of our teams, and of the need we are trying to address—we see a tremendous opportunity for thoughtful change.

This inflection point is certainly not the first one we have faced, and brings with it both old and new challenges. As before, we need the help of all those who care deeply about this work to refine a sound strategy that can be sustained by the next generation of PIHers. We are deeply blessed that every single living person involved in the first years of our endeavor, from Todd to Tom to Jim to Fritz, remains deeply involved. And as we mourn Manmito—marking, with her passing, the end of the first era of our work together—we are reminded that we must honor and preserve the core of our shared mission, and also be willing to again transform ourselves in the necessary ways to strengthen and extend it.

We do not have a “master strategy” to share with you yet. We do have a clear mission; we have a great deal of experience doing this work; and we have an extraordinarily dedicated, talented, and resourceful team. We have very thoughtful recent input from many of you, as well as your responses to the organizational survey we just conducted and the findings from that effort. With them, and with your help, we will transform the aspects of PIH that no longer serve us, and protect the aspects we want to preserve. We will need, too, the help of our Board, of supporters with management experience, students, patients, and of course our partners in our

sister organizations. It will take courage and persistence to change some of our ways of working, including ways that have worked for us in the past.

Let us be clear about what will not be changing: **PIH exists to provide a preferential option for the poor.**

Core principles

O for the P will remain our rallying cry, road map, talisman, mindfulness bell, and the source of emotional or spiritual strength it has been for so many of us. It is, before and above all else, our mission.

A **preferential option for the poor** has broad support, but not everyone agrees what it means. We're not sure we all need to. The term is a theological notion which serves as spiritual inspiration for some (especially, perhaps, in our Latin American partner organizations) and as a metaphor or reminder for others: just as heavy burdens of disease and premature death zero in on those living in poverty, so we must focus our energies and resources on the poor. This has programmatic implications—how do we attack the ranking health problems of our patients and their families? How do we find those who have never had the chance to be patients because of lack of access to care?—and should shape, too, hiring practices and the structure of our enterprise. How might we bring poor people into this work as colleagues and full partners, diminishing or even ending their poverty even as they are given a chance to fight poverty itself?

What is our work? It's easy to say "access to health care," which is an important means, often, to describe and circumscribe our activities. But we've also agreed that **we work to prevent unnecessary suffering and to promote health, broadly defined.** For many of our co-workers and supporters, this "social medicine" approach is appealing, as it allows us to encompass issues as vexing as food insecurity, and tackle barriers to a host of services, from clean water to education and on to financial services. One way of describing our work is thus: we seek to make partnerships that might permit us to break the cycle of poverty and disease, allowing those living in the communities we serve a chance to leave poverty behind even as they are helping others to do so. When circumstances and partnerships permit, PIH tries to narrow its focus to the provision of health care, especially community-based health care, since that is an area of strength. This defines a good deal of our work with the poor in middle-income countries, where others are tasked with supply of clean water and with access to education, et cetera. In rural regions of the poorest countries in which we work, our work is much broader because the needs are much broader—even limitless. It is in those settings that "to do what it takes" means to perform tasks that are rarely seen as belonging under the aegis of health care. This does not mean that we don't have to make trade-offs. The more narrowly we can define our mission, the better our chances of achieving that mission, and this is reason enough to engage in strategic planning. But if poverty reduction is one of the goals of our health care efforts, then there is no obvious list of activities to delete in an effort to streamline our efforts, even as we acknowledge that we will not flourish without strategies that permit us to narrow our focus.

Accompaniment has emerged over the years as a core principle and a strategy apposite to many settings. Again, this is a notion borrowed from theology. It implies that all of us will face problems in our lives, and require accompaniment: having others walk with us and support us. In the eighties, in Haiti, the term was used to describe much of the work of community health

workers, who accompanied neighbors with chronic disease and served as living links between villages and health centers and hospitals. But the term may be used more broadly to describe what we seek to do, as PIH, with ministries of health in almost a dozen countries. Certainly there will be times when we invoke other paradigms, from directly observed therapy to technical assistance, to describe what we do. But the notion of accompaniment can inform these other paradigms and infuse them with a pragmatic solidarity that will be visible, whether we name it or not.

Partnerships are central not only to our origin—the name Partners In Health was chosen after careful consideration of what it would take to move forward an ambitious agenda—but also, we are convinced, to our growth and to our very survival. As we seek to formulate our strategy for the next few years, our ability to “offload” tasks outside our core competencies—for example, housing, education, and agricultural efforts—will require more and stronger partnerships, since it is not possible to offer a preferential option for the poor and ignore these issues. The same can be said of sustainable and environmentally-sound ways of powering our hospitals and schools. We have sought to share this responsibility with SELF in a genuine partnership (rather than a client or donor relationship, in which we would contract SELF to solarize our facilities). We have fought to build this partnership, even when it meant jointly cultivating donors and supporters. We have, similarly, worked hard to forge and strengthen our partnerships with the Global Fund, CHAI, Operation Blessing, BRAC, Fonkoze, and other partners. It is urgent that we seek similar partnerships not only with ministries of health, which share the infinite need but which have very finite resources, and also with groups that have complementary core competencies and are able to draw on their own partnerships to bring a new cohort of supporters to our work.

Finally, and most critically, we underline the indivisibility of **research, teaching, and service**, and their collective centrality to this vision. Of all of the partnerships that we need to underpin our future growth, this one is the most important. Indeed, when we first thought, spoke, and wrote about “three pillars,” it was not in reference to specific institutions (PIH, HMS, BWH) but rather to the pillars of service, research, and training. Although the importance of such a feedback loop was evident by 1984, let’s take an illustration from a decade later: our response to epidemic drug-resistant TB. First, responding to a treatable cause of premature death and suffering was in keeping with our core principles. Second, it played to our key competencies (management of chronic infectious disease, mustering resources to fill gaps, and using accompaniment to afford a community-based response) in ways that proved decisive in Peru. But our effort there, more than any previous endeavor, also drew on the resources of a research university. This allowed us to make a great leap forward as PIH.

Looking forward

In short, the *what* of our work will remain a preferential option for the poor, rooted in social and economic rights. We will continue to rely on the core principles limned above: accompaniment, partnerships, and integrated service, teaching and research. We would like to consider together the *how* of our work—the external and internal financial, management, programmatic, and HR strategies that will serve us best going forward.

Our original vision was to build local organizations—Haitian, Peruvian, Mexican, Russian, Rwandan, et cetera—that would be in service to the poor as long as they were needed. If we are still agreed upon this model, we need to invest more effort in identifying leaders who believe in O for the P and wish to pursue such efforts in their home countries; we need to

strengthen their hands. We don't wish to be naïve about this, since nationality is not the litmus test for success in transfer to authority "peripherally": we started working in Haiti when a home-grown dictatorship was still in power. We should not simply transfer power to others because they have the right passport, but because they agree with the philosophy of social justice that is about the only party line we have. For our work to succeed, they will also need to embrace this vision—to understand, embrace and advance the indivisibility of research, teaching and service, the importance of partnerships, and the centrality of accompaniment. These are our core principles. It is essential that we all embrace them if we are to succeed in providing a preferential option for the poor.

We must also transfer power within PIH, empowering, supporting, and making room for new leaders. PIH has been built in part by students and trainees; much that is innovative and enduring about the enterprise will come from the fact that we continue to bring in new blood. Many of the younger leaders at PIH, and at sister sites, are former students or interns or people who have helped to build the enterprise since they were the age we were in 1983. Elements of our retirement plan are, as we write this, rounding at the Brigham and learning to write software and studying nutrition and—our dearest hope—attending grade school in Cange, and in rural communities in the twelve countries in which we now work. Other leaders are talented professionals who have joined PIH in recent years, drawn to our work by the core values of social justice and human dignity from which we launched PIH, and we have been immeasurably enriched by their insight, energy, and dedication.

In the early days of PIH, there was not a long line of people wanting to help create a movement for global health. In fact, at times it was hard to recruit folks. Now, we often feel we can't respond adequately to the burgeoning interest in our work. This is a good problem to have, and we can solve it by partnering with institutions like Harvard, the Brigham, Dartmouth and Duke to help create true career paths for those who wish to join us, whether they are in clinical or academic medicine, or outside medicine entirely. And the majority of our team should continue to come from the ranks of the people we serve: one of the best ways to create a preferential option for the poor is to offer opportunities, including training opportunities, to people living in poverty. As one of you said recently: "PIH hires mostly poor people, and that keeps us honest." Here, too, we need to make space for new leaders: we must reward good service from those who start at the bottom rung of the ladder by moving them up through training.

As we have grown, we have developed new ways of living out our mission: new strategies, new angles of attack on the problems of poverty and injustice. We have increased our efforts in advocacy, training, research, and teaching—and we must do more in all of these areas. We will also need to increase our efforts to analyze our own work, from the level of an individual health center on up, striving to continuously improve it. Ultimately, we will measure ourselves not only by how many people we have served directly, and how well—but also by how many people we have served indirectly, through our efforts to change minds and laws and budgets and policies and the health care that is delivered by others to the poor. And we will be able to measure ourselves—and replicate our own successes, learn from our failures, and share this knowledge with everyone else trying to do this work—by increasing our commitment to research and associated activities. The self-critical practice of reflection and analysis has always been central to PIH's identity. Whether we speak of monitoring and evaluation or operational research or reporting treatment outcomes, our collective enterprise necessarily involves universities and teaching hospitals. This intimate relationship among research, teaching, and

service is the fundament of our strategy and our success. It is the best—perhaps the only—way for us to improve the quality of our services and to remain viable as long as we are needed by the people we seek to serve.

Focusing on reporting outcomes (by 1997, we were doing so in scholarly journals) and seeking to influence global policy (by 1997, at the latest, Jaime Bayona had convinced us of the need to make this a primary focus of our work, and Jim led this charge) not only built on a decade of TB work in Haiti but led to the great leap that was the Gates grant for Peru. None of this would have happened if we'd focused on service alone, without bringing in trainees who would later become leaders in our work (the student nurses who became the leaders of Socios, and many graduate students) and the rigorous documentation that we're here calling research. Over the past decade, we have published scores of articles and built a research and training platform, which has been parlayed into the largest NIH grant ever awarded to study MDRTB. And we are poised, now, to begin clinical trials with our Peruvian partners—something we would not have seen as a PIH function only a decade ago. This work has also served as a training ground for future leaders in our Africa expansion and in our leadership structure.

Much of this feedback loop among service, training, and research is hidden, and we need to make it much more explicit if we are to make another leap forward in the future—and also if we are to become a learning organization in the best senses of the word. Why is it hidden? In part because we have believed so much in the partnership model that we have “offloaded” many of the research functions (and some of the training functions) to Harvard Medical School and to the Brigham. They don't always appear on the books of PIH. This is of course intentional, as it reflects our views on what a research university should offer to the broader enterprise of global health. But it is imperative that PIH and its sister service organizations appreciate the importance of this feedback loop and its centrality to our collective endeavor.

As we seek to serve ever-increasing numbers of people, we will need to adapt our organizational structures and practices to best accomplish that end. We will need to find better and more consistent ways of supporting the talented, committed people we already have: creating clear pathways for advancement, transparency in roles and responsibilities, and accountability for results. We are committed to creating an environment at PIH that offers everyone here a respectful hearing, the opportunity to advance, and the same hermeneutic of generosity we strive to offer those we serve.

And we must do the hard work of adapting ourselves and PIH to the work that is now at hand. We have accomplished the difficult first step of opening ourselves to an analysis of our organizational health, and of surfacing our vulnerabilities as a team and as an organization. We have before us the work of deciding what the findings mean for us, and how to change accordingly—and then doing it.

PIH has grown rapidly in response to vast needs, more than 30% per year over the past few years. With this welcome growth has come inevitable tradeoffs: less intimacy, more fundraising pressure, greater difficulty communicating with the sites and less time to connect with one another, more room for mistakes and more opportunity to forget the important details. And, of course, the pressure to become more systematized, and to adopt proven strategies to help us manage these changes. We acknowledge that we have much to learn from other leaders and organizations. A great many of the stresses of our work are due to the

struggle for resources in a social field characterized by want, and these are unlikely to let up. But we are reminded by recent events that our hard-won reputation and our results have given many people the confidence to invest in us. We feel a great responsibility—not just to our patients and staff, but to all who have supported us with money, solidarity, time, belief—**not** to change the elements of our work that we believe are essential to our success. To all for whom PIH has been an antidote to despair, we must continue to raise hopes and standards—and then to meet and exceed them. And we have a further responsibility, to all who would follow our example, to make what changes we do make transparently and with great care.

Last month, we gathered in Cange to honor the life of Manmito, Mme Lafontant. We were in the church near the soccer field on which the young woman had collapsed, over a quarter-century before; it is still there, surrounded now by housing and the large pharmacy warehouse. An accomplished young medical student spoke eloquently of the force of Manmito's influence on our community, of her far-sighted and far-reaching accompaniment. Bobby had survived, in utero, the malaria that nearly ended his mother's life—born, barely, into a squatter settlement; now a multilingual doctor-to-be—and stood that day in embodiment of the extraordinary change that has been wrought in a single generation. It is an appropriate time for us, too, to consider the changes we have been part of, and what we wish to carry forward into the next generation of PIH.