

## Challenging Orthodoxies in Health and Human Rights

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### 1. Fissures in the Orthodoxy

Seven years ago, I was afforded several pages in the *American Journal of Public Health* in order to reconsider the vexed question of how medicine and public health might contribute to the broader struggle for basic human rights.<sup>1</sup> The essay was informed by a dozen years of work. Together with hundreds of people working for a small group called Partners In Health, I've been part of an effort to provide basic services—medical care, primary education, clean water, even exhumation and proper burial for the victims of mass violence—in Latin America and Siberia and inner-city Boston. These people had neither a language nor a culture in common. What they had in common, by and large, was poverty. More than half of those we sought to serve were women and children. Most were sick, many with AIDS or tuberculosis or malaria; others were neighbors or relatives of the sick. But regardless of whether they were sick or well, all shared that vague status known widely as “at risk.” Whether in informal settlements in rural Haiti or urban Peru, whether in Siberian prisons (where the great majority were men) or in poor areas of an American city, the people served by Partners In Health were and are at risk of dying prematurely because their basic right to survive had not only been shoved aside by the powerful in their home country, but was not even considered a ranking concern by many in mainstream human rights groups. Using the rights argot of our day, I argued against a prevailing human rights orthodoxy: although those we served ardently desired civil and political rights, they spoke more often of what are termed “social and economic rights.” These rights include the right not to starve to death or die in childbirth; the right to treatment, even for chronic and difficult-to-treat afflictions such as AIDS or multidrug-resistant tuberculosis; the right to primary schooling and the right to clean water. It was such rights as these, or so I argued in transmitting our patients' views in the pages of the *AJPH*, which should be our focus in the public health and medical communities. The issue was urgent, in part because public-health professionals should have been fighting to advance them anyway and in part because these rights were too rarely mentioned by the “orthodox” human rights organizations based in North America and Europe. It was an argument partly about the intrinsic merits of an issue, and partly about its near-invisibility.

I wrote that in 1999. Some things have changed since then; others remain the same. PIH has expanded considerably. Over the last two years, building especially on our experience in Haiti, PIH has launched three new projects in rural Africa. But our recent experience offers scant reason to change the basic thesis advanced in 1999. Both international health and human rights are set in their ways and continue to proffer what amounts to an orthodoxy. In so-called “resource-poor settings”—in other words, among the poor—the orthodoxy in public health today is to formulate

policy that promotes “cost-effective” and “sustainable” interventions, which are often noble enough in spirit but lack the commitment needed to stop the epidemics, much less the poverty, registered in the poorest parts of Africa. In human rights, the orthodoxy is to focus solely on civil, legal and political rights, putting off issues of food, health, and education to some later stage. Both these orthodoxies fit neatly into a neoliberal political and economic agenda propelled by the world’s most powerful governments and international financial institutions. My comments today are not meant to be ideological. Still, you should know that I believe that the very notion of public health, and our practice, must be shielded from the harshest neoliberal ideologies; those ideologies were not crafted by or for the people we seek to serve. People actually living in “resource-poor settings” do not usually clamor for “cost-effective” solutions to their problems; they want first and foremost effective solutions. And that is our specialty. We might not know how to grow national or transnational economies, but we do know how to protect the health of the poor.

The two orthodoxies I’ve just outlined in public health and human rights are tightly linked, even though the links are often buried and elusive. I’ll seek to support this general argument with specifics. Since I’m just returning from Malawi, where maternal mortality is said to be the third highest in the world and where hunger and other afflictions abound, I’ll cite a recent essay by an expert on the country: “The tenets of liberalism in both politics and economy are now shared by all the political parties... Everybody, it seems, is committed to multiparty democracy, human rights, and the market economy.”<sup>2</sup>

How are democracy, human rights, and a “market economy” linked together? Are they so linked for the poor in particular? Amartya Sen, among others, has offered compelling evidence that genuinely democratic governance is associated with more development and less poverty.<sup>3</sup> But there is no magic formula that leads from the “shared tenets” of “multiparty democracy, human rights and the market economy” to a reduction in the appalling privations still faced by many Africans and by hundreds of millions elsewhere.

Our ostensible beneficiaries are sometimes called the “voiceless poor.” But the epithet is misapplied. They have much to say, and they do so, as any clinician knows. Whether or not we listen to them is a different story. Are human rights and public health groups even prepared to listen? In an essay titled “Why more Africans don’t use human rights language,” Chidi Anselm Odinkalu puts it this way:

In Africa, the realization of human rights is a very serious business indeed. In many cases it is a life and death matter. From the child soldier, the rural dweller deprived of basic health care, the mother unaware that the next pregnancy is not an inexorable fate, the city dweller living in fear of the burglar, the worker owed several months arrears of wages, and the activist organizing against bad government, to the group of rural women seeking access to land so that they may send their children to school with its proceeds, people are acutely aware of the injustices inflicted upon them. Knowledge of the contents of the Universal Declaration will hardly advance their condition. What they need is a movement that channels these frustrations into articulate demands that evoke responses from the political process. This the human rights movement is unwilling or unable to provide. In consequence, the real-life struggles for social justice are waged despite human rights groups—not by or because of them—by people who feel that their realities and aspirations are not adequately captured by human rights organizations and their language.<sup>4</sup>

Odinkalu's language is uncompromising. I don't want to mislead you into thinking that there is nothing but conflict between human rights groups and the humans desiring to win rights. Despite neoliberal orthodoxy in both international health and human rights, much has changed over the past few years, and some of it for the better. Allow me to take the example of AIDS. Following the lead of groups led by people living with HIV, by student activists, and by a small number of organizations serving the destitute with or at risk of AIDS, the recent influx of funds designated to treat poor people with AIDS in the spirit of providing a public good, rather than a commodity, has challenged modern public health orthodoxy.<sup>5</sup> Although many will no doubt conclude that it is ultimately cost-effective to lessen, through the only means possible, the horrific mortality registered among poor people living with HIV, the large-scale efforts I am referring to were not launched on grounds of cost-effectiveness. Instead, they were the result of powerful thinking about ethics and the alleviation of suffering. Human rights and social justice, once staples of public health, are slowly being revived on a grand scale.

Speaking from our own experience, PIH, having focused for over a decade on AIDS prevention, launched AIDS treatment for the poor of central Haiti in 1998,<sup>6</sup> an initiative cheered by patients but dismissed by influential international health leaders as neither cost-effective nor sustainable. PIH was then small and without the influence necessary to do more than challenge such orthodoxy. So we turned to the human rights community, launching, in 2001, the Health Action AIDS campaign with Physicians for Human Rights. To make a long story short, Jim Kim and I went to the PHR board and argued that *this* was what a human rights campaign around AIDS needed to look like: we sought to protect the civil and political rights of people living with HIV at the same time that we protected their right to live. And that simply could not be achieved without diagnostic tools, medicines, and even food and water. PHR, it transpired, had never before launched a campaign for social and economic rights. But together we did so gamely, and this effort galvanized many students across the country, preceding the creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria and major bilateral programs such as PEPFAR. These funding mechanisms may have their weaknesses, but at least we're no longer spending all our time arguing about whether or not we should bother even trying, in Africa, to prevent and treat these three major infectious killers—all of which will become more difficult to treat in the future, since prevention and supervised therapy need to be more aggressive in the absence of effective vaccines and since the organisms all develop resistance to the antibiotics used against them.

## 2. "Food, food, food"

The willingness of the public health community to embrace and promote the right to health care is the fulcrum of our ability to address these complexities. Particularly crucial are the responses of those of our peers who are global public-health leaders. For example, will the inexorable rise of drug-resistant HIV, TB, and malaria lead those at no risk of these diseases to argue, whether from Geneva or New York or London, that it's OK to use now-inexpensive first-line drugs for AIDS, TB, and malaria, but that it's neither sustainable nor cost-effective to treat even more complex forms of these diseases? What if we confess, from Haiti or Rwanda, that many of our patients are hungry and that, last time we checked, the treatment for hunger was food? What if we tell those who hold the purse strings that we don't really know how to treat diseases, much less to prevent them, without promoting basic social and economic rights for the poor? Will the next orthodoxy in public health be that it's acceptable to offer medicines but not acceptable to offer, say, access to microcredit, school fees, or food? That it's not "sustainable" to pay community health workers for their labor on

behalf of their neighbors, even though we pay ourselves handsomely enough as international health consultants engaged in a network that spans rich world and poor?

Last week, in Malawi, I confessed to a small group of friends and co-workers that I was anxious about being invited to address you all. We'd just spent part of that day visiting, in their homes, people living with HIV. Most of these patients had not yet received antiretroviral therapy. They were slated to be enrolled in a treatment program that, though community-based, did not include paying community health workers; nor did it include assistance with transportation to and from health centers; nor did it include food or the means to buy it. At the end of the day, over dinner—my colleagues and I enjoy ready access to food—I asked my friends what should be my message to you today. “Food, food, food,” intoned one of my colleagues, a former medical student of mine who had completed his training and had spent 18 months in Malawi working on a research effort. One word, repeated three times. But we all knew just what he meant: that without what some term “wraparound” services (including food) it will not be possible to scale up ambitious programs, because people in places like Malawi usually don't have enough to eat, nor do they have the resources to go to health centers for a work-up, or the money to pay whatever hidden users' fees lurk in ostensibly free ART programs. Over the past few years, we've seen some governments adopt, sometimes reluctantly, AIDS treatment programs that are “free” to their poor citizens. The poor show up, only to learn that it costs money to be tested for HIV or that they need an ID card or a chest film. We've seen programs that claim to prevent transmission of HIV from mother to child but do nothing to provide breastmilk substitute and clean water to women living in poverty. We've even seen programs providing, through Global Fund funding, free ART even as condoms or prophylaxis medicines are sold through social marketing schemes funded by resource-rich institutions. These institutions have promoted a public health orthodoxy that leads most people in the richer countries to conclude that it is impossible to sustain public health interventions that do not generate profit or break even.

Food, food, food. How on earth can we make sure that those sick with consumptive diseases like AIDS or TB recover unless they have access to both medicines and food? That said, even those of us involved in treating such diseases in places like Malawi or Rwanda or Haiti know that there is a role for sustainable development. That's why we're involved in efforts to improve seed quality, and to increase access to fertilizer, water, microcredit, and land reform. These will be difficult programs; mission creep will abound. But if we believe in health and human rights, we will need to broaden, very considerably, our efforts to promote social and economic rights for the poor. This, I would argue, is the leading human rights issue now facing public health.

### **3. The Case of Maternal Mortality**

Lest this sound too general, allow me to consider maternal mortality. Gender inequality and poverty, together not apart, are the cause of almost all deaths during childbirth: half a million women die each year in childbirth, but these deaths are registered exclusively among poor women. They can all be prevented, but to do so requires that women with obstructed labor have access to modern obstetrics: an operating room, electricity, sutures, blood, clean wards and good post-operative care. I wish that when I first traveled to Haiti, in 1983, someone had told me that to advocate for human rights there we'd need to consider learning to build operating rooms and to procure equipment and supplies; it would have saved us a great deal of time and made us more effective. We did learn that lesson, but only after presiding over the grisly spectacle of young women dying because they were pregnant and poor. One community-based survey conducted in rural, southern Haiti in the early

1980s pegged maternal mortality at 1400 per 100,000 live births—far and away the highest in the hemisphere.<sup>7</sup> Rates of caesarian delivery were about zero in rural Haiti. Imagine my surprise when I later learned that, elsewhere in Latin America, public health advocates were fighting to *reduce* rates of caesarian delivery. This is the nature of inequality in Latin America: self-styled human rights activists could in one setting (Mexico) spend their efforts trying to reduce the number of caesarians while others similarly inspired worked in Haiti to increase poor women’s access to caesarian delivery. I’d say something here about the ironies of inequality if the story weren’t so abominable as to be beyond irony.

I saw the same thing last week in Malawi. In the largest public maternity ward in the country, in Lilongwe, two obstetricians and a handful of nurses struggle mightily to deliver 12,000 babies each year. This is not much more than the number delivered in Harvard’s Brigham and Women’s Hospital, where I was trained and still work. The Brigham delivers more babies than any hospital in New England: we have, in just that one hospital, more than one hundred obstetricians, without counting the dozens of doctors and students training in obstetrics and gynecology. In the Malawian hospital, there is a single OR; in the Brigham there are over 40, with four in the women’s health center alone. To use non-PC language, it’s almost unheard of for women, even poor women, to die during childbirth in the United States. Here are some numbers: the maternal mortality ratio in Malawi is pegged at 1800 per 100,000 live births. In the United States, an estimated 17 women die per 100,000 live births. Twenty-nine other countries, most of them affluent countries with national health insurance, match or beat that ratio. The figure is zero for Iceland.<sup>8</sup>

In Malawi, I spent some time with one of the two obstetricians tending to the women who deliver their babies, or fail to do so, in the maternity hospital. He showed me a hospital that was fairly clean, but sorely lacked supplies and personnel. The blood bank closed at 5 pm; the only way to care for critically ill women or infants was to transfer them to another under-resourced public hospital, a difficult procedure since calls had to be made, transport arranged, et cetera. (Two kilometers separated these two facilities, but it took an hour or more to arrange emergency transfers.) My guide, an inspiring man, spoke explicitly in human rights terms even as he detailed the material shortcomings of his facility. Outside the doors of the single OR was a gurney piled high with surgical drapes in tatters. He referred to the hallway as “post-op.” (I wondered, just then, how often he’d been obliged to receive visitors like us, and what they did to help the hospital.) “This is an abuse of human rights,” he said, lifting up one of the rags. “It would never happen if people considered the women we serve as human beings.” The doctor felt sick, he said, that maternal mortality *within* the hospital was 300 per 100,000 live births, even though one might note, by way of consolation, that this was a six-fold reduction in the national rate. It seemed better to say nothing.

Should there be a right to sutures? To sterile drapes? To anesthesia? Just two weeks ago, my colleagues and friends at PHR announced a new program to reduce maternal mortality. The project will be named in honor of Alan Rosenfield, longtime advocate of the right to safe childbirth and of women’s health in general. This will be PHR’s second social and economic rights program, and Partners In Health will again join them. But it will be difficult to accomplish much without more partners, since, again, we will need electricity to respect the rights of women living in poverty. We will need gloves. We will need sutures. We will need drapes, and hot, clean water. This is uncharted territory for human rights organizations but is exactly the direction in which we need to go if we wish to move beyond studies and exhortations and actually reduce the number of deaths.

Certainly there are many groups that understand that it's impossible to make rights meaningful without the material resources I mention above. But human rights orthodoxy has left us weak in this arena. While many of us are eager to discuss gender inequality, too few of us are ready to buy generators, c-section kits, sutures, or OR lamps. Not even contraceptives are considered in pragmatic enough terms. But how on earth will we ever stand in solidarity with women living in poverty if we're unable to move resources, the fruits of modern science and technology, to them? So many NGOs, including human rights organizations, regard such pragmatic solidarity as off-topic, beyond their mandate; research universities are worse, by and large; and rich-world public health authorities are trammled by administrative boundaries of county, state, and nation, even though they know that Malawi's nurses, like Malawi's epidemics, are in fact transnational: nurses move out, epidemics move in. The NGOs which fight for the right to health care by serving the African poor directly often do so at the expense of the public sector, creating a local brain drain by luring nurses, doctors, and other professionals from the public hospitals, like the one discussed here, to NGoland, where salaries are better and the tools of our trade more plentiful, thanks not only to corruption, which is oft underlined, but also to the structural adjustment programs imposed by the international financial institutions staffed in part by people like us gathered here today.

How can this sorry human rights situation best be addressed? It's been analyzed exhaustively; let's just say no to more surveys. And although I confess that PIH, an NGO, is moving into Malawi, I'll add quickly that we do not wish to expand the population of NGoland, nor to repeat our past mistakes. NGOs committed to the rights framework have to learn how to strengthen the public sector, since only governments can guarantee their citizens' rights. No one elected us to set things right. We're all self-appointed. Those of us in public health will have to learn to move beyond crude notions of cost-effectiveness and sustainability and to return to the concept of social justice, which once inspired public health but now seems to embarrass us. First-world universities, which are very much in evidence in African capitals, have to learn how to challenge not just public health and rights orthodoxies; they have to learn how to share their abundant resources if they wish to conduct research across steep grades of inequality. It's fine that there are more American pediatricians than African ones in some of that continent's poorer cities and towns, including Lilongwe, but what are our long-term plans for rebuilding health care infrastructure and for training and retaining local professionals? What are our plans for making certain services, including safe childbirth, a right rather than a commodity?

All this is to say that health and human rights needs to move beyond its traditional exhortatory role, which stems from insistence on respect for conventions to which most states are signatory, and think about such prosaic issues as supply chains for sutures, generators, magnesium sulfate, and OR lights. And of course we need to do this at the same time that we continue and expand our struggle for civil and political rights. Enforcing rights is another matter altogether, since it is often the signatory states themselves who are responsible for rights violations, from torture to neglect of the public sector. Even more disturbing are the shadow governments above the state: the international financial institutions, the tacit pacts among powerful nations who agree to disagree on Darfur or to ignore genocide in Rwanda until it's too late, the worsening concentration of health and wealth in our inegalitarian world. But where's the lesion? Health and human rights needs a legal framework, true, but who is responsible for spending caps on health and education in the world's poorest countries? Certainly not the hapless medical professionals of those countries, and not the Ministries of Health, either. How can we legislate in an effective manner when governments such as Malawi's and Haiti's work with national budgets far less than that of a single Harvard teaching hospital? To understand why there are so few personnel and supplies in Malawi's largest maternity hospital we'll

need more than an immediately local analysis; we'll need to lift our eyes to look hard at history, political economy, and the powerful transnational institutions that have determined many policies in post-colonial Africa and in much of Latin America.

The yield on an expanded and pragmatic view of health and human rights might be greater than we think. Preventing disease, saving lives, eradicating malnutrition, and promoting universal primary education will help to reverse the concentration of power in the hands of a few. It might not be naïve to argue that when people are not facing both destitution and disease, they might be able to participate more in civic processes, both local and national (although, granted, this hopeful hypothesis is not always borne out in affluent democracies). In short, I advocate, as a public health activist, reversing the present priority which places civil and legal rights first and adjourns substantive rights for another day. It is when people are able to eat and be well that they have the chance to build democratic institutions.

#### **4. Measuring the Efficacy of Accompaniment**

So where does one start in an effort to support “an expanded and pragmatic view of health and human rights”? Even though there are no secret formulas, there is an urgent need to support what may seem to be a rather prosaic agenda. I mentioned food above, and also sutures, medications, electricity, water, and other basic goods that may not seem very sexy to most people now commenting on health and human rights. Is this all there is? The transfer of mundane enough material resources to the very places that lack them? Well, pragmatic solidarity of this kind would come as a huge relief to populations who right now occasion much commentary but little in the way of such transfers. And although it's true that there's no magic bullet<sup>9</sup> to counter poverty, ill health, and a lack of both materials and personnel, there's much that could be done to address poverty and the diseases and complications that accompany it. Perhaps the most important of these, in the places in which PIH has worked, has been the recruitment and training of community health workers.

Much is made of the brain drain and the lack of medical personnel in places like rural Haiti or rural Malawi; as many have shown, under-resourced systems such as the public sector in either country are unable to retain the nurses and doctors trained there, even though they were educated, by and large, within facilities financed publicly; their medical training is supported as much by the local poor, who are taxed indirectly, as by private financing, including tuition.<sup>10</sup> In order to reverse the brain drain, we will have to invest heavily in institutions such as the maternity hospital in Lilongwe; we will have to make sure not only that health professionals receive salaries that are adequate, we will also have to make sure that they have the tools of the trade. One study in urban Kenya shows that, although young physicians are unhappy with their salaries and the way they're treated by their superiors, they are also unhappy because they don't have the diagnostic tools and medications needed in order to treat their patients. “Before training,” said one young Kenyan physician, “we thought of doctors as supermen... [now] we are only mortuary attendants.”<sup>11</sup> How long can African doctors and nurses tolerate being little more than spectators to the grisly parade of suffering and premature death within the walls of that continent's public hospitals? No small amount of that suffering is caused within these institutions, which are right now the very settings in which nosocomial outbreaks of tuberculosis, including extensively drug-resistant tuberculosis (XDR-TB), are now registered.<sup>12,13</sup>

But even as we make long-overdue investments in the public sector in Africa, there is reason to invest in people who do not work within the hazardous confines of the public hospital. Community

health workers are mostly poor people; most have little in the way of formal education; most were unemployed or underemployed prior to becoming CHWs. And make no mistake about it: there is a huge difference between community health *volunteers*, which is the preferred term in NGOland, and community health *workers*, who are paid, however modestly, for their efforts on behalf of their neighbors.

Some here today would have you believe that there's no difference between CHVs and CHWs. This is a fraud perpetuated by our own "community of experts." Those who argue that we should encourage volunteerism, and not pay the poor for their labor, have not placed themselves in the positions now occupied by the vast numbers of rural or urban poor people who would happily become community health workers. The problem with volunteerism is that these workers are themselves poor (and often sick) and can ill afford to spend hours each day checking on their neighbors when they are obliged, NGO fantasies to the contrary, to plant millet and corn in order to feed their own families. But there's more. We have argued—and argue is the operative word—that community-based care involving CHWs is the very highest standard of care available to the poor who live with chronic disease, whether that disease be AIDS or diabetes or major mental illness. There's a reason that we have taken the model developed in Haiti and applied it not only in rural Rwanda<sup>14</sup> or urban Peru,<sup>15</sup> but also in the poorer parts of Boston<sup>16</sup>: in seeking to promote excellent outcomes in treating chronic infectious disease, we've found that doctors and nurses and even social workers cannot ensure that our patients are able to adhere to complex regimens unless our patients are offered what we've referred to as "accompaniment." Although public health jargon is full of other terms to describe close, community-based follow up, and although we ourselves have too often contributed to this jargon, we've come to understand that something far better than supervision emerges when we support CHWs with even modest honoraria or incentives. If volunteers are themselves poor enough to warrant food assistance, then they may declare themselves happy enough to volunteer, but this mutually tolerated fraud is in no way genuinely mutual: the "international health community" promotes it, and the rural and urban poor tolerate it because without this charade they would receive even less assistance as they seek to prevent premature death in their own beleaguered communities.

Over the past decade, we've sought to present the task of sustaining community-based care in settings of poverty as a human rights challenge. Don't expropriate the labor of the poor; champions of volunteerism within our ranks should feel free to volunteer but should be uncomfortable asking the destitute sick to do the same. So although we're embarrassed that the honoraria we provide to our CHWs are so modest, we nonetheless insist on supporting them, and seek to promote such remuneration in all of the settings in which we work. We've been rebuked for this stance, but the rebukes have never come from the CHWs or their families or their patients. The rebukes have come from our peers, those obsessed with "sustainability" and "cost-effectiveness." Within international public health circles, we've found ourselves swimming against a strong undercurrent of censorious opinion.

Perhaps if our profession had embraced a rights-based model rather than those now in vogue in public health, we would not be obliged to spend so much effort arguing that such care is cost-effective, although it almost certainly is.<sup>17</sup> We have every intention of stooping to the level of our critics in an effort to show that our model is indeed sustainable—we're not proud. But we also argue that the first thing to be sustained is first-world commitment to global pandemics and other problems of the world's poor and that this is the way to begin a "virtuous social cycle" that might lift the destitute sick out of extreme poverty.<sup>18</sup>

To bring these disparate themes together in a rights-based framework is, I hope, a useful exercise. If we believe that health care is a right, we need to address problems such as AIDS and maternal mortality with the highest standard of care possible. If we believe that the treatment for hunger is food, we will address food insecurity with both short-term and long-term strategies, even if this means we must learn about improving seed quality and procuring fertilizer. If we believe that it's wrong to appropriate the labor of the poor, we will insist that CHWs be compensated for their labor, even as we celebrate volunteerism among people such as those gathered here today. If we put even a shred of stock in the notion of solidarity, then we will press for basic social and economic rights for the poor, regardless of whether we term our efforts “wraparound services” or accompaniment.

## 5. Conclusions: A New (Old) Rights Paradigm

In many senses, nothing I've said is new. The struggle for social and economic rights has been outlined many times before; the Universal Declaration of Human Rights mentions them explicitly, and 155 countries have ratified the International Covenant on Economic, Social and Cultural Rights. My own country is not among them, which will not surprise public health advocates here today, since we all have a long way to go before we see the right to health care in the United States. There is no cause for smugness in this city or state, either, since there is a difference between mandating that people *buy* insurance—standard procedure for all car owners—and insuring that everyone has access to care.

There's much to be done right now if we wish to address orthodoxy in health and human rights. To my knowledge, there is only one U.S.-based human rights organization that is focused on social and economic rights, and it is as small as it is new.<sup>19</sup> But Amnesty International too now boasts leadership with a clear commitment to social and economic rights<sup>20</sup> and will next year unveil its first programming in this arena. I mentioned already that, together with other partners, both PIH and PHR will launch a program designed not only to draw attention to maternal mortality but to lessen it, and this cannot be accomplished without the tools of modern obstetrics. This will mean that PIH will have to learn more about advocacy and about which levers to pull in Washington and in the international rights machinery; it means that PHR will have to learn more about procurement of sutures, generations, OR lights, and blood banking.

Finally, I have been invited by Jim Kim, the new director of the François-Xavier Bagnoud Center for Health and Human Rights, to announce today that I will be assuming the role of editor for the journal, *Health and Human Rights*. I say this with no small amount of trepidation, since I have been more deeply involved in programs to expand access to medicine and public health than in the hard work of receiving and reviewing manuscripts in what is, and will remain, a contested field. But I will consider it a privilege to assume this role if Sofia Gruskin and others who've made this journal into such a precious resource will continue to help shift the paradigm in health and human rights. This doesn't mean changing directions so much as assuming even more responsibility. It does not mean abandoning the legal scholarship and assessment of existing rights documents and laws and conventions. It *does* mean challenging orthodoxy in both public health and human rights discourse. It does mean understanding the ways in which poverty seeps into every aspect of both health and human rights. I pray that we can agree to consider not only the sorry spectacles of Guantanamo or Abu Ghraib or state-sponsored torture and execution—the grotesque tip of the abuse iceberg—but also the long and painful processes through which the world's poor meet a premature end. When we

can discuss solemnly the “right to sutures” even as we discuss gender inequality and torture, we will have succeeded in shifting the agenda in a way that makes sense to the world’s poor and marginalized. This should be the goal of the health and human rights movement in the 21<sup>st</sup> century.

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<sup>3</sup> Sen A. *Development as Freedom*. New York: Knopf, 1999.

<sup>4</sup> Odinkalu CA. Why more Africans don’t use human rights language. *Human Rights Dialogue: Human Rights for All? The Problem of the Human Rights Box*, Carnegie Council on Ethics and International Affairs. Winter 2000:2. Available at: [http://www.cceia.org/resources/publications/dialogue/2\\_01/articles/602.html](http://www.cceia.org/resources/publications/dialogue/2_01/articles/602.html).

<sup>5</sup> Kim JY, Farmer P. AIDS in 2006—Moving toward one world, one hope? *N Engl J Med*. 2006;355:645-7.

<sup>6</sup> Farmer P, Léandre F, Mukherjee JS, Claude MS, Nevil P, Smith Fawzi MC, et al. Community-based approaches to HIV treatment in resource-poor settings. *Lancet*. 2001;358:404-9.

<sup>7</sup> Jean-Louis R. Diagnostic de l’état de santé en Haïti. *Forum Libre (Santé, Médecine et Démocratie en Haïti)* 1989;1:11-20.

<sup>8</sup> World Health Organization. *Maternal Mortality in 2000: Estimates Developed by WHO, UNICEF and UNFPA*. Geneva: World Health Organization, 2004. Available at: [http://www.who.int/reproductive-health/publications/maternal\\_mortality\\_2000/index.html](http://www.who.int/reproductive-health/publications/maternal_mortality_2000/index.html).

<sup>9</sup> Tarek Meguid, who happens to be the obstetrician who led me through Malawi’s largest maternity hospital, wrote that “One does not claim to be in possession of the magic bullet that will solve the problems of health care delivery in rural Africa. On the contrary, I do not believe in bullets, magic or not.” Meguid T. *The Challenge of the Periphery*. Capetown, South Africa: HARPS Publishers, 2001; p. 5.

<sup>10</sup> In a comprehensive recent report, PHR summarizes the findings of several studies on the African brain drain: “The vast majority of students in Africa attending health training institutions attend public schools, where tuition is paid for primarily or exclusively by the government. When physicians, nurses, and pharmacists trained in these institutions leave the country, a significant public investment leaves with them. It has been estimated that developing countries spend about \$500 million annually on training health professionals who migrate to developed countries. In South Africa, where training a physician costs about \$61,000-97,000 and training a nurse costs about \$42,000, the overall loss to that country for all health professionals practicing abroad may top \$1 billion.” Physicians for Human Rights. *An Action Plan to Prevent Brain Drain: Building Equitable Health Systems in Africa*. Boston, MA: Physicians for Human Rights, 2004. Available at: [www.phrusa.org/campaigns/aids/bangkok/braindrain.html](http://www.phrusa.org/campaigns/aids/bangkok/braindrain.html).

<sup>11</sup> Raviola G, Machoki M, Mwaikambo E, Good MJD. HIV, disease plague, demoralization and “burnout”: resident experience of the medical profession in Nairobi, Kenya. *Cult Med Psychiatry*. 2002;26:55-86.

<sup>12</sup> Centers for Disease Control and Prevention. Emergence of *Mycobacterium tuberculosis* with extensive resistance to second-line drugs—worldwide, 2000-2004. *MMWR Morb Mortal Wkly Rep*. 2006; 55:301-5.

<sup>13</sup> Harvard Medical School, Open Society Institute. *The Global Impact of Drug-Resistant Tuberculosis*. Boston: Program in Infectious Disease and Social Change, Department of Social Medicine, Harvard Medical School; 1999.

<sup>14</sup> Farmer PE, Nizeye B, Stulac S, Keshavjee S. Structural violence and clinical medicine. *PLoS Med*. 2006;3:e449.

<sup>15</sup> Shin S, Furin J, Bayona J, Mate K, Kim JY, Farmer PE. Community-based treatment of multidrug-resistant tuberculosis in Lima, Peru: seven years of experience. *Soc Sci Med*. 2004;59:1529-39.

<sup>16</sup> Behforouz HL, Farmer PE, Mukherjee JS. From directly observed therapy to accompagnateurs: enhancing AIDS treatment outcomes in Haiti and in Boston. *Clin Infect Dis*. 2004;38:S42936.

<sup>17</sup> One recent review addresses, perhaps sympathetically but certainly out of need, the question of whether or not community health workers are cost-effective. Walker DG, Jan S. How do we determine whether community health workers are cost-effective? Some core methodological issues. *J Commun Health*. 2005;30:221-9.

<sup>18</sup> Walton DA, Farmer PE, Lambert W, Léandre F, Koenig SP, Mukherjee JS. Integrated HIV prevention and care strengthens primary health care: lessons from rural Haiti. *J Public Health Policy*. 2004;25:137-158.

<sup>19</sup> The National Economic and Social Rights Initiative ([www.nesri.org](http://www.nesri.org)) “promotes a human rights vision for the United States that ensures dignity and access to the basic resources needed for human development and civic participation. Towards this end, NESRI works with organizers, policy advocates and legal organizations to incorporate a human rights perspective into their work and build human rights advocacy models tailored for the U.S.”

<sup>20</sup> A recent article in Amnesty International’s newsletter details the commitment of its new executive director, Larry Cox, to advancing social and economic rights alongside the organization’s longstanding activism in the realm of political rights. Jamison L. A commitment to change. *Amnesty International*. 2006;32:10-2.