

Community Involvement is an Essential Ingredient

An Interview with John Damonti,
President, Bristol-Myers Squibb Foundation

EDITORS' NOTE John Damonti has served as President of the Bristol-Myers Squibb Foundation since 1993. He received his undergraduate degree from Bowling Green State University and a master of social work degree from Fordham University. In 2007, he was also awarded an Honorary Doctorate degree from Fordham University. He began his career as Manager of Contributions and Community Relations for Mutual of New York. He was also Director of the Primerica Foundation (now part of Citigroup) and served as Director of State Government Relations for Ciba-Geigy Corporation (now Novartis).



John Damonti

FOUNDATION BRIEF The Bristol-Myers Squibb Foundation is committed to improving the health outcomes of populations disproportionately affected by serious diseases by strengthening healthcare worker capacity, integrating medical care and community-based supportive services and addressing unmet medical need. The Foundation engages partners to develop, execute, evaluate and promote innovative programs to help patients in areas of high HIV prevalence in Africa, Hepatitis B&C in China and India, lung cancer in the U.S., cancer nursing in Central and Eastern Europe and a new initiative focused on disparity populations and the barriers that exist to accessing specialized care in the U.S.

How has the mission of the Bristol-Myers Squibb Foundation evolved?

The Foundation's mission has evolved over the past 20 years since our major investment into Sub-Saharan Africa. While BMS is focused on discovering new medicines to help people with serious diseases, the Foundation's focus centers on the knowledge that medicine is only part of the equation to improve people's health.

When we seek to help vulnerable populations and people at risk in very challenging geographies, such as HIV and AIDS in Africa, Hepatitis in Asia or lung cancer in the U.S., we have to think about the entire patient and patient journey to educate people and remove barriers to ensure they can benefit from medical innovation.

Over the years, the Foundation has built programs focused not only on what happens in the clinic through capacity building of medical personnel, but also focused on what happens when the individual leaves the clinic and goes back into the community. With these diseases and geographies,

what happens outside the clinic is almost as important as what happens inside the clinic.

We also know that it is in the community where we engage people around medical issues in the first place.

This has become the platform on which we create our programs, regardless of disease or geography, around the world.

Do the Foundation's focus areas align with BMS's business and strategy or are there also employee-driven initiatives?

Almost all our major programs are therapeutically aligned with the company's strategy. However, there is one that is more of an employee-engagement program, which evolved out of a therapeutic area program on serious mental illness.

We had a long running community-based mental health program in the U.S., through which we learned a lot about community involvement in terms of developing capacity and helping people who did not have easy access to care.

When the company exited serious mental illness as a therapeutic area, we realized that the lessons we learned in community-based care for mental health could have an equal impact on returning veterans and the reintegration of post-9/11 veterans and their families into society after leaving service.

We had to consider carefully where we could meet this population, and our community-based approach, working through peers and mentors, university-based or technology-based, was needed to reach this contingent.

As an outcome of the Foundation initiative, we have created an employee resource group, the Veterans Community Network, which engages well over 650 of our employees to support and mentor veterans, both inside and outside the company.

Would you discuss the impact the Foundation has had on pediatric HIV in Sub-Saharan Africa and if this can be duplicated with other childhood diseases?

When we engage in philanthropic initiatives to create change, we look to invest for the long term.

We started our work with pediatric HIV in 2001 in Sub-Saharan African countries. Children were dying in huge numbers and there wasn't a comprehensive approach to treat them.

We partnered with the Baylor International Pediatric AIDS Initiative (BIPAI), local governments and NGOs to tackle the problem and, over

a 15-year period of building local capacity, we created the largest pediatric HIV network in the world.

In this five-country program, we have touched over one million kids and families and currently have over 300,000 in our own network, over one third of whom are now adolescents. The mortality rate is less than 2 percent, which is similar to what we would see in the developed world.

As the funding pool for HIV has grown and support for HIV infected children in our programs became sustainable, we shifted our focus to the overlooked need in non-communicable diseases, and specifically oncology. Most children with cancer in Sub-Saharan Africa face a grim prognosis.

In the United States, there are approximately 15,000 diagnoses of pediatric cancer and blood disorders every year and 80 percent of those kids survive. In Sub-Saharan Africa, there are about 100,000 diagnoses per year and 90 percent of those children die. Children are dying from the same reasons we saw with HIV – there is no capacity to treat these kids.

Last year we launched Global HOPE, a comprehensive initiative to combat pediatric cancer, working with BIPAI, Texas Children's Hospital and local governments. We knew we could apply the lessons we had learned to build HIV training and treatment capacity to help these kids.

We have just begun, and building capacity for treatment and care for pediatric cancer is very complicated, but we proved this model works in HIV, so we're confident we can use this model effectively in cancer. We have no choice but to succeed.

How important are metrics when it comes to the type of investments BMS is making in these areas?

From our perspective, metrics are critical to everything we do. We're not in the position, either through our mission or from a financial standpoint, to be a direct service provider. We provide the R&D money to test and measure the models and help build and develop local resources to support patients and to deliver care.

The long-term care itself needs to come from other sources, hopefully from national governments or multilateral or bilateral funding streams.

So yes, the right metrics are essential to prove that the models work, and to demonstrate to others that these can be and should be brought to scale. We need to work with our grantees to advocate that these initiatives are saving lives, are cost effective, and can be effectively rolled out throughout a province, state or nationally. ●