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# 15 Minutes

## Paul Farmer

Founder, Partners in Health

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# Paul Farmer

## *Founder, Partners in Health*

*In 1987, physician and anthropologist Paul Farmer (above) founded Partners in Health to treat tuberculosis and other infectious diseases among Haiti's rural poor. Since that time, his organization has expanded to care and advocate for the world's poorest and sickest, in sites as diverse as Siberian prisons, Peruvian shantytowns, and Boston's inner-city neighborhoods. The organization has also clarified its broader goal: to address the inequity and injustice that underlie much of human suffering. In an age of bottom line-driven, "surgical strike" medical care, Farmer's commitment to bringing about widespread social change, in part by cultivating long-term relationships with people in impoverished communities, is nothing short of radical. Recently, former President Bill Clinton's foundation gave Farmer $5 million to fund a pilot in rural Rwanda in a hospital abandoned since the 1994 genocide.*

**Your motivation for founding Partners in Health was that everyone, whether poor or affluent, deserves the same standard of healthcare. What are the barriers to equity in healthcare?**

A lack of equity in general. Poor health outcomes are associated with poverty and inequality. Relieving health inequalities depends ultimately on addressing basic social ills. We can address the lack of basic tools, from diagnostics to therapeutics; the lack of healthcare workers; and the absence of community-based models of care in locations lacking laboratories, doctors, or nurses. And we can also tackle broader obstacles to well-being, such as no roads and cultural and linguistic barriers. In so doing, we hope also to contribute to the basic goal of alleviating poverty.

**Many people doubt such obstacles can be surmounted.**

Yes, indeed. The naysayers may still outweigh those who believe it can and must be done. But who are these naysayers? Are they people living in dire poverty? Do people living in poverty ever say to us, "Don't bother to try to address this health problem in our community, there are too many obstacles"? In 20 years, I've never heard it from that quarter. It's usually "experts" like me who underline the obstacles as a way of stopping the conversation and hence the admittedly colossal output of energy it


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takes to address all these obstacles. When there's a constant undertow of censorious opinion from decision makers, it's often best to leave arguing aside and find a way to make projects work in poverty-stricken and disease-burdened areas. Then you can say, "Look, it's possible."

**A controversial aspect of your program is that you maintain close contact with patients to make sure that they take their medicines. Can you sustain this level of commitment?**

It's strange, no, that this would be controversial? After all, what makes more sense than maintaining close contact with patients who are being treated for chronic, life-threatening infectious diseases? We sustain commitment by working with community health workers, most of whom are the neighbors of our patients. Responding to epidemics is a public good, not a burden to be borne by patients and families alone. The alternative? To regard AIDS and TB as private problems. Then the world stands by as the poor and afflicted are unable to buy medications.

**When you first recognized that delivering good healthcare might also mean thatching roofs and training locals to be nurses – "whatever it takes" – was there concern about losing focus on medicine itself?**

I wouldn't want to make it sound as if we have this all figured out. But it's hard to focus on clinical medicine when what ails your patients is not only disease but also poverty and hunger. So we must do as much as we can.

**What has happened to the first patients and communities?**

Many of our first patients are now our co-workers. Although these individuals, their families, and their communities still struggle with poverty, it strikes us as progress that they're still with us and often now working on the behalf of others.

**How do you measure and evaluate progress?**

It's important to measure progress by whatever metrics are available. But it's also important to acknowledge that we don't always have a sound way of measuring progress. How do you measure the impact of bringing someone back from the brink of death and then seeing them involved in projects to help others?

**Most people who go to a place like Haiti from a place like Stanford, Harvard, or Duke do not know how to listen to the poor. Where would they have picked that up?**

**What makes Partners in Health effective?**

The organization is underpinned by solid and, we'd like to think, innovative ideas. But many of these ideas were not original when we founded PIH. We'd encountered them in poor communities in Latin America. Our innovation was largely in listening and translating these ideas into projects to serve the poor. That's been a constant over the years – listening.

**Just listening? You make it sound easy.**

I don't think listening is all that easy. Most people who go to a place like Haiti from a place like Stanford, Harvard, or Duke do not know how to listen to the poor. Where would they have picked that up? It requires discipline and linguistic capacity, although this is the least important part. Simply sitting in a dirt-floor shack and listening – I don't know that many people who do it humbly and regularly. We insist that our clinicians make house visits. This is true in Boston, just as it is in Haiti.

**How do you create leaders within your organization?**

I don't like the term "empowerment," because it's so abused in modern parlance. But we must ensure that our leaders have tools. We give our doctors and community leaders tools with which to fulfill our mission. Indeed, the real leaders are local leaders who are committed to improving the health status of their communities and their compatriots.

**After Tracy Kidder's book, you received media attention – and money. What challenges has this introduced?**

In principle, the more we expand, the better for those we serve. But we rely heavily on locally rooted sister organizations. In some settings, we lack people with management skills and basic literacy. Management issues are really the most daunting challenges, especially in Haiti and Rwanda.

**With multiple offers of partnerships and global pleas for help, how do you choose where to focus efforts?**

This is inevitably painful. In the past, our ability to choose partners was lim-


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ited by resources. We don't want to become "consultants" or "advisers" dispensing counsel that cannot be followed by those seeking to serve the poor. We refused to spread ourselves thinly; in the last decade, we expanded only three times. But we have long wanted a project in Africa.

**Why did Partners in Health extend its operations to Rwanda?**

First, Rwanda's recent history makes it compelling for any group with more than a passing interest in health and social justice. Second, PIH has hard-won expertise in responding to AIDS, TB, and malaria – Rwanda's three leading infectious causes of death. Third – though this was never part of our original vision – we have survived in areas torn by conflict. Fourth, our institutional partners, the Ministry of Health and the Clinton Foundation, are committed to health equity.

**Haiti experiences coups. Genocide afflicts Rwanda. How do you weigh potential benefits of going into politically unstable regions against major hazards?**

There's no clear formula. Doctors Without Borders left refugee camps in Zaire after deciding, bravely in my view, they were doing more harm than good. I must confess: We have stumbled into conflict zones in the past – Haiti as we were getting started; Chiapas before a rebellion; Guatemala after following co-workers back from Mexico after signing of peace accords; and Lima when we thought civil war was over. Rwanda is the most considered decision we've made. We feel perfectly suited for the work, partly from so much experience in settings riven by conflict.

**How do you adapt to these starkly different settings and issues?**

To serve in these different areas, we have to be nimble. We can't get caught up in too much red tape. Otherwise, people we've pledged to serve end up dead. We also build sister organizations headed by colleagues from those countries. These basic principles lead us, inevitably, to neglected diseases such as TB, AIDS, and malaria. They also lead us to focus, whenever possible, on basic social and economic rights for people living in poverty.

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**With so much suffering, is it sometimes hard to maintain a positive outlook?**

Very difficult. It's important to see the little victories, which are not so little to those who are served by these projects. If a woman who was dying of AIDS only a couple of years ago comes to you, looking great on therapy but complaining about her kids not being in school, about violence on the road, about having no land – it is hard to say, "Hey, sorry, but at least you're not dying anymore." We don't say that stuff out loud. Better to say it to oneself – then work on at least getting her kids in school. Problems of poverty *are* complex and huge.

**As a nonprofit celebrity, your name is virtually synonymous with your work. It is *you* in whom prospective donors want to invest. If something happens to Paul Farmer, what happens to Partners in Health?**

I'm one of several founders still associated with PIH. I'm not the CEO. We have talented people, most of them younger than I, whose careers are devoted to this. For example, Ophelia Dahl, the director, has reinforced our organizational structure. I'm not worried about the future. There's a solid vision – and many visionary partners.

**What is the largest challenge in meeting your vision? And what stands in the way?**

It's comforting to think of a world in which a small number of social and economic rights – the right to healthcare, housing, food, and primary education, and also the right to be free from abuse of one's human rights – were seen as the only way of really being human. And humane. We don't live in a utopia, I know. But imagine if our dystopia was at least reconfigured so that people living in poverty did not have to die of treatable illnesses, in childbirth, unvaccinated, or unable to read and write. We've got a long way to go. What stands between us and that goal is the unacceptable divide between the world's rich and poor and the fact that the powerful make all of the decisions. □


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