



By John Donnelly | Photographs by Dominic Chavez

GO TO THE PEOPLE

Management Sciences for Health: 40 Years of Improving Health

From community health workers in Haiti, to drug shop owners in eastern Tanzania, to midwives in western Afghanistan, the impact of Management Sciences for Health (MSH) has been felt throughout the developing world. Now, after 40 years of hands-on work helping build strong health systems, *Go to the People* tells the stories of the philosophy, the motivation, and the strategies used by MSH staff and local partners to improve the health of vulnerable people.

These stories give insight on how an organization's approach to development can be a critical factor in failure or success. MSH's approach is underscored by the title of the book, *Go to the People*, which is the first line of a Taoist poem about showing respect to others, developing trust, imparting knowledge, and leaving the work in the capable hands of the community.

That has been MSH's philosophy from day one. "When we talk about success in this work," says MSH founder Ron O'Connor, "it stems from two things—what we contribute, and more important, what people running their own health programs in their own country build themselves. That's what we're about."

GO TO THE PEOPLE

Dedicated to the leaders, communities, and families improving health around the world.

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40 Years of Improving Health timeline photos courtesy of MSH staff (pp. 18-19)

Nigeria: Leadership training fit for a king—and lab scientists and nurses, too photos by David Wole Olukotun (pp. 20, 22)

Bolivia: “We found a role model” photos courtesy of MSH staff (p. 23)

An area of critical importance: Managing drug supply photos by Glenn Ruga (p. 25)

MSH's Approach to Health Systems Strengthening illustration by Peter and Maria Hoey (pp. 34-35)

Afterword: Dr. Ariel Pablos-Méndez photo courtesy of USAID (p. 38)

Front cover photo: Amon Chimphepo, a community-based family planning distribution agent, rides his bike through Mndola Village, Malawi.

Back cover photo: Chimphepo (far right), talks about family planning with Charles Jasi and his wife, Christina Charles, in Mndola Village, Malawi.

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Foreword by Dr. Tedros Adhanom Ghebreyesus

Afterword by Dr. Ariel Pablos-Méndez



CONTENTS



vii	Foreword: His Excellency Dr. Tedros Adhanom Ghebreyesus
1	Dr. Ron O'Connor: For MSH's founder, it started with values
3	Health in fragile states
5	South Sudan: The art of expanding health care
10	Rebuilding Afghanistan, one clinic at a time
14	Haiti: Responding to emergencies
18	40 years of improving health: A graphic timeline
21	Nigeria: Leadership training fit for a king—and lab scientists and nurses, too
23	Bolivia: “We found a role model”
24	An area of critical importance: Managing drug supply
26	Ethiopia: “It’s about becoming human again”
31	Malawi: Building a health system piece by piece
34	MSH’s approach to health systems strengthening
36	Universal health coverage: The ultimate test of a health system
38	Afterword: Dr. Ariel Pablos-Méndez
39	“Tao of Leadership”
40	Acknowledgments





FOREWORD

His Excellency Dr. Tedros Adhanom Ghebreyesus



Dr. Tedros Adhanom Ghebreyesus

What do we need to build strong health systems in the developing world? We need strong leaders who can articulate a clear vision. We need to set top priorities. And we need partners who will support the country's vision and priorities in a multitude of ways. Management Sciences for Health (MSH), now 40 years old, has been supporting countries from its very beginning. As the Minister of Health in Ethiopia, a country of 83 million people, I have appreciated MSH's strong partnership over a number of years.

You will understand why I say this after reading this timely book, *Go to the People*. The book is about MSH's experiences in many countries around the world, including Ethiopia and its work in empowering HIV-positive women to live positively. It is full of powerful lessons for all of us about taking the right approach to development.

MSH's approach is to be humble. It is committed to learning from local people and local leaders about the issues they face, listening to their solutions, and then finding ways to build on that local knowledge in partnership with the people it is serving. It is instructive to read in these pages how MSH builds on local knowledge: MSH trains leaders, such as the Sarki of Ibi in Nigeria and nurses in Aswan; builds pharmaceutical management systems such as the one it helped start in the Eastern Caribbean a quarter-century ago; and builds a sturdy foundation for health care in fragile states such as Afghanistan, Haiti, and our own neighbor South Sudan. And often, when it has done its job, MSH leaves behind a strong local institution, such as PROSALUD in Bolivia, which now has the tools and the knowledge to succeed. That is a great gift.

We are now in an era where more and more developing countries are in serious discussions with partners and donors about how to promote country ownership of health programs. These discussions are critical to the health of people in Ethiopia and other countries because the only sustainable way forward is for countries to first own their programs and, second, to make a strong commitment to strengthening their health system based on that ownership.

We need more groups such as MSH to help foster greater country ownership and more fruitful partnerships. The captivating stories and photographs in *Go to the People* reflect just how closely MSH, often with generous US Agency for International Development (USAID) support, has worked with country leaders. They are advancing a great model for development. I am grateful for all they have done, and continue to do now and in the future.

His Excellency Dr. Tedros Adhanom Ghebreyesus
Minister of Health, Federal Democratic Republic of Ethiopia



Dr. Ron O'Connor, founder of MSH

Dr. Ron O'Connor: For MSH's founder, it started with values

CAMBRIDGE, MA – It felt like coming home, only there was no telling who would be there or what he would find.

Flying into Kabul just four months after the September 11, 2001 attacks, Ron O'Connor, MD, founder of Management Sciences for Health, known as MSH, had been waiting years for this moment. He dearly wished that MSH would start—for the third time over four decades—work in Afghanistan.

After landing in an airport littered with broken glass and rimmed with bullet-holed walls, a group of former Afghan colleagues and friends hugged and clasped hands with Dr. O'Connor and a small group of MSH staff. One, Assadullah Alam, took them to his home, where he led O'Connor into his basement. He pulled out trunk after trunk, and then began opening them.

Inside was treasure—faded MSH documents that years before, taken together, laid out a blueprint for building the country's health system.

“There were records of the supply system, the basic medicine packages, the courses of treatment,” O'Connor said, looking back at that moment. “It had me in tears. Assad saved them because he thought it would be valuable for the future of his country. He had no idea we would be back. He just had faith.”

From the day in 1971 that O'Connor founded MSH, he had faith too, if of a different sort. His belief was that a nonprofit organization could distinguish itself through values he had absorbed in another remote outpost as an impressionable man of 22. He should show respect to others, build on what local people know, develop trusting relationships, impart knowledge, and then leave the work in the hands of the local people.

Those values began to take shape in 1962 when O'Connor traveled to Nepal. He had been raised in Scarsdale, NY, the eldest of two sons, to a father who worked at an advertising agency in Manhattan and a mother who worked at a local hospital. O'Connor had just finished his first year at Columbia Physicians Medical School, and a minister from a local church gave him a plane ticket to Nepal, where he would travel to a mission hospital in Tansen. The church had supported the hospital, but no one had ever seen it. Traveling with his father's battered leather suitcase, O'Connor flew into Kathmandu, took a propeller DC-3 plane to a grass-field airport in Bhairawa near the Nepal-India border, and then hiked into the hills for two days.

When he reached Tansen, he met a Japanese doctor named Noburu Iwamura, and immediately was drawn to him. Iwamura, who as a teenager had survived the atomic bomb attack in Hiroshima, had arrived just a few months before with his family. To the young American, the Japanese doctor seemed like he had been there for years.

“He had already learned the language,” O'Connor said. “He was very respectful of people, not like other doctors who would tell you what to do. He engaged people. I could see that people were listening to him; he was more successful than the more traditional guys. I thought to myself, ‘How can I do that? How can I be like him?’”

Iwamura showed him how—by example and through a short Taoist poem on leadership that a Chinese teacher named James Yen had taught Iwamura:

“Go to the people. Live with them. Love them. Learn from them. Start with what they have. Build on what they know. But of the best leaders, when their task is accomplished, the work is done, the people will all say, we have done it ourselves.”

The lessons for me were around the importance of the empowerment of women, the liberation of women.

O'Connor returned to medical school, and after his third year, he took another year off, this time traveling to Asia to learn about the crush of population growth, the need for greater family

planning services, and the strategic importance of supporting girls and women.

“The lessons for me were around the importance of the empowerment of women, the liberation of women,” he said. “In Bangladesh, you could see how the village women blossomed when given an opportunity to work. Over and over again, I would see this. It was so powerful and so obvious.”

Several years later, after looking unsuccessfully for a place to work that emphasized values apparent in the Taoist poem, O'Connor, at age 31, started MSH in Cambridge, MA. He set about recruiting others who, like him, were more interested in promoting the work than themselves. They included Glen Urban, an MIT management professor; Joel Lamstein, who later was co-founder and president of John Snow, Inc.; Terry O'Connor, Ron's brother, who was MSH's first chief of party in Afghanistan; and Peter Huff-Rousselle, MSH's first field assignee in South Korea.

Two years later, MSH received USAID funding for health work in Afghanistan, which became the first of scores of large-scale overseas development activities. Today, MSH has more than 2,200 employees who work in nearly 40 field offices around the world, including offices in Arlington, VA, and Cambridge.

But in 1973, MSH consisted of just a handful of workers. Grace E. Langley, then the USAID health officer in Kabul, was one of the first to support MSH and O'Connor. "They were proposing rural work," she said, remembering MSH's application nearly four decades later. "And so much of that was absent from what we were doing in Afghanistan at the time."

There was respect, and the general principle was always upheld: You build for the long haul by building some sort of structure.

"They brought splendid people," she said. "They were all very experienced, and that was very useful in a country like Afghanistan."

The Afghanistan work unfolded in three distinct periods, including a seven-year period of war from 1987 to 1994 when MSH was based in Peshawar, Pakistan and trained and supplied Afghans who trekked days or weeks to Pakistan and then returned home. The most recent work in Afghanistan started soon after the 2002 trip.

For Drs. Paul Ickx and Laurence Laumonier-Ickx, who began working with MSH in 1986, O'Connor's imprint was felt in Afghanistan and elsewhere. Ickx said his dedication to saving lives was so strong that it impelled O'Connor to ask tough questions.

"In public health, you often have all kinds of ideas that sound nice, and they may or may not work," Ickx said. "Ron will always ask, 'What difference will it make for the people who need health care?'"

The couple remembered one moment in which O'Connor and a US government representative got into a shouting match about a health delivery program in Afghanistan during the early 1990s. According to the government representative, O'Connor was resisting efforts to spend down a budget quickly. "Ron kept telling him, 'We will need this money later when we can put it to real use,'" Ickx said. "He always said we must build a system to make sure all the money will be used to save as many lives as possible."

O'Connor didn't remember the episode, but he said disagreements were not uncommon. "We were not doing this just to win another project," he said. "There was respect, and the general principle was always upheld: You build for the long haul by building some sort of structure."

Today, O'Connor, now 71, sits on MSH's board and goes into the office in Cambridge periodically, sometimes to talk to new employees about MSH's history. The talk invariably delves into MSH's values.

Even though the organization has grown tremendously, O'Connor said those early values from a half-century ago still hold fast.

"I learned by example," he said. "What I saw in Nepal really made sense to me, both because it felt right and because it worked. I could see that when you treat people with respect, offer them experience that can help, and then step into the background, they're positioned to solve their own problems. When we talk about success in this work, it stems from two things—both what we contribute, and more important, what people running their own health programs in their own country build themselves. That's what we're about."



Dr. Ron O'Connor and Dr. Noburu Iwamura

Health in fragile states

A fragile state can be defined as a country “in the midst of war” or just “emerging from the fog of conflict.” It may have experienced violence so widespread that its institutions are left in ruin. MSH knows these places well. Its work in three of them—South Sudan, Afghanistan, and Haiti—is portrayed in the following pages. MSH uses a two-step approach that, first, works with governments to rebuild their capacity. At the same time, it also works with communities to ensure service delivery, build trusting relationships, identify low-tech interventions, and train local health workers by the thousands.



Children who have fallen victim to nodding disease sit in silence, along with family members and neighbors in Witto Payam Village, South Sudan.

South Sudan: The art of expanding health care

WITTO PAYAM VILLAGE, South Sudan – The village looks like many in South Sudan. Thatched-roof huts of wooden poles bound by mud are laid out in an orderly way. Mango trees create pools of shade. Women walk in and out of the village balancing large plastic buckets full of water atop their heads, sidestepping thickets of green thorny bushes.

But something is amiss. A mysterious illness called nodding disease has stealthily taken root, afflicting 70 children in this village alone in recent years with epileptic-like symptoms, mental retardation, stunting, and, in some cases, death. No one knows the cause, and the disease is spreading. Investigators have found more than 500 cases reported in health facilities in Juba, South Sudan's capital, and other outbreaks in northern Uganda.

“We have lost hope with these children,” says Robert Ariamba Michael, a village elder in neighboring Jambo. Five of his eight children have nodding disease. “Some children have died, but even those who live, we don’t expect anything from them.”

For MSH, which is overseeing the rollout of addressing immediate health needs and strengthening the health system in 14 of South Sudan's 79 counties—a \$44 million, three-year project—the emergence of a new disease is part of the reality of working in fragile states. The unexpected has to be expected. This area of expertise—building a strong foundation for health care in a place once awash in conflict—started in Afghanistan and continues here, as well as in the Democratic Republic of Congo.

In fragile states, MSH's approach has been to confront the largest issues that cause high death rates, ranging from maternal health to childhood vaccinations, and deliver results across that wide spectrum of health care.

“There’s a direct line from Afghanistan to South Sudan, and from South Sudan to the Congo,” said Fred Hartman, the MSH country lead for the Sudan Health Transformation Project (SHTP II). “Much of what we’re doing in South Sudan—the concepts and the applications—was done in Afghanistan. What we did in Afghanistan in three years took Cambodia ten years to achieve, and now we are doing the same in a three-year period in South Sudan.”

Now, in the third year of the South Sudan project, which is done in coordination with the ministry of health and funded by USAID, results are beginning to show significant gains. MSH managers in South Sudan spent a day analyzing what had gone right, and what hadn't. They wanted a snapshot that would allow them to make adjustments; the figures would show how the programs were doing, compared to the year's targets. Anything above 50 percent meant they were ahead. Well above the targets: immunization for children under the age of one (78.7 percent), vitamin A for children under five (60.5 percent), women with at least four antenatal visits (61 percent), and number of counseling visits for family planning (80.6 percent). Below the target: percentage of births with a skilled attendant (32.7 percent).

“It was a very good day,” said Dr. John P. Rumunu, MSH's chief of party in South Sudan, referring to the session. “We still have room for improvement, but the numbers were really good.”

Dr. Thuou Loi, director of the ministry of health's hospital services, says MSH's help has been invaluable. “You have to keep in perspective that South Sudan is starting from scratch,” he said. “We need support of partners, and we need to build our health systems. Our big challenge is expanding services to the whole country, and MSH has been contributing effectively toward that goal. It's been great to work with them.”

...the emergence of a new disease is part of the reality of working in fragile states. The unexpected has to be expected.

MSH's approach is to develop a basic package of health services that focuses on seven high-priority areas, paying special attention to the health of women and children and infectious diseases. “If you focus your resources on the seven high-mortality areas,

it gives you the biggest bang for the buck,” Hartman said.

Under the US government-funded work, MSH hired ten partners, most of them international nongovernmental organizations, mainly to support the management of primary health care facilities. It also started leadership training for a wide range of people, from those in the ministry of health to those working in county health offices.



Loice Kamal (foreground), with her sons Elikima Kode and Eliaza Minara, fight their own battles against two powerful diseases. Kamal is living with river blindness and her sons are newly infected with nodding disease. Witto Payam Village, South Sudan.

“As monthly data is collected, which shows what is being done in the health system, we are training people how to act on it,” Hartman said. “We are developing the capacity of the managers.” MSH also guided training for health workers to start family planning and maternal-newborn health programs.

In Mundri West, a four-hour drive west of Juba, Kiden Harriett, a mother and child health supervisor at the local health center, says that her training allowed her to introduce family planning services for the first time in February 2011. In the first two months, she counseled 218 women on family planning.

“Before, we didn’t talk much about the spacing of births,” she said. “But now, after the training, I talk about it a lot. I can see the difference. Women are coming; they want it.”

One, who received a Depo-Provera shot, a birth control drug that lasts for three months, was Naomi Aja, 21, who has a four-month-old daughter, Karama. “I’m young and I want this baby to get healthy,” she said. “I want to look after her properly before I have another one.” Aja plans to have two children; her mother had ten.



Mundri West, South Sudan

Vivian Bawa, 25, the mother of one, also received the birth control shot. “I want to go back to school—to university,” she said. “I’d like to become a nurse, so I will wait to have more children.” She said she is planning on four children; her mother had eight.

Dr. Omer Mohamed, the medical director for Action Africa Help-International, a Kenyan nongovernmental organization and a partner on MSH’s project, said he sees a major change as a result of the training of health workers to educate people on family planning and the greater distribution of contraceptives.

“The training is removing myths around family planning,” he said. “Before, family planning used to be seen as ‘stop giving birth.’ Now, it’s children by choice, not by chance. Couples are getting the right information. And they feel free to come and hear it.”

Despite the strong gains in immunization, vitamin A, care for pregnant women, and family planning counseling, the growing foothold of nodding disease has many local officials—and MSH staff—increasingly concerned. The disease was given its name because those infected start to nod when they become cold or when food is put in front of



Rebeka Sadaraka comforts her grandson, Wisley Malawo, eight months old and fighting diarrhea in Witto Payam Village, South Sudan.

them. They nod so much that they cannot eat. The cerebral dysfunction has made many susceptible to other diseases or conditions, leading to an unknown number of deaths.

Nodding disease first appeared in isolated cases in 2000, but since 2005 the numbers have exploded to create the current crisis. It is found right now only in the Yei River Valley (a tributary of the Nile River that runs through Juba), and seems to be related to the growing number of children infected with river blindness. No one yet knows why river blindness is increasing in numbers, or its relationship to nodding disease.

“We’re doing great with all our benchmarks but our job ultimately is to create conditions that bring better health for people,” said Hartman. “Nodding disease is a real threat to that.”

In Mundri West, James Smith, the secretary for the South Sudan Relief and Rehabilitation Commission, said the disease had been affecting five- to nine-year-olds. But now, he said, children from 12 to 18 years old are getting it. “It’s reducing the manpower of our people. It seems to be in every household, affecting one or two people in each one. We are very worried. What’s most troubling is we cannot come up with the cause of it.”



Children sit with family members and neighbors in Witto Payam Village, South Sudan.

Dr. Victor Guma, an MSH child health adviser, traveled to Witto Payam Village and Mundri West to talk to people about the disease. He left extremely concerned at the extent of its prevalence.

At Witto Payam Village, more than 70 children and a couple dozen adults gathered to talk about it. Nearly all the children had contracted the disease. The children’s eyes seemed vacant. Some slept on the ground.

“My daughter was a normal girl, and then at age six, she started nodding whenever she saw food,” said Rasul Kegi. “Three years later, she started convulsing. Her mental ability is so diminished. Even when I call her sometimes, she doesn’t respond.”

The villagers say they need a comprehensive study aimed at finding the cause. They also wish they had a day care center to take care of the children affected by the disease. The toll on families, they say, is physical, mental, and emotional.

On the drive back to Juba, Dr. Guma seems lost in thought. “I didn’t know the scale of nodding disease at all,” he said finally. “We need to take more time to talk with people and then establish serious research to learn what causes it. It’s so serious.”

Returning home; improving health



Dr. Edward Luka

“I always wanted to come home”

Dr. Edward Luka became a medical doctor by default. He entered college during the middle of Sudan’s long civil war in 1993, traveling to Khartoum from South Sudan, and his first choice was to study architecture. But it was offered only in Arabic, not his native tongue. So he opted for medical school, which was taught in English.

Luka, 38, became an expert in public health by choice. He earned his master’s degree in public health, at Heidelberg University in Germany, because he felt he could better help his native land, South Sudan, by building better health systems.

He and his wife Poni, a dentist, moved back to Juba in February 2010 to help rebuild South Sudan. Luka, the son of a telecommunications technician and a nurse, the fifth of nine children, is a primary health care adviser at MSH.

He works with partners to ensure that they are following the government’s policies and guidelines.

“I always wanted to come home,” Luka said. “The health system is working now. After 20 years of war when there was no central authority to take over health care, you can now see the system working on a county health level.”

Luka has traveled to some of the most remote areas of South Sudan to look at health facilities, and “you would think nothing exists. But you find a maternal and child health worker, you find anti-malarial drugs, you find the start of a system. You could even be in a village of grass huts, and it has a health worker there.”

He realizes that much needs to be done to improve the system—especially training more doctors, nurses, midwives, and technicians. But he is heartened that the system is running. “It’s amazing that it exists,” he says. “Now we need to make it better.”



Dr. John P. Rumunu

“I have a story to tell”

Dr. John P. Rumunu has had a life full of movement. He left Juba, as a medical student in the late 1980s because his school moved to the northern part of the country to escape the effects of the civil war. He fled Darfur in 1999 because of threats to his life, resettling in Uganda. Rumunu went to Great Britain for a year to get his master’s degree in public health, for which he traveled to war-torn areas in the south of Sudan, Chad, and Sierra Leone. Finally, he moved back to Juba in May 2005 after the peace deal ending the civil war was signed.

Rumunu is staying put now. He is chief of party of MSH’s South Sudan operations, overseeing 21 staff and USAID-funded health projects in collaboration with the ministry of health and health departments in 14 counties—roughly one sixth of South Sudan. Rumunu served in senior positions in the ministry from 2005 to 2009 before joining MSH.

“What we are doing is an extension of what the ministry is doing,” Rumunu said in his office, which on this day he shared with three others. “I have been involved in developing the guidelines and strategies in the ministry, and now I want to see those guidelines implemented all over South Sudan.”

His staff—roughly 90 percent South Sudanese—is highly motivated. “They are serving their own people,” he said. “Many left and now have come back. They feel this is a great opportunity.”

Rumunu also wants to grasp the opportunity. He is not looking to move. He and his wife, Florence Bayoa, and their three children have settled in their homeland.

“Many South Sudanese have contributed to our independence,” he said. “Some contributed with their own lives. Me, I have not gone to the bush to fight with guns. But I contributed through my profession. During the war, I worked in war-affected areas. After the war, I contributed to rebuilding the country. I now feel part of the struggle for a new country. I have a story to tell.”



Juliana Bol

“We are all different...
but we all have to fit in”

Juliana Bol is from many worlds. Her parents are of Sudanese descent, but she was raised in Kenya because of the long wars in Sudan. She attended the University of North Carolina for undergraduate work and then Columbia University for her master’s degree in public health. In August 2009, after just turning 30, she “came home” to South Sudan.

“I think this feeling of South Sudan as home came from my grandfather, who lived in Kenya as a refugee; he always talked about coming back home to Sudan,” said Bol, a quality assurance specialist at MSH. “His whole being was in Sudan.”

For Bol, it’s not the same. “After living away for so long, I don’t totally belong here,” she said. “Part of the start of this new nation is we are all different, and we’ve had different

experiences, but we all have to fit in. It’s a matter of challenging people’s perceptions of who is South Sudanese, and pushing boundaries.”

Her work at MSH, she says, has been rewarding. She evaluates the quality of health care in the country and helps train staff. “Here in South Sudan, we have some of the worst health outcomes in the whole world. Working to strengthen the health care system, you can make some incremental improvements that will make a huge difference in people’s health. That’s very important to me. That’s how I can contribute.”

Rebuilding Afghanistan, one clinic at a time

KABUL, Afghanistan – For MSH, helping Afghanistan is a road well-traveled. Over three distinct periods MSH has worked here, through conflict and dangerous situations. From 1973 to 1979, when the Soviets invaded the country, it helped strengthen the Afghanistan Ministry of Public Health and promoted the use of village health workers. From 1986 to 1995, MSH returned to start a major USAID-funded program based in Peshawar, Pakistan. That cross-border project provided training, support, and monitoring for over 300 health facilities in Afghanistan, and workers often traveled several weeks from their homes, sometimes by camel, to receive help in Peshawar.

After the US attacks in Afghanistan to remove the Taliban and wage war against Al Qaeda in the fall of 2011, MSH started its third period of work. This time it conducted the Afghanistan National Health Resources Assessment to clearly assess available Afghan health services and health professionals. With that information, MSH assisted Afghanistan's Ministry of Public Health in developing a basic package of health services, with a particular focus on maternal and child health.

“MSH has a rich history here,” said Dr. Mubarakshah Mubarak, MSH's chief of party for the Tech-Serve Project. “There are so many people who have been involved in the projects, and they have good stories to tell. So much of the work has been about strengthening the community health services. That's a critical step in establishing a health system that will last.”

RIGHT | IMPROVING ACCESS TO CARE IN CLINICS: In the town of Kalakan, just outside Kabul, an Afghan woman in her first trimester of pregnancy goes to a clinic for a checkup.

OPPOSITE PAGE | ADVANCING MATERNAL HEALTH: Nazima Haqaba, a midwife at the Kalakan Basic Health Center, who has received training from MSH, assists a pregnant woman during her routine visit.









LEFT PAGE | **HELPING THE CHILDREN:** At a clinic in Aqu Ali Khwaka Village outside Kabul, Shirin Jan (in the foreground with white veil), a child survival officer who has received training by MSH, encourages mothers to feed nutritious foods to their children. Overall, MSH has refined its integrated child survival package in Afghanistan, providing medicines and supplies and training workers in clinics, to battle pneumonia and diarrhea and increase immunization coverage.

TOP LEFT | **TREATING CHILDHOOD ILLNESSES:** Ahmad-Sayer Paninbagha, a 9-month-old baby who suffers from diarrhea, waits with his mother to see the family doctor at the Kalakan Basic Health Center.

TOP RIGHT | **EMERGENCY CARE:** Dr. Noar-Rahman Burhan looks closely at a small boy in the emergency room at the Indira Gandhi Institute of Child Health in Kabul. The boy is suspected of having meningitis.

LEFT | **LIGHT AND LIFE:** At the Indira Gandhi Institute of Child Health, a newborn child with jaundice receives phototherapy treatment. MSH supplied the hospital with the equipment as part of its efforts to bolster lifesaving emergency care and response in clinics and hospitals in Afghanistan.

Haiti: Responding to emergencies

PORT-AU-PRINCE, Haiti – At the SCMS program warehouse in the capital city, the packers move nimbly from one aisle to the next, each holding a picking list. All day, they pick packets of drugs or supplies from the labeled shelves, pack marked boxes, and prepare the boxes for shipping around the country. It is part of their daily routine, but it also is part of a complex behind-the-curtain choreography. The dance here involves working through a procurement and distribution system finely tuned to efficiently get medication to people who often live hours from a paved road.

The packers are a part of a chain that saves lives.

Starting in 1980, MSH has worked to build Haiti's health system, expanding delivery to rural areas; helping construct a national system for better access to reproductive, maternal, and child health services; constructing a drug procurement and distribution system; training leaders; and greatly expanding the battle against HIV & AIDS and other infectious diseases.

Then, on January 10, 2010, a level 7.0 earthquake struck Haiti, killing thousands and leaving an estimated 1.5 million people homeless. MSH adapted to the emergency. It used its well-honed system, including the USAID-funded Supply Chain Management System (SCMS), and formed new partnerships to get emergency help to those in need within 48 hours after the earthquake. Later in 2010, a second disaster struck: Haiti's first outbreak of cholera in more than a century.

"If we look at the transition after the earthquake, although we are not a relief organization, we dealt with emergency problems just as we maintained our regular services," said Georges DuBuche, MSH's senior technical advisor for private sector coordination. "It was amazing, a kind of a two-pronged approach: continue to provide services in the 147 sites and respond to emergencies. Despite the disaster, we kept the system running and we met our health goals."



ABOVE | **CLEAN WATER:** One of the important lessons MSH teaches about water: keep hands out of it. In a Port-au-Prince neighborhood, two girls, at right, carry a 5-gallon jug of water, but one girl's thumb is in the water—a seemingly small but prevalent problem.

OPPOSITE PAGE | **FOUNDATION OF A HEALTH SYSTEM:** Altineus Pierre Roberson (front left) and colleague Jean Marc Duvivier, SCMS employees, fill orders from clinics for drugs and supplies in Port-au-Prince. Many of the drugs in this warehouse are antiretroviral medicine, purchased under PEPFAR, the US global program to battle AIDS.



RIGHT | **ADVANCE OF THE TENT CITY:** A tent city on a hillside in a Port-au-Prince neighborhood. More than a year and a half since the earthquake, the camps continue to expand, greatly complicating efforts to handle health problems such as the cholera epidemic.

BOTTOM LEFT | **FOR NEWBORN HEALTH:** Health workers trained by MSH teach a new mother how to breastfeed her child and explain the nutritional benefits of breastfeeding.

BOTTOM RIGHT | **ACCESS TO IMMUNIZATIONS:** Delcelia Deltor's baby girl, Lantara Alderis, 19 months old, receives vaccinations at the Clinique Communautaire de Martissant in Port-au-Prince, Haiti.

OPPOSITE PAGE | **INSIDE A TENT CITY, A HEALTH LESSON:** A nurse holds up flashcards that show how people can avoid contracting cholera and how it is spread.





40 YEARS OF IMPROVING HEALTH

1971

MSH began supporting family planning management with a first long-term field project in **South Korea**, funded by USAID.

1973

MSH began work in **Afghanistan** to strengthen family planning and rural health services, a relationship that endures nearly 40 years later.



1977

The first list of essential medicines for global health conditions was published by the World Health Organization (WHO).

1978

The Alma Ata Declaration was announced at the International Conference on Primary Care, promoting health as a human right and calling for the establishment of primary health care worldwide.

1981

MSH published **Managing Drug Supply**, a field-defining handbook documenting practical actions to help countries manage medicine supply systems.



1983



MSH embarked on a 30-year relationship working with **Haiti** on rural health delivery, helping provide access to primary health care to nearly 50 percent of the population.

1984

A key conference in Bellagio, Italy established the Task Force for Child Survival to increase immunization levels and promote effective measures for healthy children and families.

1985

MSH commenced a groundbreaking 25-year commitment to leadership, management, and governance, developing skills in all areas of health systems for leaders and managers in 19 countries.

1986

The US Centers for Disease Control began surveillance of maternal mortality.

1986

MSH helped pool the resources of eight nations in the **Eastern Caribbean** to lower the cost of procuring medicines, establishing a self-sustaining agency that has provided access to medicines for 25 years.

1987



MSH started ten years of work with **Bangladesh** to improve family planning by training staff and leaders to manage local programs and serve 4.5 million people.

1990

The United Nations Development Programme's first Human Development Report shifted the focus of development initiatives to people-centered policies.

1990

MSH entered into a 15-year relationship with the **Philippines** to improve family planning and child health services, develop a national health information system, and enroll low-income families in health insurance programs.



MSH established the **International Network for Rational Use of Drugs (INRUD)** to improve the way medicines are managed.

1993

MSH began managing the worldwide **Basic Support for Institutionalizing Child Survival (BASICS)** project, established by the Partnership for Child Health with John Snow, Inc. and AED.

1997

MSH began work in post-apartheid **South Africa** to establish equitable, accessible primary health care services, including prevention and treatment of HIV & AIDS.

2000

The Millennium Development Goals were adopted by the United Nations, including targets for improving maternal and child health, treating and preventing HIV & AIDS, and promoting gender equality.

2002

The newly established Global Fund to Fight AIDS, Tuberculosis and Malaria approved 36 countries to receive its first round of grants.

2002

In **Egypt**, MSH began building the leadership and management capacity of health workers, who increased access to family planning, and expanded the program to train additional health workers.



2003



MSH started work in **Malawi** to reduce child mortality and extend community-based care for HIV & AIDS, TB, malaria, and family planning and other services in 10 of the country's 29 districts.

2003

The landmark US global AIDS response, the President's Emergency Plan for AIDS Relief (PEPFAR), was launched, committing \$15 billion over five years.

2005

In **Rwanda**, MSH launched performance-based financing (PBF) programs for health services, dramatically increasing HIV testing, assisted births, and contraceptive use.



MSH published *Managers Who Lead: A Handbook for Improving Health Services*, its seminal publication providing practical strategies and tools for health managers.



2005

The Paris Declaration on Aid Effectiveness established a plan to increase country ownership of development and encourage donors to focus on measurable results.

2009

The Obama Administration announced its Global Health Initiative, a comprehensive strategy to strengthen health systems, with a particular emphasis on woman- and girl-centered approaches.

2010

In **Malawi**, MSH distributed mobile phones to more than 600 community health workers, improving their ability to request supplies, information, and emergency support.

2011

The WHO warned of the enormous burden of chronic diseases worldwide.

The 64th World Health Assembly adopted a resolution calling for a United Nations resolution on universal health coverage.

USAID celebrated its 50th anniversary.

2011

With **Ethiopia**, MSH completed Africa's largest national expansion of HIV & AIDS services, reaching 33 million people by shifting health tasks from physicians to community providers.



MSH added chronic diseases, such as cancer, diabetes, and heart and lung disease, as an organizational priority health area.



The Sarki of Ibi, His Royal Highness Alhaji Abubakar Salihu Dan Bawuro III (center), in traditional dress with members of his court.

Nigeria: Leadership training fit for a king –and lab scientists and nurses, too

ABUJA, Nigeria – His Royal Highness needed help. The Sarki of Ibi also known as His Royal Highness Alhaji Abubakar Salihu Dan Bawuro III, in Taraba State, is a local leader with 200,000 followers in east-central Nigeria. He is known for being committed to improving the health of his people. But he faced something he called the “devilish monster”—AIDS—and he needed advice.

In 2009, he asked MSH to assist him. MSH experts traveled to the Sarki of Ibi’s palace, listened to his concerns, and then devised a plan to educate people about the epidemic that encouraged them to seek services. Some of the work centered on the Sarki of Ibi himself: MSH’s leadership development program, which began a quarter-century ago and is driven by the vision that strong leadership is critical to any major health reform.

“I am a natural leader,” the Sarki of Ibi said in an interview. “But I learned a lot from them. They educated me, and being educated means that I can educate the whole domain of my people. MSH allowed me to get acquainted with what was not clear to us; not available to us. They brought out the student in me.”

They brought out the leader in him as well. The Sarki of Ibi already had been tested for HIV twice and publicly released the results in hopes of encouraging others to get tested. Following MSH’s advice, and with USAID support, he led a decentralization of HIV services in Ibi and the surrounding area so that care and treatment extended deeper into communities. He also launched a community-based food bank for orphans and vulnerable children and their caregivers in late 2010. Much of the food was grown on his 2,000-acre farm.

Dr. Barry Smith, who has worked for MSH for more than two decades, mostly in Central America, explained how the work of the leadership program in Nigeria was one of the most exciting initiatives in his career.

“From the first day, we tell the leaders that, to a certain extent, help is not coming,” said Smith, MSH’s Nigeria country director. “You are it. Locked in everybody is tremendous potential. What the leadership program does is unlock the potential in you. It sends you out with a whole different worldview.”

MSH has been mentoring and helping to train leaders across a large swath of developing countries for 40 years. Another recent example is Egypt, where MSH started leadership programs in Aswan in 2003. The first one targeted doctors, nurses, and heads of all primary health units to improve maternal and child health. The second, starting in 2010, included training for 120 nurses in its first year, aiming to improve infection control and nursing, and communications skills.

I am a natural leader, but I learned a lot from them. They educated me...I can educate the whole domain of my people.

Dr. Abdo Al-Swasy, MSH’s project manager in Egypt, said one of the keys of the leadership training was to educate nurses on best practices utilized

elsewhere. “Some nurses said it was the first time that someone told them how they compared to other places,” he said. “When we told them how they were doing, it really shook them up. They really started to move and corrected things themselves. They owned the challenge.”

In Nigeria, several people who took part in the training told similar stories.

Comfort Abu, a nurse and midwife who is AIDS program coordinator for the Kogi State AIDS Control Program, says the training changed her approach to work.

“I learned to be a leader, and that when you have a team, you go together, carry everyone on board,” she said. “Being a leader means you find solutions to challenges, think outside the box. If you are not getting the results you want, you don’t sit back.”

Told by MSH trainers to “dream big,” she decided to establish three new comprehensive care treatment centers. Many discouraged her, saying she was aiming too high. But after persistent communication with local and national leaders, Abu won approval for the centers. “This has brought services closer to people, and members of the communities are highly appreciative,” she said.



The Sarki of Ibi, His Royal Highness Alhaji Abubakar Salihu Dan Bawuro III

Professor Anthony O. Emeribe, the registrar/chief executive of the Medical Laboratory Council of Nigeria, which oversees the accreditation of medical laboratories and the licensing of tens of thousands of medical lab employees, says the trainings have led to numerous new efficiencies in the council's management. The staff now meets more frequently and documents decisions more carefully. Their communication also has improved.

"We now have much more dialogue in the decision-making process," Emeribe said. "It's not based on a top-down approach. The trainings by MSH helped show the benefits of the entire management staff participating. We all need to share the vision and mission of the council."

The Sarki of Ibi in Taraba State said that the MSH training has helped him and others approach the HIV & AIDS epidemic much more openly. That, he strongly believes, will lead to a reduction in the spread of the virus.

"Orphans had been asking questions among themselves: 'Where are our parents?'" he said. "Before, people didn't say anything. Now answers are provided instantly. We say that AIDS took them away. These children are growing up with the knowledge of this devilish monster and what they can do to avoid it. I am very grateful. This is having a great impact on our society."

Bolivia: “We found a role model”

SANTA CRUZ, Bolivia – It was a simple ceremony in the city of Santa Cruz, Bolivia, marking the end of a five-year relationship. It felt, in the words of one participant, “like the cutting of the umbilical cord.”

Newly free were two organizations: MSH and PROSALUD, a nonprofit Bolivian health care group. The two had worked intensely together with USAID funding designed to support the local group in building up health systems in Bolivia.

Mission accomplished.

For MSH, that ceremony in 1990 fulfilled one of its fundamental goals: When its work is over, it leaves behind a locally run center of excellence in health care.

For PROSALUD, the ceremony signaled the beginning of being on its own.

Now, more than a quarter-century since the start of the relationship, both organizations look back and see they forged an approach to development that allowed a local organization to prosper.

“It was a moment of celebration, of joy,” Carlos Cuellar, one of the founders of PROSALUD, said as he recalled the long-ago ceremony. “It was not a moment of concern that one side was losing the opportunity to do more business. From our side, it was a moment of uncertainty because of the many challenges left, but we also thought, ‘OK, we need to be on our own.’”

Ron O’Connor, MSH’s founder, says the relationship worked because both sides had the same goal.

“Some of the success was due to MSH’s willingness to recognize good people whose strengths we could support and build on,” he said. “There were highly motivated Bolivians concerned about how to get health care to a wide array of people in Santa Cruz, in the lowlands area in Bolivia. What we really did was orient them: help them organize systems of affordable care and preventive medicine. They organized the community in a way that allowed them to begin on a small scale to provide health care for a low fee.”

PROSALUD soon started securing its own funding from the US government. Even as it expanded services in Bolivia, it also was advising other nonprofits in other countries on how to operate more efficiently and build stronger health systems.

Today, PROSALUD has created a primary and secondary health care model that works in six of Bolivia’s nine departments, operating 27 clinics, five hospitals, and one child development center. All of its clinics have pharmacies, delivery rooms, waiting rooms, and reception rooms. The clinics and ambulance services operate every hour of the year. And while it is primarily known for providing quality services at a low cost, its reach and accessibility has combined to produce extraordinary numbers in health service delivery: more than 6.7 million medical consultations, more than 2.2 million immunizations, and more than 75,000 births.

When Cuellar looks back at the start of the relationship with MSH, he sees many factors were in alignment.

“We were a group of young people, and we were naïve to believe that we could become an institution and not just a project,” he said. “I was just 30 years old. Most of us were that age. We believed a dream was possible. We were lucky to find a good partner—actually, we found a role model—and MSH was lucky to find people who really believed this was possible; that we could build something that lasts.”



An area of critical importance: Managing drug supply

CAMBRIDGE, MA – When Jonathan D. Quick, MD, MPH, started international health work in 1978 for MSH, he traveled around the world stopping at hospitals, health centers, pharmacies, and medical stores to see how countries supplied and used medicines. In many places he found chaos.

“At that time, people didn’t really know what to do. They knew medicines were essential for health. But they were expensive, highly variable in quality, used quite irrationally, and too often out of stock. There weren’t any sort of systems,” said Quick, now president and CEO of MSH. “You’d find prescriptions completely unrelated to the patient’s problem, and the same drug kept in three different places in the same medical store.”

Those field visits led to the publication of *Managing Drug Supply*, a landmark book that outlined a systematic approach to selection, procurement, distribution, and use of drugs. It wasn’t based on opinion, but on “best practices from around the world,” Quick said.

That publication also was the first step in MSH’s expansion into pharmaceutical management and training health workers. The training focused on making sure people have both access to medicines and the knowledge to properly use them.

From that point on, supported by funding from donors such as USAID, the World Health Organization, Pew Charitable Trusts, the Danish International Development Agency, The World Bank, The Rockefeller Foundation, and more recently the Bill & Melinda Gates Foundation, MSH began working to improve access to medicines. From the start, those involved in the process found they could make major improvements in health systems.

One of the first major projects, starting in 1986, helped the Organization of Eastern Caribbean States (OECS) form what is now known as the OECS Pharmaceutical Procurement Service. The idea behind the project was that pooling the resources of the countries could create a system to reduce prices, assure quality, improve use, and avoid stock-outs of lifesaving medicines.

“We helped them develop a restricted procurement list, along with a system to more accurately forecast total demand for those items, and a system to pool financial resources,” said James R. Rankin, formerly an MSH vice president. “All of this—including a computerized information system designed by MSH—enabled a centrally managed competitive bidding process. In the first bidding cycle, average prices for the list of products went down by 44 percent compared to the prior year.”

Rankin said the program worked in part because of MSH’s advice, but also because of the quality of work by the people operating the program. “It was their commitment and the capacity to run the system that really made it work.”

They taught me how to keep the drugs, how to dispense them, and how to keep the books.

The program has worked so well that it continues today—roughly two decades after MSH stopped its consulting work with the Eastern Caribbean organization.

MSH has also worked with local health authorities to strengthen private-sector pharmaceutical systems. An innovative program that started in 2000 in East Africa with a Gates grant worked with hundreds of private drug shop owners to improve access, quality, and consumer knowledge of medicines at their shops.

With further support from the Bill & Melinda Gates Foundation, the program has expanded from Tanzania to Uganda and Liberia. From Quick’s perspective, drug sellers should be an integral part of the health system, but virtually nowhere do they get help in achieving both public health and business goals.

“These drug sellers are commonly the first source of care outside the household,” Quick said. “If someone is sick, people will go to the drug seller’s shop. Until the Gates grant, few countries had effectively addressed this area. But today, within the space of a few square feet, these shops provide condoms for AIDS prevention, family planning medicines, and key products for prevention and treatment of childhood killers such as diarrhea, pneumonia, and malaria.”

Josephine Tuswbira, 52, the owner of The Lord is My Shepherd drug shop in the western Ugandan town of Kadabi, said that the MSH training helped her in a number of ways.

“They taught me how to keep the drugs, how to dispense them, and how to keep the books,” said Tuswbira, a single mother of two. “I am providing much better services than before. I can give my customers much more detailed instructions on how to use the drugs. They very much appreciate it. In all, compared to the way I ran my shop before, it’s a big difference. It even looks a lot nicer.”



Josephine Tuswbira in her drug shop.



Exterior of Josephine Tuswbira's shop, Kadabi, Uganda.



Young clients bring in prescriptions for medicines for their sick family members.

Ethiopia: “It’s about becoming human again”

ADDIS ABABA, Ethiopia – Addis Mamo had many things going for her. She came from a strong family. She was attending college and studying information technology. She was married. Then one bit of news tore her world apart. During her checkup, she learned she was pregnant—and she had HIV. Her husband tested negative, he left her, she dropped out of school, delivered a baby girl, and sank into depression.

And there she might have languished. But on a spring afternoon inside a small room outfitted with sewing machines, Mamo, 23, is taking a course in being a tailor and weaver. Around the room are nine other HIV-positive women also learning these skills.

For Mamo, there is hope. She is out of the house, she is with others, she is learning.

“I was totally depressed,” she said. “But someone at the health center told me about this program and about the support group for HIV-positive women, and so I started coming. I couldn’t just sit at home and do nothing. I was so stressed. This helps. Now I’m thinking about going back to college.”

For MSH, Mamo’s story is one of countless tales of its service in Ethiopia, part of a tapestry of programs all aiming to assist the government’s efforts in strengthening its health system. The MSH approach, complementing the government’s, is to make sure all health facilities are connected to the communities. For instance, when Mamo showed up for immunizations for her baby, who is HIV negative, a nurse told her about the local chapter of a national network for HIV-positive women. During a visit to help the child, the nurse was able to help the mother as well.

Belkis Giorgis (right), MSH gender adviser in Ethiopia, and Tigist Tesfeye (a mother who is HIV positive) stand outside a center in Addis Ababa, Ethiopia, where Tesfeye is learning to sew and weave. Tesfeye, a member of the National Network of Positive Women Ethiopians, which MSH has helped support, explains how she is struggling to feed her daughter, who also is HIV positive. Giorgis encourages Tesfeye to turn to her daughter’s case manager for help.







Mekdesyilme Yilma (left), talks at the National Network of Positive Women Ethiopians in Addis Ababa, Ethiopia.

Such efforts come in the context of the Ethiopian government's efforts to greatly expand its HIV services by shifting the burden from hospitals and physicians to health centers and nurses and other health workers. "It's the largest expansion of services attempted in Africa in terms of geographic scope and number of people involved," said Bud Crandall, chief of party for MSH's HIV/AIDS Care and Support Program in Ethiopia. "It's a very ambitious program."

And so MSH's role, with funding from USAID, in part entails helping health systems offer a broader range of services to families, particularly to women. One person making that happen is Belkis Giorgis, MSH's capacity-building adviser and gender adviser in Ethiopia.

Sitting in the backseat of a car in Addis Ababa on the way to the headquarters for the National Network of Positive Women Ethiopians, Giorgis explained: "MSH has been looking at health systems and how they respond to women. When women go to the clinic for HIV, for instance, we want to be able to do comprehensive care."

An example is the network of HIV-positive women. MSH backed the network with funding and technical advice, and the group has grown in five years from one chapter in Addis Ababa to 24 across the country, each with an average of 300 women. The numbers speak of major inroads, but the impact also is in the individual women's stories. Many have become public speakers and in the process have turned into role models for all Ethiopian women.

One of those heroes is Mekdesyilme Yilma, who was HIV positive for several years before telling anyone outside her family five years ago. Now she is known around the country as one of the leaders of the HIV-positive women's network. She has spoken at rallies, press conferences, briefings, and community gatherings, helping to greatly reduce stigma and discrimination against those with the virus. In the process, all women and men in the country are publicly getting to know a woman who speaks her mind.

"Women were never encouraged to get out and address people in public," said Yilma, 37, a mother of two. "Women can't even laugh loudly in this country. It's the way we were raised. If I didn't have HIV, I couldn't have gone to the media. But being positive gave me the strength to do it."

Giorgis said: "They are the most articulate women you can imagine. The founder of the organization wanted to start her own Oprah Winfrey-type show. That should tell you something."

Women were never encouraged to get out and address people in public; women can't even laugh loudly in this country. ... If I didn't have HIV, I couldn't have gone to the media. But being positive gave me the strength to do it.

"One of MSH's tasks with the network of HIV-positive women was to help them better focus their core activity: mobilizing communities through personal testimonials that increase support for prevention and encourage mothers to be tested for HIV and utilize prevention of mother-to-child transmission services," Giorgis said. "Their use of testimonials is like AA [Alcoholics Anonymous] meetings in the States. It is a very arresting concept, and if you look at them closely, you can see the impact they have made. So many women have come out about their status because of them, and now they are living healthier lives."

This network is just one example of MSH's work in Ethiopia. In its work with HIV & AIDS and its overall health work, it has helped train over 7,000 volunteers who work in 550 health centers. Of those centers, 394 now oversee antiretroviral therapy, while the remainder offer other HIV services.

Suddenly, women such as Mamo hear about services that can help them, and life changes. "I am humbled when I talk to these women," said Giorgis, who, after meeting Mamo, purchased a scarf made by one of the women in the program. "This program isn't just about helping them rise from the dead with the medicine. It's about positive women living positively. It's about becoming human again."



Mothers weigh their children while seeking medical assistance at Salima District Hospital in Salima, Malawi.

Malawi: Building a health system piece by piece

SALIMA, Malawi – An ambulance sped toward Salima District Hospital. In the back were a mother, father, and their very ill 19-month-old boy. At the hospital, the parents simply walked in and stood at the end of a very long line. This was how things were always done here: first come, first served.

Now it's different.

A nurse, performing triage in the line, noticed them. She examined the boy, Baliyasi Samson, whose eyes were closed and who appeared listless. The mother said the boy was sleeping, but the nurse thought otherwise. She called in clinician Rodrick Kaliati.

Kaliati examined the boy, asked questions of the parents, and then moved rapidly. The boy, he said, was in a coma and likely had severe malaria. He started oxygen therapy and inserted an IV line of glucose to raise the boy's blood-sugar level. Hospital workers monitored him, and a couple of hours later, the boy's eyes opened.

The fast-acting hospital team had saved a child's life and they pinpointed one of the reasons why: a five-day course had given them the basics of triaging, which they and hundreds of other pediatric nurses and clinicians around Malawi had put in place. The training, put on by MSH, was called ETAT—Emergency Triage Assessment and Treatment.

“We were really fed up with these deaths,” Kaliati said, referring to the many babies dying soon after arrival. “MSH's training taught us so many new things. We had just five days of training, but those five days changed us so much.”

MSH's work in Malawi began in 2003 and has been intensive and all-encompassing. Programs have covered a wide range of health services, from training community health workers on expanding their services in remote areas to putting in place the triaging in hospital waiting rooms. As USAID's lead partner in eight districts, MSH started with child health programs and worked on building up the health system through financial and pharmaceutical management and teaching managers to lead.

The work grew from there, moving into community-based family planning, HIV testing, pediatric AIDS, preventing the transmission of HIV from mother to child, strengthening tuberculosis programs, improving pharmacies, and finding ways to better treat pneumonia and diarrhea.

“What we have been doing is part of an ongoing journey to strengthen health services in Malawi,” said MSH's chief of party in Malawi for the BASICS project.

Through it all, MSH closely aligned its work with the Malawian Ministry of Health and its district offices. “They have worked so closely with us, within our system,” said Willie Samute, secretary for health in the ministry. “In fact, they are us. We are that close. They work in our greatest areas of need. They are not just a Lilongwe-based group. They are out there in our most remote areas. It's been a real partnership in those areas where we really needed it.”

In those rural areas—home to 82 percent of the population—a key focus has been on expanding family planning services through both health surveillance assistants and community-based distribution agents.

Atop a hill in the village of Michulo, Brenda Katumphika, 34, a health surveillance assistant, has been trained to give women Depo-Provera shots, which prevent pregnancies for three months. The injection has proven popular. The area she is responsible for includes just 2,195 people, but in less than two years she has administered 255 shots. “They really like it because it lasts long, it's 100 percent effective, and it's private,” she says.

In Mndola, another community in the Salima district, roughly 100 kilometers east of the capital in Lilongwe, Amon Chimphepo, 35, was trained by MSH to be a community-based distribution agent. He has papered his three-room house with charts, graphics, numbers, and statistics: a feast of figures that would appeal to someone like Bill Gates and other late-night readers of health minutiae. One poster showed that from August 2008 to May 2011 he administered 1,319 HIV tests (including 416 by going door-to-door) and counseled 159 people on family planning (including 41 women who started on birth control pills and 46 who went to a health facility for longer-term birth control procedures).

“At the moment, many women want to use the pills,” said Chimphepo, who has a high school education and was trained in administering HIV tests, counseling couples, and educating people on family planning. “Before, many women were using native methods, such as boiling and drinking herbs or roots of plants.”

Like other community-based workers in Malawi, Chimphepo received a USAID package of goods that included a single-gear bicycle, backpack, raincoat, umbrella, solar charger, and a cell phone. Every day he makes his rounds on his bicycle, carrying materials in his backpack. And nearly every day, he sends text messages over his cell phone to a central collection service that records the numbers of people he has helped.

Three years ago, that boy would not have survived because the system was not there. Now it is.

The statistics show the major need for family planning services. A 2006 national survey found that the fertility rate in the Salima district was an

average of 7.1 children for women in reproductive years, the second highest rate in Malawi. On his rounds one day, Chimphepo stops his bike ride to talk with one couple, Charles Jasi, 31, and Christina Charles, 29, whom he had previously counseled.

“What he’s doing is very important,” says Jasi. “Before he provided information to us, we thought it was no problem to have children born so close to one another. Now we in the village know that it’s good to space our children, for the mother’s health and also for the baby’s.” The couple has five children, and Christina Charles recently had an implant that will prevent her from getting pregnant for five years. “That’s the end,” she says, laughing.

For counseling on family planning and testing for HIV, MSH’s approach has been to support the government’s efforts at various points in the health system, starting in the village with people such as Chimphepo and continuing into the hallways of district hospitals.

Starting in 2004, MSH employed 16 people to perform HIV testing and counseling in hospitals around the country. They tested roughly a half-million people over seven years. One particular focus is to test as many pregnant women as possible in the efforts to prevent transmission of the virus from mother to child.

At Salima District Hospital, two counselors, Lucia Afiki, 36, and Esther Goodson, 38, explain how more and more people in the last few years have been willing to take HIV tests. Both Afiki and Goodson are HIV positive and they don’t hesitate to reveal their status during counseling sessions.

“When we are open with them about our status, some people say to us, ‘Can you come closer, we want to learn from you,’” said Afiki. Goodson added: “And they say, ‘What should I do to look as good as you look?’”

The two counselors laugh at that, but Afiki provides an answer: “I say to them, they should remove their fears, see their doctor, meet with a support group, and live positively.”

Sitting in a waiting area next to the counselors are two-dozen people—all waiting to be tested for HIV. Gone are the days early in the response to the AIDS epidemic when just a few people a day would check their status at many counseling and testing centers throughout Africa.

Near the HIV testing site is the hospital’s pediatric ward. It was there that the young boy Baliyasi Samson awoke from his coma and began his recovery. Four days after he entered the hospital, his mother took him home.

MSH district coordinator Kuzemba Mulenga later found the family in their village about a half-hour drive from the hospital. There, the father, Samson Sinoya, 35, a shoemaker, looked at the boy and marveled that he was well. “I thought my child would die,” he said. “I had given up.”

The father told Mulenga the story of the boy’s illness, and Mulenga said that while the triage system at the hospital ultimately saved the child’s life, many other things in the health system also had to work well. The boy had been brought to a neighboring health center, where a clinical officer, recognizing that the boy needed emergency care, arranged to have an ambulance take him to the hospital.

“We had to have the drug supply and the equipment in place,” Mulenga said. “The district health officer had to have emergency vehicles in the outlying areas, to take that boy to the hospital quickly. And when they got to the hospital, the team there had to act fast, and they did.”

As he spoke, a couple of dozen children in the family’s village were dancing, singing, and laughing. In one corner, several women, including Baliyasi’s mother, Sayankhalana Sakola, were sitting and talking.

“It’s great,” Mulenga said of the scene, but also of the boy who was saved. “Three years ago, that boy would not have survived because the system was not there. Now it is.”



Sayankhalana Sakola, 27, and her son, Baliyasi Samson, 19 months old, in the Salima District Hospital, Malawi.



Annie Chingoneka, 14 years old, Manase Village, Malawi.



Mexon Nyirongo stands outside the MSH office in Lilongwe, Malawi. Nyirongo is chief of party of the Community Family Planning and HIV Services project.



Grace James, 23, listens to the advice of Timothy Kachule, outside the Bwaila Maternity Unit in Lilongwe, Malawi. Kachule is MSH's deputy chief of party of the BASICS project.

MSH's Approach to Health Systems Strengthening

In Malawi, MSH prioritizes child health programs in cooperation with the Malawian Ministry of Health. After assessing the country's health system, MSH identified financing, drug management, and leadership training as areas where it could best support the ministry's efforts. Together, MSH and the ministry strengthen the country's health system with targeted interventions where there is the greatest need – Malawi's most remote areas.



Analyze the Challenge



Salima District Hospital in Malawi had multiple challenges. It was known as one of the filthiest hospitals in the country. Turnover was high. Its health care was substandard. One major problem was the high number of children dying within 24 hours of admission.



A new management team came in 2008 and MSH advised them on how to analyze their challenges. The hospital focused on improving child hygiene, retaining and training staff, and building trust in the community.



The hospital painted a sign at its entrance: Salima District Hospital is Baby Friendly. But the hospital's leaders still needed to get to the bottom of why so many children were dying.



MSH sent several nurses and pediatric clinicians for a five-day training in emergency triage.

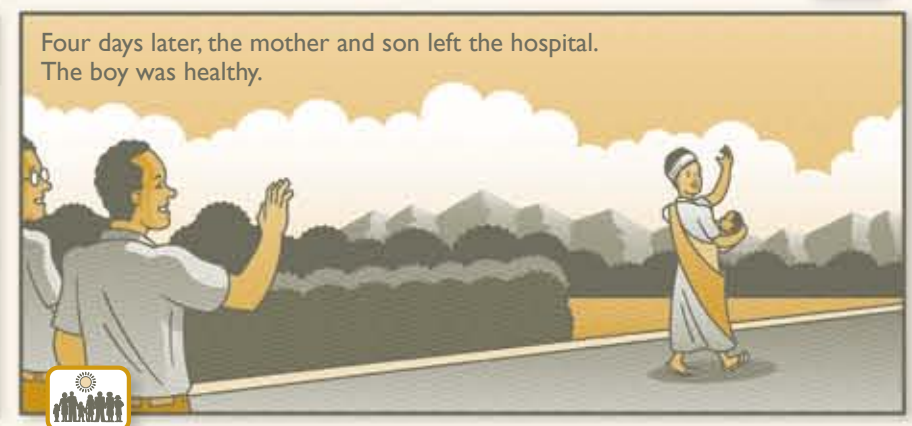
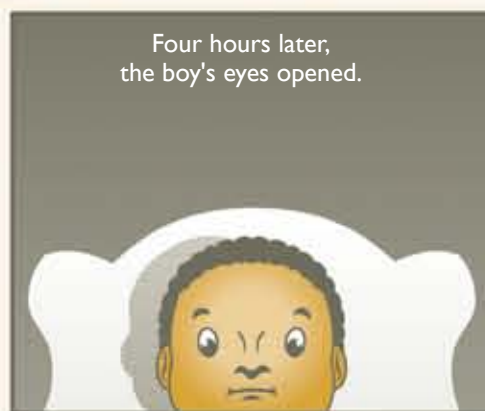
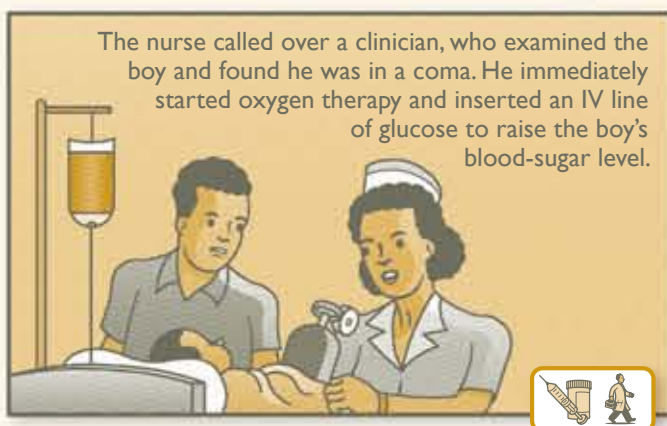
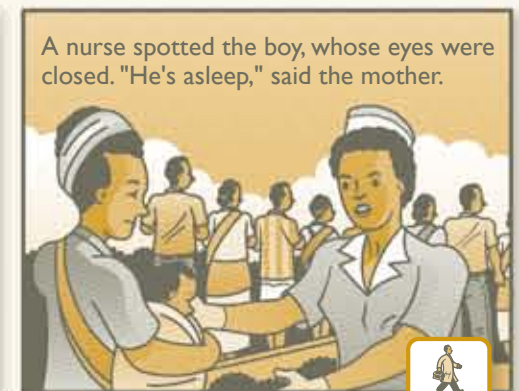
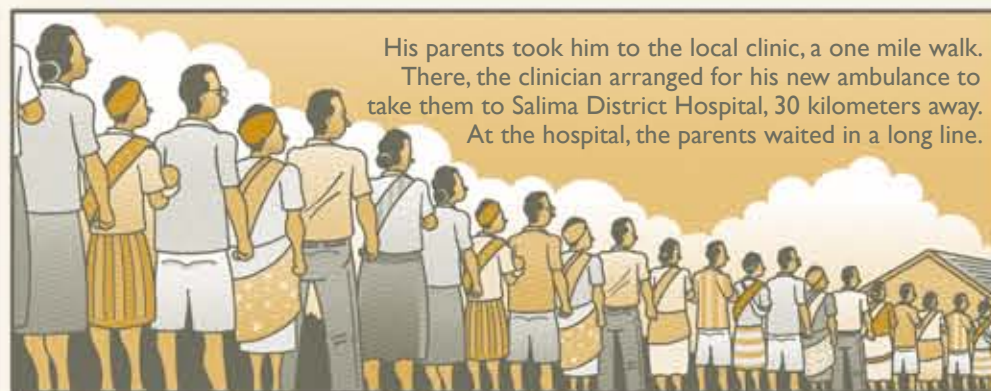
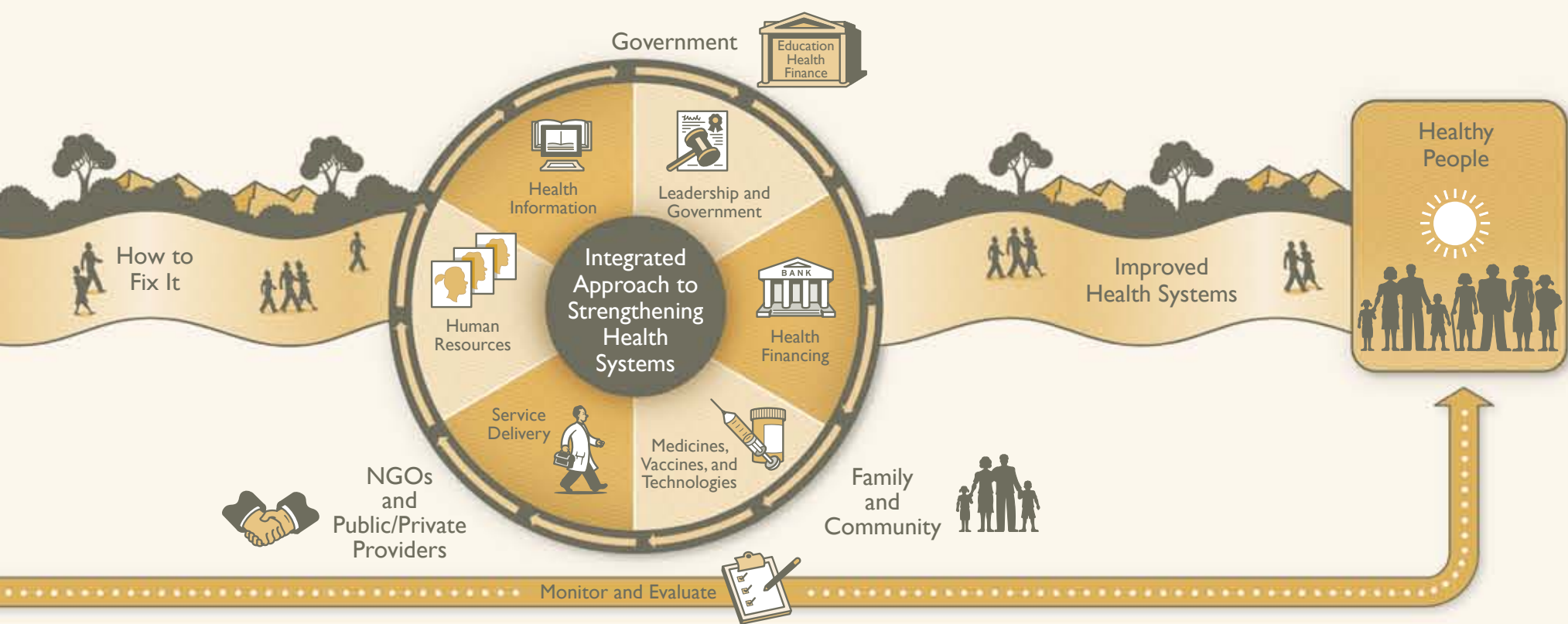


The clinicians and nurses said it changed their jobs completely. They began to look for critically ill children waiting in the hospital lines and treated them immediately.



Other challenges remained. One was getting sick children to health facilities quicker, so MSH supported an educational awareness campaign. It also worked with the district health officer to deploy three ambulances to strategic remote areas.





Universal health coverage: The ultimate test of a health system



Dr. Jonathan D. Quick, president and chief executive officer of MSH

Jonathan D. Quick, MD, MPH, a family physician and health management specialist, is the president and chief executive officer of MSH. Dr. Quick first started working for MSH in 1978 as a third-year medical student. For nine months, he traveled to ten countries on five continents to research pharmaceutical management and supply. He later joined MSH full-time. From 1996 to 2004, Quick was director of the World Health Organization's Essential Drugs and Medicines Policy. In 2004, he returned to lead MSH.

The challenge right in front of us now is universal health coverage. ...We need to take the lessons of the failure of primary health care in the '90s and learn from them.

What lessons did you take from those early experiences that stay with you today?

In those first nine months, I traveled to ten countries, and what was really striking was how similar the challenges were from place to place. But people faced those challenges differently. I felt like I was collecting pearls of wisdom from around the world so that people could learn from each other. I also learned how important it is to support and build champions. Behind every successful program is somebody with the vision and passion to drive it.

Why did you return to MSH in 2004?

When I got the call inviting me back, I was really excited. MSH was becoming a much more diverse organization. At the WHO, my leadership team had five people from five different countries. I really liked that. At MSH, we had people from 70 different countries; we Americans were less than one in eight of the staff. I also saw a lot of very creative work going on in leadership development, ways of empowering people, the work on performance-based financing, and all the intensive work on the ground.

MSH's founder, Ron O'Connor, has ingrained Lao Tzu's "Tao of Leadership" in the organization. Why is that important?

I'll answer that with a Kenyan proverb: "Songs brought by foreigners are not long used at the dance." There's a tendency of people coming from the outside to think just because they know things local people don't know, they must have the solutions. They arrive not with questions, but with answers. But development driven from the outside normally doesn't stick, just like the songs by foreigners. The whole idea of working shoulder to shoulder with our local colleagues is what makes lasting success. Our work is based on an attitude of humility.

When you travel to see programs, what do you look for?

One of the things I like about field visits is the long drives I have with people. I always try to ride with our local counterparts and talk to them to try to understand where they are coming from. I'm always inspired. You hear great stories on these trips.

In the years ahead, what will be the big challenges in global health?

The challenge looming in the background is the economic crisis. Countries are struggling in different ways, but not all countries. There are the 16 African tigers, as the economist and author Steve Radelet calls them. Those countries are moving forward with lots of economic diversity, and we will have opportunities to move forward with health programs in ways we haven't before.

The challenge right in front of us now is universal health coverage. If primary health care was the unifying principle and vision in the 1980s, I believe that universal health coverage will be the unifying principle over the next decade. We need to take the lessons of the failure of primary health care in the '90s and learn from them. Universal health coverage is the ultimate test of the efficiency and effectiveness of a health system.

A second major challenge ahead of us is the demographic transition of large numbers of people growing older, and the growing issue of people suffering from chronic disease. Cancer already kills more people than AIDS, malaria, and tuberculosis combined in developing countries. But the systems are not in place to deal with it.

In the last few years, many people have questioned the value of development aid. What examples do you have of MSH's lasting impact?

We have many. One is PROSALUD in Bolivia, which we helped in the beginning and has just turned 25 years old. It is today the largest private nonprofit health service in Bolivia and the largest provider of family planning services. Another is a ten-country drug procurement program we helped start in the Eastern Caribbean, also celebrating its 25th anniversary. In the Philippines, we helped put together a management process for the decentralization of the health system. In South Africa, just after the end of apartheid, we helped create something closer to a nonracial health system. There's also the scale-up in Afghanistan of community health workers, and there's the drug sellers in Tanzania—great examples of community-based care. I could go on and on. It's great to see a few years of intensive investment yield a generation of development and health impact.

USAID Administrator Rajiv Shah says that he wants his agency to be so successful that it will eventually work itself out of a job. What do you think about that?

First, we should recognize the huge gift American people have given the rest of the world through USAID. There are many examples of lasting successes that USAID and the American public can be proud of. I wholeheartedly agree with Dr. Shah's ideas on innovation, monitoring and evaluation, and measurable results. But I don't think we will see development ending, at least not in the foreseeable future. Let's look at it this way: Will there be enough equality in the world so that there will not be less fortunate countries looking to the more fortunate for assistance? Unlikely. I think it's the right thing to do for those farthest ahead to help those who haven't gotten there yet.

As for working ourselves out of a job, we did that with PROSALUD and the Eastern Caribbean procurement system 15 years ago. We moved on. Now we are helping others. We have been continually working ourselves out of a job for the last 40 years and are proud of it—out of a job, but not out of the mission of helping countries build strong local health systems that achieve lasting impact.

AFTERWORD

A moment of critical importance in global health

Dr. Ariel Pablos-Méndez



Dr. Ariel Pablos-Méndez

A third of a century ago, world leaders came together at Alma Ata and crafted a vision of health for all. We have the tools to make this vision come to life now. We can do it. I have no doubt.

On March 22, 1961, President John F. Kennedy wrote an impassioned letter to Congress conveying a genuine belief that life, liberty, and the pursuit of happiness is more than just an American right—it's a human right. The letter inspired the creation of a US government entity that for the past 50 years has drastically reduced poverty, fueled the spread of democratic values, opened the floodgates for economic opportunity, and enhanced well-being for millions around the world.

This entity, the US Agency for International Development (USAID), has been tenacious in its pursuit to fulfill President Kennedy's vision by convening and supporting partners that share this vision, like MSH, around the globe. The inspirational stories in this book

chronicle a portion of the larger history of foreign aid that has left an unmatched legacy of progress in human development and are a testament to the power of partnership.

At USAID, we've learned through experience that investing in global health provides a cascade of benefits across the development spectrum. We've reached a pivotal moment in our efforts to provide quality health care to people around the world. By building on best practices and lessons learned, we are charting a course forward that will ensure future success through continued partnership. We are driving procurement reforms and strengthening our ability to research, share knowledge, monitor and evaluate progress, and increase technical capacity.

President Obama's visionary Global Health Initiative is acting as a catalyst for reform by improving collaboration across the US government, increasing integration of health services, embracing a women-centered approach, encouraging country ownership, and elevating the need for innovation.

As a result, countries are better able to provide a wider range of medical and health services at a single location, the paradigm has shifted from a disease-centric to patient-centric model, and we have found new ways to reach those who will likely never set foot in a health facility with a full range of basic health services.

On behalf of the American people, USAID will continue to challenge established systems that inhibit human development. The successes outlined in this book demonstrate the power of development done right and celebrate the remarkable people who contributed to the cause.

A third of a century ago, world leaders came together at Alma Ata and crafted a vision of health for all. We have the tools to make this vision come to life now. We can do it. I have no doubt. Just read these stories.

Dr. Ariel Pablos-Méndez is assistant administrator for the Global Health Bureau at USAID.

Tao of Leadership

Go to the people

Live with them

Love them

Learn from them

Start with what they have

Build on what they know.

But of the best leaders

When their task is accomplished

The work is done

The people will all say

We have done it ourselves.

— Lao Tzu



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John Donnelly & Dominic Chavez



John Donnelly

is an award-winning writer specializing in global health and development issues. His work as a journalist included assignments for *The Boston Globe* in Washington, DC and Africa and for the *Miami Herald* in the Middle East and Haiti. Now living in Chevy Chase, MD, Donnelly is a vice president at Burness Communications and directs Long Tail Media.



Dominic Chavez

is a former staff photographer at *The Boston Globe*. He has won many awards for his work, including a first place in the Pictures of the Year International Competition for his pictures during the war in Iraq. For more than a decade, Chavez has covered global health issues in Latin America, Africa, the Middle East, and Asia. He lives in Chelsea, MA.

