



How to use the PIH Engage Curriculum

Led by: Community Building Lead

Each of the lessons revolves around a specific theme pulled from research, writing, and experience that is integral to the PIH mission and model of global health care delivery. There is a suggested order; however, each lesson can stand-alone and spark unique discussion pertinent to the movement for the right to health. Choose lessons to curate specific meetings, and play into the interests of your team members.

There are two different ways to use these lessons, either through the discussion guide or lesson plan; however, every lesson has an overarching goal. By the end of the lesson, whether you use the discussion guide or the lesson plan, you should accomplish this goal. Goals can be shared with your team, or simply used to guide how your time is spent.

It is imperative that the Community Building Lead deeply engages with and has a strong understanding of the readings to properly facilitate these discussions. Reviewing the discussion guide and lesson plan prior to the meeting is also necessary. The Community Building Lead should also make sure team members have copies of the reading, either digital or physical, prior to and during the meeting. Additionally, the Community Building Lead should feel free to use additional resources (e.g. videos, handouts, slides, etc.). It is also helpful to be interactive while conducting lessons –use blackboards/whiteboards, projectors, and any other resources available to you.

Discussion Guide

Use the discussion guide if your team members will fully engage with the readings and come with a solid understanding of the literature. This will help generate a discussion that feels like a free-flowing reflection on the reading.

Suggested Discussion Questions:

The suggested discussion questions should push your team to think critically about some of the themes presented in the readings. These are merely suggestions—feel free to present your team members with additional questions!

Key Quotes:

Key quotes have been pulled from the text to highlight especially important or provocative ideas. Share these quotes to spark discussion on the specific topics addressed.

Lesson Plan

Use the lesson plan if you think your team members may not fully engage with the reading or if you are looking for more structure or guidance. These lesson plans have been developed to summarize the key points of each reading and foster meaningful, provocative discussion.

Lesson plans are split up into seven separate parts, each designed to take 3-15 minutes. Spend some time before a discussion thinking about how long to spend with each section. Prioritize sections, knowing which ones you will cut if time runs short. Lessons are built to take about an hour.

Lessons include:

Warm Up: Spark discussion about a relevant theme. Time: 3-7 minutes.

Diagnostic: Figure out how much knowledge your team has on a given topic. Feel free to adjust the lesson accordingly or call on specific individuals with a high level of prior knowledge based on the diagnostic. Time: 3-5 minutes.

Teaching Bit: Teach new information. This section summarizes key points. Time: 7-10 minutes.

Guided Practice: Explore the teaching bit. Process lessons and push provocative thought. Time: 7-15 minutes

Independent Practice: Take the lesson a step further. Apply the lesson to your work as PIH Engage. Time: 7-15 minutes.

Assessment: Assess if you accomplished your goal. Contextualize your team's campaigns if possible. Time: 3-7 minutes.

Closer: Close out the lesson with a quick reflection, thought, or idea. Time: 3-5 minutes.



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- Goal: Explore the history and values of PIH in order to contextualize how PIH Engage advances PIH's Mission.

Structural Violence: Addressing the Root of Illness

- Reading: Farmer, P. (2004). Health, Healing, and Social Justice- Insights form Liberation Theology. In, *Pathologies of Power* (pp. 379-394). Los Angeles: University of California Press.
- Goal: Understand how social, cultural, economic, and political factors influence health.

A Social Justice Approach to Global Health

- Reading: Farmer, P. (2004). Health, Healing, and Social Justice- Insights form Liberation Theology. In, *Pathologies of Power* (pp. 394-402). Los Angeles: University of California Press.
- Goal: To inspire PIH Engage to act in accordance with the social justice approach to global health.

The Right to Health Movement

- Reading: Farmer, P., Kim, J. Y., Kleinman, A., & Basilio, M. (2013). A Movement for Health Equity? A Closing Reflection. In, *Reimagining Global Health- An Introduction* (pp. 340-353). Los Angeles: University of California Press.
- Goal: Explore global health history to inspire teams to commit to the Right to Health Movement.

Leadership and Organization in the Right to Health Movement

- Reading: Ganz, M. (2010). Leading Change: Leadership, Organization, and Social Movements. In N. Nohria & R. Khurana (Ed.), *Handbook of Leadership Theory and Practice: A Harvard Business School Centennial Colloquium* (pp. 1-8 & 33-38). Boston: Harvard Business Press.
- Goal: Explore how PIH Engage will use the work of PIH to advance the right to health movement.

The PIH Approach to Health Care Delivery: PIH Engage's Role to Echo, Amplify, & Advocate

Global Health: From Theory to Practice

- Reading: Kleinman, A. (2010). The Art of Medicine, Four Social Theories for Global Health. *Lancet*, 375, 1518-1519.
- Goal: Acquire a toolkit of social theories to reframe or contextualize arguments in global health.

Health Care Delivery: Staff, Stuff, Space, and Systems

- Reading: Kim, J. Y., Farmer, P., & Porter, M. (2013). Redefining Global Health-care Delivery. *Lancet*, 382, 1060-1069.
- Goal: Dissect this framework for health care delivery and the importance of best-practices.

Horizontal and Vertical: Challenges in Approaches to Global Health

- Reading: Mills, A. (2005). Mass Campaigns versus General Health Services: What Have We Learnt in 40 Years about vertical versus horizontal approaches? *Bulletin of WHO*, 83 (4), 315-316.
- Goal: Explore these approaches and how to overcome the challenges they pose.

Scaling Up in Global Health: Bridging the “Know-Do” Gap

- Reading: Farmer, P. (2013). Chronic Infectious Disease and the Future of Health Care Delivery. *N. Engl. J. Med.*, 369 (25), 2424-2436.
- Goal: Explore ways to bridge the “know-do gap” when scaling up in global health.

Ethical Global Health Research

- Reading: Chu, K. M., Jayaraman, S., Kyamanywa, P., & Ntakiyiruta, G. (2014). Building Research Capacity in Africa: Equity and Global Health. *PLOS Medicine*, 11 (3), 1-4.
- Goal: Understand equitable global health research and how research can be used to build local capacity.

Case Studies and Global Health Priorities: Contextualizing with History

MDR-TB: Redefining Health Care Delivery

- Reading: Farmer, P. (2010). Optimism and Pessimism in Tuberculosis Control: Lessons from Rural Haiti. In H. Saussy (Ed.), *Partner to the Poor: A Paul Farmer Reader* (pp. 195-205). Los Angeles: University of California Press.
- Goal: Explore care delivery and equitable research interventions conducted alongside the poor.

The AIDS Epidemic Launches Global Health

- Reading: Farmer, P., Kim, J. Y., Kleinman, A., & Basilio, M. Redefining the Possible: The Global AIDS Response. In *Reimagining Global Health – An Introduction* (pp. 111-121). Los Angeles: University of California Press.
- Goal: Understand how the AIDS movement played a critical role in advancing the field of global health.

Activists and the Success of PEPFAR

- Reading: Farmer, P., Kim, J. Y., Kleinman, A., & Basilio, M. Redefining the Possible: The Global AIDS Response. In *Reimagining Global Health – An Introduction* (pp. 121-132). Los Angeles: University of California Press.
- Goal: Understand how advocacy led to the success of the AIDS movement including the passage of PEPFAR.

Structural Violence and Health Equity at Home

- Reading: Scott, J. (2005, May 16). Life at the Top Isn't Just Better, It's Longer. *The New York Times*, pp. 1-17.
- Goal: Question the term global health and explore health equity in high income countries.

Global Health Financing: The Need for Advocacy:

- Reading: Keshavjee, S. (2014). Bretton Woods to Bamako – How Free-Market Orthodoxy Infiltrated the International Aid Movement. In *Blind Spot* (pp. 85-99). Oakland: University of California Press.
- Goal: Explore foreign aid and how PIH Engage can help stabilize global health financing.



History and Values of Partners In Health

Reading: PIH Change Narrative: 1984-2010

Discussion Guide

Goal: Explore the history and values of PIH in order to contextualize how PIH Engage advances PIH's mission.

Suggested Discussion Questions:

1. How did the origin of Partners In Health inform the values of our organization and the model of health care delivery in which PIH believes?
2. Accompaniment, partnership, and creating a preferential option for the poor are the core founding values of PIH. How have these values influenced efforts in advocacy, training, research, and teaching? Why is it important that we are driven by a mission as we grow as an organization?
3. How do the three pillars of PIH Engage, advocacy, education, and fundraising, help expand PIH's goals of access to health care for the poor?

Key Quotes:

"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 these areas... 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, throughout our efforts to change minds and laws and budgets and policies and the health care that is delivered by others to the poor" (6).

"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 lead to the great leap that was the Gates grant for Peru. None of this would have happened if we'd focused on service alone" (7).

"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" (8).

Lesson Plan

Goal: Explore the history and values of PIH in order to contextualize how PIH Engage advances PIH’s Mission.

Warm-up: Ophelia states, “a preferential option for the poor has broad support, but not everyone agrees what it means. We’re not sure we all need to” (4). Providing a “preferential option for the poor” or “O for the P” is at the core of the PIH mission. In your own words, discuss what this phrase means.

Diagnostic: Share as a group what you know about PIH and how your relationship with PIH began.

Teaching Bit: Give a brief history of Partners In Health. Highlight lessons learned at each step. These are some of the key pillars of the PIH model of health care delivery.

In Cange in 1984, PIH began when Paul Farmer and Ophelia Dahl met their first teachers and partners in health, Pere and Mme. Lafontant. In early years, despite some failure, they learned the importance of:

- Community health workers and accompaniment (i.e. leveraging resources that one person has to stand in pragmatic solidarity with another suffering individual)
- The need to consider education and socioeconomic needs in order to address health
- Maintaining focus on individual patients
- Research to prove the success of their methods

In Peru in 1994, PIH was able to secure a \$44 million grant to treat MDRTB because of their proven success treating this disease with funding and faith from Tom White. Changes in national and international treatment policies and massive reductions in drug prices followed. They thus learned the importance of:

- “Creating change with the largest levers of international policy-making and financing” (2)

In Rwanda in 2005, PIH began “delivering care, rebuilding infrastructure, and training local people, all within the ministry of health system” (2). Here, PIH developed and learned the importance of:

- The “public-sector strategy” of accompaniment: partnering with local ministries of health to build health systems that will ultimately be able to be sustained by countries themselves

Guided Practice: To provide “access to health care” most generally means to “prevent unnecessary suffering and to promote health” (4). Brainstorm as a team how the three pillars of PIH Engage help advance access to health care.

Advocacy	Fundraising	Education
Ophelia states that “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” (6). Advocacy is a primary way to fight for stabilized global health financing, equity-driven patent laws, and high-quality care for the poor. Advocacy is key to large-scale change.	Fundraising fuels this work. Everyone who fights for global health equity will need to fundraise at some point. Making a donation can be an entry point for many future leaders in global health equity and is the ultimate means of resource reallocation.	Ophelia states that “we need the help of all those who care deeply about this work to refine a sound strategy by the next generation of PIHers... 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” (3). By educating ourselves on the body of academia shaping global health, we are arming ourselves, the future leaders in global health equity, with the foundational knowledge needed to responsibly push this movement forward and lead into the future.

Independent Practice: Within the PIH model, “[accompaniment] implies that all of us will face problems in our lives and require accompaniment: having others walk with us and support us” (4). Turn to a partner and share a time you were accompanied and a time you accompanied someone else.

Assessment: Ask individuals to share with your whole team their stories of accompaniment. Talk about how the stories being shared relate back to PIH’s idea of accompaniment, of standing in pragmatic solidarity with suffering individuals.

Closer: Ophelia states, “as we seek to formulate our strategy for the next few years, our ability to ‘offload’ tasks outside our core competencies... will require stronger partnerships (5). Have each person name one organization, type of service provider, etc., that PIH, or better yet, your PIH Engage team, could partner with to build this year’s campaign goals and advance the movement for the right to health.



Structural Violence: Addressing the Root of Illness

Reading: *Health, Healing, and Social Justice*, p. 379-394, from *Pathologies of Power*, Paul Farmer

Discussion Guide

Goal: Gain a foundational understanding of liberation theology and how it calls us to respond to the political, cultural, and economic histories that shape the health of the poor.

Suggested Discussion Questions:

1. Where have you seen or heard about structural violence? How does thinking of poverty as a result of structural violence affect your personal motivations for engaging in this work?
2. Liberation theology posits that genuine change will be rooted in small communities of poor people. Why does liberation theology call on communities of poor people, specifically, as experts on what needs to change?
3. How do you interpret the three steps of the methodology laid out by liberation theology (observe, judge, act)? Is one step more or less important?

Key Quotes:

“To those concerned with health, a preferential option for the poor offers both a challenge and an insight. It challenges doctors and other health providers to make an option—a choice—for the poor, to work on their behalf... It’s also clear that many health professionals feel paralyzed by the magnitude of the challenge. Where on earth does one start?” (380).

“The reality posed by the poor... is no rhetorical question... It is a reality that calls men and women not only to recognize and acknowledge it, but to take a primary, basic position regarding it... This same reality is a question for human beings as themselves participants in the sin of humankind... the poor of the world are not the causal products of human history. No, poverty results from the actions of other human beings” (384).

“Liberation theology would push analysis in two directions: first, to seek the root causes of the problem; second, to elicit the experiences and views of poor people and to incorporate these views into all observations, judgments, and actions” (387-388).

Lesson Plan

Goal: Gain a foundational understanding of liberation theology and how it calls us to respond to the political, cultural, and economic histories that shape the health of the poor.

Warm Up: The text states that in response to devoting oneself to populations struggling against poverty, it is “clear that many health professionals feel paralyzed by the magnitude of the challenge. Where on earth does one start?” (380). Discuss this sentiment. Does it resonate with you? Have you ever worked to combat issues of poverty and, if so, how did you initially approach and ultimately follow through with your work?

Diagnostic: Few would dispute the statement that “the poor are sicker than the nonpoor” (380). As a group, think critically about the factors (daily life choices, larger systems, etc.) that contribute to poverty. Make a list.

Teaching Bit: Gustavo Gutiérrez, a Peruvian theologian regarded as the father of liberation theology, states that “the poor are a by-product of the system in which we live and for which we are responsible” (379). Jon Sobrino echoes this, emphasizing that “the poor of the world are not the causal products of human history. No, poverty results from the actions of other human beings” (384).

Structural Violence is a term that refers to systems created by political, economic, or social histories. These systems are shaped by the powerful and keep others captive in poverty. **Liberation theology** responds to structural violence by arguing that “genuine change will be most often rooted in small communities of poor people; and...advances a simple methodology—observe, judge, act” (380 – 381). PIH has worked to address health by:

- 1) Seeking the root causes of the problem
- 2) Eliciting the experiences and views of poor people
- 3) Incorporating these views into all observations, judgments, and actions

Importantly, PIH has called upon liberation theology’s methodology by always observing first. PIH started with Zanmi Lasante, PIH’s Haitian sister organization, in Cange. Here, PIH worked with the poor to respond to their needs and acted in accordance with their desires. PIH is deeply committed to a model of health care delivery that addresses social inequities by analyzing their historical context and working with the local citizens and governments in pragmatic solidarity—solidarity that works to rapidly deploy tools and resources.

Guided Practice: While the methodology detailed by liberation theology to observe, judge, and act may seem simple, each of these three steps can take decades or more to achieve. Dissect each of these steps as a group. Talk about what is meant by each step, which questions to ask, and especially, what to be wary of before moving onto the next step.

Observe	Judge	Act
Overview: “ ‘Observe’ leads to descriptions of the conditions of the... poor, and also to claims regarding the origins of these conditions” (382). “‘Observe’... reveals atrocious conditions as atrocious” (383). “[It]... involves careful review of a large body of literature” (387).	Overview: “The reality posed by the poor... is no rhetorical question... It... calls men and women not only to recognize and acknowledge it, but to take a primary, basic position regarding it” (384).	Overview: “The act part of the formula... it’s simple: heal the sick” (389).
Key Question: What are the conditions of the poor and, importantly, why?	Key Question: Do I believe this reality is good or evil, just or unjust?	Key Question: What actions will deploy resources to heal the sick?

Independent Practice: With a partner or small group, brainstorm instances of structural violence you have witnessed or heard about domestically or internationally. How have systems caused or propagated poverty? (If stuck, consider locations of clinics/hospitals in the U.S. and abroad, costs of medications, access to and quality of health insurance, disproportionate incarceration rates of the poor, locations of housing projects, the Péligre Dam in Haiti, etc.)

Assessment: Share the instances of structural violence discussed in small groups. What are possible ways to rectify some of these wrongs? **In order to enact big-picture change, how might advocacy or PIH Engage play a role?**

Closer: Share one action that you, in your current role as a student, professional, etc., can take to help mobilize resources that might aid in the fight to heal the sick, and, specifically, heal the poor.



A Social Justice Approach to Global Health

Reading: Health, Healing, and Social Justice, p. 394-402, from *Pathologies of Power*, Paul Farmer

Discussion Guide

Goal: Deepen commitment to the social justice approach to health care delivery and inspire PIH Engage to act in accordance with this model to advance the right to health.

Suggested Discussion Questions:

1. What are pros and cons to each of the three models to addressing suffering (charity, development, and social justice) and why is it important to intimately understand the arguments for and against each of these models?
2. How does PIH's approach to health care delivery—accompaniment, partnership, and building high-quality health-care systems—contribute to ensuring a patient's fundamental right to health and dignity?
3. Is it hypocritical for PIH Engage to ask for small charitable donations to PIH, given that PIH sees human suffering and disease through the lens of social justice?

Key Quotes:

"Those who believe that charity is the answer to the world's problems often have a tendency—sometimes striking, sometimes subtle, and surely lurking in all of us—to regard those needing charity as intrinsically inferior... There is an enormous difference between seeing people as the victims of innate shortcomings and seeing them as victims of structural violence" (395-396).

"The resurgence of charity is at once a *symptom* and a *cause* of our society's failure to face up to and deal with the erosion of equality" (396).

"If we focus exclusively on aggregate data, why not declare public health in Latin America a resounding success? After all, life expectancies have climbed; infant and maternal mortality have dropped. But if you work in the service of the poor, what's happening to that particular class, whether in Harlem or in Haiti, always counts a great deal" (400).

Lesson Plan

Goal: To deepen commitment to the social justice approach to health care delivery and to inspire PIH Engage to act in accordance with this model to advance the right to health.

Warm Up: Dissect Janet Poppendieck’s statement that: “The resurgence of charity is at once a symptom and a cause of our society’s failure to face up to and deal with the erosion of equality” (396). Write this quote on the board. What does she mean by this? Can you think of examples where you have seen this illustrated? (For additional context, see the first key quote in discussion guide.)

Diagnostic: PIH is deeply committed to protecting the rights and dignity of the poor. With your team, talk about how PIH’s approach to health care delivery—accompaniment, partnership, and building high-quality health-care systems—helps to ensure a patient’s fundamental right to health and dignity.

Teaching Bit: The text states that “in looking at approaches to [the suffering that surrounds us], one can easily discern three main trends: *charity, development, and social justice.*” PIH works to always approach suffering through the lens of social justice and Farmer states his belief that “the first two approaches are deeply flawed” (395).

- **Charity** relies on an individual with excess offering a good or service to someone without this good or service.
- **Development** relies on technological and economic advancement to raise the overall standard of living.
- **Social Justice** sees conditions of the poor as the result of human-made structural violence and works alongside the poor to address root causes of suffering and injustice.

Guided Practice: In the text, Farmer voices strong opinions about each model and a strong preference for the social justice approach. However, there are many individuals who believe strongly in development and charity. In order to believe in one approach, it is important to discern the pros and cons of each. Discuss in small groups.

Charity Model	Development Model	Social Justice Model
<p>Pro: Discuss—what are pros here? (Think: small donations keep PIH going, entry point for many people.)</p> <p>Con: There is a tendency “to regard those needing charity as intrinsically inferior [rather than] powerless or impoverished because of historical processes and events” (395-396). Health care is not high-quality: “Charity medicine too frequently consists of second-hand services... doled out in piecemeal fashion” (397).</p>	<p>Pro: Discuss as a group. (Think: improved infrastructure and other large-scale projects.)</p> <p>Con: In this model the poor aren’t a priority: “Developmentalism... erases the historical creation of poverty [and] implies that development is... a linear process.... Leonardo and Clodovis Boff argue: “Reformism can lead to great feats of development in the poorer nations, but this development is nearly always at the expense of the oppressed poor” (398).</p>	<p>Pro: This model works to combat the conditions of the poor and see them “not only as unacceptable but as the result of structural violence that is human-made.” (400). It works “with poor people as they struggle to change their situation” (400). It relies on an analysis that is “historically deep... [and] geographically broad... so as to understand that what happens to poor people is never divorced from the actions of the powerful” (401).</p> <p>Cons: Discuss as a group. (Think about how difficult this approach is!)</p>

Independent Practice: The text states “there is an enormous difference between seeing people as the victims of innate shortcomings and seeing them as the victims of structural violence” (396). Discuss this statement—what are dangers in victimizing poor patients or romanticizing poverty? What are ways to ensure that we do not victimize?

Assessment: As PIH Engage, we often ask people to offer a small donation to PIH. How can this act of charity play into the bigger goals of advancing health as a human right, as seen through the lens of social justice?

Closer: Have each person share a brief general reflection to the question: What did you learn about the various models of addressing suffering?



The Right to Health Movement

Reading: A Movement for Health Equity, from *Reimagining Global Health*, Paul Farmer, Jim Yong Kim, Arthur Kleinman, and Matt Basilio

Discussion Guide

Goal: By exploring global health history, inspire teams and their members to commit to participating in the Right to Health Movement.

Suggested Discussion Questions:

1. What does the phrase “right to health” mean?
2. How can advocacy be leveraged to build a social movement and to ultimately achieve the goals you are fighting for? (Think: organization, coordination, informed activists, etc.)
3. Why is the PIH Engage network uniquely positioned to contribute, in a meaningful way, to advocacy efforts in the right to health movement? What power do we draw from our teams, our network, and Partners In Health as an organization?

Key Quotes:

“The successes of AIDS activists created a new model featuring direct action, self-empowerment, and self-education first for other health-based groups and ultimately even for activist groups outside the health realm” (343).

“Supporters of global health equity do not need to hold official positions of power to make a significant impact. Students, health workers, lawyers, people living with HIV, and other grassroots activists have changed global health policy through effective advocacy; their tactics are available to anyone with a passion for equity” (347).

“Former U.S. surgeon general Julius Richmond, who taught us a great deal, described three components of policy change: knowledge base, political will, and social strategy. This model is worth adopting in the global health movement” (349-350).

Lesson Plan

Goal: By exploring the history of the health equity movement, inspire teams and their members to commit to participating in the Right to Health Movement.

Warm Up: Throughout history, social movements have been a potent force in bringing about change. Give an example of a social movement and the change it affected.

Diagnostic: What does the phrase “right to health” mean to you?

Teaching Bit: The text highlights three organizations that believe in the right to health and how they contributed to the health equity movement. All three cases used effective, coordinated advocacy to capture the power of grassroots organizing to bring about social change:

- **AIDS Coalition to Unleash Power (ACT UP):** ACT UP is an international direct action advocacy group formed in New York. As “an organization that aimed to combat ‘the government’s mismanagement of the AIDS crises,’” ACT UP was able to speed up the approval process of HIV drugs, lower the prices of ARVs, and spark a larger movement of public participation in consumer health policy. ACT UP utilized “a model featuring direct action, self-empowerment, and self-education... [drawing] a broad spectrum of people and [uniting] them into a cohesive organization” (341-343).
- **Treatment Action Campaign (TAC):** TAC, also a direct action advocacy group, based in South Africa, was founded “to challenge by means of litigation, lobbying, advocacy, and all forms of legitimate mobilization, any barrier or obstacle, including unfair discrimination, that limits access to treatment for HIV/AIDS in the private or public sector.” Similar to ACT UP, and even working collaboratively, TAC’s approach included a strong emphasis on “treatment literacy” as well as education on social and economic rights among affected communities. TAC leveraged its broad, diverse grassroots constituency to achieve large-scale political outcomes. TAC and ACT UP, utilizing similar approaches, and supporting one another in the process, created a successful transnational activist movement (343-345).
- **2004 and 2008 STOP AIDS Campaigns:** During both the 2004 and 2008 election seasons, a coalition of AIDS activist groups including Health GAP, the Global AIDS Alliance, and the Student Global AIDS Campaign (SGAC), collaborated to get commitments from presidential candidates for increased global AIDS funding. By coordinating their efforts, the coalition was able to have activists present at many key election events. Using the tactic of “bird-dogging,” when audience members repeatedly asked candidates to commit to a cause, they were able to confirm a pledge to global AIDS funding. The campaigns were a great success, resulting in multiple commitments from candidates and ultimately an increase in funding (345-347).

Guided Practice: Social movements cannot happen without advocacy, but advocacy does not necessarily lead to a social movement. How can advocacy be leveraged to not only build a social movement, but to ultimately achieve the goal you are fighting for? (Think: organization, coordination, informed activists, etc.)

Independent Practice: The majority, if not all, social movements start with an idea and a small group of individuals committed to bringing about social change. With a partner or small group imagine that you are establishing an organization with the goal of ensuring the right to health. Strategize how you would build your movement. What would be your organizational structure? What partnerships would you form? What tactics would you utilize? (Think: media, congressional visits, bird-dogging, etc.)

Assessment: PIH Engage is a national network of committed but vastly unique individuals. PIH Engage is also a network intimately connected to the work of Partners In Health. Why is the PIH Engage network uniquely positioned to contribute in a meaningful way to advocacy efforts in the right to health movement? What power do we draw from our teams, our network, and Partners In Health as an organization?

Closer: Through our efforts as well as those of the rest of the global health community, what is a milestone in global health equity that you would like to see achieved? By when?



Leadership and Organization in the Movement for the Right to Health

Reading: Leading Change: Leadership, Organization, and Social Movements, (focus on p. 1 – 8 and p. 33-38), Marshall Ganz

Discussion Guide

Goal: Grasp the magnitude of a social movement and contextualize the actions of PIH Engage in the movement for the right to health.

Suggested Discussion Questions:

1. When you hear the term social movement, what do you think? How is a social movement different from a fashion, style, fad or interest group? What are some of the key social movements that have defined our country?
2. In the text, Ganz states that because of the uncertainty of what is desired from social movements is daunting, maintaining access to a source of hope is essential. Where do you find hope? Has PIH given you, your community, or the field of global health hope?
3. What is your vision for the changes that the social movement for global health equity will accomplish and how will you get there?

Key Quotes:

“Social movements emerge as a result of the efforts of purposeful actors... to assert new public values, form new relationships rooted in those values, and mobilize the political, economic, and cultural power to translate these values into action. They differ from fashions, styles, or fads... They differ from interest groups... In the United States, they have been the major drivers of social and political reform since the American Revolution” (1).

“A deep desire for change must be coupled with the capacity to make change. Structures must be created that create the space within which growth, creativity, and action can flourish... and leaders must be recruited, trained, and developed on a scale required to build the relationships, sustain the motivation, do the strategizing, and carry out the action required to achieve success” (4).

“Psychologists showed that grievance leads to action only if combined with efficacy, or hope. Thus, action on a grievance becomes more likely when it is experienced as an injustice, coupled with the presence of the sense of efficacy, solidarity, and hopefulness required to undertake the sacrifice... and take the risks that acting to create change entails. The... challenge, then, is not only to articulate grievances but also to muster the moral energy, especially the hope, to drive the whole project” (7-8).

Lesson Plan

Goal: Grasp the magnitude of a social movement and contextualize the actions of PIH Engage in the movement for the right to health.

Warm Up: When you hear the term *social movement*, what do you think? What are some of the key social movements that have defined our country? What are social movements that are currently developing?

Diagnostic: What is a fashion, style, or fad? What is an interest group? How is a social movement different from all of these?

Teaching Bit: Teach how social movements enact change and discuss how PIH Engage will push forward the movement for the right to health:

- **Social Movements must be intentional and strategic:** Social movements often respond to deep-seated discontent and have the potential to be the key driving force in social and political reform. This change, however, must come from intentional, strategic, and purposeful organization. Ganz states: “Strategy is how actors translate their resources into power to get more bang for the buck” (21). With organization, our individual goals can coalesce and become a much more powerful movement. This organization must begin by harnessing deep-seated emotions and values.
- **Social Movements must have sources of hope:** Ganz also states that because the uncertainty of what is desired from social movements is daunting, maintaining access to a source of hope is essential (15). Without hope of what is possible, actions lack purpose and direction.
- **PIH Engage will call on the work and history of PIH to give hope:** PIH Engage must call heavily on the work of PIH to push forward the movement for health equity. PIH has spent decades proving what is possible. PIH Engage must take these lessons and use them to echo and amplify the hopeful message that health equity can be a reality.

Guided Practice: As a group, construct a vision for what the social movement for global health equity will accomplish. Make a list of changes on the board. Start broad, but also push each other to think specifically about policies, institutions, systems, and beliefs that could change.

Independent Practice: In partners or small groups, outline the steps that would build the momentum and movement needed to accomplish these changes. (Hint: start with one-on-one meetings to build personal relationships, end with large-scale political actions or beyond.)

Assessment: Ganz writes, “A campaign is a strategic and motivational way to organize change activity” (31). As a group, discuss how your chapter is engaging or could be engaging in the steps needed to organize a successful campaign: building relationships, telling a story, developing a strategy, taking action.

Closer: The text states, “action on a grievance becomes more likely when it is experienced as an injustice, coupled with... efficacy, solidarity, and hopefulness” (7-8). Have each person answer this question: What is one source of feelings of efficacy, solidarity, or hopefulness in this fight for global health equity?



From Theory to Practice: Four Social Theories for Global Health

Reading: The Art of Medicine: Four Social Theories for Global Health,
Arthur Kleinman

Discussion Guide

Goal: Apply four important social theories to global health problems, allowing team members to contextualize their advocacy and fundraising efforts.

Suggested Discussion Questions:

1. Early in the piece, Kleinman states, “global health, many would agree, is more a bunch of problems than a discipline” (1). Why does Kleinman not consider global health a distinct discipline? What characteristics of a discipline is global health missing?
2. What role do social theories play in shaping how we deliver care, in medicine, or in global health?
3. What are some examples of case studies in global health and how could we use the four social theories (unintended consequences for purposive social action, social construction of reality, social suffering, and biopower) to help us gather generalizable lessons from these case studies?

Key Quotes:

“[Theories] can generalize findings... into durable intellectual frameworks that can be applied not only to distinctive health problems, but to different contexts and future scenarios” (1518).

“And one of the pedagogic responsibilities of medical humanities and social science programmes must be to introduce students to intellectual frameworks that lead to both a deeper critical reflection on disease and caregiving and new tools to improve practice” (1519).

“The UN system and its agencies as well as individual nation-states frequently govern via biopower so that global health programmes can come to serve ulterior purposes” (1519).

Lesson Plan

Goal: To apply four important social theories to global health problems, allowing team members to contextualize their advocacy and fundraising efforts.

Warm Up: Early in the piece, Kleinman states, “global health, many would agree, is more a bunch of problems than a discipline” (1). What characteristics make up an academic discipline? Why is global health not yet its own discipline?

Diagnostic: What role might social theories play in shaping how we deliver care, in medicine, or in global health?

Teaching Bit: Kleinman argues that theories “can generalize findings... into durable intellectual frameworks that can be applied not only to distinctive health problems, but to different contexts and future scenarios” (1). He lays out four previously existing social theories that can help generalize lessons in global health from individual case studies:

- **Unintended consequences for purposive social action** “holds that all social interventions have unintended consequences, some of which can be foreseen and prevented, whereas others cannot be predicted” (1)
- **Social construction of reality** “holds that the real world, no matter its material basis, is also made over into socially and culturally legitimated ideas, practices, and things” (1)
- **Social suffering** “conveys the idea that the pain and suffering of a disorder is not limited to the individual sufferer, but extends at times to the family and social network” (1)
- **Biopower** holds that governments wield power over their citizens’ bodies and health, and thus may use health as a form of social control

Guided Practice: Break into four different groups. Assign each group a social theory and make sure they have a printed or digital copy of the text. Have each group present:

- An easy to understand explanation of the theory
- In-depth explanations of two examples of the theory drawn from the text, prior knowledge of history and global health, or simple observations of the surrounding world

Independent Practice: Read aloud this description of the flooding of the Péligré basin from the article “Solidarity can end structural violence” by Loune Viaud and Joia Mukherjee:

“In 1956, with a loan from the International Bank for Reconstruction and Development (now the World Bank), a hydroelectric dam was built in one of the most fertile valleys of Haiti, the Péligré basin of the Artibonite River of the central plateau. Thousands of families, who had farmed this fertile land and lived decently for generations, were suddenly forced to leave their land. When the dam was closed, the valley flooded. With little warning the water rose rapidly to such levels that many families fled up the steep hillside with nothing but the clothes they were wearing. All their possessions and even animals were lost. The displaced peasant farmers, many of whom are our colleagues, friends and patients at Clinique Bon Sauveur today, received no compensation for the permanent loss of their fertile land. To this day, they recount stories of the nightmare when the water rose. Cange, where we started working more than two decades ago, is a squatter settlement just north of the dam that still does not appear on maps of Haiti.”

The Péligré dam was responsible for sinking many families into poverty and has been largely responsible for the poor health of many residents. As a team, discuss which social theories could be applied here. By viewing the Péligré dam through the lens of one (or multiple) social theories, what general lessons can we take from this case study? Can anyone think of other case studies that could be interpreted through the lens of a social theory?

Assessment: Have each group answer the question below that applies to their original theory. Present to the team.

- How should **unintended consequences for purposive social action** inform our advocacy work?
- How do **social constructions of reality** in very diverse places affect the efficacy of global health interventions?
- How can **social suffering** help persuade a potential donor that their money will be well spent if given to PIH?
- How can **biopower** allow us to be more effective in advocacy work that targets the government?

Closer: Which of these social theories do you think has most influenced the work of PIH and our partner organizations?



Health Care Delivery: Staff, Stuff, Systems

Reading: Redefining global health-care delivery, Jim Yong Kim, Paul Farmer, Michael Porter

Discussion Guide

Goal: Dissect this important framework for health care delivery and understand the importance of integrating and coordinating care between community-based services, clinics, and hospitals.

Suggested Discussion Questions:

1. How can global health frameworks created in developing countries be used to inform global health delivery work in the United States? What unique challenges might arise in the United States that wouldn't arise elsewhere?
2. How can effective health care delivery help break the cycle of poverty and disease?
3. Why is it important to create systematic best practices, especially in the field of global health care delivery? What are challenges to creating and compiling these best practices?

Key Quotes:

"[Many] initiatives to address the unmet needs of those facing both poverty and serious illness... are designed in an ad-hoc manner to address one health problem among many... [and accordingly] best practices spread slowly" (1060).

"In our view... the biggest obstacle facing global health is a failure of delivery... Global health care is understood to mean the provision of a limited set of health services to underserved populations in resource poor areas of the world... By health care delivery, we mean the effective provision of services to people with diseases for which proven therapies exist" (1060).

"A policy focus is well represented in the published work on topics including health-care financing, insurance systems, social safety nets, health-related human resource development, and drug pricing... However, a detailed understanding of value-based delivery systems themselves has been largely absent... Every technique available for tracking patients and aggregating data should be put to use" (1067).

Lesson Plan

Goal: Dissect this important framework for health care delivery and understand the importance of integrating and coordinating care between community-based services, clinics, and hospitals.

Warm Up: The text states that many “initiatives to address... unmet needs of those facing both poverty and serious illness...are designed in an ad-hoc manner to address one health problem among many... [and accordingly] best practices spread slowly” (1060). Why is it important to consolidate practices that have proven effective and deliver integrated services in the field of global health? What are challenges to creating and compiling best practices in integrated care delivery?

Diagnostic: Make a list of key “staff, stuff, space and systems” needed to deliver health care. Then, categorize the services, specialists, and programs offered at different types of care facilities—communities, clinics, and hospitals. Finally, consider why it is important and cost-effective to integrate the services offered at each facility.

Teaching Bit: Too often, services are delivered in a disease-specific, vertical manner. The strategic framework for global health delivery systems put forth in this paper lays out the argument that when approached strategically, services can be delivered in an integrated manner that increases efficiency (and thus value) for the patient, while reducing overall health care costs. It details four levels of value to ensure development of a high-quality and integrated system.

1. **Integrating care for independent medical conditions** over the full cycle of care using the concept of the care delivery value chain (CDVC). In other words, for independent medical conditions, ensure that care from community to clinic to hospital is integrated, accessible, efficient, and high quality.
2. **Using shared delivery infrastructure across multiple medical conditions** to maximize cooperation and collaboration between personnel and facilities when working to prevent and treat conditions
3. **Incorporating knowledge of the local patient** and community constraints
4. **Designing health care delivery systems to maximize their contribution** to equitable economic and community development.

These levels of value inform the integrated and high-quality development of all components of a health care system (design, management structure, operational best practices, regulatory bodies).

Guided Practice: Think of real-life examples that illustrate the importance of each value level.

Independent Practice: Knowing what questions to ask is key to developing a strong model or project. Split into four smaller groups. Have each small group brainstorm 3-5 key questions to ask at one of the four specific levels of value before implementing a model or project.

Assessment: As a group, make a list of the key questions to ask at each level of value and share. Examples are:

Level of Value	Key questions to ask to ensure high-quality, integrated system development:
1. Integrating care for independent medical conditions over the full cycle of care	What activities are best performed within a single care center and which are best shared? How are prevention, diagnosis, and care for a particular medical condition related? How is each activity in the care cycle best performed? Where and by whom? How is the effectiveness of one activity affected by others?
2. Shared delivery infrastructure across multiple conditions to coordinate prevention, treatment, staff, & space	How can we integrate care for related pathologies? How can we most efficiently and cost-effectively use scarce personnel and facilities? How can shared infrastructure improve effectiveness of prevention, screening, and care as compared with vertical programmes and facilities? (See p. 1065 for additional strategic questions in shared delivery infrastructure design)
3. Incorporating knowledge of the local patient and community constraints	How do social/economic factors underlie more direct influences, such as poverty/education? What are the direct influences affecting the incidence of disease and injuries? How does access to health care services affect the type, frequency, and quality of care received? Do patients adhere to prescribed preventative measures or therapies? Why or why not?
4. Designing health care delivery systems to maximize contribution to equitable economic or community development.	How is poverty causing illness and how can we address these issues of poverty? How can public spending on health care delivery be an investment that will directly benefit economic development? How can the health of a population enhance economic development in low-income countries?

Closer: As a group discuss ways effective health care delivery helps break the cycle of poverty and disease.



Horizontal vs. Vertical: Challenges in Approaches to Global Health

Reading: Mass Campaigns Versus General Health Services: What Have We Learnt in 40 Years about Vertical Versus Horizontal Approaches?, Anne Mills

Discussion Guide

Goal: Explore vertical, horizontal, and diagonal approaches to global health care delivery and how to overcome some of the main barriers to successful implementation.

Suggested Discussion Questions:

1. How is global health usually funded and how does this relate to the type of initiatives that are implemented? What are the horizontal, vertical, and diagonal approaches to global health?
2. What measures could be taken to ensure that health systems are strengthened even in the context of a vertical program?
3. How can the focus on securing “limited” funding inhibit us from dreaming about what is possible in global health care delivery? What are some ways that this focus prevents us from working towards the overarching goal of delivering high quality health care to the poor?

Key Quotes:

“Problems [with the relative merits of vertical and horizontal approaches] included the very limited number of countries researched, the predominance of opinion pieces rather than empirical studies, and the poor study design” (316).

“Perhaps the one clear area where the nature of the debate has changed is the argument that general health services should focus on a limited set or package of cost-effective interventions. This can be seen as a middle way—avoiding the selectivity of the vertical approach, but seeking to ensure that general health service resources are devoted to interventions that are prioritized on the basis of their cost-effectiveness” (316).

“With respect to health workers, Gonzalez stresses the importance of ensuring that front-line workers in general health services feel fully part of the mass campaign, and of ensuring that they are not overburdened by demanding duties” (316).

Lesson Plan

Goal: To explore vertical, horizontal, and diagonal approaches to global health care delivery and how to overcome some of the main barriers to successful implementation.

Warm Up: List some ways (e.g. government grants, international organizations, private philanthropy, etc.) global health initiatives or research are financed. Consider the key pieces of information required to secure this funding. (Hint: consider metrics needed to prove effectiveness, goal setting, long-term health outcomes, etc.)

Diagnostic: At PIH, we always try to push back on the status quo of what is believed to be possible. How can the focus on securing “limited” funding inhibit us from dreaming about what is possible in global health care delivery? What are some ways that this focus prevents us from achieving the overarching goal of delivering high quality health care to the poor?

Teaching Bit: In global health, the terms “vertical” and “horizontal” are frequently used to describe a program’s general approach and characterize the overarching goals of a program.

- **The Horizontal Approach:** according to the text, this approach “seeks to tackle the over-all health problems on a wide front and on a long-term basis through the creation of a system of permanent institutions commonly know as ‘general health services’” (315). The goals of this approach might cut across specific diseases and focus on building health care systems that are able to tackle diseases in a long-term way.
- **The Vertical Approach:** according to the text, this approach “calls for solutions of a given health problem by means of a single-purpose machinery” (315). The goals of this approach might be to treat or eradicate a single disease by vaccination or disease-specific campaigns.

Although these have historically been two key approaches to global health, as stated in the text, “the two approaches should not be seen as mutually exclusive” (315). A third “**diagonal approach**” aims to accomplish disease-specific goals by means of health system strengthening. This approach has largely emerged due to funding mechanisms and more frequent investment in disease-specific vertical programs.

Guided Practice: One of the biggest ongoing challenges in global health is convincing funders that global health initiatives are worth investing in and will be successful. Because vertical programs often have objectives that are easier to measure (ex. halve the number of infected HIV patients by 2020), they are typically more easily funded.

As a group, compare and contrast vertical and horizontal programs. Consider: obtaining funding, implementing programs, tracking progress, sustainability, and achieving health outcomes.

Independent Practice: The text emphasizes the importance of “ensuring that front-line workers in general health services feel fully part of the mass campaign” (316). With a partner, discuss how integrating front-line health workers into mass campaigns could ensure that health systems are strengthened in the context of a vertical program. Think of other ways to use components of vertical programs to strengthen health systems—a “diagonal approach” to health care delivery.

Assessment: The text states, “problems [with promoting the service delivery approaches] included the very limited number of countries researched, the predominance of opinion pieces rather than empirical studies, and the poor study design” (316). In pairs, come up with three research questions that could help horizontal approaches to health care delivery secure funding.

Closer: How can we as PIH Engage challenge the status quo of funding in global health? (Think: what types of approaches are typically funded? Are there adequate funds available? Is it possible to change the status quo?)



Scaling Up in Global Health: Bridging the “Know-Do” Gap

Reading: Chronic Infectious Disease and the Future of Health Care Delivery,
Paul Farmer

Discussion Guide

Goal: Understand PIH’s approach to scaling up global health delivery and explore ways to bridge the “know-do” gap.

Sample Discussion Questions

1. What is the “know-do,” or delivery, gap? Why does this gap exist? What are barriers to bridging this gap and scaling up in global health and how can we overcome them?
2. How do tuberculosis and AIDS offer two different stories about funding and translation of discoveries into large-scale delivery? What can the lessons learned from combating these two diseases teach us about how to further the movement for global health equity?
3. How can advocacy contribute to securing funding and ultimately achieving scale?

Key Quotes

“Simultaneously, rising life expectancy and rapid social change have led to an increasing burden of chronic diseases for which we have effective therapies but inadequate innovation for delivering them efficiently to the neediest people—the so-called know-do, or delivery gap” (2424).

“The global AIDS debate, in the years between development and delivery, was really about funding; claims that treating a chronic infection with a multidrug regimen was impossible in poor settings were invalid. And in 2002, the Global Fund to Fight AIDS, Tuberculosis, and Malaria and the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) changed the equation not only for millions of people dying of untreated HIV disease, but also for global health” (2429).

“Bridging the delivery gap is important for the future of clinical medicine and public health globally. The success of global AIDS efforts offers one reason for optimism about future endeavors to improve care for other diseases. We are likely to face precisely the same delivery challenges whenever new diagnostic tests and therapeutic agents are developed for any chronic communicable infection” (2433).

Lesson Plan

Goal: Understand PIH’s approach to scaling up global health delivery and explore ways to bridge the “know-do” gap.

Warm Up: At PIH, we often talk about “global health delivery.” This work revolves around the idea that we have effective therapies but inadequate means of delivering them to the poor. Together list different therapies or treatments that are easily accessible to some, but might be inaccessible to those who live in poverty or low resource settings.

Diagnostic: In global health, what barriers exist for delivering known technologies to the poor in a large-scale way?

Teaching Bit: The “know-do gap” is a gap between what we know and how we take action (do things) with this knowledge. In this piece, Farmer provides five fundamental lessons derived from the history of tuberculosis control that can be applied to HIV disease. By examining these lessons, we see a clear argument and steps to bridge the gap:

1. **Drug resistance is here to stay**, but the rate of its emergence can be slowed.
2. **The development of robust delivery platforms will lead to improved clinical outcomes** if what is being delivered is clinically effective.
3. **It is our responsibility to ensure patients maintain access to care**, thus care for patients who do not require inpatient care should shift from hospitals to clinics and community-based care.
4. **We must quickly acquire and develop effective therapeutic innovations**, thus they need to be linked more rapidly to equitable delivery, which requires new financing mechanisms.
5. **We must believe this is possible:** It is not clear that any disease is helpfully termed “untreatable.”

Guided Practice: As a group, discuss these three questions. Suggested responses are listed here:

- Why is there a know-do gap?
The text states: “many care providers wanted to apply their knowledge to bridging the know-do gap, but there were no funding mechanisms to bridge a gap that spanned both borders and sharp disparities in infection risk, disease progression, and access to care” (2425). The gap exists largely due to a lack of funding of delivery.
- What are key barriers to bridging the know-do gap?
Conventional wisdom is a huge barrier. Citing a finite number of resources and cost-effectiveness, many deem chronic infectious diseases “untreatable” in resource poor settings. However, in reality untreatable “really means difficult or costly to treat,” highlighting “delivery, rather than clinical, failures” (2426, 2433).
- How can we overcome these barriers?
It is important to recognize that many of the barriers to bridging this gap are socially constructed and can be overcome by challenging the status quo. Financing can be stabilized through advocacy, which will certainly play a critical role in securing public funding streams.

Independent Practice: The text states, “tuberculosis and AIDS offer two very different stories about funding and translation of discoveries into large-scale delivery” (2432). In pairs, discuss how these two stories differed, and how they were similar. Then, discuss what this can teach us about how to further the movement for global health equity.

Tuberculosis	Both	HIV/AIDS
<ul style="list-style-type: none"> • Began treating a small handful of patients for TB specifically • Resistance to treat poor patients was extremely high • Ineffective therapies were embraced because of cost 	<ul style="list-style-type: none"> • Neither disease had a magic bullet and treatment required some development • Complex combination therapy was required to treat both diseases • Innovative initiatives proved what was possible, leading to activism and advances in policies that would help secure funding 	<ul style="list-style-type: none"> • AIDS activism played a huge role in challenging the status quo • A large spike in funding for ART led to interest in treating HIV disease • The Global Fund, PEPFAR and other funding flowed to AIDS, TB and, importantly, primary care

Assessment: Instrumental funding streams like PEPFAR and the Global Fund provided the means for substantial investments in robust delivery platforms. How can PIH Engage work to secure the necessary resources for bridging the “know-do” gap and achieving scale in global health?

Closer: In the absence of robust delivery platforms, the “know-do” gap will persist, as “we are likely to face precisely the same delivery challenges whenever new diagnostic tests and therapeutic agents are developed for any chronic communicable infection” (2433). Have each person hypothesize a new issue that might be a part of the “know-do” gap.



Ethical Global Health Research

Reading: Building Research Capacity in Africa: Equity and Global Health Collaborations, Chu et al.

Discussion Guide

Goal: Grasp the importance of transferring skills and building local capacity when conducting research in low-income countries.

Suggested Discussion Questions:

1. Discuss as a group how you feel about approaching research through an equity lens—relying on locals to set agendas, be primary authors, etc. What are barriers to promoting ethical research?
2. What activities led by high-income countries (HICs) in low- and middle-income countries (LMICs) other than research could benefit from following the guidelines for ethical research detailed in this article?
3. We all know it is important to conduct ethical research, but why? What consequences might arise from conducting research without collaboration from (or better, being led by) local institutions?

Key Quotes:

“Collaboration with HIC colleagues and institutions has enormous promise to bring expertise, funding, and resources to Africa. However, there is great potential for a power imbalance in these relationships. Much of the research carried out in Africa is led, funded, and published by HIC researchers without equal collaboration from LMIC colleagues” (2).

“HIC academics work for universities that typically measure the success of their faculty by research funding and publications. Even if HIC scientists genuinely want to advance African research agendas, building the research capacity of African collaborators may not be an important objective to their institutions” (2).

“Challenges arise, however, because some African hosts may be enthusiastic about twinning with ‘prestigious’ US universities, which consequently creates a power dynamic that can be inherently unequal and make African institutions reluctant to say ‘no’ to research requests and risk offending their new colleagues” (3).

Lesson Plan

Goal: Grasp the importance of transferring skills and building local capacity when conducting research in low-income countries.

Warm Up: As a group, discuss some of the key components of effective research. Then, list some of the skills required to successfully conduct effective research.

Diagnostic: Sift through the list of skills required to successfully conduct effective research. For each skill, discuss how one acquires this skill. Consider the institutions, programs, or specific trainings required.

Teaching Bit: The article states that effective research has four pre-requisites:

1. Individual research skills and ability
2. Appropriate infrastructure
3. Relevance to national policies
4. The ability to contribute to global research and policy needs

These pre-requisites, while accessible in most high-income countries (HICs), are harder to come by in low-and middle-income countries (LMICs). For this reason, combined with the accessibility of funding, institutions from HICs often lead research projects in LMICs. The article offers guidelines for how HICs can conduct ethical research in LMICs:

- **Always focus on the transfer of skills** from HICs to LMICs
- **Adhere to priorities and agendas set by locals**, assisting in developing agenda setting skills where possible
- **Form regional partnerships and long-term relationships** that cultivate trust, promoting mutual learning and transparent communication about goal setting, progress, and discoveries
- **Rely on local coordination and supervision** to prevent research duplication and to ensure that studies remain in line with local policies and priorities
- **Require authorship and dissemination of results by LMIC counterparts** in order to encourage ownership of scientific knowledge, clinical care, evidence-based research, and public policy locally
- **Think innovatively about ways to build partnerships** that will aid in the transfer of clinical, teaching, and research skills

Guided Practice: Research has great potential to contribute to meaningful health outcomes. However, research is often a metric by which faculty at academic medical institutions are evaluated-- it has the potential to secure funding for a specific project or could offer opportunities for career advancement.

Discuss as a group how you feel about approaching research through an equity lens—relying on locals to set agendas, be primary authors, etc. Then, answer the question: what are primary barriers to promoting ethical research?

Independent Practice: This article discusses ethics in relation to research; however, one could consider the same argument about many other activities that HICs lead in LMICs.

With a partner, first think of one example of an activity (other than research—e.g. medical brigades, teaching, etc.) that is normally led by a HIC in a LMIC. Then, have pairs answer the following three questions. Come back together and share with the larger group.

- Is this activity normally carried out in a way that transfers skills to build local capacity?
- How does this activity benefit the local community?
- How could this activity be altered to better transfer skills and be led by local needs and desires?

Assessment: Bring the discussion back to research—we know it is important to conduct ethical research, but why? As a group, discuss some examples of unethical research. What consequences might arise from conducting research without collaboration from (or better, being led by) local institutions?

Closer: Before leaving, ask if anyone is comfortable sharing research or another project that they have either been part of or heard of in a LMIC that may not have adhered to ethical research guidelines. Discuss how this project could have been designed and carried out in a more equitable manner.



MDR-TB: Redefining Health Care Delivery

Reading: Optimism and Pessimism in Tuberculosis Control: Lessons from Rural Haiti, from *Partner to the Poor*, Paul Farmer

Discussion Guide

Goal: Use PIH's fight for treatment of MDR-TB in settings of poverty as a case study to redefine what it means to deliver health care and conduct equitable research interventions alongside the poor.

Suggested Discussion Questions:

1. How did Partners In Health ensure that the *Proje Veye Sante* intervention was conducted in an equitable manner? Consider the study design and how it benefited the community.
2. As described in this chapter, community health workers, who shared the living conditions of patients, and physicians and nurses, who did not, had two different ideas as to why the then current MDR-TB treatment system was not as effective as it should have been. What did each group blame for the treatment regimen's shortfall? What was right and what does this reveal about health care delivery in settings of poverty?
3. How was or could the success of this intervention be used to accomplish advocacy goals that amplify the lessons learned about health care delivery systems in settings of poverty?

Key Quotes:

"The factors that govern treatment success or failure there—factors such as initial exposure to mycobacteria, reactivation of endogenous tuberculosis infection, complications, access to therapy, length of convalescence, development of drug resistance, degree of tissue destruction, and, finally, mortality—are determined chiefly by economic variables" (202).

"Projects designed to prevent tuberculosis among the very poor must keep in mind a central maxim of tuberculosis control: treatment is prevention... In a sense, the high cure rate we achieved also shows that debates over whether to treat tuberculosis or to prevent it are essentially false debates, whose costs are borne, as usual, by the poor" (203).

"Although drug resistance represents a new and potentially significant problem, most studies of treatment failure agree that the problem is predominantly one of designing and implementing programs that are appropriate to the needs of the population to be served" (197).

Lesson Plan

Goal: Use PIH’s fight for treatment of MDR-TB in settings of poverty as a case study to redefine what it means to deliver health care and conduct equitable research interventions alongside the poor.

Warm-Up: Haitian peasants have compared treating TB without providing food to “*lave men, sive até*” (*washing one’s hands and wiping them in dirt*). How might this proverb inform PIH’s approach to improving health or delivering care?

Diagnostic: Often, securing research funding and publishing results are the metrics used to measure faculty’s success. What are important factors to consider when hoping to secure funding or get published? How might prioritizing these factors skew global health research away from projects that address poverty and local needs?

Teaching Bit: In extreme poverty, achieving health often requires much more than providing treatment. PIH believes that building health care systems and addressing education, nutrition, and unemployment—the symptoms of poverty—is key to improving health. Further, ensuring that all research is equitable, that is, fair and beneficial for local communities, when working to prove an intervention’s success, is critical to PIH’s mission of serving the poor.

The *Proje Veye Sante* intervention is a classic example and shows how PIH designed a trial for the benefit of the community. In the intervention to treat MDR-TB patients in Haiti, Sector 1 patients received “financial aid of thirty dollars per month... nutritional supplements... [and] were to receive a monthly reminder from their village health worker to attend clinic” (198). Sector 2 patients “were a ‘control group’ only in the sense that they did not benefit from... community-based services and financial aid” (199). The study addressed the health of the community by:

- Providing all participants free MDR-TB treatment
- Fighting poverty by providing employment through reliance on paid community health workers
- Building and testing a high-quality community-based health care delivery system to address preexisting issues

Guided Practice: In *Proje Veye Sante*, two groups were cited hypothesizing barriers to successful care: community health workers, who shared the living conditions of patients, and physicians and nurses who did not. Discuss what each group thought were barriers to treatment and why. The community health worker’s hypothesis ultimately proved correct. Discuss the importance of community-based care in proving what is possible.

Hypotheses of Community Health Workers	Hypotheses of Physicians, Nurses
<ul style="list-style-type: none">• TB patients with poor outcomes were the most economically impoverished and thus the sickest• Patients stopped chemotherapy once symptoms disappeared in order to provide for their families	<ul style="list-style-type: none">• Poor compliance resulted from beliefs that TB resulted from sorcery, leading patients to abandon therapy• There was ignorance or misunderstanding of causes or treatments on the part of the patients

Independent Practice: For years, the argument of treatment vs. prevention dominated conversations in global health. Farmer makes the case for “a central maxim of tuberculosis control: treatment is prevention” (203). With a partner, discuss the treatment vs. prevention dichotomy. Which side normally prevails? Why? What are problems with seeing treatment and prevention as a dichotomy? What did Farmer mean that treatment is prevention? Consider equitability, effectiveness, research and program implementation and how treatment and prevention are inherently joined.

Assessment: This project showed what was possible in settings of poverty with health care delivery and TB. How can projects like this be used to accomplish advocacy goals, secure funding, and amplify this approach to global health?

Closer: This study proved that “high cure rates are possible in settings of extreme poverty in which hospital-based care is unavailable” (202). Prior to this intervention, conventional wisdom would have said that care was not possible. Have each person share where we, future leaders in global health, can fight currently prevailing notions of what is possible.



The AIDS Epidemic Launches Global Health

Reading: Re-Defining the Possible: The Global AIDS Movement, Pg. 111-120, from *Reimagining Global Health*, Paul Farmer, Jim Kim, Arthur Kleinman, Matt Basilio

Suggested Documentary: How to Survive a Plague

Discussion Guide

Goal: Investigate how the AIDS epidemic launched the field of global health and encourage PIH Engage team members to consider how they can utilize their skills to contribute to this new sector.

Suggested Discussion Questions:

1. The authors note that until the AIDS movement, global health had been a field that was “socialized for scarcity” (115). What was the original focus of public health institutions in developing countries before the AIDS movement? How has that focus shifted with increased funding and better tools available in the global health era?
2. Andrew Natsios, who at the time was the head of USAID, is quoted discussing why ARVs supposedly cannot be delivered in low-income countries. He notes that care would fail because people in Africa “do not know what watches and clocks are. They do not use Western means for telling time” (119). Why is it critical to avoid this “immodest” line of thinking when working in global health? How has PIH challenged such immodest thinking?
3. A successful response to the AIDS epidemic required innovative work from pharmaceutical companies, governments, activists, private foundations, and researchers. Consider your background, education, and previous experiences. What unique perspectives and skills do you possess that allow you to contribute to the field of global health and the right to health movement?

Key Quotes:

“No past effort to combat disease captures the promise of medicine and global health like the worldwide response to AIDS” (111).

“Over time, policymakers, donors, and health professionals had all become socialized for scarcity: they focused on optimizing use of a tiny resource pie instead of also reimagining and seeking to expand the size of that pie” (115).

“This statement helped policymakers reimagine the possible in global health: if delivering HAART—chronic care for a chronic disease, was feasible in Haiti and South Africa, why not scale it up around the world? Why not use HAART to usher in a more ambitious agenda of health system strengthening globally?” (120).

Lesson Plan

Goal: Investigate how the AIDS epidemic launched the field of global health and encourage PIH Engage team members to consider how they can utilize their skills to contribute to this new sector.

Warm Up: Discuss what it might look like to achieve an AIDS-free generation. Do you believe this is possible?

Diagnostic: What factors have contributed to global health's massive growth over the past two decades? (Think: funding, social interest, key pieces of literature, rising disparities, social movements, etc.)

Teaching Bit: The text notes that "during the 1980s and in the early 1990s an HIV diagnosis was a guarantee of early death" (116) but, by 1996, HAART, a highly effective treatment regimen, had been developed. Still, funding limited the scope and scale of global AIDS interventions.

Activists played a huge role in expanding access to AIDS treatments and funding. Activists worked tirelessly to drive down prices of AIDS drugs, increasing access for the poor and contributing to a massive increase in funding. Until the AIDS epidemic, global health had been a field "socialized for scarcity," or in other words, we were made to believe there were a limited amount of resources available. However, with AIDS came not only new medical tools and new means for making those tools accessible, but massive increases in funding.

International Funding Institutions:

- The Global Fund to Fight Aids, Tuberculosis, and Malaria was established in 2002, and as of December 2011, has approved \$22.6 billion in grants
- In 1996 the IMF and World Bank began offering debt relief to poor countries, writing off \$76 billion in hopes of freeing up resources for public health in poor and developing countries
- WHO and UNAIDS established the 3x5 initiative, with the goal of treating 3 million AIDS patients in the developing world by 2005

Governments:

- George W. Bush passed the President's Emergency Plan for Aids Relief (PEPFAR) which has disbursed billions to fight AIDS in low and middle-income countries

Private Donors:

- The Gates Foundation disbursed \$10 billion for Global Health initiatives by 2009

This collaboration among donors, institutions, governments, activists, and groups like PIH and MSF, who proved AIDS care could be effective in developing countries, created a massive new field, global health. They did this by reimagining what is possible in health care and expanding funding to make scaling up achievable.

Guided Practice: Focus on the claims made by Andrew Natsios regarding why treatment of AIDS in Africa would fail: "[People in Africa] do not know what watches and clocks are. They do not use Western means for telling time" (119). The text refers to this claim as immodest. Together, develop a definition of "immodest claims" in global health and discuss why it is critical to avoid "immodest" thinking when serving the poor. How did innovation from groups like PIH and MSF challenge immodest thinking? (**Hint: immodest claims**—blaming patients' beliefs or behaviors for failures of treatment, rather than recognizing that fixable failures in delivery are to blame.)

Independent Practice: In the past, global health had been a field "socialized for scarcity," which solely focused on targeting "low-hanging fruit." Discuss what it means to be socialized for scarcity. How would the shift from exclusively targeting "low-hanging fruit" to providing holistic care and securing more resources for interventions expand the size and scope of global health rapidly? How can PIH Engage continue to secure more resources for global health work?

Assessment: Global health is a diverse field requiring professionals with a wide range of skill sets. With a partner, discuss your background, education, career interests and trajectory and how you can harness your unique abilities to contribute to the right to health movement. Have a few team members share their partners' thoughts.

Closer: In order to truly achieve global health equity and continue to advance the field of global health, we will need people from all backgrounds. Before exiting, have each team member name one type of professional that could be useful in the field of global health to a master list. If an answer seems to be a stretch, have them defend their choice.



Activists and the Success of PEPFAR

Reading: *Redefining the Possible: The Global AIDS Response*, Pg. 121-131, from *Reimagining Global Health*, Paul Farmer, Jim Kim, Arthur Kleinman, Matt Basilio

Discussion Guide

Goal: Understand how strategic advocacy efforts contributed to the passage of PEPFAR and how this set the stage for massive advancements in the right to health movement.

Suggested Discussion Questions:

1. Why is it important to be strategic about goal setting, in addition to being collaborative and coordinated, when thinking about advocacy efforts?
2. Why were activists during the AIDS movement so successful? Consider differences in strategy between the activists who protested at Al Gore's rallies and advocates like Franklin Graham. Then, consider the current state of the movement for the right to health. What unique challenges exist now?
3. The text notes that due to diminishing support for AIDS care efforts following the 2008 economic downturn, "Across the developing world, hospitals and clinics have had to turn away new AIDS patients" (131). How does our work as an Engage Chapter help to ensure fewer patients get turned away?

Key Quotes:

"Activists interrupted his speech with whistles, banners, and chants of "Gore's greed kills! AIDS drugs for Africa!" In the ensuing days, similarly disruptive protests took place at other campaign events, lending the bilateral dispute prominence in the US press. Soon after these protests, the political winds shifted decidedly against the pharmaceutical lobby" (123).

"Spurred by the same forces—lower drug prices, growing evidence of treatment efficacy in resource-poor settings, grassroots activism, and advocacy by elites—other rich nations also increased their allocations to global AIDS programs" (129).

"The first decade of the twenty-first century raised the bar in global health. The failures of imagination that had long been the status quo fell prey to evidence of effective health care delivery in resource-poor settings matched with bold visions of global health equity... yet, it is still a long road to 'health for all'" (130).

Lesson Plan

Goal: Understand how strategic advocacy efforts contributed to the passage of PEPFAR and how this set the stage for massive advancements in the right to health movement.

Warm Up: What values inspire people of disparate backgrounds to advocate for the right to health?

Diagnostic: It is important to be collaborative and coordinated between diverse groups in advocacy efforts. Why is it also important to be extremely strategic about goal setting, that is, about choosing which of many diverse issues to pursue?

Teaching Bit: While there is still much work to be done, the AIDS movement has been a great success story. Activists of many different backgrounds, who seemingly had little in common, were able to come together, driving forward these strategic successes:

- **Drug prices:** When antiretrovirals were first developed, they were heinously expensive. This created a significant barrier for poor countries (and individuals) to access care. In an effort to overcome this barrier, the South African parliament passed the Medicines Act, declaring that in cases of public health emergencies, generic drugs could be produced or procured. This caused both diplomatic and legal backlash from the U.S. government and pharmaceutical industry, largely due to a loss of profits from brand-name pharmaceuticals. A small group of activists (who would become Health GAP) took carefully planned action by repeatedly protesting Al Gore's campaign events. In a matter of months, the Clinton administration reversed its stance on the Medicines Act and the pharmaceutical companies withdrew their lawsuits.
- **PEPFAR:** With medicines now affordable, activists turned their attention to securing funding for broad treatment interventions. During an era of Republican control over the executive and legislative branches, the AIDS lobby, a broad and diverse group consisting of religious organizations, students, gay rights activists, African Americans, and HIV+ individuals, was able to inspire unheard of levels of support from the US government. One of the most ambitious funding programs came from President George W. Bush, who established the President's Emergency Plan for AIDS Relief (PEPFAR), a massive \$15 billion pledge to fight AIDS in Africa and the Caribbean. As stated in the text, unlike many previous global health initiatives, which focused on specific diseases in specific countries, PEPFAR "established new goals to strengthen health infrastructure—recruiting and training (and retaining) 140,000 health care professionals and paraprofessionals in partner countries... in addition to expanding AIDS treatment and prevention services" (130).

Guided Practice: PEPFAR's massive pledge to fight AIDS in multiple nations changed the face of global health. In pairs, first brainstorm a list of specific potential goals that AIDS activists could have set. Consider the initial goal of fighting for drug prices, potential educational campaigns that might have taken place, international work, or other policies, facilities, etc. that might have made AIDS treatment possible. Then, talk as a group about these goals and why fighting for a broad funding mechanism is a smart and strategic goal.

Independent Practice: As a group, consider who fought in the AIDS movement and brainstorm what made their advocacy efforts so effective. Consider who was leading advocacy efforts, who was being affected by policy decisions and lack of care, the political actors being targeted, etc.

Assessment: Sadly, the text notes that due to diminishing support for AIDS care efforts following the 2008 economic downturn: "Across the developing world, hospitals and clinics have had to turn away new AIDS patients" (131). How does our work as an Engage Chapter help to ensure fewer patients get turned away? Have each person hypothesize potential advocacy goals, considering current PIH Engage advocacy goals, and consider which would be most strategic when working to advance the right to health movement.

Closer: Reflect back on the AIDS Epidemic Launches Global Health lesson. In that lesson we discussed what an AIDS-free generation might look like and if we thought it was possible. Keeping in mind the great success of the AIDS movement has your outlook on an AIDS-free generation changed at all?



Structural Violence in High-Income Countries

Reading: *Life at the Top in America Isn't Just Better, It's Longer*, Janny Scott

Discussion Guide

Goal: Question what it means to work in global health and how the actions of PIH Engage can work to advance health equity in the United States and other high-income countries.

Suggested Discussion Questions:

1. What systems in high-income countries like the United States contribute to, make up, or define a social class? How does structural violence manifest itself in the United States?
2. Discuss the differences between public health, international health, and global health.
3. Currently, PIH is involved in the Navajo Nation, United States, and in Tomsk Oblast, Siberia—both sites in high-income countries. Should PIH do more work domestically? What are unique barriers to delivering high quality health care to the poor in high-income countries? (Consider: political systems and structures, types of health insurance, income of health providers, stigma and prevailing judgments about the poor, educational structures, a country's historical context, etc.) How can PIH Engage help combat some of these barriers?

Key Quotes:

"Class informed everything from the circumstances of their heart attacks to the emergency care each received, the households they returned to and the jobs they hoped to resume. It shaped their understanding of their illness, the support they got from their families, their relationships with their doctors. It helped define their ability to change their lives and shaped their odds of getting better" (2).

"Class is a potent force in health and longevity in the United States. The more education and income people have, the less likely they are to have and die of heart disease, strokes, diabetes and many types of cancer. Upper-middle-class Americans live longer and in better health than middle-class Americans, who live longer and better than those at the bottom. And the gaps are widening, say people who have researched social factors in health" (2).

"We're creating disparities. It's almost as if it's transforming health, which used to be like fate, into a commodity. Like the distribution of BMW's or goat cheese" (3).

Lesson Plan

Goal: To question what it means to work in global health and how the actions of PIH Engage can work to advance health equity in the United States and other high-income countries.

Warm up: In global health, we often think about illness as caused by man-made systems that force populations into poverty. This article discusses the importance of social class in determining health outcomes in America, a high-income country. What systems in high-income countries like the United States contribute to, make up, or define a social class?

Diagnostic: Is global health the same as international health? What about public health?

Teaching Bit: Our fight for global health equity must recognize that where poverty exists, there is inherent structural violence. PIH, a global health organization, works to dismantle the social barriers to health and provide a preferential option for the poor, a mission not defined by national borders. Compare global, international, and public health.

	Geography	Cooperation	Access Goals
Global Health	Health issues that transcend national boundaries	Global	Health equity among nations
International Health	Focus on issues outside one's own country	Bi-National	Help other nations
Public Health	Focus on or within specific communities or countries	National	Health equity within a nation or community

Source: Kaplan JP et al. *Lancet* 2009, 373:9679 p 1993-1995

Guided Practice: In the article, we see clear examples of how social class, created and perpetuated by structural violence, affects an individual's health. Consider systems each individual in the article had access to after having a heart attack. Choose a few key systems listed below to discuss the implications of systems on health.

System	Jean G. Miele, Architect	Will L. Wilson, Utility Worker	Ewa Rynezak Gora, Maid
Transportation	Drove or cab.	Drove or subway.	Public transportation.
Support System	Supportive stay at home wife— took ownership of his care	Supportive fiancé—did less independent research	Limited—moderate tasks consumed entire days
Nutrition	Healthy grocery stores nearby	Fried and canned food easily available	Fried food and fast food nearby
Employment	Able to take time off without concern for money	Laboratory technician. Able to continue working "on restriction"	Received disability payments briefly and months later returned to work
Health Care	Necessary procedures immediately available. Consistently seen and treated quickly and respectfully. Specialists recommended.	Transferred within 24 hours to a hospital for necessary procedures. Eventually received needed procedures. Stopped going to doctors—he did not feel respected.	Not seen in a hospital for hours, not treated for days, resulting in complications. Required to visit with doctors across town and had difficulty paying.

Independent Practice: PIH has historically focused on extremely rural and disproportionately impoverished settings in low-income countries. In doing this, PIH has created and tested models of health care delivery that prove what is possible in the most difficult settings, which often completely lack health care systems for the poor. Currently, PIH is involved in the Navajo Nation, United States and in Tomsk Oblast, Siberia—both sites in high-income countries.

Should PIH do more work domestically? What are unique barriers to delivering high quality health care to the poor in high-income countries? (Consider: political systems and structures, types of health insurance, income of health providers, stigma and prevailing judgments about the poor, educational structures, a country's historical context, etc.) How can PIH Engage help combat some of these barriers?

Assessment: In reference to high-income countries, the article states: "we're creating disparities. It's almost as if it's transforming health, which used to be like fate, into a commodity. Like the distribution of BMW's or goat cheese" (3). How does the commodification of health create systems that perpetuate poverty? Is there a difference in how the urban poor vs. the rural poor experience this structural violence?

Closer: Ask if anyone is comfortable sharing a time when they or someone they know experienced structural violence.



Global Health Financing: The Need for Advocacy

Reading: Bretton Woods to Bamako, from *Blind Spot*, Salmaan Keshavjee

Discussion Guide

Goal: Understand the deep-seated challenges in global health financing and the need for advocacy in securing a large-scale financing mechanism by exploring the history of key institutions funding global health.

Suggested Discussion Questions:

1. Why do you think there is a lack of stable investment in global health and health system strengthening?
2. How can problems or challenges in global health financing be traced to neoliberal politics?
3. What historic actions have resulted in advancements regarding stabilized financing for global health? In what ways can you, your team, or the PIH Engage network contribute to stabilizing global health financing?

Key Quotes:

"The inner meaning of history... involves speculation and an attempt to get at the truth, subtle explanation of the causes and origins of existing things, and deep knowledge of the how and why of events" (title page).

"In Bretton Woods... the discussion... was about significantly more than fixed exchange rates and monetary policy: it was a much broader debate about the relationship between the citizens and the state, and the role government should play in furthering social and economic life" (86).

"They saw economics as embedded in politics and hence, saw the 'free market' as an economic form of political democracy" (88).

"Structural adjustment policies, at their root a fundamentally neoliberal approach, were a game changer for the developing world" (93).

"User fees were not likely to have an impact on the ability of sick people to access care and, in fact, would be better for the poor because the fees would lead to improved quality of medicines and clinics" (96-97).

Lesson Plan

Goal: Understand the deep-seated challenges in global health financing and the need for advocacy in securing a large-scale financing mechanism by exploring the history of key institutions funding global health.

Warm Up: Much of today's discussion will hinge on an understanding of neoliberalism, which is a political ideology birthed from fear of communism and big governments during the Cold War. Begin by broadly asking your team to define neoliberal politics. If needed, **Neoliberalism**, broadly defined, adheres to three key points:

- Supply and demand leads to "equilibrium" with efficient resource allocation and no government distortion
- Individuals always make choices that satisfy personal objectives and fixed preferences
- Individuals always make the economically correct and informed decisions

Diagnostic: Barriers to expanding global health initiatives often arise from a lack of financing or from restrictions placed on funds. Why do you think there is a lack of investment in global health and health system strengthening?

Teaching Bit: In July 1944 in Bretton Woods, New Hampshire, 44 nations came together to discuss Europe's postwar recovery strategy. Following World War II, paranoia around the role of government festered. In order to aid in economic reconstruction, the **Bretton Woods Agreement** established two important international institutions within a framework that supported supply and demand economics, leaving almost no room for government regulation:

- **International Stabilization Fund** (later known as the International Monetary Fund, **IMF**)
- **International Bank for Reconstruction and Development (IBRD)** (later the core of the **World Bank Group**)

These institutions received money from many different nation states and were able to disperse loans to other nations in order to aid development and recovery. Loans had the power to reward nations for adhering to anti-communist governing rules and, as the text states, "the largest donor[s], [had] significant influence over recipient countries and the bank" (88). The neoliberal agenda put huge pressure on the IMF and World Bank to award loans to nations working to shrink their governing bodies and national expenditure.

Neoliberalism, however, was not easily applied to health care. There was great tension between those who wanted to invest in public health initiatives and those who wanted to adhere to neoliberal ideology, privatizing all spending.

In 1968, World Bank President Robert McNamara pushed for the World Bank to become more involved in international nutrition and health. The *Health Sector Policy Report 1975* emphasized that health care is more like a public utility than a private good. However, the **structural adjustment programmes** (loans awarded by the IMF and World Bank), emphasized user fees at public health clinics, laying off staff, and privatization of services.

By the time the WHO and UNICEF convened at the meeting of African ministries of health in Bamako, Mali in 1987, "affordability," "effectiveness," and the use of prices and markets to allocate health care largely dominated decision making by the IMF and the World Bank. Other officials, responding to the urgent action to achieve health for all called for by the 1978 **Declaration of Alma-Ata**, pushed for aggressive government investment in primary care services. In 1987, the **Bamako Initiative** reached a compromise by guaranteeing "the availability of a limited, but lifesaving package of health service, both preventative and curative" (98). This compromise has largely dominated funding mechanisms in global health since.

Guided Practice: We can trace many trends in global health financing back to the Bamako Initiative, and earlier still, to the Bretton Woods Agreement and efforts to reconstruct Europe after World War II. In small groups, discuss three problems or challenges in global health financing that have their roots in neoliberal politics. Share with the group. (Hint: focus on cost effectiveness, privatization of health care, "basic package" of health services, etc.)

Independent Practice: History has clearly created many challenges in global health financing. The history of the right to health movement, however, offers an opposing narrative and vision for what is possible. Discuss as a group:

- Historic actions that resulted in advancements regarding stabilized financing for global health (PEPFAR, etc.)
- Ways that you, your team, or the PIH Engage network could contribute to stabilizing global health financing

Assessment: Why is it important to understand this history of global health financing before advocating for a change in its current state?

Closer: Have each person share one policy, institution, or idea that could help stabilize global health financing.