under the best of conditions, we worry about kids who come in like this back in San Francisco and Boston. If they have had profound oxygen deprivation for a long period of time, should they survive, they often survive lacking even the most rudimentary abilities like being able to suck, swallow, breathe consistently, let alone walk, talk, and think.

"His blood glucose is 156."

"Nice stress response. His adrenal axis seems to be working."

Several high quality studies from the earlier part of this past decade demonstrated the efficacy of the cooling neonates after an asphyxiating event. As is the perpetual wonder of modern medicine, now many babies with this kind of injury and who can reach a hospital within a few hours after birth are being cooled to a core temperature of about 33.5 degrees Celsius for a couple of days. If we were back in Boston, I would have seriously entertained chilling this latest patient of mine.

Cooling. It must have been over 100 degrees in Port–au–Prince that morning.

MRIs. It costs patients one hundred US dollars to get a cat scan in Port–au–Prince. Out–of–pocket. There's that damn equity gap again.

"What do people think? Should I intubate him?"

"What do you think the outcome will be?"

Reflexes are not just physical. Here's a classic reflex in clinical medicine when no one wants to make a decision. Ask the question in a slightly altered way back to the questioner. I was the expert in this situation. In more ways than one.

Emotional Baggage

I wept uncontrollably at the airport when my colleagues finally found me. I avoided them throughout the baggage screening, ticketing, passport control. I ran from the anticipated consolation. Hid with my face toward the bar on the balcony of the pristine air–conditioned American Airlines terminal. I didn't want to appear vulnerable.

"So much for me and my detached enlightenment."

"It's okay buddy. You made the right decision."

"Now you guys can officially say I am human—just don't tell anyone back home."

"It's okay."

People will ask me, "How was Haiti?" and I'll say something like, "It was okay—challenging—hard at times." Knowing that the question itself is nonsensical despite being asked with the best of intentions.

How was Haiti? Do you have a few hours to listen to my real answer? Or would you just prefer the not–so–polite one liner? Here, let me summarize my last few minutes in the hospital with my last patient for you: Good luck dad getting back to your tent safely on your moped with your dead son wrapped in a blanket tucked under one arm. Good luck telling your wife her newly born son is dead. Good luck finding a place to bury your baby tonight.

On Partnership

Ryan Schwarz, Duncan Smith–Rohrberg Maru, Dan Schwarz, Bibhav Acharya, Bijay Acharya, Ruma Rajbhandari, Jason Andrews, Gregory Karelas, Ranju Sharma, and Mark Arnoldy

Recently, Bayalpata Hospital, in the rural district of Achham, Nepal almost collapsed under the weight of its own staff's discontent. The hospital had been largely abandoned until 2009 when our organization, Nyaya Health, renovated and opened it in partnership with the Nepali government. Since then, the hospital has seen great progress and has experienced widespread community support. Nonetheless, earlier this year, a broad–based staff revolt occurred, led primarily by our senior clinical staff members, raising concerns that Nyaya's management policies were ineffective, and wages and benefits were too low. The unrest included everything from a strike, limiting services to our patients, to aggression against non–strikers and slander and racist comments in public media against the Nyaya Health Board of Directors. Ultimately, the conflict was resolved, though not without the departure of our three most senior clinicians. The incident deeply damaged staff morale

and impeded basic services to our patients, and from our perspective as a leadership and management team, it was deeply troubling and spiritually challenging. We have learned much in the wake of the strike, but here we focus more narrowly on the concept of partnerships in our work by examining the recent strike and the two key issues that lead to it: wages and benefits, and management policies at Bayalpata Hospital.

In grappling with the recent staff crisis, some of our leadership team expressed concerns that we would never be able to develop a true partnership in Achham if our senior–level employees led strikes against the organization. The leaders of the strike were our most well–educated and high–ranking staff. They were also individuals who had come to work for us specifically citing the moral imperative of our work, and their pride in helping to serve the poorest of the poor. One leadership team member asked, "What is 'partnership' then? We came into this work with the premise that we would work together, with our partnership built around the right to health—but who are our partners if they lead strikes damaging the very services our collective mission aims to offer?"

Another leadership team member commented, "The first time I visited Achham I was invited for tea at Meena's* house (one of Nyaya's midwives). We arrived at her house and Meena greeted us warmly. She showed us in to a small room: there was no furniture, but there was an immaculately swept mat which we joined her on. We drank tea, seated on her rug, and listened to her tell us how she had come to live in the house, how she had come to work for Nyaya, and her pride in now being able to provide both for her own children, as well as, the children of her relatives. As the only employed family member, she now had the challenge of providing for all of them. When we question our partnership, I'm taken back to Meena's warm, but extremely poor, home. She has worked for Nyaya for almost four years. She has helped our organization provide free care to over 75,000 people. Is this not a type of 'partnership'?"

**Name changed for privacy reasons*

Allow us to offer some background on the issue of wages—Meena has been with our team since 2008, and has been paid about $2,500 per year—a generous wage compared to other employers in the region. Meena was one of the striking staff members. Among other concerns about the way the hospital was being run, she and other staff asked indignantly why we couldn't provide them with higher wages, better benefits, and more resources, both for her and the hospital. Notably, Meena's salary (and the rest of our staff's) was well above her equivalent in other, more urban hospitals (to compensate for the extremely remote area in which we work), and in a district where most families are farmers, our staff's salaries occupy the highest income bracket in the region. Nonetheless, as is common throughout the world in both rich and poor areas, our staff regularly asks for raises. We have consistently provided our staff with annual raises to incentivize long–term employment, as well as additional benefits for longer–term employees, though it is nonetheless exceedingly difficult to maintain skilled professionals in an extremely remote and impoverished area. However, in keeping with our commitment to support the public sector, and as signatories to the NGO Code of Conduct (for more information on the NGO code of conduct, please visit htpp://ngocodeofconduct.org/), we aim to ensure our salaries are in keeping with a long–term and sustainable approach to the public health system. To the extent possible aim to avoid the detrimentally high salaries provided by some other NGOs that often have the unfortunate and unintended consequence of recruiting staff away from the public sector.

As our leadership team grappled with the strike, a key lesson we learned was that we may have entered the discussion with a falsely elevated sense of what "partnership" implies. Nyaya's leadership team is comprised of Nepalis and Americans. We have trained and worked at some of the finest institutions in the world. We are privileged enough to travel around the globe when we choose, and our day–to–day lives are primarily in well–developed cities with access to great luxury. For us, our "partnership" consists of giving our time to support

Nyaya's work, but many of us will also come and go, intermittently or permanently, from this work when our jobs and lives take us in different directions. Conversely, Meena's life has been lived primarily in the destitute and rural west of Nepal. She has never received the opportunity to travel leisurely throughout her own country, much less to a different country 8,000 miles away to do "global health work." By the time she was in her mid–20s, she was responsible for her own *and* someone else's family. To Meena, her partnership to Nyaya has been showing up to work, every week for the last four years, and ensuring that our organization has successfully seen over 75,000 patients.

The ideal of partnership is often glorified in images of "struggling equally, for the cause, together." In reality, however, it is a much more complicated concept. A true partnership necessitates that each partner bring to the table what they are able, making each contribution quite different than the next, and indeed, sometimes "unequal" in magnitude or scope. But the point is that it is not about keeping score—it is about working together for a common purpose. As we have volunteered our time building the organization and fundraising, Meena's service to our "partnership" has been her employment. If another job with a better salary arises, she will take it—and we will continue to struggle through the complicated issues of internal and external brain drain—but that does not cheapen her role in our partnership over the last four years. In the same way, any of us as leadership team members moving on to a new job would not call into question our commitment to Nyaya's mission.

Back to our discussions, another team member countered, "Okay, we all understand that poverty and structural violence are inextricably linked to this work and do deeply impact how our staff are able to live their lives and work as Nyaya employees. But that doesn't explain or excuse some of the unprofessional, hurtful, and deconstructive things that were said and done during the strike." And another leadership team member reminded us, "I agree with that too. But let's also not forget how many mistakes we made that led to this strike in the first place."

As always in Achham, poverty played a significant role, and it's easy to understand a continued push for higher salaries and better benefits when our staff live in a setting of abject poverty, supporting not only their own families, but the families of their relatives and friends as well. We have seen this before, and we know we will see it again. We choose to work in Achham for these very reasons, and these same factors will continue to lead to staff displeasure with any salary we offer. But this strike was different than staff conflicts in the past. Never before had Nyaya's employees publicly defamed the organization, nor had such internal strife arisen amongst our staff, pitting one side of the conflict against the other.

As the strike progressed, we came to understand it more clearly, and learned that while it was in part about wages and benefits, there were other grievances as well. Staff told us that our leadership team had done a poor job of supporting them with effective management structures. Our policies, guidelines, documentation, and reporting structures were deeply flawed. There were redundancies and gaps that resulted in ineffective work place policies and made our staff's day–to–day jobs significantly more challenging. While money was certainly a key cause of the strike, we were surprised to learn how our own mistakes as a management team had also lead to continued and progressive staff discontent, ultimately culminating in the strike. We have made significant changes to our policies in an attempt to avoid such conflicts in the future; we share a summary of some of these in Table 1.

The leadership team member who started the discussion continued, "Yes, I do understand that we made a lot of mistakes here as well. But neither our mistakes nor the impoverished conditions that we work in excuse the way certain employees acted; so, what next?"

Ultimately, the answer to that question resulted in three of our most senior staff leaving—one's contract was allowed to expire and two resigned. Their actions had crossed the line from constructive dissent to frank unprofessionalism and destructive behavior. They were successful in highlighting our inadequacies as a management team, but they also

Table 1

Description of Mistakes, Mis-steps, and Systems Changes During the Bayalpata Hospital Staff Crisis

Core Mistake	Practical Mis-step	Systems Changes
We did not appreciate the power of pride and shame, particularly given that we call upon very inexperienced leaders and clinicians to work in an extremely challenging environment.	We suggested we would not provide a letter of recommendation to our Medical Director; we provided a strongly-worded letter of condemnation for various destructive acts perpetrated by the physicians; we used the NHI leadership as a condemnatory structure without previously having established it as a supportive one.	We have established new roles within our NHI leadership that will communicate regularly and provide greater support to our clinical staff and leaders.
We allowed salary negotiations to serve as a wedge between the core hospital leadership: the Medical Director and Country Director.	We left salary negotiations for both senior clinical leadership and other staff members in the hands of the Country Director alone.	We will revise our policies such that NHN negotiates the salary directly of the Country Director and the senior clinical leadership, we will de-authorize the Country Director in any role in salary negotiations with senior clinical leadership. As had been previously, the hospital management committee, including the Country Director and Medical Director, will have hire, fire, and salary power of mid-level staff but not over the firing/hiring over senior leadership. This will hopefully prevent power struggles as we saw previously. We will provide block salary budgets to the Country Director and Medical Director to negotiate with staff.
We had a weak Nepali leadership, and a Country Director hamstrung by being an expatriate and without effective Nepali support mechanisms.	We had been unsuccessful at recruiting a more experienced hospital administrator and clinicians. This necessitated a more forceful/involved Country Director, the only non- Nepali on site, to help get things accomplished. However, while we had over one month prior agreed to hiring a translator/assistant for him, we had failed to do so.	We will prioritize, and be willing to pay more for, more experienced, older, more mature Nepali leaders who have been extremely difficult and costly to recruit. For those positions requiring an on-site expatriate leader, we will have an effective Nepali assistant or translator.
Our leadership has been continuously changing, with most physicians, Medical Directors, and Country Directors staying on for less than one year.	Due to the challenging circumstances and remote area of Achham, we have not been able to recruit, establish contractual mechanisms, or provide supportive environments, to make long-term commitments feasible for leaders.	We will revise our recruitment strategies to look for longer term leaders; we will develop mid-level leadership positions to cultivate leaders; and we will look harder for local Achham-side leaders.
Bayalpata Hospital staff in general had unclear structures for staff grievances and management	Owing to our multiple transitions of leadership, many of our hospital operations, oversight, and management documents were unclear or outright contradictory.	We have revised all these documents, following reflection and input from the various staff and community meetings.

NHI had itself unclear roles for its leaders during the crisis.	Because NHI leadership lacked clear roles, many of us took part in providing advice and support as ways to help out, but that ultimately was not done in an efficient or effective ways. As such, while many people spent much time on the crisis, we still were unable to get core tasks accomplished.	We have started to carve out more clear roles, with clear chains of command and specifications of who is in charge of what type of crisis, among our NHI leadership.
There was a lack of a sense of partnership between NHI and Bayalpata Hospital staff throughout this crisis.	We had not prioritized regular, consistent mechanisms for the staff to understand who NHI is and what NHI does.	We will start regular conference calls between an NHI leader and local Bayalpata staff, with photos and stories about NHI members, and with more readily available documentation about NHI.
Staff were overworked and overwhelmed by the work load.	We failed in identifying and recruiting additional mid-level and ancillary staff.	We will endeavor to hire several new staff to better manage the workload.
During the transition, we did not have rapid ways for recruiting new doctors.	While we knew even before the crisis that we needed an extra doctor and had agreed to recruiting one, various priorities had made it such that we did not get our application process started for over two months since we had agreed we would start recruiting.	We were able, through our contacts, to get a doctor out within a week after our previous doctors left. We are aiming to recruit more senior doctors for longer periods and to have more doctors on staff at all times.
Our procurement mechanism did not have appropriate safeguards for ensuring quality.	We did not provide sufficient oversight and support to our new young, inexperienced hospital administrators. We were unable to recruit and pay for a more experienced team. We failed to involve NHN leadership, who have experience in procurement, to assist in reviewing potential vendors and offers.	We will engage NHN in better oversight over procurement. We will work to better capacitate and support a more effective hospital administrative team, with the organizational willingness to pay a higher salary.
When the procurement problems happened, we failed to address them sufficiently in the eyes of staff.	While we discussed the problems internally and with the Hospital Administrator, we did not communicate this effectively to the staff.	We are conducting an independent investigation, led by external community members, into the affair.
We underestimated the importance of having on-site presence from senior members of Nyaya Health Nepal leadership to help guide NHN's local staff.	We could not create an effective local non-profit organization, owing to various challenges with the culture of non-profit industry in Nepal and the lack of a solid base of core leaders living in Nepal willing to be volunteers without economic gain.	The President of NHN, for the first time, travelled to Achham from Kathmandu to help mediate the community and staff meetings. We are working with him to engage NHN more effectively in Achham, and to evolve into a more legitimate non-profit organization, rather than a legal mechanism.

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brought about unnecessary and unhelpful strife that damaged our ability to serve our patients—the primary mission and one that we all share, despite our disagreements. As we reflected further, where we had initially questioned our staff's fulfillment of our partnership, we found that we had also failed to deliver on our own end. We also came to realize that while some staff had acted in inappropriate ways, many of our staff had not. The majority of our staff—including Meena—had joined the strike seeking better salaries and because they were understandably frustrated with the inefficiencies and ineffectiveness of their hospital's management.

Work in the global health field is both morally compelled and deeply challenging. While the partnerships involved are often discussed superficially and glorified as seamless, in practice they are rarely such, and at times can be extremely difficult to navigate. It is critical to understand the context each partner comes from, and that privilege, contrasted by the structural violence of poverty, impacts heavily on how partnerships evolve and interact. Further, partnerships are dynamic, and sometimes hard choices must be made to ensure that the mission of that partnership is upheld. For our role as a management team, we had failed our staff and are working presently to amend our policies to enable them to better fulfill their own part of the partnership (Table 1)—employment and the day–to–day health care that Nyaya provides our patients. In parallel, this incident also highlighted that ultimately, Nyaya's mission is to serve our patients, and a professional and respectful partnership must be maintained to ensure that our mission is successful. Unfortunately, implementing that mission sometimes requires making difficult and painful decisions.

We know that there will be many more challenges ahead; if there were not, we would not have chosen to work in Achham. While the unfortunate recent events have not helped our patients in the short–term, they have taught us much about this work and helped us to better understand how, as an organization, we can continue to work towards our mission. While our initial reaction was to see only our staff's errors, we've learned to be more critical in understanding our own. All crises are opportunities, and no matter how painful such conflicts are, we are confident that as a team we are stronger and better, and such experiences will indeed serve our patients in the future.

Pains And Gains Of Rural Health Practice: Lessons Books Never Taught

Sridevi Seetharam, Bindu Balasubramaniam,
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How The Journey Began

In the early 1980s, as fresh graduates from Mysore Medical College in southern India, we were brimming with a zeal to "cure the sick" and "change the world." We had an ideal of evidence–based, rational, ethical and equitable health care and set out to serve rural and under–served communities which included displaced forest–based tribes. In the initial years, with the naivety of the inexperienced, we believed that by correcting the dehydration of the doe–eyed six–year–old Mare and giving her a free course of antibiotics, we had made health care accessible to her. Much to our dismay, within a month, Mare was back in the outpatient clinic, with diarrhea all over again and looking thinner than ever. We realized that it was a losing battle to keep her healthy as long as she continued to drink water from the same contaminated stream, live in unhygienic surroundings, and eat only the paltry meals that her family could barely afford. We gradually began to connect these living examples to what our preventive medicine text books had stressed all along—there are many social determinants of health which, if left unaddressed, do not permit realization of the vision of health for all.

Such instances continually pulled us out of the hospital building and into the villages and tribal hamlets. We discovered that our textbook of *Preventive and Social Medicine* (Park, 1986) (P&SM as we used to call it), was our most valuable possession.