Building Solidarity Assets

Dr. Paul Pierre, MPH, the Director of Community Programs for Partners in Health's sister organization in Malawi delivered the remarks below, on the importance, and value of building solidarity assets, on September 25, 2010, at the 17th Annual Thomas J. White Symposium in Boston, titled "Lessons from Haiti: Tackling Acute and Chronic Disasters." Dr. Pierre is a native of Haiti who spent years in Hinche as well as Canges. He now leads the program in Malawi, and completed his medical fellowship in global health delivery through Harvard, Brigham & Women's Hospital, Zanmi La Sante, and the Ministry of Public Health in Haiti. When the earthquake hit in January 2010, Paul, like so many of PIH's Haitian staff in leadership abroad, left his family, his wife and his 2 year old daughter, in Malawi as he headed back to Haiti to spearhead the community effort [following the earthquake] in Port-au-Prince. The original livestream video of his presentation, transcribed below, is online at http://www.pih.org/news/entry/the-voices-of-our-colleagues (begins at 1 hour, 13 minutes):

I went to Haiti 12 days after the earthquake and a lot of the things that we were able to do, we were able to do because of what I call "assets" These are assets not of any economic or financial assets, but were what I would call solidarity assets. For example, in Haiti when Paul and Ophelia and all the team came more than 20 years ago and started building the project which is PIH now, they start building assets and they start building trust assets – I'm going to call them understanding assets - they trusted us. They allowed us from the beginning to have a major role in the response. But also, more importantly, I think, they build what I would call solidarity assets with the community. And they will trust us from the beginning and will let us be involved; they will trust whatever we will do because they have that experience with us and they know that we will deliver in the Central Plateau for more than 20 years.

I will illustrate that by one of the first things that I was involved with when I had just got to Haiti [after the earthquake]. There was a list that Patrick and the team that were before me—Louise--a list of places in Port-au-Prince where the Ministry of Health were hassling us, "We need help in those specific areas. You guys can pick two or three or four of them and help us in providing care." But, for people who know Port-au-Prince. Port-au-Prince for the last 40 years has been divided into zones, like "red zone" "green zone." The red zone will be a place where it is "unsafe," like close to the *bord du mer* and Cité S*oleil*. And areas that are closer to the mountain are kind of "green zones" where there are more residential area. So we went and we

surveyed all those regions to see where other there were other NGOs that were providing services. Of course, most other partners, they were providing services in the "green" zones. And the "red" zones were – there were a lot of needs, but there were not that many providers. So we decided, as you know, to go working in those very difficult places where the needs were so high.

When we start working there, just putting up a tent, just talking to the people, talking to the community, there was a little bit more –anticipated more resistance, because those places are traditionally considered as dangerous. But I would go there with our team and say that "We are PIH," and they will say, "Ok, you guys are Canges," I said, "We are doctors—" and they said, "No—you are Canges; just put your tent here and we need services." So we didn't have to explain, because we had all those assets of trust that were built for a long time. And actually, those areas get more services and more people were able to provide services in those areas through us. For example, when we started the clinic in Parc Jean Marie Vincent, there was, I think a Major from the US Army, who came to me and they asked me 'What is the schedule for the clinic?' because the clinic was intermittent it was Monday, Wednesday, and Friday. And I said, "It's Monday, Wednesday, and Friday." And I said, "Why? I mean, we don't really need security because I think we are fine." They said, "No, it's that we think you guys have good contact with the community so we have some distribution project so when you are there we will try to match our distribution schedule on yours." Actually, we were the ones providing the security for people because we had those assets! But those assets are very difficult and take a long time to build. And right now I'm working in Malawi and we have a very young project there. We are starting to build those assets. And those assets are: being on time in the clinic, having the drugs there, having a clinician there, having water, having electricity, having internet, providing good services, and make people in those communities who are very, very poor have access to those minimum social and economic rights. Those assets, I think, they are really the main element that explain that we are able to do what we have done, but also that in the future we will be able to keep doing those kind of intervention because the shocks—I have been reading some economics lately so I like to think in those ways--the shocks – the earthquake is a shock. I think a drought, for instance, in Malawi is a shock. So those shocks are happening all the time in poor communities. But it is only when you have enough assets – understanding assets, solidarity assets, or even financial assets—that you can be able to respond to those shocks. So it's important to be able—in other countries where we are all working, where the shocks are not as violent or as meta- as the earthquake was – to keep building those assets. And another way to build those assets and I think that's part of our work, within the community-- is to make people, make the community we are working with to be involved in our work, the way we can do it, like, clearly, it's to increase the awareness of what we are calling now the 'burden of disease.'

For example, we have community meetings that we are holding in Malawi where we will ask, we will meet with all the leaders in a village and we will talk to them about our work and what they think we should do for them—and typically we will ask them them questions to see what they perceive as acceptable or not acceptable. One question that comes up again and again was maternal mortality. People – I was very shocked to hear that in most villages where we are conducting those kind of meetings people will perceive that having – let's say—the kind of question that we will ask – "If there are one hundred women in your community that are pregnant, how many of them do you think should have a normal delivery and have healthy babies?" They will say, "Well, if 70% are able to have healthy deliveries, that will be fine." But that's not fine; that's not fine at all! So we need to say, "Ok, but in this country, which is on the border, things are different. And people don't need to die. We don't need to lose three pregnant women out of ten. That's unacceptable." This is the kind of awareness that it's important to work with the community and to make people understand that this is not acceptable at the beginning. Actually the awareness works both ways. It works also for us. When we are in those

kinds of meetings, we are also in some area where we can improve in our response to those community challenges. For example, we have been supporting in those communities it's evidence-based, using bednets to prevent malaria. It's a public health evidence-based solution that reduces the prevalence of malaria and reduces morbidity and mortality of malaria. But when you are using bednets and you don't have a bed, it doesn't work, really. It might seem obvious but it's not that clear. I've been doing a couple of home visits lately and I've been paying attention to how many of our patients in Neno district have beds. And it's not a big number--it's zero, so far. So it's important to have a bed, so you can optimize the use of the bednet. So this is something we are learning when we are conducting those awareness.

I will stop there-- but I will just add that it's important that all of us understand that there is a critical mass of people that need to understand what we have understood, and that we need to build those assets in order to cope with the shocks because they will happen. They will happen in Haiti. They will happen in Malawi. They will happen all over the world. But in the meantime the only thing we can do is building assets.

Thank you.

To read more:
More about the Malawi site is available at http://www.pih.org/pages/malawi/
For more on maternal mortality in Malawi:

1. Tarek Meguid, "Notes on the rights of a poor woman in a poor country," *Health and Human Rights: An International Journal* 10/1 (2008): online at
http://www.hhrjournal.org/index.php/hhr/article/view/19/63.

2. Paul Farmer, "Challenging Orthodoxies in Health and Human Rights," Keynote Address to the American Public Health Association, November 5, 2006, online at
http://ftp.pih.org/inforesources/essays/APHA_2006_keynote-Paul_Farmer.pdf, pp. 4ff.