

Phone call between GiveWell and Partners in Health (PIH) on July 12, 2012

Participants:

- PIH: Paul Zintl, Chief Operating Officer; Lisa Hirschhorn, Director of Monitoring Evaluation and Quality; Susan Sayers, Chief Development Officer; and Angela Letizia, Senior Manager, Corporate and Foundation Relations
- GiveWell: Elie Hassenfeld, Co-Executive Director, Natalie Stone Crispin, Research Analyst, and Eliza Scheffler, Research Analyst

GiveWell: If PIH received more funding than it budgeted for in FY13, what would it do with the extra funding?

PIH: We have 4 priorities:

1. Deliver high quality health care and build health system capacity in countries where PIH works
2. Transform medical education in those countries to improve local capacity and commitment in delivering care to the poor
3. Conduct research to document what PIH does and show its applicability within and across countries
4. Broaden the impact of PIH's most successful programs, by providing technical support and guidance to organizations committed to care for the poor

As we budget every year we look at what we have been doing in each country that needs to be continued, like the provision of basic health care. We hope that governments will pick up increasing amounts of ongoing care so that we can direct care to the margins where there is a need for capacity building.

In FY13, we have had to cut spending in Lesotho, where we have documented an uptake in services to prevent maternal mortality and improve maternal outcomes, and through the end of FY12 we have had no maternal deaths in the program. For children under 5, we have reached 100% of surveyed children under 5 for important health services including malnutrition screening/treatment, and immunizations. However, we decided to put \$300,000 back into the FY13 budget for this project because the project is our most successful maternal mortality reduction program. If we had an influx of money, we could put even more into tackling maternal mortality and health issues in Lesotho.

Additionally, we would like to augment our recently reduced budget in Malawi, where our work would be supporting the president of Malawi's efforts to improve the health of the poor, centering on maternal health.

There are two crosscutting themes of our work: improving the ability to monitor and evaluate and improve the quality of our work, and "pushing the envelope of what is possible" in global health.

GiveWell: Can you expand on what the maternal mortality programs would look like in Lesotho and Malawi? What specifically would PIH need funding for and what are the

other inputs that would be required to make those programs happen?

PIH: We have a project in Lesotho that trains and compensates maternal health agents to canvass their communities and refer and accompany pregnant women to antenatal care and facility-based births. Investment in maternal health agents and in the clinic sites are the specific cost areas. The Lesotho program's top priority is to get a skilled birth attendant in each of the sites and improve the quality and capacity of the program, especially improved access to emergency obstetric care. This program has the benefit of having already secured a partnership with the government of Lesotho.

The \$300,000 that was put back into the budget for Lesotho will add 7 nurses, 4 nurse midwives and 1 laboratory technologist to the program, and increase the budget for critical medicines and supplies. This amount, only, was granted out of \$1.2 million of extra funding requested by the Lesotho team. We will send you the details of the Lesotho request for \$1.2 million.

We have to raise the revenue goal in order to fund our budget, every year. We raise about $\frac{1}{2}$ of the funding from individual and family foundations, $\frac{1}{4}$ from corporate and foundation sources, and $\frac{1}{4}$ from government multi-lateral funding agencies. Most of this is raised on an annual basis. When we say we have committed funding for a program, that commitment is based on projected revenue, not what is already in the door. While we do have the benefit of a relatively large amount of unrestricted funding, we also have a lot of uncertainty from year to year.

In the global health arena, projects tend to be driven by funding. Many organizations will start a new program or new site when funding is available and then cut that program or site entirely when the funding ends. In the end, this means that on-the-ground care may be driven by donor priorities, not by community priorities. In contrast to this model, PIH asks our country team to set their clinical and program priorities based on what they are witnessing on the ground and what the communities themselves are naming as the priority. PIH headquarters is then charged with securing the funds to meet these needs. While this forces us to accept a degree of risk, it allows us to make long-term commitments to our patients and be sure that we are responding to rather than mandating their priorities.

GiveWell: Has it happened in the past that PIH has set a budget that it could not fully fund, requiring you to cut funding to programs?

PIH: We had budgeted for FY12 and 13, but halfway through FY12 we decided we were not going to meet our projected revenue. In order to deal with this, all of our country offices had to cut their spending.

GiveWell: What activities did country programs choose to cut for the FY12-13 period?

PIH: The country programs cut staff in most cases, and cut the scope of programs rather than cut out programs completely. In some cases, the countries reduced salary top-off

support that was given to Ministry of Health partners. The top-offs are given to retain staff in rural areas and to compensate staff for additional work that they do. Some infrastructure projects were delayed or cancelled due to lack of funds. Another area that countries trimmed back on were the “wraparound services” – provisions that address the social and economic determinants of health (e.g. food packets, vocational training, agriculture programs, funding for school fees).

GiveWell: Have those cuts now been funded or are they still on the backburner?

PIH: Maternal mortality reduction programming has not been funded. Our Board has required that we raise revenue first to fund the whole budget before adding programs back on. In Lesotho, extra revenue would be used to restore budget items that have been cut, but in other cases the budget cuts have forced our country teams to rationalize the size of their workforces and become more efficient, or to scale back funding for wraparound services that weren't effective.

GiveWell: Do you believe that you will meet your revenue projections for the adjusted FY13 budget?

PIH: We are confident that we will meet our adjusted projected revenue of \$88.4 million. We have projected more modest growth in our individual giving in FY13. Also, projections for corporate and foundation sources as well as government multi-lateral and research institutions are two areas that are down considerably. The reasons for this are that in FY12 we received a number of one-time grants. Our revenue projections only include grants that have already been identified and essentially committed, it doesn't account for grants that may come up in the middle of the year. So we are confident that we'll meet our projected revenue for FY13, but it's entirely possible we will raise more restricted revenue than we had hoped (restricted to non-budget items). Again, our Board has required that we raise enough to fully fund the budget before implementing any additional programs.

GiveWell: Changing topics to monitoring and evaluation, we are interested in what kind of information you use to make decisions about how programs should be run. What information are decision-makers looking at to determine that the program is of high quality or is not of high quality and that something needs to be changed? What are the questions being asked and what information is collected to answer those questions?

PIH: There is a Monitoring, Evaluation, and Quality (MEQ) team in each country. With the data gathered, these teams try to answer three questions:

1. How many? (How many people are reached? This is compared to population projections to get a sense of coverage; is PIH serving the population that it should be?)
2. How well? (Use country standards if they are available, if not use internal standards; have various programs for data collection; look for gaps in critical domains)
3. So what? (What is the change in this program over time? How do PIH

intervention areas compare with other areas where we are not working? How do this program's efforts and successes fit into larger metrics of population health, such as MDGs 4, 5, and 6?)

We use "cross-site indicators" to compare HIV data across countries. This data is available to each of the country programs and reviewed by the executive leadership. We are working to share MEQ innovations across the countries that we are supporting, across the practice network, and through the Hilton Foundation's Good and Promising Practice Monitoring & Evaluation guidebook (coming out soon).

GiveWell: Could we see an example of a country report with all the indicators that the executive committee reviews?

PIH: We cannot send a full report right now because we have promised to keep the data reports internal until the country programs are comfortable with what is shared. We started using these indicators about a year ago. Right now country teams are not sure if they are seeing care quality gaps or data quality gaps, and want to sort this out before publishing the data. The country programs want to have the ability to understand and address the gaps before it goes public so that they can say, 'we have this problem, here's what we did, and we've made it better.'

Another thing we've been doing over the past year is explicitly funding quality improvement. We have seen enthusiasm from our employees about using data to identify and address problems.

The Boston office is in regular conversations with the field and knows what challenges the country programs are facing. We don't necessarily have high-level documents because we are enmeshed in the process. We do send out about 100 reports per year to corporate foundation donors, which put us in frequent conversation with program sites so that we can report back to donors.

GiveWell: Could you share the reports that are given to donors?

PIH: We can send you 1 or 2 reports that are representative of our programs. The data in these reports cannot be shared publicly, and donors' names will have to be blocked out.