ACCOMPANIMENT: THE MISSING PIECE OF THE FUNDING PUZZLE

Paul Farmer

It is a great honor to be here, to be invited to talk with people who are setting the trends and thinking hard about how to do philanthropy.

I am going to begin my remarks with Haiti but digress immediately back to an American city, the one I know best — Boston — to point out how some of the lessons learned in Haiti have been applied elsewhere. And then I will close by taking you to a place that has been riven by violence and by the very heavy burden of a preventable disease: Rwanda.

I feel emboldened to start grandly by introducing a word that is new to some people in the health community, although others will know it well, and that is the term "accompaniment." This notion of accompaniment and some of the other lessons learned have been just that: lessons learned the hard way in settings where there are many obstacles to improving health. In each instance, in our experience, these obstacles can be overcome.

I am not so sure that I would have used the word "accompaniment" even five years ago in a speech such as this. The concept it embodies has been a very frustrating one for many of us since it is abused much more often than it is used effectively. But I think that I can clarify what we mean by sharing some examples as well as by referring to bigger issues that have already been mentioned by earlier speakers about community. These examples also can start to answer big questions — questions about social justice, what philanthropy means, and how we might invoke different models in thinking about our collective work.

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I have thought a lot about what Dr. Martin Luther King, Jr. may have meant in saying that, "Of all the forms of inequality, injustice in health is the most shocking and the most inhumane." I think he was getting at something that resonates widely with all of us. The problem he refers to so astutely is not just about health and heath inequalities but is about inequality of opportunity and access and about the direction in which the world is going. What I think Dr. King meant is that everyone here is going to be sick or has been sick. And everyone can imagine what it would be like to be sick but not have access to any kind of decent care, to say nothing about the kind of prevention that would make sickness involve less suffering and less early death. Dr. King said, I believe, something very profound: that thinking this way can bring a lot of people on board to support a broader movement for equity and to promote human rights.

Now I am going to turn briefly to the very specific, and this will be a sharp

turn from what has been discussed already. (Of course, being a Harvard professor and a professional nerd, I am going to start with statistics because I want to talk about expert opinion in a loyal insider way. I will be very critical, as you can guess, about expert opinion and expertise as it is wielded today.)

The *British Medical Journal* published, in 2002, a graph that showed the plummeting life expectancies of Africans living in the Sub-Saharan countries with a high prevalence of HIV: South Africa, Botswana, Zimbabwe, and Zambia. When I first saw it, I thought it was a graph that I had seen before. I almost skipped right over it because I thought it was a graph of projections made a decade earlier by people such as Jonathan Mann at UNAIDS, for example, who predicted that HIV and related diseases, such as tuberculosis and malaria, would have a profound impact on life expectancy in many regions and especially in Sub-Saharan Africa.

But this was not a projection; it had actually happened. Amazingly, with all the frailties of demographics, epidemiology, and other quantitative methods, the predictions were stunningly accurate for the impact of this epidemic, or, rather, for the twin epidemics of HIV and tuberculosis, the latter of which is actually the major cause of death among people with HIV in Africa.

When we think about Hurricane Katrina and other problems that have afflicted this country, we refer to it as a "biosocial event", because the real disaster is sociological and not really a natural biological one. HIV and resurgent tuberculosis, however, have been big biosocial disasters. If this profound and abrupt a decline in life expectancy takes place, it does not take a degree in demography to imagine what this means for the fabric of society. (I will return to the question of AIDS orphans in closing, but let me just say now that there are an estimated 14 million children orphaned, one parent or both, by HIV just in Sub-Saharan Africa. Nothing of this sort has happened, really, in modern times. I am not sure it has ever happened.) This phenomenon should be more than just the blip on the grantmakers' radar screen. In this country and elsewhere, it really is a significant and transregional issue. (Terms such as "transregional" and "translocal" are less appealing than terms such as "community" but they are better at describing epidemic disease.)

In contrast with the situation in Sub-Sahara Africa, there is now, in the United States, decreased death expectancy for people with HIV. Here we have our own health care system, which is ineffective, inefficient, and expensive. But even with that, our affluence and ability to get our hands on effective interventions still has a profound impact in decreasing bad outcomes. In other words, speaking more generally to grantmakers, in spite of all of the problems facing us, we can have an enormous impact on just about any major health problem that could be mentioned today.

How to explain the decreased death expectancy in the U.S.? Obviously, something happened in the mid-1990s, and that something was the develop-

HIV and resurgent tuberculosis have been big biosocial disasters.

SPEAKER PROFILE

Paul Farmer is a founding director of Partners In Health, an international charity organization that provides direct health care services and conducts research and advocacy activities on behalf of those who are sick and living in poverty. His work is documented in Tracy Kidder's best-selling book, *Mountains Beyond Mountains*. Dr. Farmer's work draws primarily on active clinical practice. He is an attending physician in infectious diseases and chief of the division of social medicine and health inequalities at Brigham and Women's Hospital in Boston and medical director of the Clinique Bon Sauveur, a charity hospital in rural Haiti. Working with his colleagues, Dr. Farmer has pioneered novel, community-based treatment strategies for AIDS and tuberculosis in the countries of Haiti, Peru, and Russia. Dr. Farmer has successfully challenged policymakers and critics who claim that quality health care is impossible to deliver in resource-poor settings.

ment of effective suppressive therapy for AIDS. We call this combination chemotherapy, the word that gets used sometimes for antibiotics against tuberculosis and HIV disease, because you are using more than one drug. And in the case of tuberculosis, it is eventually curative, although it takes a long time. In the case of HIV, it is suppressive, not curative, but it is effective in managing this chronic illness.

In spite of all of the problems facing us, we can have an enormous impact on just about any major health problem that could be mentioned today.

Now I would like to invite you to imagine what it felt like to be moving between Harvard and Haiti at this time, in the mid-1990s. I had been doing that for more than a dozen years. Going back and forth between Haiti and Harvard has been really the most daunting and, in a way, inspiring learning experience, just as has been the shock of moving between Miami to Haiti in an hour and a half. To pick just one year for illustration, I chose 2003. I wanted to see how much money Haiti had for public health and education in that year. The answer was that in 2003, in the face of a massive international aid shutoff to Haiti and to the elected government of Haiti, the budget for the entire country of between 8 and 9 million people was $300 million. To compare, the city of Cambridge, Massachusetts, with about 120,000 people, had a budget that was higher than that. The teaching hospital where I work, just one hospital, had an estimated income of $1.2 billion. These are just impossible inequalities.

In this era, about 1995, I was a fellow, doing my training in infectious disease at a Harvard teaching hospital where I still work. I was seeing lots of people with AIDS on both sides of that troubling trajectory between Boston and Haiti. In one day I found myself begging my patients in Boston to agree to take these antiretroviral medications and then spending my time a

few hours later in a place where I was being begged for access to the same medications.

I would submit that this experience a decade or so ago was not just anecdotal nor just my own. It was also the experience of others who were doing this work. We knew the medications were effective and we knew the burden of disease was growing rapidly in some places and shrinking in others. But it took us a long time, I thought — two or three years — to get these medications to Haiti, even though we were really trying hard. And we found ourselves completely alone. Here I am speaking to grantmakers: we could not find anyone willing to support a project to introduce this therapy to Haiti. It was a very difficult time.

Now fast forward to 2002, and think about the Global Fund (the Global Fund to Fight AIDS, Tuberculosis and Malaria), which was the first funding mechanism to take on these complex health problems. In 2002, this would represent 20 years I had spent in Haiti watching and waiting, since the very first case of AIDS in Haiti. And for the people, of course, who are living with these diseases, most of them did not last the 20 years. We had scrapped our way forward — begging, borrowing, though not stealing. I do not want to go into details, but we did just about everything to get these medicines. It was a very difficult row to hoe.

Then I got invited to give a plenary address to the 2002 global AIDS meeting in Barcelona. I thought, well, even though I've gone to these meetings before, it would be irresponsible of me not to go this time because the battle is just now being engaged and maybe I can make an impact. And although 2002 may have been the year that the Global Fund was announced, the funding had not started flowing. At that point I do not think the President's Emergency Plan for AIDS Relief (PEPFAR) was even operational.

So I decided to go and to prepare my remarks carefully. I was going to talk about the importance of thinking outside the box, how to use these complex and expensive interventions in places such as Haiti and Rwanda, or wherever the burden of disease was heaviest. This does not sound like a very controversial thing now perhaps, but then it was. Some of you may have long enough memories to remember this.

In preparing my remarks I was using the Internet in, of all places, rural Haiti. I was looking at medical journals and just pulling things out of them. I found these two papers. (I will not tell you the authors' names because I do not want to get into a battle in this setting.) One said, and I quote, "Data on the cost-effectiveness of HIV prevention in Sub-Saharan Africa and on highly active antiretroviral therapy (HAART) indicate that prevention is at least 28 times more cost effective than HAART." The other said, "The most cost-effective interventions are for prevention of HIV/AIDS and treatment of tuberculosis, whereas HAART for adults, and home-based care

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organized from health facilities, are the least cost effective."

Imagine slogging through the effort to get some of these medicines out there and then to read such things! There was this constant undertow of censorious comments about efforts, such as ours, given that the current religion or ideology was cost-effectiveness. I know you are subjected to it too because it is still the global religion of funding. But the confidence with which the claims in these articles are made is startling given their level of specificity. Obviously, you feel like a complete buffoon if you have spent all your time on the vastly less-effective intervention.

I was in Haiti then, so I asked a research assistant at Harvard to find me the references that were used to make such bold and confident claims because you could not see the references in the on-line version. In one of the two claims, the only data cited was a mathematical modeling exercise and some data from a *proposed* project in West Africa. In contrast, we had been doing this work for five years and we had real data.

What are the metrics by which we can assess interventions? And what are the shortcomings of the current religion out there? Are they really ideologies?

But my big question here is not about AIDS or treating AIDS in resource-poor countries. Why would I importune you with these specifics? What are the metrics by which we can assess interventions? And what are the shortcomings of the current religion out there? Are they really ideologies?

Now I had learned the answers to many of these questions from Haitians and I want to have the chance to give you one specific example that illustrates what it is we are working on and talking about in asking these questions. I live and work in a squatter settlement in the middle of central Haiti. And it looks, as you might imagine, very different now from 20 or 25 years ago. But it is a squatter settlement. People do not own the land, by and large. These peasant farmers — that is a term they use — were driven out of the valley by development of a hydroelectric dam that brought neither water nor electricity. It is a long and sad story. But, of course, living there and talking with people makes you very aware of what it actually means when you hear terms such as "sustainable development" given that the dam was one example of these development projects. It is similarly frustrating when you hear that certain approaches are not cost-effective or do not use "appropriate technology." The Haitians have some words for these confident claims from experts and are suspicious of them as well.

So, we started this sassy project within our bigger health care program, and called it the HIV Equity Initiative, providing directly observed antiretroviral therapy and social support free of charge to more than 2,030 HIV-infected patients. The name perhaps was an unnecessary rhetorical flourish, but the Haitians really liked it. (When I say the Haitians, I mean our patients.)

I want to introduce you to a couple of our patients, with their blessing,

since they have asked me to use their images and their names whenever possible. Most of you are involved in making the grants, but some of you are working in the very institutions, the frontline institutions, that meet people like the ones I am going to introduce you to.

Several years ago, I treated a young man who was wandering around urban Haiti sick with this consumptive disease. It turns out he had two diseases, and I am sure you can guess what they are. He got sicker and sicker, and eventually went home to central Haiti to die, ending up in a place called Los Cahobas, his home town. (By the way, whenever you privatize things and defund the private sector, notice how so-called free care from your mother or your aunt is gendered. It is another interesting story that is worth investigating, I believe.)

Just as an aside, speaking earlier of the Global Fund, we knew well before March 2003 that we would get money from the Global Fund to do this work, but then it did not show up. We had made promises to the community, to the people who we were serving, that we would open the public clinics in the area and introduce services like the ones in Cange to their communities. So we actually took out a loan from a commercial bank. We had to get one of our supporters, a Boston businessman, to back us up, to cosign the loan. That is how we started this project in August 2002, as promised, on schedule.

It made a difference to this particular patient because he arrived in Las Cahobas before the money started flowing from the grantmakers. Normally I would not go to this town, an hour-and-a-half away, to see a patient with AIDS and tuberculosis — an assessment by coworkers are more-than-able to do. But they asked me to come and see this patient, and I agreed, although I was not sure why I was necessary.

It turns out they wanted me to come and talk to him because this man, Joseph, had said he was going to die and his family had already purchased his coffin. I was asked by Haitian doctors and a student of mine to convince him that therapy was worth it and that it was not too late for him. (Of course, you can never be sure when someone is this sick, but his story turned out happily because as you can see from this photo, six months later, after therapy, this same man is alive and much healthier.)

There is more to this story, and now I want to go back to these broader themes of what does community mean? What does engagement mean? How do you measure the cost-effectiveness of that intervention for Joseph, for example? People in Haiti do not have much faith in public health because the public sector was defunded through a series of rapacious policies that were foisted by the donor community on poor countries. (More on that later if you would like.)

What reason would the villagers have to believe that someone could come

back from the brink? If you look at who would go into a prenatal clinic and ask to be tested for HIV ten years ago, before we introduced any of these interventions, it would be a very small fraction. Last year alone we did 52,000 voluntary testings with counseling, what are now called in the jargon "VCT", which are a cornerstone of prevention. People such as Joseph helped make this happen just by surviving. But he did more.

I will return later to talk about the model of accompaniment that characterizes our medical care. Accompaniment here, for us, means that the patient does not have to get all the way to the clinic to get his care. He gets his care — and here I think is a good use of the word community — in his community, in his village. He has a community health worker whom we call an "accompagnateur." She provides him accompaniment — not just giving him his pills but asking how he is feeling, finding out if he needs help with anything from child care to fees for education. Interestingly, in an interview that Joseph later had with another Haitian in my presence, he was asked a good question. The question was, "What do you want to do with your life now?" And he said, "I want to learn how to read." That was his goal, to learn how to read. Now Joseph is going around and giving talks to other communities about AIDS prevention.

Earlier I mentioned the question of cost-effectiveness and confident claims about cost-effectiveness using the experience of someone I treated.

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But let me be a little bit more hard bitten and less anecdotal. We go back to 2002 again, when it is held that one intervention is 28 times more effective than another. Here are the real data; this is not a mathematical modeling exercise. It costs about $10,000 per patient per year to deliver one of those three-drug regimens. And already that year we were getting the same medicines for $700 per patient per year. And the International Dispensary Association, which is the world's largest nonprofit procurer of drugs, was already getting prices well below that. And then the price was lowered to just over $400 per year. This is, again, not by accident. Some of you have heard about the Clinton Foundation's engagement in this effort, which has been very helpful to us because they went and renegotiated the prices even lower. So it is now about $150, or maybe less, per patient per year. This is a really profound change.

I use 2002 data because it was the very time during which the general wisdom was that you should not be providing this therapy in what are now called "resource-poor" settings. And then other critiques arrived: "You may be able to do this in Cange, Haiti but it is really not scalable. You cannot replicate it elsewhere." We said, "Sure we can. What we need is for the grantmakers to support us." This is what happened with the Global Fund grant.

Central Haiti is, as some of you know, very forbidding terrain. There are no roads, no telephones, and massive

political upheaval. And yet during the worst years of the epidemic, the last few years, we have scaled up this same comprehensive project to improve primary health care and access across central Haiti.

I live in Cange, in the Central Plateau of Haiti, where there are only public facilities. Again, learning from our earlier mistakes in philanthropy, we spent ten years working very hard with our Haitian partners. We asked ourselves, after ten years, what have we done to strengthen public health, the public sector? Everybody said the public sector is no good. That is a long time to wait to ask that question. But again, just as with AIDS drugs, is that the beginning of a conversation or the end? You have to ask why. Why is the system no good? So we thought, how can we be unlike other nongovernmental organizations and grantmakers and contribute to rebuilding the public health system in Haiti? Our answer was to scale up our efforts with public institutions. So by the time we got to Rwanda, we knew what we were doing (the Haitian team particularly).

Now remember, this scale-up has taken place in the middle of some of the worst political turmoil Haiti has known. The reason that our patients never went without their medications is not because we were able to prevent our doctors and nurses from being kidnapped or our ambulances from being stolen by rebels. It is because we had made sure that this care would be delivered in the villages, in the community, by their neighbors. That is "accompaniment." It is accompaniment that made this project work under these circumstances.

Now what else does accompaniment mean? The experience of working in Haiti in the 1980s and 1990s without medicines was pretty much the same every time. People would come in and they would be withering away and they would say, "I can't eat. My throat is too sore. I have diarrhea 10 times a day, I can hardly walk."

Then you put them on proper therapy and they come back in the clinic, chatty as they can be. And sometimes I'm thinking, okay, we've got a long line here but they are saying, "Now I really need to get my kids in school and my house has a dirt floor," and it goes on and on. The options, at that point, are to say "please leave," or to listen to the patients. We listen to them when they talk about sending their kids to school or having clean water or having housing or learning how to read, as Joseph had answered. It was obvious that we had to get involved in this accompaniment in order to make these projects work.

But to go back to the human rights logic and Martin Luther King's statement, is it not also good to say that we used the circumstance of AIDS to get at these broader questions of equity and of basic human rights? You know, human rights language is frowned on in public health circles, interestingly, because it used to be very popular. In the 19th century, efforts were largely focused on basic rights. The language may have been a bit different but

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people were given the right to clean water and the right to decent housing and the right to school. That is really strangely absent from the public health discourse today. (Not so absent, interestingly enough, as in a teaching hospital.) In the places where we need it most, discussion about human rights, community health and public health is missing.

Let me now go back to my home country. Some of you may know Carlos del Rio, who is an infectious disease doctor at Emory University. His team put together a comprehensive AIDS clinic right where it should be located in the city of Atlanta. When I say comprehensive, I mean it has a WIC office and a dental office. You can get chemotherapy. It is all right there.

So it is as good a job, in my opinion, as the medical profession can do without real accompaniment. And yet, if you look at the numbers, and it is a small cohort, only 13 percent of the patients enrolled on antiretroviral therapy have suppressed viral loads (a measure of how much virus there is in the blood) a year later. That figure in Haiti, with accompaniment and community health workers, is probably 90 percent. We are not even doing those tests anymore in Haiti because we know that the viral loads are suppressed. The tests are expensive to do, and we are not going to do them, not in Rwanda, either. That is not how we measure. One of the radical and novel metrics we use to measure our patients' response is to ask them how they are doing.

What if we could take the experience of accompaniment of our patients in Haiti and bring it to Boston?

So this experience in Haiti and working as a doctor in Boston, along with many others, of course, led us to say: what if we could take the experience of accompaniment of our patients in Haiti and bring it to Boston, bring it to the so-called inner city? (Now I made a mistake in my university of saying, "how about if we take a Haiti-level of care and try to bring the Harvard-level of care up to the Haiti-level of care?" My colleagues were irritated beyond belief, so I was asked to stop saying that.) But that is basically what we did. We took the same model of accompaniment, using community health workers, except that the enrollment criteria were much more stringent. In other words, we offered these services in the United States only to patients who had failed conventional therapy and had drug-resistant HIV. And they had to have low CD4 counts. These were really the sickest patients. These were the people who were ending up in the emergency room getting expensive high-tech care for primary health care problems.

So we took the model to Boston. And actually, guess what kind of problems we had starting this, oh dear grantmakers? We could not find funders at first. (Actually, the Blue Cross Blue Shield of Massachusetts Foundation came to our rescue, as did Harvard, the teaching hospital.) People said it is too expensive to have community health workers. In Haiti, it is cheap; you only have to pay them a tiny honorarium. But it costs too much to do this in the United States. But we were saying, no, it costs

too much to *not* do it. If you have someone bouncing in and out of a Harvard teaching hospital or Boston City Hospital with complications of advanced HIV disease who has never had sustained therapy, you are spending hundreds of thousands of dollars to deliver bad care. I mean, it is good when they are in the hospital and you are putting in a shunt because they have a parasitic infection in the brain (that only happens when people do not get care) and they get good neurosurgical care and good intensive care, and then they go out into the famous "community" for follow-up health care. Nurses and doctors cannot do home visits all the time. Yes, there is a distinguished tradition of nurses doing home visits and there used to be a distinguished tradition of doctors doing home visits, but that is no longer considered a sustainable model of care.

Think about diabetes. Think about seizure disorder. Think about major mental illness. For every chronic disease for which we have an intervention, a deliverable, how are we using that deliverable? The situation with infectious disease is acute because the microbes, whether viruses, bacteria, or microbacteria, develop resistance to the drugs if used improperly. So you really are forced to think about this more quickly in talking about infectious diseases. No matter what tools we develop to take on these chronic diseases, if we do not have a plan that allows us to reach so-called vulnerable populations or the community or whatever jargon is used next year, if we do not have a good plan to use these tools wisely and equitably, we are going to have more bad medical care. And the cost is not purely economic.

We have encountered some forward-thinking funders and grantmakers. (Of course, in my position, whenever someone funds us, we say they are very forward-thinking, very progressive, very astute, and really represent the cutting edge of funding.) Our program in Boston is still, to this day, hard to fund, which is a shame, because yes, it is expensive. But it is just nowhere near as expensive as it is to provide this bad a level of intermittent medical care to Americans.

The same must be true in other affluent countries. Even those with good national health programs still do not have enough in the way of community-based care. It looks just like it does in Haiti, except that the community outreach workers have cars and not donkeys. Some of the community outreach workers from Boston came to Haiti and for the community health workers in Haiti, the accompagnateurs, the thing that most surprised them was the notion that a community health worker could have a cell phone or a car. Those in Peru, where we have also extended this model, have cell phones and now they are using hand-held Palm Pilots to enter data. Who knows where we are going to go in Rwanda, but we are going to try to strengthen the hand of community health workers because we know that is how we can provide better-quality services for the patients.

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I thought Haiti was bad, with its statistics of one doctor per every 20,000 people in rural areas. But 350,000 people without a doctor — and really without nurses either — was very, very daunting.

This model is also very important for prevention. In Boston, as in Haiti, we have been recruiting people—young people—living in these neighborhoods. As an aside, this group of, as they call themselves, kids, just wrote a grant proposal themselves and got $2,000 for their work. Grant writing is a nasty business so I am very proud of them. This is a group of people who have been struggling with addiction and now they are leading the prevention and harm-reduction side of this project.

In closing, let me take you very briefly, to a continent that I think really merits all of our attention in this interconnected, global era in which we are living now. There are many children and many older people but there are few parents. This is Ground Zero of the AIDS epidemic. I'm going back to Rwanda but before that I am stopping in Western Kenya. I will tell you why.

Recently I was invited, at the behest of funders, to go to Kenya and sort through some problems they were having with another organization. This is a very interesting position, when you have always been on the whining end of things, to be able to go ahead and say, if you really want to fix this, you ought to do this, this, and this, and then to know that the funders back you. That is a very special kind of a power trip. Anyway, I hope for the right reasons, we were able to make some very substantive suggestions — all around the idea of accompaniment — to the people working in Western Kenya. And they followed them. The results have been really exciting for us to see. So I am going back there on my way to Rwanda.

Less than a couple of years ago, we decided—and we knew not to do this until the time was right — that we could promote a comprehensive model to institute primary health care, basic economic, and social rights such as housing, primary school, and so forth. We did not want to begin working in Africa without being able to do that. So it took us two years to feel comfortable that we had the right combination of support for our comprehensive program. We had some funders of our own and support from the Clinton Foundation, and lots of what is called political will on the part of the Rwandan government and ministry of health. So finally we were going to work in Rwanda.

A year ago last November, the government in Rwanda told us that they were going to choose the sites where we were going to work. (We learned in Haiti that it is better for the government to choose the sites, to strengthen the public sector.) They took us to northern Rwanda, to a place called Ruhengeri, and brought us to a hospital. It's a very beautiful part of the world. There were lots of problems but it wasn't like Haiti. There was electricity and an x-ray machine and it was clean. It was really paradise compared to Haiti.

I made the mistake of saying to the minister of health, in front of the director of the national AIDS

program, "Is this all you got? This is easy. We can do this, no problem." The director of the national AIDS program is a Rwandan pediatrician, and she turned to the minister and said, "Throw Partners In Health into the most rotten part of Rwanda and they will flourish." So they sent us to an area of around 350,000 people where there were zero doctors. Zero. That, I would say, is really grueling. I thought Haiti was bad, with its statistics of one doctor per every 20,000 people in rural areas. But 350,000 people without a doctor — and really without nurses either — was very, very daunting. But we felt that we knew what we were doing after our experience in Haiti. It is amazing what cleaning things up and painting them and putting tile on the floor and things like that will do to bolster morale. We put in a modern lab. And we put in place the critical tools (including labs and medications) that the providers of health care, whether community health workers or physicians, need to do their work.

We hear that there is a brain drain. Is that a surprise? Who would want to be an African doctor in a place where you do not have the diagnostic and therapeutics that you need to do a decent job? I know I would not.

We also had learned from Haiti that telecommunications was a problem. But as we had learned, if you do not have a telephone, put in high-speed Internet access instead, and so we did. (If someone ten years ago had said since you do not have roads and electricity in Haiti, why not use high-speed Internet access instead, I would have thought that was silly. But it turns out to be just the way to go.) We can send, from Haiti to Rwanda, an X-ray, which is a lot of data, in a minute. And in fact, we do this all the time. The Rwandans do what we call a daily report, just like the Haitians, and we share all this information, whether we are in Siberia or Peru or Boston or Haiti or Rwanda. It has been a wonderful thing.

A lot of this began through funding to fight HIV/AIDS. But it really was never just about that. It was about these broader goals that I mentioned. We have been able to scale up in rural Rwanda much more quickly than anywhere else. In six months, we went from more than 100 patients receiving AIDS or tuberculosis treatment to more than 700 patients. This was accomplished only because we used the model of accompaniment. Accompaniment in Rwanda has meant almost the same thing as in Haiti. Say, for example, you are trying to prevent mother-to-child transmission of HIV. Mother-to-child transmission of HIV is readily prevented, which is why there's no more pediatric HIV disease in the United States to speak of. A lot of people do not know that we have almost wiped out HIV disease among children in the U.S. Because if you give the right medicines to mothers, not just to prevent transmission but to take care of the women, then their children will not get HIV.

But to do that, there is a lot else that has to be done. For example, breast

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feeding is not a good idea if you are trying to prevent mother-to-child transmission. In the United States that has not been problematic for the most part, but imagine the situation in rural Rwanda or rural Haiti, where people do not have access to water, let alone infant formula.

So we knew from our experience in Haiti that we needed to get the water, the stoves, and the infant formula to the women in this program. But then we also knew we had to visit them at home and accompany them. And what we saw was just like in Haiti. Take the family in Rwanda in this photo — a woman, she is a widow with, I think, three or four children. And on the inside of her shack, on the floor are, of course, the materials that we have given her. A thermos we provided is stuck in the wall.

Is this the beginning of a conversation or the end of one? Are we going to say well, it is really too hard to do this in resource-poor settings such as Africa? Or are we going to say, what do we do next? The answer that we developed in Haiti with our Haitian partners was obvious: we improve housing. So we started this program in Haiti called the Program on Social and Economic Rights. Let me tell you, the grantmakers are not rushing to fund that either, which is a shame really because social and economic rights are the basis of accompaniment, whether in the United States or anywhere else. I do not think it is going to be popular in many circles, expert or public health circles. But it could be very popular in funding circles. Or at least it could be mandated to be of concern.

Growing social inequality is the basis of a lot of the epidemic disease we see. It's structural violence.

There is a difference between charity, development, and social justice. I don't knock charity much, although I think charity, compassion, pity, and empathy, are unstable concepts. But they're not bad concepts, and the world would be a lot less mean if there were more of those sentiments.

Development work has become such a huge machine now that it has its own internal critics, which it can well afford. We have tried to learn from development and its formal professionalized expertise. That expertise, though, contradicts itself every ten years. It says do structural adjustment. Oops, we were wrong, we killed lots of people, don't do it anymore. Or big is good, small is bad, and so on. It is better to take what you can of the good and not be dismissive of expertise that comes from development, but know that it's not going to be a guiding light for our work.

So what does that leave? It leaves for us this notion of social justice which is ahistorical. If you talk about alcoholism among Native Americans, do you really not want to talk about land appropriation and genocide? No population appreciates having their history erased. If you want to talk about crack addition among African Americans in New York City, do you really not want to talk about racism, institutionalized racism? They hate it when we do that, to say nothing of those in Haiti and Guatemala and many other places hating it too.

So what are historically informed ways of doing work like yours, like

ours? That is, being honest about the social forces and processes that leave some people vulnerable, marginalized, oppressed, impoverished, and leave others well protected from any of those slings and arrows. And acknowledging that growing social inequality is the basis of a lot of the epidemic disease we see. It's structural violence—a term borrowed it from liberation theologians and a couple of other sources. It describes well, I think, what people are talking about when they have to fight every day.

In each of the places I mentioned — Haiti, Rwanda, Guatemala at the end of a civil war, Peru at the end of a civil war — we didn't go there because there was violence. But we did find ourselves developing expertise because of the violence. And one of the reasons that I think we're still there and we have such deep roots is because we talk the language of social justice which, by the way, we borrow from the people we serve.

Having nongovernmental organizations and charities and foundations do this work is good, but it's not the same as having these things — water, education, food — as a right. And who is the guarantor of the rights of the poor in health care and education? It is the public sector. And again, if the public sector is weak and inefficient, is that the beginning of a conversation or the end of one? Partners In Health is very committed to strengthening the public sector, not necessarily from the center outwards (beginning with a capital city or a national plan, although we do that as well). But because we believe that the ultimate guarantor of basic rights in education, water, and health is the public sector, although much maligned even by nongovernmental organizations and foundations. Community-based organizations are fine but no one elected us; it is legislation and the public sector that are the guarantors of rights.

So my one little funding story to close is this. The group that did give us some money for this project, which is called in Rwanda, as in Haiti, the Program on Social and Economic Rights, is very interesting philanthropically. The funder is major brand of lipstick. When I went to a meeting to make this pitch to an AIDS funding initiative, all the proceeds from this particular kind of lipstick, which I think is called Viva Glam, goes to AIDS work. So I went to this meeting and they said, "would you like to see Estee Lauder's bathroom?" I thought the only polite thing to say was well of course and I did.

I hope that wherever they are they are proud, because this team in Rwanda built a house in three days. The bricks were made with a little machine that mixed mud and dirt. And then it has a coating of cement afterwards. In front of house stands the mother and her baby and her other children. Also present is the same woman, the pediatrician, who banished us to this area, the director of the national AIDS program, who is very pleased, I think, with what we have been able to start in Rwanda and what we hope to keep going for a very long time.

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