

JOAN B. KROC DISTINGUISHED LECTURE SERIES - FARMER

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*Distinguished Lecture Series*

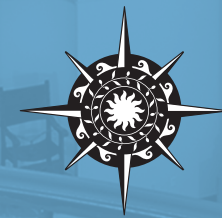
**Paul Farmer**

*Development: Creating Sustainable Justice*



JOAN B. KROC  
INSTITUTE FOR  
PEACE & JUSTICE  
UNIVERSITY OF SAN DIEGO

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Photo by Behna Gardner

*Fostering Peace, Cultivating Justice,*

Joan B. Kroc Institute for Peace & Justice  
*Distinguished Lecture Series*

Delivered on the 8th of October, 2009 at the  
JOAN B. KROC INSTITUTE FOR PEACE & JUSTICE

Joan B. Kroc School of Peace Studies  
University of San Diego  
San Diego, California

**Paul Farmer**  
*Development: Creating Sustainable Justice*

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*Creating a Safer World*



Photo: Architectural Photography, Inc.

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## JOAN B. KROC INSTITUTE FOR PEACE & JUSTICE



The mission of the Joan B. Kroc Institute for Peace & Justice (IPJ) is to foster peace, cultivate justice and create a safer world. Through education, research and peacemaking activities, the IPJ offers programs that advance scholarship and practice in conflict resolution and human rights.

The IPJ, a unit of the University of San Diego's Joan B. Kroc School of Peace Studies, draws on Catholic social teaching that sees peace as inseparable from justice and acts to prevent and resolve conflicts that

threaten local, national and international peace. The IPJ was established in 2000 through a generous gift from the late Joan B. Kroc to the University of San Diego to create an institute for the study and practice of peace and justice. Programming began in early 2001 and the building was dedicated in December 2001 with a conference, "Peacemaking with Justice: Policy for the 21st Century."

The Institute strives, in Joan B. Kroc's words, to "not only talk about peace, but to make peace." In its peacebuilding initiatives, the IPJ works with local partners to help strengthen their efforts to consolidate peace with justice in the communities in which they live. In Nepal, for example, the IPJ continues to work with Nepali groups to support inclusiveness and dialogue in the transition from armed conflict and monarchy to peace and multiparty democracy. In West Africa, the IPJ works with local human rights groups to strengthen their ability to pressure government for much needed reform and accountability.



The Women PeaceMakers Program documents the stories and best practices of international women leaders who are involved in human rights and peacemaking efforts in their home countries.

WorldLink, a year-round educational program for high school students from San Diego and Baja California, connects youth to global affairs.

Community outreach includes speakers, films, art and opportunities for discussion between community members, academics and practitioners on issues of peace and social justice, as well as dialogue with national and international leaders in government, nongovernmental organizations and the military.

In addition to the Joan B. Kroc Institute for Peace & Justice, the Joan B. Kroc School of Peace Studies includes the Trans-Border Institute, which promotes border-related scholarship and an active role for the university in the cross-border community, and a master's program in Peace and Justice Studies to train future leaders in the field.



## JOAN B. KROC DISTINGUISHED LECTURE SERIES

Endowed in 2003 by a generous gift to the Joan B. Kroc Institute for Peace & Justice from the late Joan Kroc, the Distinguished Lecture Series is a forum for high-level national and international leaders and policymakers to share their knowledge and perspectives on issues related to peace and justice. The goal of the series is to deepen understanding of how to prevent and resolve conflict and promote peace with justice.

The Distinguished Lecture Series offers the community at large an opportunity to engage with leaders who are working to forge new dialogues with parties in conflict and who seek to answer the question of how to create an enduring peace for tomorrow. The series, which is held at the Joan B. Kroc Institute for Peace & Justice at the University of San Diego's Joan B. Kroc School of Peace Studies, examines new developments in the search for effective tools to prevent and resolve conflict while protecting human rights and ensuring social justice.

## DISTINGUISHED LECTURERS

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|-------------------|--|
| April 15, 2003    | Robert Edgar<br>General Secretary, National Council of Churches<br><i>The Role of the Church in U.S. Foreign Policy</i>  |
| May 8, 2003       | Helen Caldicott<br>President, Nuclear Policy Research Institute<br><i>The New Nuclear Danger</i>   |
| October 15, 2003  | Richard J. Goldstone<br>Justice of the Constitutional Court of South Africa<br><i>The Role of International Law in Preventing Deadly Conflict</i>  |
| January 14, 2004  | Ambassador Donald K. Steinberg<br>U.S. Department of State<br><i>Conflict, Gender and Human Rights: Lessons Learned from the Field</i>   |
| April 14, 2004    | General Anthony C. Zinni<br>United States Marine Corps (retired)<br><i>From the Battlefield to the Negotiating Table: Preventing Deadly Conflict</i>   |
| November 4, 2004  | Hanan Ashrawi<br>Secretary General – Palestinian Initiative for the Promotion of Global Dialogue and Democracy<br><i>Concept, Context and Process in Peacemaking: The Palestinian-Israeli Experience</i> |
| November 17, 2004 | Noeleen Heyzer<br>Executive Director – U.N. Development Fund for Women<br><i>Women, War and Peace: Mobilizing for Security and Justice in the 21st Century</i>   |
| February 10, 2005 | The Honorable Lloyd Axworthy<br>President, University of Winnipeg<br><i>The Responsibility to Protect: Prescription for a Global Public Domain</i>   |
| March 31, 2005    | Mary Robinson<br>Former President of Ireland and U.N. High Commissioner for Human Rights<br><i>Human Rights and Ethical Globalization</i>  |

October 27, 2005 His Excellency Ketumile Masire  
Former President of the Republic of Botswana  
*Perspectives into the Conflict in the Democratic Republic of the Congo and Contemporary Peacebuilding Efforts*

January 27, 2006 Ambassador Christopher R. Hill  
U.S. Department of State  
*U.S. Policy in East Asia and the Pacific*

March 9, 2006 William F. Schulz  
Executive Director – Amnesty International USA  
*Tainted Legacy: 9/11 and the Ruin of Human Rights*

September 7, 2006 Shirin Ebadi  
2003 Nobel Peace Laureate  
*Iran Awakening: Human Rights, Women and Islam*

October 18, 2006 Miria Matembe, Alma Viviana Pérez, Irene Santiago  
*Women, War and Peace: The Politics of Peacebuilding*

April 12, 2007 The Honorable Gareth Evans  
President – International Crisis Group  
*Preventing Mass Atrocities: Making “Never Again” a Reality*

September 20, 2007 Kenneth Roth  
Executive Director – Human Rights Watch  
*The Dynamics of Human Rights and the Environment*

March 4, 2008 Jan Egeland  
Former Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator for the U.N.  
*War, Peace and Climate Change: A Billion Lives in the Balance*

April 17, 2008 Jane Goodall  
Founder – Jane Goodall Institute and U.N. Messenger of Peace  
*Reason for Hope*

September 24, 2008 The Honorable Louise Arbour  
Former U.N. High Commissioner for Human Rights  
*Integrating Security, Development and Human Rights*

March 25, 2009 Ambassador Jan Eliasson  
Former U.N. Special Envoy of the Secretary-General for Darfur and Under-Secretary-General for Humanitarian Affairs  
*Armed Conflict: The Cost to Civilians*

October 8, 2009 Paul Farmer  
Co-founder of Partners In Health and United Nations Deputy Special Envoy to Haiti  
*Development: Creating Sustainable Justice*



## BIOGRAPHY OF PAUL FARMER

Paul Farmer, M.D., Ph.D., is a medical anthropologist, physician and human rights activist who has dedicated his life to treating the world's poorest populations. In the process, he has raised health care standards in the world's underdeveloped areas. Farmer is a founding director of Partners In Health, an international charitable organization providing direct health care services to the sick and those living in poverty, and undertakes research and advocacy activities to benefit underprivileged populations. Farmer has worked in infectious disease control in the Americas for many years, and is a world renowned authority on tuberculosis treatment and control.

An attending physician in infectious diseases and chief of the Division of Global Health Equity at Brigham and Women's Hospital in Boston, Farmer is also medical director of the Clinique Bon Sauveur in rural Haiti. Former United States President Bill Clinton recently appointed Farmer the United Nations Deputy Special Envoy to Haiti to assist in advancing the economic and social development of the impoverished Caribbean nation.

Farmer's work draws primarily on active clinical practice and focuses on diseases that disproportionately afflict the poor. He is the author or co-author of over 100 scholarly publications and has published four books: *Pathologies of Power*, *Infections and Inequalities*, *The Uses of Haiti* and *AIDS and Accusation*.

His work was documented in the 2004 Tracy Kidder work, *Mountains Beyond Mountains*.



*Photo by Mark Rosenberg*

## INTERVIEW

*The following is an edited transcript of an interview with Dr. Paul Farmer, conducted on Oct. 8, 2009, by Milburn Line, executive director of the Joan B. Kroc Institute for Peace & Justice, and Jessica Capaldi, an undergraduate student at the University of San Diego (USD).*

### **JC: When did you know that you were called to serve the poor? What was that moment in your life?**

PF: It's somewhat of a mundane answer in certain ways and I think helpful in others. The reason it's mundane is because for me it was in college, and that's why I take very seriously coming to places like this one – because I was lucky enough when I was in college to take some classes that really got me engaged in social justice work. I can also go back and say that when I was a kid, before college, I knew I wanted to be a doctor. That's all true, but it was in paying attention to some of the things I was studying at Duke as an undergraduate that got me interested in Haiti and anthropology. So it sounds “old school” to say that's what got me here, that I paid attention in class, but it's true.

### **JC: So it was the anthropology class?**

PF: I took a class called medical anthropology and I thought I'd really like to study this more, and this was before the term “service-learning” was used a lot. The idea for this class was that you would go into a field site, so I went into the emergency room. I learned a lot about how race and class worked in the American medical system, even in an academic medical center. It was very instructive to me. I did a research paper that I worked hard on – I'm sure it wasn't very good, but it was good for me to invest time. And it was good to experience the practicalities of going to an emergency room, of understanding a little bit more about how the health care system worked, but also to read a lot.

### **ML: Here at USD we see people with a lot of energy and who are involved in**

### **service-oriented activities that people do more in college than afterwards when they get on the career path. How do you bring people into the fold and get them engaged in these things?**

PF: I think that a lot of this is – if you'll pardon the jargon – structural, because you have four or five years in a place like this and you're in this island of privilege and it's beautiful. This is the first time I've been here, and it's a pretty stunning place. But it's in a state and close to a lot of places where there are significant problems. I was just reading in the *New York Times* that unemployment in the state of California is over 12 percent, and there are pockets where it's much, much worse. This is a transnational system, right? We're also in a place on the border of our neighboring country. People move back and forth across these borders, and there are a lot of things that could be done right in this city. I know that to be true even though I don't know this city. It's always the case.

So how to get involved when you're in college and stay involved is a challenge because you're supposed to be in a certain place for some years – you're wedded to that place. For me as an undergraduate it was Durham, N.C., and there was a lot that was going on right there. I got involved, for example, with the Friends of the United Farm Workers (UFW), which is an organization started here in this region, with César Chávez. In North Carolina there was a significant farm workers' stream, and I grew up in Florida so I knew a little bit about farm workers. Not much, but maybe more than some American children.

There wasn't a United Farm Workers in North Carolina at the time, but there was the group of Friends of the UFW, and I started writing a piece for the student paper. I was a junior when I did this. I wrote a very long piece about Haitians and the migrant farm workers' stream. And I didn't *do* anything – I didn't do any work. I was just interviewing people and I thought, *Well, I speak French, I can interview and talk to the migrant farm workers here*, but it wasn't true – they spoke Haitian Creole, not French. And I didn't let that drop; I just kept thinking that I would like to go to Haiti. Someone suggested it to me, one of the migrant farm workers I was interviewing for the piece. It was, I believe, 1981, and I was talking to this Haitian guy through a translator.

There had been slavery charges brought against the growers – I heard about this from the Friends of UFW. I said, “Why would you leave your home country to work in these conditions?” And this farm worker said, “Have you been to Haiti?”, and I said no. He said, “Well, you should go before you ask that question.” So I said OK, fair enough, and I did go.

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*“Developing a discipline around engagement is really critical to social justice.”*

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This goes back to your question: How do you stay involved? A lot of Americans these days are getting involved in this work and then they don’t have any structural way of staying involved. They go off and they have jobs and they have families, or they go to graduate school; I went to medical school. So that’s a big challenge. I would say this, and this has been a very long answer to a straightforward question: Developing a discipline around engagement is really critical to social justice. Even if you only have an hour or two hours a week, just develop a little bit of discipline – which isn’t easy to do – and stay involved in some modest project. Maybe over the years you change what that focus would be, but just develop a little bit of time for it.

**JC: I agree. Every project I’ve done has been short.**

PF: Give me an example.

**JC: This summer we took a group of doctors from where I live and went down to a border town in Mexico, in Ensenada County. We were only there for four days. We set up a clinic, and the family practice doctors only saw people with basic complaints. We gave them insulin that would last them a couple of weeks. What can we really do?**

PF: Let me respond to that. A lot of people talk about short-term medical missions. That’s jargon now; there’s even an acronym for it. It’s possible to

be very critical of that, which I think is good – to be critical in the sense that critical thinking is a good thing. At the same time, there are people who are involved in short-term medical missions who understand that it is *their* lives that are transformed. And that’s a good thing. You can say, “Well, what does this add up to?” if you go down to Haiti or Chiapas or any place in the world. What does it add up to if it’s really just short-term engagement? And you could say, “Not much,” but if it sparks this discipline of engagement, that is a pretty good yield.

My first year or two in Haiti I met some American doctors who were doing these short-term medical missions, and they’re still involved in our work today. At the time there was no hospital, no clinic in Haiti, and as the years have gone by they’ve changed the nature of their engagement. For example, we focus more on surgical short-term missions – if you’re going to talk about short-term missions – rather than what you described as primary health care or family practice, because that requires an ongoing primary health care system. I’m thinking of one friend in particular who got involved in infrastructure, composting toilets. He’s an internist, a critical care expert in fact, and now 20-something years have gone by and his kids are grown up and he’s still involved in Haiti. I think that’s a very good thing.

So I would say yes, be critical of what you do. That’s part of the obligation of privilege. But it’s important to understand that these short-term engagements can lead to a lifetime of engagement.

**JC: What are you expecting from the students you’ve come to speak with here at the University of San Diego? What do you want from us?**

PF: I think that students in this country can help create a climate where certain things are acceptable and other things are not acceptable. I’ve seen it happen. I look at the way global health has been pushed forward by students, and some of the global social justice endeavors have been very much pushed forward by students. That’s pretty impressive – creating an ambiance or climate. Students can also do more. When I was last in this part of the country I was at Stanford, and some of the students I met there or at

Harvard have done so much work to raise consciousness and raise funds. That's the pragmatic solidarity part of it.

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*“Environmental justice is not going to be justice if it's just preserving nice things for people like me. It's really got to be pro-poor. We need a very pro-poor environmental justice movement.”*

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Let me put it this way. The grand part is students can be involved in these broader social justice endeavors in a very definitive way, I believe. What does that mean? There are two big movements I see a lot in my circles in terms of teaching; one is this global social justice movement – fair trade, the kind of work we do in global health – and then there's an environmental justice movement. Those two movements are still a little bit separate, but it's your generation's job to bring them together into one movement. Now I have my own opinions about which of those two movements should be the master movement, if you will, and that's the social justice movement. Environmental justice is not going to be justice if it's just preserving nice things for people like me. It's really got to be pro-poor. We need a very pro-poor environmental justice movement. That's the only kind of environmental justice movement that can really take off, and I think that's what can and should happen. That's what I would like to see from students.

Students are also my retirement plan. Any movement will wither and die if it doesn't have young people. That's why a university is a great place to have a peace and justice institute. It's a great way to make sure the messages get amplified and passed on.

**ML: Can you describe the popular movement in Haiti?**

PF: You can either describe the popular movement accurately or inaccurately, and the people can judge whether I did a good job describing things or not in my writing. But I did witness things. Don't forget that my writings are grounded in time and place. I have very limited experience in the capital city. I have probably been to Port-au-Prince more in the last year than in all the other 26 years combined. I've said very explicitly in my writings and my books that I'm looking at Haiti through the eyes of the people I live with and work with. That's what I feel is my job. Other people may have a different vantage point, and they do.

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*“I'm looking at Haiti through the eyes of the people I live and work with. That's what I feel is my job.”*

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From 1804 to 1990 there was a certain success in Haiti. This was brought home to me when I was talking with a historian of the Citadel.<sup>1</sup> He said, “You know, Haitian people are a success in many ways. Remember, we were only 500,000 freed slaves, and now we're almost 10 million. We survived in a hostile world.” I'm just saying that for the Haitian people – the Haitian popular movement – the platform and substance is very clear. It's around not just civil rights, but social and economic rights – that is, rights for the poor. That's why they keep pushing the same platform and the same people they feel will represent that platform with fidelity. That is, to not deform their platform. I'm in. I believe that. I believe there should be a right to health care, and so do the people who go back and try to serve.

So what does that mean? How do you take a grand notion like that – right to health care – and make it meaningful for poor people? That's what I've been interested in my whole life, especially since 1983 when I went to Haiti for the first time.

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<sup>1</sup> A massive fortification built after the Haitian Revolution, which ended in 1804. It is described in greater detail in Farmer's lecture on pages 38-39.

**ML: You've got a new job. How has being named U.N. Deputy Special Envoy for Haiti<sup>2</sup> changed your outlook and strategy?**

PF: The good thing about that job is I get to be a volunteer, meaning that I'm lucky enough to be a faculty member at a place where that kind of work is valued. When I say "that kind of work" – and this is going to sound a little bit academic – it's important in social justice work not to conflate your own disciplinary background or your own interests with the needs of people living in poverty. Let's call it structural violence. It doesn't matter what it's called. If I were to say, "I'm a surgeon, therefore everybody's got surgical diseases" or "I'm an infectious disease doctor, therefore everybody's got an infectious disease problem" – that sort of conflation of one's own professional training with the nature of the problem is a serious challenge in the social justice world.

There was a saying at one of the hospitals where I trained at Harvard, and I had this epiphany when I heard it. We had asked another sub-specialist to see a patient, who then suggested an intervention, which is always what that sub-specialty does. I asked, "Well, why do we do that? Why does this patient need this intervention?" And the response from the doctor was: "Ask a pizza man what's for dinner and he'll tell you pizza."

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*"... it's important in social justice work not to conflate your own disciplinary background or your own interests with the needs of people living in poverty."*

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This will come up tonight [at the lecture]. Some of the questions will be about what he or she can do, whether they're artists or engineers or theologians or doctors. That's OK because you want people to be engaged in a way that's genuine and meaningful for them, but at the same time we have to understand

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<sup>2</sup> Farmer was appointed U.N. Deputy Special Envoy for Haiti on Aug. 11, 2009, by Bill Clinton, U.N. Special Envoy for Haiti as of May 2009.

the nature of the problems. This is back to the question about the U.N. Special Envoy – and I'm just the Deputy. But one of the things I've learned from seeing President Clinton think about economic problems and challenges is that there are some things I don't know. I don't know about the best way to create jobs when unemployment is 60 percent or about the best way to think about renewable fuel when charcoal harvesting is damaging the environment. I don't know that. But that doesn't mean I can't learn, or you can't learn, or all of us can't learn more about how to take on these big structural development challenges. This is my 27th year working as a volunteer in Haiti, and there are things you want to learn every year you're involved in a place. It's the same if we're talking about Boston or San Diego or wherever. You just want to keep learning new things.

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*"If we had the answers, there would not be persistent global poverty. If we knew how to fix everything and had done it right, we wouldn't have over a billion people living on less than a dollar a day."*

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Back to your question, it's not a new job in a sense – it's the old job. Anybody who's facing these challenges needs to understand that one's own training and professional interests should not confuse the analysis of the problem. I could go back to when I was a student in the '80s thinking about unemployment back then. What were the interventions we did then? Did they work? Could they have been better? Can we think of new and novel ways to expand the effort? And the answer is always going to be: Yes, they could have been better. I also think that all of us involved in this kind of work need a certain kind of humility as well. If we had the answers, there would not be persistent global poverty. If we knew how to fix everything and had done it right, we wouldn't have over a billion people living on less than a dollar a day.

**ML: What do you expect to achieve then with this new profession?**

PF: I don't want to be accused of false humility, but I expect to learn a lot. One of my jobs there is to be a student and learn from other people. Yes, I also want to draw on my own knowledge of Haitian history and culture and health care, but those aren't the only problems in Haiti. And it would be a real shame if I said, "I'm a doctor and interested in infectious disease, therefore it will be pizza for dinner." There are a million ways to say that – if you're a hammer, everything looks like a nail. That's what I don't want to do. So what I expect to get out of it is learning how to serve people in Haiti better.

But I will say a couple other things. Say, for example, there's a chance to reduce unemployment and to reverse some of the ecological problems or food insecurity, to mention three big problems that are all linked – because they're all linked, all of these problems. If we could learn that – collectively, not just me – then maybe these insights could be applied in other areas of the world where cutting down trees to make charcoal is not only a terrible way to cook food, expensive, destructive for the environment, but it's also the only option a lot of people feel they have – and *do* have. They're correct in their diagnosis. So I'm hoping that this will be good for the Haitian people. I'm interested in the patients I try to listen to. That's the main point. If we're lucky, then maybe we can also apply these kinds of lessons elsewhere.

We need to set very specific targets, obviously. The Haitian people have this long-standing mission, started in the late 18th century, pushing for basic social and economic rights for poor people. We have to respect the Haitian mission of creating equitable prosperity. There are also decent plans from the Haitian government. I know because I've worked in the public sector – in health care, a little bit in education – for some time, and we have to understand what that plan is.

Since there are so many church groups and nongovernmental organizations interested in Haiti, wouldn't it be great to coordinate those efforts so that we add up to more than the sum of our parts? There are lots of very specific things that we could set out to do, but personally I hope to learn a lot too so I can be a better servant.



I would say that this started for me last year when four hurricanes struck Haiti in one month.<sup>3</sup> I went to one of these towns, Gonaïves, and I didn't want to be just a spectator. I went with my co-workers, who are Haitians, and they did a heroic job of responding over the course of some months to these storms and really serving as a sort of disaster relief organization, as well as an organization focused on health care. It was during that month that I made an appeal to a number of people I knew who are or had been in political positions in the United States, and President Clinton responded to me immediately. He got in touch with me the day after this appeal letter.

I had been working with him in Africa and I'd been with him in Rwanda in August before these storms hit and he was talking about Haiti. I had been briefly with him in Haiti some years ago, but there were a lot of problems in Haiti at that time and the work couldn't take off, so we worked in Africa instead – “we” being Partners In Health and President Clinton and his foundation. This was in Rwanda, Malawi and Lesotho. So I knew already that he was very interested in and cared a lot about Haiti, and then after the storms he said something to me. “We can't just respond to the storms willy-nilly; we need to build back better.” And that was a mantra he used a lot: Build back better. And I said, “Well, what does that mean? Teach me more about this.” That's how it started.

This summer when he was asked to be a U.N. Special Envoy, he said, “Will you help me?” And I said sure. That's how it happened. I intend to learn a lot. I want to learn about how to listen to poor people and draw on the expertise of those who perhaps have strategies around the key development issues in Haiti, including people in the Haitian government who care about this.

**JC: So it's not about you bringing development changes only through your new U.N. position. Who has to be involved? Do you want to do it through your own private organization, Partners In Health?**

PF: No – but that's a great question. What I would say is: What is the non-

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<sup>3</sup> During August and September 2008, nearly 800 people were killed in the span of 30 days, as Haiti weathered the hurricanes and tropical storms Fay, Gustav, Hanna and Ike.

balkanized (though there are those who probably don't appreciate that term) way we can bring people together? Almost all student groups, for example, are in the NGO sector. They're private. How can we link up with the public sector, the government? Like with public health – how do you have public health without a public sector? You don't. How do you have public education without a public sector? You don't. Where did you all go to high school? Public, right? All of us in this room went to public high school, and when I was in public high school it never occurred to me, not once throughout my education, to think about the importance of public education. You just assumed that you would get to go to high school, but that requires an investment in public infrastructure. In Haiti about 85 percent of primary and secondary education is in private hands. I'm not casting disparagements on those who do that work, but I think that's one of the reasons that there are such low rates of literacy in Haiti. There is no robust public education system.

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*“Social and economic rights are a serious problem in Haiti, and I learned this from the Haitians.”*

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If you look all over the world and ask, how can you assure that poor people have basic rights?, then what rights are you talking about? This is going on right now as we speak, the question of, is health a human right? Well, of course it isn't a human right – the question they're asking is *should* it be a human right? And say your answer is, yes, it should be – that would be my answer – then what do you do? You have to ask, What institutions confer rights? The public sector, usually. What kind of rights are those? The right to vote is one thing; those are sometimes called civil and political rights. The right to health care, the right to education, the right to clean water, those are often called social and economic rights. And I'm very interested in social and economic rights – it's my job as a doctor, even though I said let's not

conflate our own personal training with the nature of the problems. Social and economic rights are a serious problem in Haiti, and I learned this from the Haitians.

**JC: When you travel to different places in the world, do you have problems breaking cultural boundaries on rights issues?**

PF: I think they do know about their rights. Remember I said I learned that from Haiti. The first slide that I'm going to show tonight quotes a group of Haitians on the rights of poor people. I hear your question a lot all over the world, not just from students but from professors and everyone else. I think that it's not primarily a cultural problem, and if it is, maybe it's in our culture. In my experience in Latin America especially – working in Haiti, a little bit in Peru and in Chiapas, Mexico – the people who are my interlocutors, mostly people living in great poverty, have very refined notions of rights, whether or not they enjoy them themselves. I think that's part of the challenge of listening because it isn't always obvious when you're visiting some place. The cultural problem is really a structural problem, and that's a little bit of jargon, but one of the biggest things I see in my work is the conflation of poverty or structural violence and cultural difference. This is not how anthropologists use the term culture, but it is how it's used in popular culture. It's a problem that's really held to be in their culture, but it's really in their history of political economy.

Let me just be a little bit rhetorical. Where are the indigenous Haitians? Where are they now? They're gone. The indigenous people perished after 1492. None of them survived. By 1697 when the French took over the western third of the island, none of the natives were alive. The people who are the modern-day Haitians are the descendants of people kidnapped from West Africa and brought over the Atlantic in chains. So when you talk about indigenous Haitian culture, it's really helpful to talk about the history and political economy of Haiti. That's what I learned from them just by listening.

**ML: Your discussion of listening to Haitians and their conceptions of rights –**

**what they want – enters into a discussion on capabilities and not just deprivations. How do you envision empowering Haitians for their own social development? The United Nations has given you a platform for this.**

PF: I hope. I believe that. One of the things that we really need to do is, again, ask, “What are the pathways out of poverty toward dignity?” One of the main pathways is of course a decent job and good labor conditions, so I think that is a critical part of the equation. I learned this from Haitians but I've also been watching how Rwanda is moving forward. In 1994 there was a genocide in Rwanda and a million people perished or were killed in three months, one hundred days. The year after, I think, Rwanda was declared the poorest country in the world. You could quibble over rankings, but it can't get worse than that. How do you come back from that? How do you move beyond that kind of horrible violence and focus on, first of all, democracy and freedom? But then you also need things like gender equity, and what does gender equity mean? What is the pathway for gender inequality to damage people?

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*“... the people who are my interlocutors, mostly people living in great poverty, have very refined notions of rights, whether or not they enjoy them themselves.”*

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I would argue that the pathway is in part cultural issues, but it's also very material. It's related to jobs, education, land tenure. How do we have an analysis that's deep enough to understand the materiality of the social? These are social problems, but they're really also grounded in the economy of a place. In Rwanda they elaborated a development plan that is really Rwandan. They call it Vision 2020 and they're trying to move that forward. One of the things they've asked those who are working there is to be part of that plan. Focusing on the positives, they say, “We have a good plan, and we'd like you to be part of it.” What they're really saying is you need to be part of it. And that would probably be good for Haiti as well.

**ML: Last week the *New York Times* reported on an investors conference in Haiti,<sup>4</sup> and it reminded me of some of the things I saw in *The Uses of Haiti*,<sup>5</sup> in the sense that there's this model that's been going for hundreds of years, of Haiti being an assembly point in the *maquila*<sup>6</sup> phenomenon. Are you worried that it will just be more of the same? Is there a way to make it equitable?**

PF: Of course, of course. This is why I keep coming back to the fact that it's jobs with good labor commissions. And we can't have that just be cosmetic. I have given a talk titled "Audition and Discernment" – I don't think anyone really appreciated the title. Audition: learning to listen. Discernment: judging. It would be easy for me to say that the risk of being involved in something that in any way resembles the offshore assembly work that I've criticized in my own work over 20-something years is so high that I refuse to be engaged at all. That would be so easy for me. I already have a job. I'm a doctor. But the risk of sanctimony is also high, of saying, I'm really too good to be involved in such a risky endeavor.

So how would you not do that and say with all humility that we do need to listen to people saying, "We need jobs"? What would be the next step? It would be jobs with dignity. And how do you do that? You get proper labor conditions, you make sure people have a decent wage and you make sure that there's gender equity in access to the good jobs. Again, that's where the D-word, discernment, comes in.

I would add that if you're going to have a trade or investors conference – I was at that one, and this was the first time I'd ever been to a trade conference – you want to have a broad range, a broad menu, of possible investments in job creation. There are some people I met at the conference who were asking – and we've been doing this in our own work in Haiti – "how can you

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<sup>4</sup> Lacey, Marc. "Still Fragile, Haiti Makes Sales Pitch." *New York Times*. Oct. 4, 2009.

<sup>5</sup> One of Farmer's many books. See the Related Resources page at the end of the booklet for copyright details and more of Farmer's published writings.

<sup>6</sup> Comes from the word *maquiladora*, the Spanish term for foreign-owned assembly factories originally established in Mexico near the border with the United States. Industries such as electronics and textiles take advantage of the cheap labor and minimal taxes of offshore assembly.

build jobs in alternative energy?" It's easy to say, "I'm worried." Of course, who isn't worried about unemployment and addressing unemployment with decent job conditions? Putting in place protection for labor is critical. But it's also important not to retreat into a facile response. It's a struggle and, of course, one is always worried about doing the wrong thing, but that's where audition and discernment can be very helpful.

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*"The point here is not to win a seminar-room argument. It's to improve conditions of people living in poverty and listen to them."*

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The old school expression was praxis. And I don't think it's a bad expression. It's the idea that – to go back to liberation theology – you're going to see and judge and act. The "judge" part is the discernment. The point here is not to win a seminar-room argument. It's to improve conditions of people living in poverty and listen to them. The question is: Listening to which "them"? I try to listen to people living in poverty, and I have better access than most because I'm a doctor and I try to talk to them directly.

## WELCOME AND INTRODUCTION

**Julie H. Sullivan**  
**Executive Vice President and Provost**  
**University of San Diego**

Good evening. On behalf of President Mary E. Lyons and the University of San Diego (USD), it is my pleasure to welcome you to tonight's fabulous keynote address of this year's Social Issues Conference, entitled "Development: Creating Sustainable Justice." Tonight's address by Dr. Farmer is made possible by the collaborative efforts of the Social Issues Committee, the Joan B. Kroc Institute for Peace & Justice (IPJ) and the Hahn School of Nursing and Health Science. I thank each of these contributors and note that their effort is representative of the USD collaborations that have made this conference so rich in its programs over the past 20 years.

As I'm sure you know, the University of San Diego is a Catholic institution. Our mission is to foster compassionate service by our students, staff and faculty. This year we're pleased and proud to celebrate our 60th anniversary, and as has always been the case, USD's mission and values arise from a rich foundation of Catholic social teaching. We are committed to and seek to live the principles of Catholic social teaching – principles such as the option for the poor and solidarity, principles that commit us to provide for those in need, whomever or wherever they are. As a result the university intentionally offers its students rich opportunities to live these values through their service – service both locally right here in Linda Vista,<sup>7</sup> and service in many other far-reaching venues across our planet.

We are so grateful for opportunities such as this evening, when we can come together to be uplifted and inspired by others – others such as Dr. Farmer, who devote their lives to improving the human condition and who lead by their innovative approaches, their courage, and their lives as an example.

Now I'm pleased to invite one of our outstanding student leaders, Hannah Evans, to come to the stage to share with you more about the history of community service-learning here at the University of San Diego.

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<sup>7</sup> Linda Vista is the neighborhood in San Diego where the university is located.

**Hannah Evans**  
**Social Issues Committee Co-Chair<sup>8</sup>**  
**Center for Community Service-Learning**

Thank you, Dr. Sullivan. On behalf of the Social Issues Committee, I would like to extend a warm welcome to all of you. Thank you so much for coming. This is sure to be an inspirational night. This year marks the 20th anniversary of the Social Issues Conference. That is 20 years of exceptional speakers and events, all of which have not only created awareness on campus, but have also challenged us to become agents of change. Planning and programming this year's conference has been especially exciting because it is such a large collaboration. I can not thank enough all of the people who have been involved with putting this together. It's amazing what can come of so many people doing great work with one another.

Tonight it is my privilege to share with you the extraordinary life and work of Dr. Judy Rauner. Dr. Rauner founded the Center for Community Service-Learning at the University of San Diego in 1986 and served as its director until her retirement in 2002. The center has changed the culture of learning at USD



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<sup>8</sup> Evans was also an intern at the IPJ in the Fall of 2009.

through its community service-learning programs, which match the skills and interests of students with needs of partner community organizations.

When Dr. Rauner began at USD, she supported the growth of student-directed initiatives and social issues programming. Under her guidance, the Social Issues Committee became an integral forum where dialogue and action meet to address issues that impact our communities. In honor of her commitment and passion for social issues, the annual keynote address has been named the Dr. Judy Rauner Lecture. Dr. Rauner passed away in March of 2009 and will be remembered for preparing leaders for ethical conduct and compassionate service. Dr. Judy Rauner's visionary work in the community changed the University of San Diego. We can look back at over 20 years of collaboration among students, faculty, staff and community partners concerned with positively impacting the community.

Now I'd like to introduce Milburn Line, executive director of the co-sponsor of tonight's lecture, the Joan B. Kroc Institute for Peace & Justice, and Kelsey Johnson, co-chair of the Social Issues Committee.

**Milburn Line**  
**Executive Director**  
**Joan B. Kroc Institute for Peace & Justice**

and

**Kelsey Johnson**  
**Social Issues Committee Co-Chair**  
**Center for Community Service-Learning**



Good evening and welcome. Creating sustainable justice is indeed a tall order in a world where political, economic and social equity are a distant goal. In the long run, however, justice – in the sense of opportunity for all and impunity for none – is a key element in sustainable development and peace. The connection between what we tend to think of separately as social development and justice is what our distinguished speaker has explored in his medical practice and writing. His insights weave together anthropology, liberation theology, human rights and public health with an understanding of structural violence – not just the physical violence we often see in marginalized communities and fragile states, but the violence that is structured and enacted upon the poor and disenfranchised, through inequality, discrimination and unaccountable political and economic relations.



## *Development: Creating Sustainable Justice*

*Paul Farmer*

Our distinguished lecture tonight is framed by a challenge to understand that the convergence between underdevelopment, human rights and chronic public health problems is not randomly distributed. One does not have to travel to Haiti to see this connection between political and social marginalization. It is on display right here in the canyons, suburbs and streets of San Diego, and in the *colonias*<sup>9</sup> of our neighboring city in Mexico. The photographs of the work of Partners In Health, which the IPJ is exhibiting in the University Center exhibit hall, are not unlike realities that we find much closer to home. Integrating these linkages into our efforts is one of the key challenges for the Institute for Peace & Justice's work in places like Nepal, Guatemala and West Africa, as well as into our national, foreign and development policies.

As Nelson Mandela reminds us, "Overcoming poverty is not a gesture of charity. It is an act of justice." Tonight's speaker embodies this concept and recognizes that, above all, we are one human family, a global community, and that with privilege comes responsibility – a responsibility to serve our fellow members of this world, especially those who need it most. So without further ado, please join me in welcoming a truly transformational leader of our world today and an inspiration to us all, Dr. Paul Farmer.

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<sup>9</sup> Spanish for "neighborhoods," but along the U.S.-Mexico border *colonias* are small, unincorporated communities usually on the outskirts of cities and therefore lacking sufficient roads, water and other basic services.

Thank you very much. It's really a privilege to be here. This is only my second time in San Diego and it's wonderful to be at the university. To have this sponsored by the Joan B. Kroc Institute for Peace & Justice, the nursing school and this committee means a great deal to me and I hope to engage in conversation with those here. And that's why I'm here: to engage in conversation. I want to say in starting, though, that I was able to meet some of the students and a group of Women PeaceMakers<sup>10</sup> who are here in San Diego and have been here for a while, and I hope I get to form those kinds of connections to the university.

Before launching into an example of our work – and when I say our work, it's not mine, it's the work of Partners In Health and many, many partners in health as well – I'd like to say thank you to the Rauner family. I wish that I could have met Dr. Rauner. It's just wonderful to hear students and others here reflect on her example, and I look forward to reading more about what she has done and continues to do through her legacy in promoting critical reflection on health and social justice at this university.

I was assigned this title and I said, "Good, I like this topic," but I would add a bit of a subtitle: Health and Development as Human Rights Issues. I want to begin by saying that in discussing rights issues, the notion of rights is a very critical paradigm for the 21st century, as it has been for many, many centuries. But it has new meaning now in my view, and this is not an original view; others have written about it. One of the reasons it has new meaning in medicine and public health is that we have more effective deliverables, and I'm going to give an example of what I mean by that. We have more effective deliverables than we did in the mid-20th century or, for example, when the notion of health as a human right became enshrined in the Universal Declaration of Human Rights. I'd like to draw that out using some examples from our work and then open this up into a conversation.

There are other paradigms as well, which are complementary. I will parse

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10 The Women PeaceMakers Program at the IPJ records the lives and work of four women from conflict-affected areas around the world who are making peace in their communities. They are in residence annually every fall semester at USD.

at least three in this talk. In addition to the rights framework, the one that many of us are familiar with is the public health paradigm. It's also very useful. Another very critical and complementary paradigm is the development paradigm. Now you can meld these together. You can say that in order to see genuine development there have to be significant investments in public health and public education. You won't see genuine development – you won't break that cycle of poverty and disease – unless you make substantial investments in public health and education. I would feel comfortable using any of those three paradigms: economic development, public health or rights paradigms.

This talk will be what I've been thinking about, including in the last few months, in contemplating some of the challenges I've seen working in Haiti. This is the 27th year I've been working there. Haiti is my greatest teacher, and actually some friends from Haiti are here tonight.

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*“You have to listen. I found out in the early ‘80s when I first went to Haiti that what you read or what leaders say might or might not reflect what people living in poverty might say.”*

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I want to start with the specifics. Listening to patients is something we're supposed to learn in medicine and nursing. I was being interviewed by a student earlier<sup>11</sup> and I was talking about the importance of listening – of audition, though it sounds kind of snooty to say “audition.” You have to listen. I found out in the early '80s when I first went to Haiti that what you read or what leaders say might or might not reflect what people living in poverty might say. Now I mention poverty not because it's the defining characteristic of Haiti – it's not. I'll give other examples of how Haiti has defined itself through the struggle for dignity and freedom and really introducing modernity

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11 The interview with Jessica Capaldi, USD student, and Milburn Line, executive director of the IPJ, appears at the beginning of this booklet.

to this hemisphere. But it is nonetheless true that whether I'm in Haiti or Boston, Peru or Rwanda, the great majority of patients who I see are poor. So poverty is a defining issue for them.

One of the things that the student I met with earlier asked me was – and it was a great question – if it was a cultural problem or challenge to advance a rights model in some of these places. I said that it's not really a cultural problem, and here's an example that I would offer. This is a quotation from a rights declaration, and I've heard this sort of thing for over 20 years:

Although less preoccupied with our illness [after treatment], we still have problems paying for housing. We have trouble finding employment. We remain concerned about sending our children to school. Each day we face the distressing reality that we cannot find the means to support them. Not being able to feed our children is the greatest challenge faced by mothers and fathers across the country.<sup>12</sup>

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*“Whether or not people enjoy access to the right to health care or education does not seem to determine whether or not they're able to comment eloquently on the need for these basic rights.”*

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These are claims made about rights, including what I'm calling social and economic rights – the right to health care, to education – by people who have not enjoyed them. So there's a conundrum for us to contemplate and to think about collectively: Whether or not people enjoy access to the right to health care or education does not seem to determine whether or not they're able to comment eloquently on the need for these basic rights. I think that's something to keep in mind, something I learned in Haiti and later explored in thinking and talking about Catholic social teachings. That's what you'll hear in liberation theology as well, and it's what we're supposed to do in nursing and clinical services writ large. This has been the dominant chord struck for

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12 From the Cange Declaration on Health and Human Rights. Full text can be found at [www.pih.org/inforesources/essays/Cange\\_declaration.html](http://www.pih.org/inforesources/essays/Cange_declaration.html).

me all these years of working in Haiti and elsewhere, that people will talk about their rights, whether they've had them or not.

Then you see the alternatives offered by others not living in poverty, and here's where going between Harvard and Haiti was a very instructive experience, and remains so for me. We may or may not be lucky enough to hear people in Harvard or San Diego talk about the need for rights. Here at the nursing school for example, today there was a conference on health care as a right: You were lucky enough. Reliably, in my experience people living in poverty will demand their rights. Whether or not we listen to them is the big challenge.

Now the development paradigm. I've been working in Haiti since 1983, and I've seen a lot of ups and downs; I've also seen, talking about ups, the Haitian people rally around basic democratic goals, which include the right to health care and education. Some people would call that a social justice platform, a social and economic rights platform. It's been the most moving and instructive thing I've seen in my 50 years on the planet, but there are, nonetheless, enormous problems.

This is from the director of the Pan American Health Organization, Dr. Mirta Roses, who was herself in Haiti during this year: “Haiti will disappear from the headlines one day, but the health problems in that country remain. There is no serious hope for seeing health improvements without long-term, substantive investments.”<sup>13</sup> She's been a frequent visitor to Haiti, and I know her quite well. She cares a lot about the Haitian people, and she and others like me say that we're not going to break this cycle of poverty and disease without significant investments in health care and education. We stand by this.

That said, how do we link our work as public health practitioners to the broader social justice goals that the Haitian people clearly have espoused? This is not different in El Salvador or Chiapas, Mexico, or other places in

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13 “PAHO Director Says Long-Term, Substantive Investments Needed for Health in Haiti.” PAHO Press Release, March 19, 2004. [www.paho.org/english/dd/pin/pr040319.htm](http://www.paho.org/english/dd/pin/pr040319.htm).

this hemisphere where I've been. Nor is it different in Africa. This is a very common struggle. How can we use investments in health care and education as a lever to advance these broader development goals?

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*“... how do we link our work as public health practitioners to the broader social justice goals that the Haitian people clearly have espoused?”*

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I want to give some examples. This is a picture of the Citadel, and this past Friday [Oct. 2, 2009] President Clinton and I were there with Patrick Delatour, whose title now in Haiti is minister of tourism. He's also a scholar of the Citadel, and the reason I show a picture of it is because the Citadel is the Haitian symbol of resistance to slavery



© UNESCO/G. Hyvert

When we talk about development, and Haiti as an impoverished place, it's really important to note that Haiti was also the birthplace of the modern

rights movement in this hemisphere in many ways. In 1789, for example, when the French advanced the Declaration of the Rights of the Citizen, they had a slave colony or two or three. The largest one was in Haiti, and it was the Haitian people who pushed forward the questions: What does that mean, rights? Liberty, equality, fraternity? What does that mean? Does it really mean liberty, equality, fraternity for everyone?

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*“How can we use investments in health care and education as a lever to advance these broader development goals?”*

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I think that the starting point for me in talking about Haiti and poverty and development is always to think back to what was accomplished by the Haitian people. The Citadel is a marvel of modernity. Construction began in the early 19th century, and the story is critical to reflection on development and social justice in Haiti. When the slaves began their revolt in 1791, it led to the Haitian Revolution, which in November 1803 led to the victory of the slaves against Napoleon's army. It is estimated by some historians that up to 80,000 people – 40,000 ground troops and 40,000 marines – were conscripted from all over Europe, mostly France, by Napoleon. When they set sail for Haiti, it was the largest armada ever to go from Europe to the new world, and they were going back to re-conquer Haiti for the French.

When the Haitians – the former slaves – won this victory against the Europeans, many of them went into the hills because they didn't want any corporal forms of labor, labor that was conscripted in any way as it had been in the slave plantations. But in the north a series of fortifications were built all over the island. Instead of projecting Haitian power into the sea around them, where they were surrounded by hostile colonies, they pulled their fortifications inward, and the Citadel is one of them.

The reason I'm going into such detail is because very few people have visited this monument; even Haitian schoolchildren have not been there. And that's

something I was led to think about by Patrick Delatour. When he talks about his country, he doesn't talk about Haiti being impoverished or beleaguered; he talks about the Haitian people's success and victory – going from 500,000 slaves who became victors in this revolution to 10 million people. Some people in Haiti also think about the successes of their movement, and that's a point I like to start any reflection about Haiti with – that in many ways Haitians moved us forward as a world. I think we have a debt to the Haitian people, and I'd like to acknowledge that at the outset.

Now I'm not a historian, nor am I a development expert. I'm instead a physician, and I just want to talk a little about my own experience. When I graduated from college, I was lucky enough to go to Haiti before starting medical school. It looks kind of idyllic here in this picture, and I've described it a lot in my writings. And I know all of you have read my books – I can tell by the fantastic sales. By the way, you introduced me as writing four books, but clearly you missed my landmark bestseller, *The Global Threat of Drug-Resistant Tuberculosis*. In any case, this place looks idyllic, but it's a reservoir. It's a hydroelectric dam.



Photos courtesy of Partners In Health

This is the way I got introduced to development questions: 23 years old, learning how to speak the local language, Haitian Creole, listening to people complain about a development project. Because I was living behind the hydroelectric dam, I was living with the people who had lost their land to it. The first time I heard these stories about people being driven up into the hills by rising waters, I thought they were being a little bit poetic, but many of them really did leave their land – their ancestor's gardens, as they put it – the day the water rose. I heard the story again and again, and I realized they were not exaggerating, that this was really how they experienced that development project.

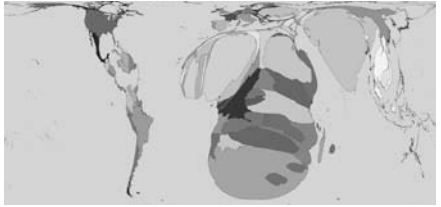
Tracy Kidder wrote a book that many people actually have read about our work in Haiti, and he asked me one day, “Do you have something against dams?” I had no idea what he was talking about because it seemed out of context. He was talking about my echoing the complaints I'd heard about this development project. I said, “Of course I don't. Why are you asking that question?” I learned a lot about how poor people experience development by starting in this squatter settlement, and I think that's been helpful for us in other places where we've worked. Certainly for me, but also for my colleagues at Partners In Health.

But again, I'm not a development expert, nor am I a historian. I chose a different path in life, which was to be a physician. I am not an infectious disease physician because of AIDS; rather, I went to Haiti before HIV came along, and as I said, I saw a number of people who I worked with displaced because of the hydroelectric dam. I worked with young people who were more or less my age, and we went around from village to village doing a basic primary health care survey. This was beginning in '83 or '84, and then I began to do this shuttling back and forth between Harvard and Haiti that I'm still doing today.

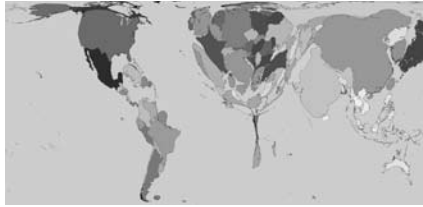
There were about six young Haitians that I was working with. Three of them died of infectious diseases: one of malaria, one of typhoid fever and one of peripheral sepsis. She basically died shortly after childbirth. I don't really talk about this very much publicly, but I can tell you that it was a terrible experience just as a friend and co-worker. I thought, thinking about the families, how does one ever recover from these kinds of tragedies? I'm not the one who got malaria – well I did get malaria – but I'm not the person who got really sick with malaria or typhoid. And certainly I'm not able to experience complications in childbirth. But these are what set me on this path of infectious diseases.

When a new pathogen came along, HIV, what struck me was (and I'm going to get back to this model that was born out of the survey being conducted by young people that I mentioned) we knew there were not a lot of physicians and nurses.

HIV Prevalence<sup>14</sup>



Physicians Working<sup>15</sup>



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The reason that we developed the community health worker model was not because we didn't have physicians. It was because the highest standard of care for a chronic disease is what Catholic social teaching would call accompaniment. Now, what is accompaniment? What does it look like? You can imagine what it might look like to you if you had a chronic disease or even an acute illness, or you didn't have housing or a job. What would accompaniment look like for you? For me, it was listening to people living in poverty in rural Haiti describe what they would regard as accompaniment. How would we walk with them? One of the things they needed of course was medicines.

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*“The reason that we developed the community health worker model was not because we didn't have physicians. It was because the highest standard of care for a chronic disease is what Catholic social teaching would call accompaniment.”*

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I started medical school in the fall of 1984, and by the early '90s when HIV was becoming a problem in Haiti and elsewhere in the world, I was training in clinical medicine. I was going from one of the best hospitals I've ever seen, the Brigham and Women's Hospital where I trained, to a place where we were struggling to build health care infrastructure. The extremity of this

14 "HIV Prevalence" is poster #227 from www.worldmapper.org.

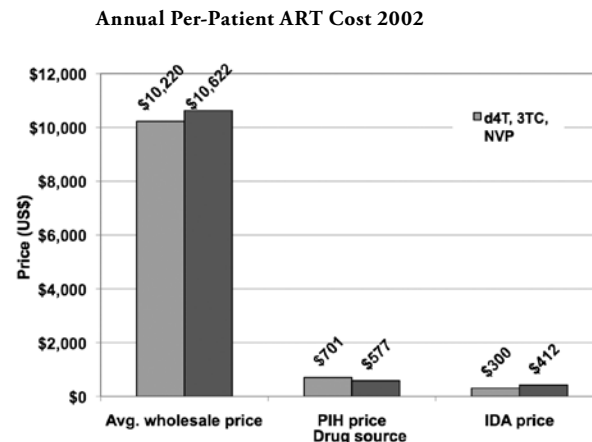
15 "Physicians Working" is poster #219 from www.worldmapper.org.



disparity was in and of itself instructive. You don't want to wish that kind of learning on just anybody. There are ways to learn about poverty that do not require you to go and be a spectator of poverty, but it's also instructive just to experience that trajectory. Again, I had these great teachers, both at Harvard and in Haiti.

So in 2002, many years after suppressive therapy for AIDS was developed, it was still being argued that it was not cost-effective to deliver this care in a place like rural Haiti or rural Africa. These were the very years that we were trying to organize a coherent response at the policy level to the fact that AIDS had become the leading infectious killer of young adults in the world and we didn't have a strategy.

Among the people who are here with me tonight is Cassia Holstein, who was one of the founders of an effort to organize and introduce treatment into broader treatment and prevention schemes. I just want to pay a tribute to her. This chart is before Cassia and people like the Clinton Foundation got involved. This was in 2002.



Graph courtesy of Partners In Health



That's the average wholesale price of drugs we had back then and drugs we still use today to treat complications of HIV disease. A three-drug regimen cost about \$10,000 per patient per year, but as one might argue and as I've said to my students: Is that the beginning of the conversation about drug pricing or the end of it? Even in that year it was possible for Partners In Health (PIH) to find three-drug regimens for \$600-\$700 per year, which is still way out of range, but it just shows that the same year there were other strategies. IDA means the International Dispensary Association, which is the world's largest nonprofit distributor of drugs – a procurement agency, basically. The point here is not about the specific regimens or specific prices because I could be talking about cancer or insulin, but the general questions about rights and development are: How do we respond to this kind of therapeutic chaos, in terms of the prices? And how do we also respond with a rights-based approach so we can advance the cause of health and social justice, and have that be the beginning of a conversation?

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*“In 2002 ... a three-drug regimen cost about \$10,000 per patient per year, but as one might argue and as I've said to my students: Is that the beginning of the conversation about drug pricing or the end of it?”*

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Photos courtesy of Partners In Health

But that's not how we got involved. These [pictures] show the kind of dramatic response that we've seen again and again to introducing the standard of care in responding to AIDS.

In other pathologies it's the same story. This next one is a patient who I knew well, a young woman who went off to the city and came back sick. That's her dying of AIDS in 1999, and then a few years later.



Photos courtesy of Partners In Health

Those two patients gave a talk at Harvard last year, and you can actually go onto the PIH Web site and listen to what they had to say. They gave these beautiful testimonies about their own experience, and I was translating for them. This guy has been on therapy for a long time (first-line antiretroviral therapy, ART), and the reason they're still getting the same regimen is that they have community health workers. More on that in a bit. There were about 1,000 people there at this conference, including maybe 50 to 60 Haitians who understood Creole. I was sitting next to him and he said, “Before I start I'd really like to thank all you bourgeois people in the audience for helping us.” That was his first line. I knew what he meant because that's the Haitian word for people who are not poor, but translating that was a bit of a struggle because everyone who spoke Haitian started cracking up before I could say a word.



Photos courtesy of Partners In Health

Listening to people with very difficult to manage problems is part of having a rights-based approach to development. That's my thesis tonight. I'm just using this one example because it's well-documented. This is a picture of a child with a malignancy, before and after therapy.

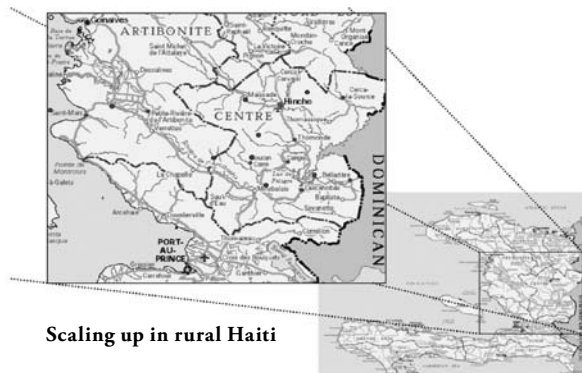
How many times have I heard people say, “We can’t treat cancer in Africa. We have to only focus on prevention”? As if these were choices you make between prevention and care. The same story that I described around AIDS could be told around diabetes or major mental health problems. It’s always the same story. It’s an equity focus – back to the hypothesis of whether you’re focusing on the development paradigm, on the rights paradigm or on the public health paradigm – and equity and justice are always important and instructive.

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*“Listening to people with very difficult to manage problems is part of having a rights-based approach to development. That’s my thesis tonight.”*

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Can you scale up models like this? This is another challenge, of course. I’m not saying it’s not a challenge. Each place you see a large dot here, these are places where Partners In Health, working with partners – and our primary partner is the Ministry of Health, the public sector in Haiti – is trying to scale this up, to find new partners in health. This is a comprehensive approach to basic health, and we’d like to link that to education and jobs outside of the health sector. I’m going to return to that question in closing.



**Scaling up in rural Haiti**

© United Nations Department of Field Support Cartographic Section, Map No. 3855 Rev. 4 June 2008. Diagram Courtesy of Partners In Health.

There are other challenges. I mention Africa because in showing you the inflated world map, if we looked at malaria or tuberculosis or the number of nurses working, it would be a very similar set of dimensions. This is something that was really posed to us most forcibly by President Clinton and the Clinton Foundation in 2003 in Haiti, saying you ought to take this rural model that’s focused on rebuilding public infrastructure and on community health workers and bring it to Africa. And we finally did. We were invited by President Clinton and the Rwandan Ministry of Health to go and work there in the fall of 2004, and it was a great privilege. The first place we went to was a town in northern Rwanda called Ruhengeri. Rwanda is an amazing and very inspiring place when you think of where they were in 1994 and where they are now in 2009 – and where they were already in 2004 at the time of this trip. But at that time they did not have a lot of health care infrastructure. Out of 28 districts, four of them had no district hospitals at all.

The first place we went did have a district hospital. It was in the north and it had electricity. There were three or four doctors there; they had an X-ray machine and it was clean. I said, “You know, you can send us somewhere more difficult.” They took us very seriously and said, “OK, why don’t you go here.”



*Photo courtesy of Partners In Health*

This place is called Rwindwavu, and I always wanted it to mean something very dramatic. But it really means “land of the rabbits,” which did not strike me as dramatic. There are a lot of rabbits there, but you want leopards. We went to the land of the rabbits, and there was an abandoned hospital. We had

the Rwandan Ministry of Health, the Clinton Foundation, Partners In Health, which was soon to form a new local organization, and our colleagues from Haiti. Actually, because we had this experience in Haiti – building up public infrastructure and working with our Haitian colleagues – we knew how to build partnerships with the local communities, which is a challenge. So we were not fazed. We kind of knew what to do. We had to build infrastructure; we had to provide services; we had to train local people to do this work. And we even did some research and advocacy work. Often what happens is people who are involved in the service delivery don't do the research, so there's not a natural feedback loop to improve the quality. It's easier in some ways to skip over that, but it's an important thing to do.

This is the image most of you have seen elsewhere in Africa of a disheveled, abandoned hospital ward. And this is the same ward just a few months later. We need to say this with some humility, but it's not that difficult of a thing to do. Implementation is always difficult, but the ideas themselves are pretty straightforward.



*Photos courtesy of Partners In Health*

I met some people here tonight who are supporting blood banking in Africa, and I applaud that because, again, infrastructure investments are critical. You can't do good medical care without the tools of the trade, and that includes operating rooms. Going in to do that was not easy, but at least we knew how to do it and we had good partners. A doctor and a nurse from Haiti, two of my Haitian colleagues who went with us to help implement this comprehensive project, are still working on these kinds of projects to this day.

So this is the model. It's not rocket science. It's not nuclear submarines. It's

not that tricky. And the results are the same – the same sort of transformations that you see in Haiti you're going to see anywhere else. There's not a different pathophysiology to these diseases. I've learned a lot just in terms of health care through working with the Clinton Foundation. There's a lot of promise in these kinds of private and public partnerships, with community organizations and NGOs [nongovernmental organizations]; there's a lot of peril as well.

With some of my colleagues at Harvard and in the field in these sites, we're trying to develop a series of case studies to look at the specific lessons – cultural specificity or historical specificity – and also the generalizable lessons learned. I think this is one of them: If you build efforts to strengthen the public infrastructure in health care and education, you raise the possibility of actually respecting poor people's rights, or people's rights in general.

A student was interviewing me earlier, and there were five of us in the room. We went around the room and said where we went to high school, and all of us went to public high schools. But when you're in public high school you don't stop to think, "Gee, I'm really glad the public sector is strong enough that I get to go to high school." The basic model is true even in California: You need public infrastructure. That may look like public schools; that may look like public health clinics. I don't think a lot of us grew up, at least I didn't, stopping to think how important this was to the rights struggle. But it's critically important, and this is why we keep getting back to learning how to do this in the public sector.

It's in some ways easier to do health and development work as an NGO or a church group or missionary group. I know many of you are involved in those activities and will remain, as I am, involved in these activities. The challenge that we're contemplating is how we can add up to more than the sum of our parts – because clearly there's a great deal of passion and interest in health and social justice, certainly in American universities. But how can we make it more effective? That's what I'd like to think about for the rest of my life.

I said I didn't want to talk about just one pathology. This [photo] is back to Rwanda. This girl's father had traveled all over Rwanda with his daughter,

who was about 12. Her name is Tushime and I remember the night she came in. People were giving her a wide berth because this growth on her ear was infected. I won't go into details, but it smelled very unpleasant.



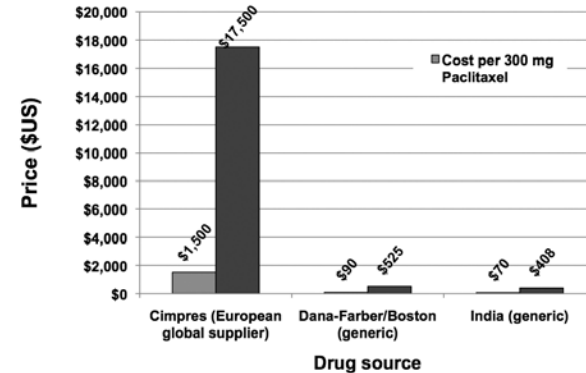
Photos courtesy of Partners In Health

I'll tell you what I thought and this is kind of pitiful. I thought, I hope this is an infection only and not cancer. This is too big of a crowd to have Socratic exchange, but I'll leave you to wonder why I thought that, and it's obvious. I thought that because it's starting the new struggle again: Is it cost-effective to treat cancer in Africa? Now it was cancer, and just as the treatment for AIDS is the same in San Diego or Haiti – antiretroviral therapy – the treatment for cancer is chemotherapy.

Someone was saying to me the other day, “I hope you win a Nobel Prize,” and I said, “Yes, I'm sure I'm slated to win one. I mean, my great discovery is that the treatment for malnutrition is called food.” It's not going to matter if you're in San Diego or Tijuana or rural Rwanda, we need to find a strategy, a way to deliver both preventives and treatment. Yes, we want to prevent rather than treat. Nobody disagrees with that in clinical medicine either, but we do need a strategy that integrates prevention *with* care. How central this is to development remains to be seen. I believe it's very central, but again, we don't want to conflate our own disciplinary training with the nature of the problem. I'm quite convinced that major investments in health and education are necessary.

Here's a slide that I just cooked up today with my co-workers. Let me show you that the same story around AIDS holds true for cancer treatment. This is a very necessary chemotherapy drug – Taxol is the way it's usually termed – and look how the prices are just all over the map. Same story.

Annual Per-Patient Chemo Cost 2009



Graph courtesy of Partners In Health

We need an equity strategy to deliver proper therapy for these pathologies, and I believe, and many others agree, that it needs to be front and center in development work, especially when cancer is going to overtake some of these infectious pathogens as the leading killer in Africa. How is that related to development? If you're a physician or a nurse sitting in a clinic and you have patients with chronic, wasting diseases, in my experience they'll come in and start talking about their symptoms. They may say, “I can't breathe,” or “I can't stand up,” or “I have chronic diarrhea,” whatever it may be. But once you get them on therapy, what do they start talking about? They start talking about their children, their housing situation.

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*“If you build efforts to strengthen the public infrastructure in health care and education, you raise the possibility of actually respecting poor people's rights, or people's rights in general.”*

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One patient of mine who came back from the brink of death did an interview with a Haitian colleague of mine. I didn't do the interview, but whenever someone asks to have something translated from Haitian Creole into English, guess who gets the job? So I'm sitting there listening with earphones and transcribing on my computer. I was all alone, and I was kind of glad I

was alone because I got very emotional when I heard what this guy said. The interviewer had just asked, “You’ve just had this incredible near-death experience. What would you like to do with your life?” And the patient said, “I think that it’s idiotic that someone who’s 27 years old does not know how to read and write. I want to learn how to read and write.”

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*“It’s just a reminder that people all over the world have similar aspirations. They want their children to go to school; they want to have jobs. ... That’s the development that they mean.”*

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It’s just a reminder that people all over the world have similar aspirations. They want their children to go to school; they want to have jobs. The jobs issue has been very critical for Partners In Health and for all of us who have worked in this arena. Partners In Health now has 11,000 people worldwide working for us. The great majority of those people have never held a job before; it’s their first job. Most of them are community health workers. I’m very proud of that, and I think my co-workers are very proud of that too. To give families the chance to have a job, that’s what people want. That’s the development that they mean.

Of course the job conditions have to be good, right? And I’m not sure we’re doing a good job yet with community health workers. We still have a long way to go. They want things like accreditation. I can’t tell you how many times I’ve been in some rinky-dink little village – that’s a scholarly, sociological term by the way, rinky-dink – and community health workers say, “What we really want is a certificate.” I say, “What do you mean?” A diploma. Accreditation. If you don’t listen to those kinds of things, you miss an important part of the whole dignity discussion.

These are just some images from our work. When patients start getting better, that’s the first thing they want to do. Work. We need jobs outside of the health and education sector. That’s what we really need. We need generative jobs that are going to be, as they say, sustainable.



*Photos courtesy of Partners In Health*

For someone who’s been critiquing this notion of sustainable development as used uncritically, you might wonder why I’m going on about jobs. The answer is we were never under the illusion that people did not need jobs. In the mid-’80s I began interviewing women with AIDS, and I wrote another best-seller with my colleagues called *Women, Poverty and AIDS* – and I know you all read it. Actually, there’s a very suspicious locus of sales activities in Orlando, Fla., where my mother lives. I remember interviewing people for this book, and many people worked on the book, but this one woman said, “Look, you want to stop AIDS in Haiti? Give women jobs.” It was true in the ’80s and it’s true now.

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*“... one woman said, ‘Look, you want to stop AIDS in Haiti? Give women jobs.’ It was true in the ‘80s and it’s true now.”*

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*Photo courtesy of Partners In Health*

This is a picture of a workshop in the land of the rabbits, Rwinkwavu. It was an abandoned workshop that we were granted permission to take over.

It had been a mining village and this equipment had just been abandoned. Some young Rwandans rehabilitated it and then created a workshop where a number of people could work.

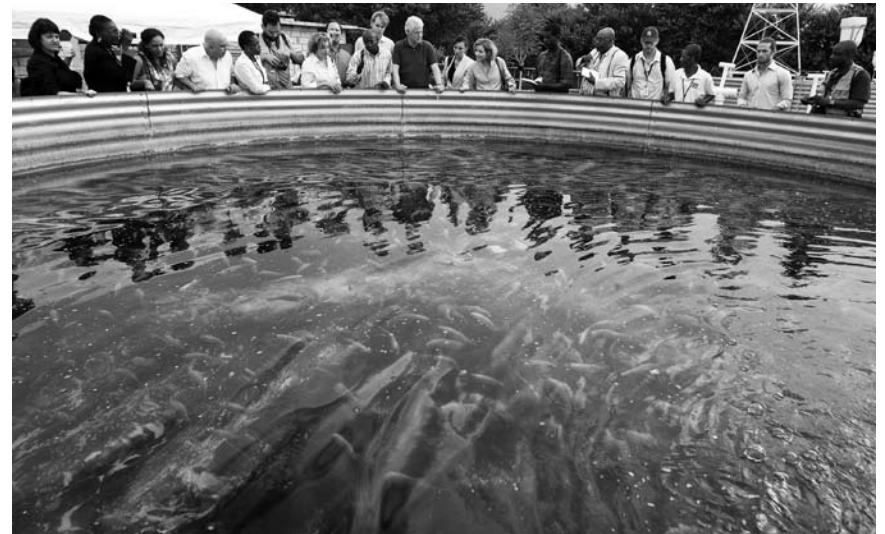
Now what they're doing is making furniture, but we're really kind of making furniture to sell to ourselves, to the hospitals and clinics. What we need is a market, and that's not something I learned how to do in Harvard Medical School. It's not like there's a fourth-year rotation in Marketing Furniture. But that doesn't mean we don't need to learn how to do it. It means it must be done, and that's something that comes out of partnerships. You listen to what people are saying about development and they'll guide you.

Back to Haiti. The border between Haiti and the Dominican Republic is a famous image, the boundary clearly delineated by the deforestation of the former and the lush forest of the latter. Last fall I was in Haiti when the hurricanes struck, and it was a very jarring experience. Four storms hit Haiti in the span of a month. And the city of Gonaïves was under water. It was a terrible thing to see and I'd only seen it once before – a city under water and people streaming out as refugees. That was in the same city, Gonaïves, in 2004 when probably 3,000 people were killed by Tropical Storm Jeanne, not even a hurricane. It hit Cuba too, and there was no loss of life. But when it hit Haiti, the trees were gone, so people in this floodplain city were swept to sea. For that to happen again last year was pretty jarring for the people of Gonaïves, of course.

I wrote a piece that we put on the Partners In Health Web site. I sent it to every political figure I knew, which isn't that many, but quite a few. One of them actually got back to me the next day, and that was President Clinton. He started talking about "building back better." I understood the rhetorical nature of building back better, that he said we can seize this opportunity to help Haiti. I'd seen him in Rwanda a couple months before, in August, when he'd come to visit the work we were doing there, and he said that this is what we should do: Think about how to rebuild Haitian institutions and infrastructure and also reforest Haiti and think about job creation. One of the things I was saying was, "How do you do that?"

How do you create jobs and how do you create the kind of dignity and social security that people in Haiti – and elsewhere in the world – are asking for?

One idea being implemented is a recycling project that uses garbage (and what's in the garbage matters) to make briquettes that can be an alternative to charcoal. This is not just a problem for Haiti; it's a problem all over the world where trees are cut down to make charcoal. In Haiti it's a crisis, but it's a problem elsewhere.



*U.N. Photo/Logan Abassi*

Fish farms like the one in this photo are another idea. The figure that I heard on Thursday afternoon when I was there was from this brilliant agronomist, who was actually from Côte d'Ivoire and had been working with Haitians for years. He said, and he had all of the facts for any question he was asked, "The average intake of fish in Haiti is 7 pounds per person per year. In Jamaica it's 70." What I was thinking of course was, "Wait, I have all these patients who come in who are malnourished, children who have protein and calorie malnutrition. What can we do to link these development efforts to the kind of public health problems that we see?" Twenty-seven years after going there, that's where I am now. That's what I'm interested in and many of my co-workers are interested in.

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## QUESTIONS AND ANSWERS

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*“The same story: People want jobs. They want to control their own fates. They want assistance, yes, but they also want dignity.”*

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Again, back to what we heard in the early ‘80s when we first went to the area disrupted by a development project, a hydroelectric dam. The same story: People want jobs. They want to control their own fates. They want assistance, yes, but they also want dignity. I think that this is something we can draw on, the sort of social teaching and work discussed here by those like the Women PeaceMakers. Bringing this all together in a seamless approach to health and social justice and development is where I think we’re headed today.

Thank you very much, and I’ll open it up for discussion now.

*Both the physical and virtual audiences (via overflow viewing and Twitter) submitted questions that were read by Executive Director Milburn Line and Diana Kutlow, senior program officer at the IPJ.*

**ML: Thank you, Dr. Farmer. Back in the ‘80s when you were beginning in Haiti, there was kind of a revolution in the development world called participatory development – the idea that the poor had much to teach us, and that this kind of technocratic vision of development often created problems, like the dam, that were unanticipated because they were done by external elements. Twenty-five years later our own development agencies and many of the world’s implementing agencies still continue in this technocratic fashion. Is there a scenario where we can take the learning that Partners In Health has achieved in Haiti and transfer that to start transforming the institutions that continue to use this top-down approach to development?**

PF: I hope the answer is yes. Wouldn’t it be horrible if I said, “Yes,” and then, “Next question?” Contemplating development work, looking back at the models of development – say you start at the late 19th century, early 20th century – you see various fashions in development over the years. It was different in different parts of the world; I’m thinking of the United States and Europe. I think that it would be wrong for us to dismiss broad-brush the major infrastructural projects that are sometimes said to be imposed from above.

I’ll give the example of a project that at one point, from what I understand, involved up to 2.5 percent of the U.S. gross domestic product, and that was the Marshall Plan to rebuild Europe. The destruction of Europe in the war is not the subject of my discussion here. But the rebuilding of Europe after the war with the Marshall Plan, I think most people in Europe and the United States think of as a success. It was a huge, huge amount of money compared to what we put into development assistance now. One of the differences, though, is that money went directly to the Europeans. There wasn’t this huge intermediary class of contractors at the time. The overheads of a lot of these



*Farmer listening to a question from Peace and Justice Studies master's student Upendra Malla Tara*

official development projects are routinely more than half – and I know that is a very freighted area, but I think it is a problem.

What would be a solution to that problem? You need to rebuild local institutions or build local institutions. Foreign assistance can't be an entitlement program for contractors from the United States or Europe; it has to build local capacity. That's something we try to do at Partners In Health, and again I say that humbly because there are a lot of things we haven't done yet. In addition to audition (listening to people) and in addition to discernment (judging the quality and the individual merits of the case), there are also some other structural problems, like the way aid is set up to be very top heavy and really is not committed enough to building local capacity. I could go back to examples from health care, where you have a good project but one that could be made better by having a component that's really built into it that could strengthen local capacity. As the Rwandans say, they want to make it unnecessary to have foreign aid at all, and they actually have a timeline for that. By the year 2020 they don't want to have any aid coming into the country.

**ML: Excellent, thank you. What can we in this audience do to help you and your work with Partners In Health?**

PF: Now, I didn't actually pay anyone to ask that. Do look on the Partners In Health Web site and Facebook page. What we're trying to do is look forward to the future where we're better at these partnerships. If we have 11,000 employees, we're living on triple tenterhooks every year. How do we meet payroll? I won't hide that from you. That's the nature of the beast right now. Especially, I think, in the economic global recession, when other groups have said, "We need to scale back," we've tried to say, "It's really not a good time to scale back on social services for poor people in the middle of a recession."

We're really grateful to our supporters for stepping up to the plate for Partners In Health, but it's going to be tough. There's this long-term vision, which I've tried to at least mention here, that we need to see economies grow. We need to move into the public sector. We need to rebuild these partnerships.

I just want to brag because the parents of a friend of mine are here today. How many friends do you think I have who are rock stars? One. And she happens to be Haitian. Anybody ever heard of Arcade Fire?<sup>16</sup> If you look on the back of Arcade Fire's last album, it says [www.arcadefire.com](http://www.arcadefire.com) and underneath it just says [www.pih.org](http://www.pih.org). When they went on tour they donated a dollar of every concert ticket and a euro of every concert ticket in Europe. Who would've think it, that we'd be partners with a rock band?

Here's Arcade Fire's latest thing. Instead of just saying, "Thank you very much, rock stars," we said, "Well, what we really need are jobs." One of the things that they said was, "Why don't we do our T-shirts and album covers here, in Haiti?" That's a way to create jobs. I wouldn't have thought of that. It's just an example of how you wouldn't think of a partnership like that with a musical group, and now they want to do all their T-shirts and album covers in Haiti so they can create jobs with dignity for Haitians. I think that's a great

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<sup>16</sup> Arcade Fire is a rock band based in Montreal, Canada. One of the lead singers, Régine Chassagne, is of Haitian descent.

way to help PIH too – help the Haitian people achieve what they want, which is dignity. Thank you for asking.

**ML: In cases of preventable disease, how does Partners In Health advocate and educate for prevention?**

PF: That's a great question too. I focused a lot on treatment, and I would hope I didn't do that because I am a clinician. In every example that I could give you, prevention is an important part of the work. I think one of the best ways to do it – and we can always be getting better – is to work with community health workers. I didn't speak as much about them as I should have. If all their time is caught up in responding to acute illness, then we're going to see this constant parade of pathology.

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*“... in the economic global recession, when other groups have said, ‘We need to scale back,’ we’ve tried to say, ‘It’s really not a good time to scale back on social services for poor people in the middle of a recession.’”*

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Let me give you a specific example: malaria. Better case finding and treatment is critical, but what about hanging bed nets in people's houses? What about taking on the vector of the mosquito? For us not to look at this comprehensive approach would be an error. One of the problems we see as these insecticide-treated bed nets become more available is they still don't get put up. There are lots of debates in the bed net world – I'm sure you all are very familiar with the bed net world debates. I cannot believe how arcane our debates are. There are lots of debates inside the malaria world, but if bed nets aren't being hung, why don't you have the community health workers hang up the bed nets? It's not rocket science.

That's just an example. I could go on and on. I'm thinking about infectious diseases, but you could go on and think about obesity. Though that's not really a problem in any of the places I've discussed, it is a problem elsewhere in the world and it's related to diabetes. So, the general model is to try and integrate prevention in care, and I think it's a solid one, and the more we can get community health workers involved the better.

One last thing before you go on to the next question. In California the unemployment rate is 12 percent or more – that's what I read in the *New York Times* two days ago – so we have an unemployment problem in our country. Wouldn't it be good to train community health workers in the United States of America? Wouldn't that be a good thing? Maybe people would be community health workers for their whole lives; maybe they would go on to other work, to advanced training. But I think it's still something we need in this country as well. Lessons learned in Haiti or Africa can be applied to chronic disease and disease prevention here.

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*“...sustainability as a notion can be used in several ways. One is as a blunt instrument against poor people. I've seen it happen many times. All of the clichés of development can be turned into weapons.”*

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**ML: Here's one from a graduate student in Peace and Justice Studies. What is the sustainability approach of your project? Are there local contributions that will support your eventual withdrawal strategy?**

PF: Yes, that is obviously a critical issue here. Let me just say, in the spirit of the 20th anniversary of this conference, that sustainability as a notion can be used in several ways. One is as a blunt instrument against poor people. I've seen it happen many times. All of the clichés of development can be turned into weapons. Let me give an example so it's not too arcane. When someone says, “How is this sustainable?”, one of the answers one is tempted to give is, “Well, is our commitment to social justice sustainable? How can we sustain



that?” – sort of flipping the concept on its head.

That said, look at the Rwandan plan, Vision 2020. They’re saying, “We have to have investments in development that match our national plan and allow us to grow our economy so that we don’t need aid.” They have a sustainability plan with a growing economy. They have the security that they need. Haiti can have that too. It’s going to be more difficult. The ecological devastation in Haiti is much more profound, but that is not out of reach. If the sustainability plan involves creating jobs for Haitians and then finding jobs for Haitians in this generative sector in addition to health and education, then I think that’s one way to break the cycle of poverty and disease – so the investments needed are not the same ones 20 years after you started.

Twenty-seven years ago when I first went to this squatter settlement – and I was not a doctor yet – I remember people saying, “Paul, we don’t have any food, we’re hungry.” And now I get snippy e-mails from them saying, “You promised us iPhones.” I call that progress. Is it sustainable? I’m not sure. But it’s progress.

**DK: Could you talk about the fight you still face against multidrug-resistant tuberculosis (TB) and if that’s related to the socio-economic status of the patients?**

PF: That’s a great question. The problem with that pathogen is that it represents a specific threat: Multidrug-resistant TB is an airborne disease and it’s not going to go away, as was hoped. But it’s also a general problem of drug-resistant pathogens, which are a new problem. Before the mid-20th century, we didn’t have the challenge that would force these microbes to mutate, but it’s a very huge problem. If you look at *staph aureus*,<sup>17</sup> in the ‘40s you could kill it with penicillin. Now 95 percent is resistant to penicillin. So this is a specific and a general problem. Specifically, multidrug-resistant TB is a growing problem and we’ve only begun to scratch the surface.

We need to link prevention and care. How do you prevent it? You have a good tuberculosis control program in place, which is almost always, in my experience, a public program. You need a public health infrastructure. You can’t have all this overcrowding in prisons and homeless centers, and you have to have plans for hospitals.

The prevention part is key, but you also have to treat people – because you should, but also because it’s an airborne disease. The only way to stop transmission is effective therapy, unless you can quarantine all these people, which is hundreds of thousands, probably millions of people. And you can’t and you shouldn’t. Linking prevention and care is critical right now, and we have to hurry. We have to make sure that the resources we need to do this are available, and they’re not available. But it’s also a general problem. We need new diagnostics – how to diagnosis this better and more rapidly. We need new drugs, and to do that we need more basic science research.

**DK: That’s the perfect lead-in to the next question, which is whether or not the open-source model of technology could be applied to drug development.**

PF: I want to just say that I don’t know the answer to that. I’ve worked with lots of groups – Universities Allied for Essential Medicines,<sup>18</sup> a lot of student

<sup>17</sup> Staph infection

<sup>18</sup> <http://essentialmedicine.org>

groups – and I would hope that is the case, that we can use various models including open-source. But I don't know enough about the economics of new drug development to answer that with confidence. What I will say is this: I'm not arguing that we should move all this new drug development into an open-source model of a public-private partnership. What I am saying is there have to be some equity strategies built in so that people with the disease in question have access to the therapeutic. That's the general response.

When I say, "Look, we need strategies so we can treat poor people with AIDS or cancer," some people come back to me and say, "Well, what's your business plan?" And I want to say, "Well, I'm sorry I didn't work that out before asking for the drug." We are trained to diagnose and care for these people, so we need a strategy where we can link to the pharmaceutical industry, link to the people working on open-source access to scientific information, and link to the implementers. We need to have that strategy not only respected, but called for by all parties, including those who are interested in patent law for example.

**ML: I'm going to link together two questions on the issue of gender inclusion, which you mentioned in the framework of the Declaration of the Rights of Man and Citizen, but also has been a key cornerstone of your work on the book *Women, Poverty and AIDS*. Does a generalized human rights paradigm eclipse women's rights? In most third world countries women are second-class citizens. And a related question: Is there a place for treating and preventing domestic violence victims and offenders in the Partners In Health vision?**

PF: Let me just say, the answer to the first question is it has eclipsed gender equity. That's just a historical fact. In other words, a generalized rights model has not put gender equity front and center in a robust enough manner. But I would argue that that need not be so, that a generalized rights model could advance gender equity to the top of the list, as long as we understand the way that gender inequality – like racism – gets in the body. One of the questions I've been interested in as an anthropologist and researcher is the

paradigm of embodiment: How do social forces get in the body? How does racism or gender inequality get in people's bodies? It's through, usually, material pathways. You have a socially constructed problem – racism, gender inequality – but the way it works is by denying access to jobs, education, land tenure, etcetera. I think a general rights model could be improved to make sure that gender equity is front and center.

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*"How do social forces get in the body? How does racism or gender inequality get in people's bodies?"*

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On Saturday I got back at 1 in the morning from Haiti, and the reason I was rushing was to introduce Nicholas Kristof<sup>19</sup> – he was speaking at the Partners In Health symposium. I think he does a good job saying that the problem of gender equity is the leading rights problem of the 21st century, but he also links it to how you can change material conditions so the impact of gender inequality is lessened.

The short answer to the question on domestic violence is yes. Again, I'm going to go back to community health workers. You have to go back to legal frameworks and cultural norms, but Nicholas Kristof made this point at the Partners In Health symposium at Harvard: When women have jobs and control resources, they're less vulnerable to domestic violence than when they don't.

When writing *Women, Poverty and AIDS*, we reviewed a lot of literature from public health, feminist literature and biomedicine. I remember one study came from California, which linked U.S. women's vulnerability to HIV to whether or not these women depended on their boyfriends or partners for rent money. I think that's a lesson we need to learn – that women need to control more in terms of access to jobs and there has to be parity in pay.

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<sup>19</sup> Kristof is a columnist for the *New York Times* and, together with his wife Sheryl WuDunn, the author of *Half the Sky: Turning Oppression into Opportunity for Women Worldwide*.

We have to address these really material pathways that allow for domestic violence and gender inequality and get those front and center.

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*“When women have jobs and control resources, they’re less vulnerable to domestic violence than when they don’t.”*

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**ML: Another series of questions: What do you say to critics who ask why you focus on health disparity abroad when it also exists in our own country? How will the decision about health care funding in the United States affect your work on behalf of the poor? And, how do you rate the quality of health care in the United States?**

PF: When someone asks me that question – Why do you focus on health care disparities abroad when there are ones in this country? – I try to figure out why the person is asking that question. Is it to start a conversation? Or, is it said with an animus? I can tell it’s the former here, but I do get asked the question in the other way as well, as you can imagine. When it’s to start a conversation I say that we don’t make that choice. We also work in the United States.

A former student of mine, when she was a fourth-year medical student probably 15 years ago, said, “I want to go to Iran.” And I said, “Why do you want to go to Iran?” She said, “I speak Farsi and my father’s from Iran.” I said, “Well, why don’t you just work here? Right here in the shadow of the Harvard teaching hospital there are enormous disparities.” And she did. Now she tells that story charitably; I’m sure that’s not how she made her decision. We’ve been working together ever since. She also goes to Iran, and to Haiti. What she did was take this model of accompaniment and community health workers and bring it back to Boston.

I speak about the need for community health workers to manage chronic

ailments in the United States with some confidence, seeing how effectively it can work in Boston. So, that’s one thing I say, that we don’t make that choice any more than we make the choice between prevention and care.

We need to think hard about disparities wherever they exist. In fact, what used to be called international health when I was a student, isn’t a term that’s used anymore. We call it global health equity. And as Jim Kim<sup>20</sup> used to always say, “Boston’s on the globe too.” San Diego’s on the globe. This is a global economy. And we’re not using that term rhetorically, but to underline the fact that we’re not talking about the nation state as the primary unit of analysis but rather equity in general.

Take New York. There are five boroughs, and there are huge disparities between Manhattan and the Bronx, but you wouldn’t want people to focus on one borough rather than the others if they all represent the city of New York.

The second question is related to the first, I think. If we get a good national health program in this country, with concern paid not only to lowering cost, improving the quality of care and reducing medical error, but also to equity and covering everyone here, it will have a very profound ripple effect elsewhere in the world, especially I think in Latin America and Africa. Even if you were interested in global health equity in the old school sense of international health, you would still very much want to see real, genuine health care reform in this country – and I think it’s something every doctor or nurse should support. Certainly we need it in our country.

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20 Dr. Jim Yong Kim is one of PIH’s co-founders and the former executive director. He is also the former director of the World Health Organization’s Department of HIV/AIDS and subsequently served as chair of the Department of Global Health and Social Medicine at Harvard Medical School, chief of the Division of Global Health Equity at Brigham and Women’s Hospital, and director of the FXB Center for Health and Human Rights at the Harvard School of Public Health. Kim is currently president of Dartmouth College.

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*“If we get a good national health program in this country, with concern paid not only to lowering cost, improving the quality of care and reducing medical error, but also to equity and covering everyone here, it will have a very profound ripple effect elsewhere in the world, especially I think in Latin America and Africa.”*

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On the third question I could be glib and say, “Well, we’re number 37 in the WHO [World Health Organization] ranking,” or, as I think President Clinton said, something about our infant mortality being higher than Slovenia. I think the Slovenians complained, “Why are you using us as a negative example?” So you’ve got to pay attention. Ever since I’ve been working with President Clinton and the United Nations, I’ve taken the term “balkanization” out of my vocabulary because people say, “Hey, we’re from the Balkans, will you stop already?”

So I could go to the rankings, and those are interesting and worth looking at – the World Health Organization’s rankings by infant or maternal mortality. What I will say, though, is that I’ve seen the best medical care I’ve ever seen in the United States in some of these tertiary hospitals. I’m glad – I almost said I’m glad I got hit by a car in the United States. That’s not what I meant. If you choose to ignore your mother and don’t look both ways before you cross, better to be in the United States. I’ve seen and been the recipient of excellent medical care. I know how it can be very good, but it’s not good enough if we have so many people who don’t have insurance and have such enormous disparities from place to place. So I would not rank U.S. health care very highly. It should be at the top and we should drive it up there, and we’re not going to do that without having some broader national health insurance scheme.

**DK: Could you comment on treating mental illness, which affects one in four people, especially in the developing world?**

PF: If you go back to the burden of disease model, which I think is a very important thing for all of us to do, look at the leading pathologies. That’s one issue. Another is: Where are the gaps? Either way, if you look at mental health it’s not only a huge burden of disease but it is also sorely neglected, more maybe than any other problem. In 2002 I argued that AIDS treatment was completely neglected. It’s a different situation now; things have improved. What I think we should do (and what a lot of people are doing, so this is not very innovative or insightful) is use interest in AIDS treatment or malaria treatment, a lot of which comes from the United States, to strengthen health systems.

Health system strengthening is part of the answer because if you have a decent health system – and you already heard me say I think that should be led predominantly by community health workers, but also nurses, doctors and social workers – then you can adapt it to whatever the prevailing or prevalent problems may be. We’re trying to build this into our work, whether it be in Peru where there are psychiatrists to help us or rural Rwanda. There are only two psychiatrists in Rwanda after the genocide, and they’re in cities. In sub-Saharan Africa some people think that there are only 100 psychiatrists practicing psychiatry full-time. So, we need to think hard about using the skills and insights of psychiatrists (and nurses are just as rare) and not just how we can involve the professionals – doctors, nurses and social workers – but also the community health workers.

The last thing I want to say is we do have some deliverables too. We do have some treatments and preventions. We need to find out how to rank them, the best and most effective deliverables in mental health services, and then get a strategy together where we can incorporate that into all our primary health care efforts.

**ML: What happened with Father Jean-Bertrand Aristide's ideals and movement in Haiti?**

PF: The popular movement in Haiti is always going to be there. The popular movement springs out of privation and lack of equity, and that's still a big problem in Haiti. People don't have jobs; they don't have access to the things they need, like the right to education and the right to water. Just to give a number, probably 85 percent of primary and secondary education in Haiti is private, not public.

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*“The popular movement in Haiti is always going to be there. The popular movement springs out of privation and lack of equity, and that's still a big problem in Haiti. People don't have jobs; they don't have access to the things they need, like the right to education and the right to water.”*

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There's a pernicious expression in Haiti used to describe rural people: “people outside.” Whether they've been in the slums or the rural areas, they've been outside the political process too long. The popular movement springs from the wellspring of people wanting to be regarded, literally, as adults in their home. They do not want to be talked down to. They want full participation. So, the movement is there and the ideals, I think, are very robust: that people should have the right to jobs with dignity, the right to health care and education, and the right to participate fully in the process.

**ML: Excellent. And it's related to a question from another master's student of Peace and Justice Studies from Côte d'Ivoire. He says, “It seems to me like our leaders in Africa take advantage of sickness as a strategy of government, as they know that the sick are not in a position to reclaim their rights. I'm wondering if sickness is not really a strategy of governance.”**

PF: I have heard that question many times before, and I think that we have to be very respectful of that question. I'm sure that you read my first book, *AIDS and Accusation*, and the reason I'm bringing up my own book again is because the subtitle to that book was *Haiti and the Geography of Blame*. As a physician and anthropologist, or a student really, I was very struck by how often I heard just that accusation regarding HIV. I heard people say, “Well, you know, it was created in Fort Dietrich, Md.” I like that one best. I was in Haiti when I heard someone say that.

Then I heard something else that really changed the way I saw this, the big literature in anthropology on what are sometimes called conspiracy theories. I wasn't willing to do that though, to call them conspiracy theories. Humans don't have the ability to create a virus, as far as I know, but that wasn't the interesting part to me. What was interesting to me was why I hear the echoes of these kinds of comments again and again and again. That's because they come from a wellspring of social inequality and persistent poverty and injustices, and those conditions will always generate these kinds of reflections and questions.

Another thing that gave me real pause about dismissing these questions as conspiratorial was when someone said back in the '80s, “The reason that Haiti has AIDS is there's a traffic in Haitian blood.” And I thought, well, that's kind of poetic. I was thinking back to the slave trade in the 19th century and before, but there actually was a traffic in Haitian blood, which I'd found was richly documented in the scholarly literature, meaning people – donors – were selling their blood. I don't think that's what really fanned the epidemic, but it's just that, again, sometimes in these conspiracy theories there's a grain of truth.

Now back to your question specifically. Performance in post-independence Africa since the 1960s has been poor, and the question of why is a huge debate. You could read Martin Meredith or Dambisa Moyo<sup>21</sup> and compare that to other assessments, but really if you look at the aid machine and

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<sup>21</sup> Books by Meredith and Moyo are included on the Related Resources page at the end of this booklet.

governments in Africa, there are a few stand-outs. I'm just going to say very openly that I think Paul Kagame<sup>22</sup> is really trying to lead in Rwanda. I'm not embarrassed to say that. I think it's great what they're doing, but it's not everywhere. At the same time, I would not say that corruption is the leading problem in Africa; I think there are other problems as well. I don't think that's the number one.

What is left if I say it's not corruption and there's some good governance? It's that there is a heavy burden of colonial structures in Africa that are related to post-independent political realities. We should be honest about that, and we should also be honest about the cynical way that aid was deployed during the Cold War for various reasons that were not development, and see if we can do a better job now. And I think we can do a better job. We'll find good partners, leaders who really care.

The last point I'll make about leaders who really care is, in my experience, even in countries with poor governance you can always find civil servants who care about the right thing. That may be at the village level, the district level, the state level or, if you're lucky, at the national level. But you'll always find people who care, just as you do in our country. You always find people who are good, honest civil servants, and you always find some who perform less well. I think that's important to keep in mind when we look at the future. I think there's a lot of reason to be optimistic too about the potential for Africa in growth and development. I'm a bit of a booster as you can tell.

**ML: One last question. Has Partners In Health considered partnering with the microfinance organizations like BRAC and Grameen<sup>23</sup> that generate jobs for the needs you identified?**

PF: We've been working with a microfinance organization called Fonkoze<sup>24</sup> since they were formed in Haiti. We just launched a new project that President Clinton announced at the Clinton Global Initiative, with Partners In Health,

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22 Kagame has been president of Rwanda since 2001.

23 [www.brac.net](http://www.brac.net) and [www.grameen-info.org](http://www.grameen-info.org)

24 [www.fonkoze.org](http://www.fonkoze.org)

Fonkoze and BRAC. It's a big project. To my knowledge, it's probably going to be the largest collaboration between these microfinance institutions and health and social justice organizations. And I'm very excited about that. I would sound one note of caution, however, and that is every time we look for a panacea, we never really find it. Microfinance, microcredit and microinsurance are not panaceas for global poverty. They're part of the solution.

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*"I would sound one note of caution, however, and that is every time we look for a panacea, we never really find it. Microfinance, microcredit and microinsurance are not panaceas for global poverty. They're part of the solution."*

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It was very moving to me to see my friend who heads Fonkoze, Anne Hastings, in a meeting in Haiti not too long ago. One of the problems I see when we have these meetings that bring together NGOs or doctors or whoever you bring together is that usually they stand up and say, "What I do is important." Do you know what I mean? I was talking to a student earlier today about the hospital at Harvard when I was a medical student. I asked a doctor, "Why do we do that procedure?" And the answer that this doctor gave me was, "Ask a pizza man what's for dinner, and he'll tell you pizza." So, ask a microfinance person what's for dinner, and he or she will tell you microfinance.

We need a broader vision of complementarity where microfinance institutions understand the need for investments outside of that arena, just as health care providers need to understand the importance of microfinance. What my friend Anne Hastings did is get up and start talking about food security and malnutrition. It's bad that she would have to do that, but it's good that she didn't only talk about what she did – just like if I got up and started talking only about delivery of health care services. It wouldn't be a good thing if we're contemplating development, as we are here today.

## RELATED RESOURCES

**Clinton Foundation and Clinton Global Initiative.** [www.clintonfoundation.org](http://www.clintonfoundation.org)  
and [www.clintonglobalinitiative.org](http://www.clintonglobalinitiative.org)

**Farmer, Paul.** *AIDS and Accusation: Haiti and the Geography of Blame.* Los Angeles: University of California Press, 2006.

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**Farmer, Paul, Margaret Connors and Janie Simmons, eds.** *Women, Poverty and AIDS: Sex, Drugs and Structural Violence.* Common Courage Press, 1996.

**Kidder, Tracy.** *Mountains Beyond Mountains: The Quest of Dr. Paul Farmer, a Man Who Would Cure the World.* New York: Random House, 2004.

**Kristof, Nicholas D. and Sheryl WuDunn.** *Half the Sky: Turning Oppression into Opportunity for Women Worldwide.* New York: Alfred A. Knopf, 2009.

**Meredith, Martin.** *The Fate of Africa: A History of Fifty Years of Independence.* New York: PublicAffairs, 2005.

**Moyo, Dambisa.** *Dead Aid.* New York: Farrar, Straus and Giroux, 2009.

**Partners In Health.** [www.pih.org](http://www.pih.org)

**United Nations Special Envoy to Haiti.** <http://haitispecialenvoy.org>

**Universal Declaration of Human Rights.** [www.un.org/en/documents/udhr](http://www.un.org/en/documents/udhr)

**World Health Organization.** [www.who.int/en](http://www.who.int/en)



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The USD campus, considered one of the most architecturally unique in the nation, is known as Alcalá Park. Like the city of San Diego, the campus takes its name from San Diego de Alcalá, a Franciscan brother who served as the infirmarian at Alcalá de Henares, a monastery near Madrid, Spain. The Spanish Renaissance architecture that characterizes the five-century old University of Alcalá serves as the inspiration for the buildings on the University of San Diego campus. The architecture was intended by the founders, Bishop

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