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Voiceover: *A Deeper Look. Exploring what works and what doesn't in development, and the changes we can make together to turn ideas into action.*

Patrick Fine: I'm Patrick Fine, CEO of FHI 360, and today I'm very fortunate to be joined by Dr. Paul Farmer, a public health practitioner whose commitment to building authentic partnerships in public health has made him a legend in international development. Dr. Farmer, welcome to the podcast.

Paul Farmer: Thank you Patrick. It's an honor to be here.

Patrick Fine: Paul Farmer is the Co-founder, Chief Strategist and Chair of the Board of Trustees of Partners in Health, an organization that all of us working in this field have great respect for. He is a medical anthropologist and physician and a Professor and Chair of the Department of Global Health and Social Medicine at Harvard University. He's also a Professor of Medicine and Chief of the Division of Global Health Equity at Brigham and Women's Hospital in Boston. He is a staunch advocate for universal health care and human rights.

Dr. Farmer serves on numerous advisory panels and boards and his most recent book is *Fevers, Feuds, and Diamonds: Ebola and the Ravages of History*. And Dr. Farmer, I'd like to start there with your book. I believe it came out last year. I remember Partners in Health played a very important role in fighting the 2014 Ebola outbreak in West Africa. In fact, you were one of the first organizations that really helped to mobilize a response. That pandemic ultimately killed over 11,000 people in Liberia and Sierra Leone and in Guinea. It was a kind of a wake-up call for the threat of global pandemics in the 21st century and I think one we didn't pay enough attention to in light of our experience over the last year. But, let me ask you about the connection between the Ebola pandemic in West Africa and the ravages of history.

Paul Farmer: Well, you know, when you're in the thick of something, particularly something frightening like an explosive epidemic, there's a sense of messiness and fuzziness from everyday practice. You're not sure of what step to take next. And, maybe sometimes we're even encouraged to pretend we're sure when we're not. And so, there was that feeling throughout and not just in 2014, all the

way through to the end of the epidemic a couple of years later. You know, what are the paradigms and experiences that lend force to our interpretations. You know, you know as well as I do that a lot of that is lived experience or not thoroughly processed kinds of knowledge. And, when you end up going to a place like Sierra Leone for the first time in June of 2014, by my age, you realize that the most important thing to recognize is what you don't know.

So, I knew a lot about how to rehydrate someone who is sick with an acute viral infection. I didn't feel particularly deficient in that arena clinically, although there were lots of things about this understudied disease that we didn't know of course. There was no vaccine at the time. The diagnostics were sluggish and not very specific. There were again new variants coming out all the time that community based transmission was going on. It was a mess. And, a book is really an attempt to impose order on a lot of mess. Right? Without doing violence to the material. And, that's what I was trying to do and I couldn't do that without looking back over the history of West Africa.

How do you explain how a clinical desert got to be a clinical desert and why it's necessarily a public health desert if you don't know about the history? So that was an exercise I really never permitted myself to do in ten years in Rwanda. You know, I was there to help strengthen the health system and help take care of patients, and that's what I did. But, on this go-round, I just wanted to learn more about the place and its history. And it was – I know it sounds weird, Patrick, but it was a real pleasure to spend that time, you know, learning about the place.

Patrick Fine:

That, that doesn't sound weird at all. In fact, I think one of the things that anybody working in human development, whether it's international or whether it's going to another community, that learning about the community, understanding the historical events and forces that have shaped that community is one of the best practices. It's one of the things we can do to equip ourselves to be effective partners to the community members or the institutions that we're working with. So, when you looked back at the history of the region, what kind of lessons did you see that informed practice in tackling the pandemic?

Paul Farmer:

Just so many things just flood into my mind, Patrick. Almost like revelations. Right? Meaning, almost, like well, you see this thing that you don't understand, which for me was the trigger to write something down, like, I don't know what the hell is going on here,

then I just write that down and then see if historical understanding wouldn't reveal why things came to be the way that they were. But, just to show how, in a way, messed up we are by everyday experience, it was certainly obviously cognitively that every adult patient with Ebola that we had had also survived a brutal civil war. That was obvious, right? But it doesn't mean that your clinical practice in the acute moment or the heat of the moment is going to be changed. But, it always means that your feeling about why you're doing it is going to be a change. And, I think it reinforced our commitment understanding more about the history of what these people we were caring for, and who cared for us I might add, understanding their own lived experience became almost urgent feeling by the end.

I understand that that's not why we were there. We weren't invited into the clinical desert to reflect on the history of the clinical desert and how it came to be. We were invited there to help with a very acute problem, which we did. We tried to acquit ourselves admirably. But, the real learning is still taking place and it's still proving, still giving those a-ha moments where you go, a ha, now I understand why they did that or wouldn't do this or responded with such mistrust to that. That's what we're dealing with right now in the middle of the COVID epidemic when we talk about things like vaccine hesitancy as if that were a straightforward matter. We're not spending the time that we need looking back at the lived experience of the people we're trying to reach.

Patrick Fine:

In West Africa during the Ebola epidemic and more recently in the Democratic Republic of the Congo, in the eastern DRC, in 2018, 2019 that you had many instances where communities would actually attack the health workers. And, I know that in the beginning that was perplexing to those teams that were trying to get to a community to help them cope with the crisis. But, as you said, if you understand that this is a community that has gone through a horrible civil war, that can help explain why there's that deep mistrust of outsiders. And, in the case of Ebola, when you have people who are completely wearing spacesuits to protect themselves from contagion and going into a community, it can look like an alien invasion.

Paul Farmer:

You know, what really surprised me was not the level of mistrust. And, just to quantify it, there was a point in the epidemic where the Ghanaian Red Cross reported an average of ten attacks per month on burial teams, orders to shelter in place without the kind of

wherewithal that's required to shelter in place, particularly food, water, etcetera, who is going to tend the garden.

So, the degree of mistrust makes sense with any kind of ecological analysis of the situation. But, what really struck me more was how quickly mistrust can melt away when you show yourself to be a member of a community that is a caregiving community. It's hard for the burial teams, of course. We don't need an in-depth social analysis to understand why. But, in terms of the caregiving for the living, our experience in multiple settings across at least two of those countries, Liberia and Sierra Leone, showed us that the best way to garner trust is to show that you care for the patients, to provide care for them visibly and consistently. And, what is remarkable, really, is that mistrust can melt away fairly rapidly. Imagine how many people in eastern Liberia and Sierra Leone must have been on opposite sides of the conflict.

And, I saw this in Rwanda as well, but I never explored it. It wasn't really part of my remit in Rwanda. And I'm, I'm kind of glad I made it part of mine in West Africa.

Patrick Fine:

I also have seen the power of authentic partnership, or maybe it's just the power of being human and reaching out to members of a community, exposing your own vulnerability and then seeing distrust fade away. In the eastern Congo, we organized, FHI 360 led, the safe and dignified burial teams. And, that involved going out, spending time in communities and getting to know the community before we tried to start to organize or to inform. The first step was just to go and, and get to know each other. And, that then paved the way for our teams to work in areas that were insecure and where other teams weren't able to go.

Paul Farmer:

One of my closest associates was part of that response team. His name is Gene Richardson, and he just wrote a book about Ebola as well. We worked together mostly in Sierra Leone and Liberia. But, when Gene was there in the eastern DRC and I was in Rwanda on the other side of the border where there were no cases and where, you know, this recent response in vaccination efforts surely informed their response to COVID as well. The Rwandans, I don't know about DRC, but what Gene started writing about was really, you know, what we're calling mistrust really could be better described as eluding predation. I know that it's hard for public health workers especially when they're not familiar with the ravages of history to misunderstand what this means in a messy situation. Although that happened, the misunderstandings in a

rapidly changing situation, there was also a lot of lessons learned in the West African outbreak that could be applied, like the vaccine in the Congo.

Patrick Fine: I think that's a great insight that you're pointing out, that the reactions in many cases are seeking to elude predation or exploitations.

Paul Farmer: Yeah.

Patrick Fine: Because that's another sentiment that communities have. They've been exploited over the years, and it's a reaction against that. In my experience, the only way to overcome that is to connect with people on a personal level so that they see that you are not there to exploit them.

Paul Farmer: Patrick, before, before you leave this fruitful arena, I would just say that's also the reason that Partners in Health began its work in West Africa, by recruiting and working with survivors, because we had already learned that around HIV, TB, you name it, cancer care, that survivorship is an important part of getting through any kind of health challenge.

Even though the specialists in communication were saying let's get the message out there on a billboard that Ebola kills everybody, it's hopeless. That's never the case with an infectious pathogen. I mean, maybe rabies, but otherwise that's not how they work in the body, and some people are always spared and that number is going to be a substantial majority when medical care is good. So, we focused on medical care and improving it, you know, and we're still doing that in Liberia and Sierra Leone. This human connection that you underline as the key to really successful partnership can be sped up in various ways that are also authentic. Like our friendships with these former patients – some of them are patients, some of them not – are very profound and, and continue to shape our work. I was just there, and the best part of those trips is really getting together with the survivors.

And, they call themselves the survivors. Some of them say the conquerors. But, that's a way of speeding up this process of connection that we not only need for our work, but we hunger for.

Patrick Fine: Yes. It's so rewarding when you achieve it. We've all been preoccupied with the COVID pandemic for the last 16 or 17 months, and we still can see that here in the U.S., there's months to

go. And, in the world, we have years to go before we can see the pandemic behind us. What lessons do you draw from this collective experience over the last 16 months and what should the global community be doing to prepare for future global health threats?

Paul Farmer:

Patrick. I mean it's been a very disappointing thing to watch largely from within the confines of the United States. I've lost family, friends, patients and so has everybody else.

And then you know, you go to a place like Rwanda, which I was lucky enough to do last year in August, and you see how they have marshalled staff, stuff, space, systems and support in a very impressive way to keep infections down but also to keep mortality down. I was very impressed going from urban United States to rural Rwanda to see how high rates of mask wearing were even in rural areas and even outside. I think we'll be sorting through these specifics for years to come and learning lessons from them.

As far as India goes, that tragedy, listen to what people are saying. They're asking for pragmatic solidarity, for oxygen, for help with the most banal nursing issues and contact tracing approaches that are well known already in that community health facility. So, it's at our peril if we edit out the parts of their cries for help. We notice that most of the things they're calling for are material things as well.

And, you know, if you look at the United States, you can say, oh my god, you know, no wonder we had so much trouble. We have a patchwork system and a very weak safety net compared to other peer nations, as we like to call ourselves.

You know, in Massachusetts alone, there are 350 local public health departments. So, if you're working on a statewide initiative to stand up, for example, contract tracing with support, you're going to bump into that incredibly Byzantine bureaucracy, which is also underfunded. And, so no wonder our colleagues in public health are complaining. They've been starved for resources much as public education has across the continent where you've spent most of your time. I think we really need to attend to the material side of this whenever we can. Yes, they want solidarity. Yes, they want concerts and whatever. Make sure that there is at the end of that process a real link to the material concerns that face those trying to get through this epidemic. And, that's very often vaccine

– I mean India, the largest vaccine manufacturer in the world, hasn't even vaccinated five percent of their population.

So, we have a lot to do, and our goal here should be how can we bring the full complement of preventive and therapeutic and diagnostic resources to bear on a rapidly evolving situation, knowing that we're not going to be able to address the chronic deficiencies of the Indian health care system. We can improve them by doing a good job addressing the explosion of cases and deaths that we're seeing now.

Patrick Fine: What I hear you saying is that it's pretty simple. We know what can improve the situation. We know what kind of response will help provide the desperately needed material that these communities or these institutions require in order to cope with the scale of illness that they're dealing with right now.

Paul Farmer: I just want to say, Patrick, what does it mean if we ignore those material requests? It implies to some that we're suggesting that they, they just don't have the intellectual and cultural capital to respond effectively. And, we know that can't be true of India, right?

Patrick Fine: Right.

Paul Farmer: Even in the clinical desert, you know, like Sierra Leone, there were, you know, perfectly able community health and health professional leaders who were making the right recommendations. As you said, you have to learn to trust your partners. I think that a trusting relationship with our interlocutors in India will acknowledge at least the nature of their requests.

Patrick Fine: Yes. And, you also mentioned here in the U.S., the weakness of our public health system. Having spent much of my life in Africa, it was shocking to me to come back to the U.S. and find that to get a childhood vaccine, you had to go through a whole process of connecting with a private primary health care provider and that we just didn't have the basic public health systems say in New Hampshire or in North Carolina, the two states where I spend my time, at the same level that they did in Uganda.

Uganda had a better vaccine system than New Hampshire had. And this has been exposed by the COVID pandemic in the U.S. We've seen that we have public health systems, as you say, that are fragmented, that are underfunded, that are understaffed, that don't

have the mandates to respond to the public health needs of the population and particularly of those people who don't have access to high-priced private health care. Do you think we're going to learn anything from that as a nation?

Paul Farmer:

Well, you know, one of the real ironies there is they do have the mandate but they don't have the resources. Right? And we bump up into that in Massachusetts and Newark and the other parts of this country where, where Partners in Health is working. That's the first thing we bump into, is the travesty that is public health investment in this country. Do I think we're going to get out of it? Yeah. I think this has been the most clarifying moment of my life, 61 years.

And, even before the murder of George Floyd, even in April of 2020, things were starting to come into view around our health insurance and unemployment insurance systems that really haven't been discussed much in my lifetime. Not to the extent that they were discussed during the pandemic. And, again, there's been clarifying events regarding our social pathologies as well. So, I mean these feed into my optimism in any case. If we have, you know, a solid understanding of what we're facing as a nation, then there's no reason we won't prevail in a health crisis. We have the resources. They're just poorly distributed and unevenly distributed.

Patrick Fine:

We're in the midst of a pandemic now. We are learning lessons from it, and I think it has raised the consciousness of the public that there are global health threats that we have to pay attention to. And, we do need to have health systems that can both identify, head off and if necessary respond to these threats.

As you look at the future, aside from another novel infection arising, what do you see as the main public health threats that we should be focusing on and putting resources into? And, I'm thinking of things like antimicrobial resistance or multidrug-resistant TB or maybe noncommunicable diseases. But, what do you see as the priorities ?

Paul Farmer:

This is why health system strengthening is so key, because if you take the problems that you mentioned, even awareness of them requires the ability to measure in lab capacity. Like, for example, if you're looking for drug resistant pathogens or the failure of antibiotics or looking at drug-resistant strains of tuberculosis, you need lab capacity. And, of course that's very unevenly distributed

and tends not to overlap much with the settings in which laboratory capacity is required.

So, health system strengthening is one way not of avoiding the question, because we have to be able to assess threats and rank them. It's because it's hard to imagine a system so ingenious and designed with so much information about particular disease entities that would respond in the face of a new challenge. Right?

Obviously, airborne challenges, respiratory pathogens, should be at the top of the list. Tuberculosis, it's persistence doesn't leave a ton of room for optimism on this score. But, we should be worried about respiratory pathogens. Back to this question of how do we assess? Well, it's straightforward. You know, you have to be able to understand the burden of disease in a particular community. That could be a city, a state, a nation, a region, whatever, right, a village, a family. You need to understand the burden of disease and to be able to say this is number one. This is number two. Among certain age groups, certain times, you know it's a freeze-frame kind of analysis.

And then to ask, ok, here's our burden of disease. We see NTDs and mental health way up here. How big is the gap between what we're doing and what we need to do? And so, that burden and gap analysis should inform every kind of discussion, and it has to be updated and refreshed regularly.

Otherwise, it's the discussion about things that happened years ago. My confidence and optimism is not based on seeing us deal a death blow to tuberculosis or any other respiratory pathogen. I'm happy that influenza is down. Right? But, we really need to have strong health systems, and those include surveillance capacity, insurance, unemployment insurance and all of the bells and whistles that will respond to the burden of disease analysis and the gap analysis.

Patrick Fine:

So, the key, whatever the health threat is, is to invest in strong public health systems that are going to be versatile and able to both identify, contain and respond to whatever the threat is, whether it's an NCD or whether it is a new airborne pathogen.

Paul Farmer:

And, if those people who are staffing our newly enhanced public health capacity were to keep one thing in mind, I would say don't fall for the control-over-care paradigm. Whether you're talking about NCDs or anything else, people when they're sick or injured are always looking for one thing and that is care. They're not

looking for containment and control and all the rest of it or even effective communication or resilient burials. They're looking for care. And, when our public health systems are caring, we're going to know.

Patrick Fine:

You've co-founded Partners in Health in 1987, and what many of our listeners may not realize is that that terms partners and the concept of partnership was not nearly as mainstream in 1987 as it is today. Today, we always talk about partnerships. Back in the '80s, we talked about technical assistance. We talked about international experts. And yes, partnership was a concept, but it didn't have the same weight that it has today. So, I just want to acknowledge your role in helping to promote the idea of authentic partnerships, where each partner is equal and that connects directly to the equity challenges that we're seeing and that we're grappling with today.

Now, Partners in Health stresses the importance of building strong health systems. In the countries where you've worked, what do you see as the biggest barriers to building strong health systems?

Paul Farmer:

Well, in the countries where I work its always, and I hate to be so predictable, but it's resources. It's resources. And, if you look at the United States or Russia, two highly developed and technocratic countries in which I've worked, inside these uneven and wealthy countries, the chief obstacle is also resources because they're not moving to the people most in need of them.

That's one reason that I'm so excited about some of the developments coming out of Washington recently is there's an acknowledgement that yeah, there are cultural problems and even culture wars. There are cognitive issues. There are, there are bureaucratic issues, significant ones. But, mostly the problem over the last few decades is that resources are moving up and not down. That is an inequality trap that we're all stuck in including development economics. Right? So, that's the number one obstacle. You know, people think that because I'm an anthropologist, a card-carrying anthropologist, that I'm going to say well, cultural obstacles are the biggest barrier. I've never, never believed that even in the height of my grad school mania, because I was trained by the Haitians. The partnership in Partners in Health really comes from those early experiences in the '80s, where our hosts in Haiti, rural Haiti, really demanded that kind of egalitarian interaction.

That was a cultural hallmark, you know, and that was a great experience for me who would later head off to the same continent that you did and have this very, very different experience in rural Haiti of living in a squatter settlement and learning the cultural ropes from people who had had a lot of life experiences different from my own.

Patrick Fine: If you see resources as the overriding obstacle to building strong health systems, that really takes us into the domain of health system financing.

Paul Farmer: Yeah.

Patrick Fine: How societies financed health care for their citizens. Of course, we see different societies doing it in different ways. I struggle when I think of many poor countries. The wealth that that country produces is not sufficient to finance the modern systems that have propagated, that set the standards internationally.

Paul Farmer: Yeah.

Patrick Fine: Both in health and in education. So, if you think what is the average expenditure on health care, say, in Europe or, say, Canada, the average expenditure would exceed the entire annual production of a country like Rwanda. How do you reconcile these high standards and expectations for what constitutes quality care and that they have real costs in facilities, staff, materials with the ability of a nation to use its own resources to finance it?

Paul Farmer: That's the rub, Patrick, I agree. But there are interesting bits of the story, the challenge of resource flows in and resource flows out. When you look at a place like Sierra Leone. I mean Rwanda, you may surely have a point, right, that there is no way to do the accounting to make it possible to have such a large expenditure per capita in Rwanda. But Sierra Leone, the year before the outbreak of Ebola in 2013, had the highest rate of GDP growth in the world. And, a year later it was second from the bottom above only war-torn Yemen. Right?

So, what that means is that not only are the resources insufficient, they're also being siphoned out of the country. And sometimes, that's happening in real time, like in Sierra Leone. You know, which as your listeners know is the place where the term blood diamonds became famous. But, then you look at Haiti and say well, when did the extraction take place there in a previous century?

There's no way Haiti could ever balance its books and provide that kind of care without some kind of reparative action.

And, you know, reparation as a term sets off all kinds of alarm bells, uh, but not in Haiti and not in Sierra Leone, but certainly not in the places that I work. So, I think Patrick if we are rigorously honest about the nature of resource flows in and out of a certain place, we see the trends of extractive colonialism laid out very clearly. And, its going to require a reparative action to address those insufficiencies. So, Partners in Health regards this health system strengthening not as some endless investment into a bottomless hole. On the contrary, we have no experience of seeing sustained attention to a problem fail.

It's that we need resources. That's a very taxing part of this work. It should not be necessary after an outbreak like the Ebola epidemic to argue in international fora or anywhere else that it is important that Guinea, Sierra Leone and Liberia have a proper health care system able to prevent these kind of catastrophes and care for the critically ill or injured when they fall sick. And yet, we spent a lot of our time arguing just that. So, it makes no sense for any historically minded person, but alas, we're not a very historically minded species.

Patrick Fine:

So, you've come back to the impact of history and how it shapes our present, and you've touched on a couple of movements that I see really gaining momentum in international development and human development. One is decolonization. On *A Deeper Look* podcast, we've touched on that subject a number of times. And, the other is on reparations. So, what does collective responsibility actually look like? And, you're right, reparations is a triggering word in certain countries. Certainly in the U.S. it's a triggering word. But, as one of my recent guests on the podcast said, it's actually it's the word repair and repairing things. There's nothing scary or ugly or, or negative about the concept of repairing things.

Paul Farmer:

Yeah. I mean it, it surges forth in every major religious tradition, as you know very well. And, it's possible to understand why it's triggering by exploring the historical record, just as it's possible to understand why it's important to think in terms of repair and exploring the historical record. I do believe that the sea change that you've described in development work is part of countering this ahistorical tendency to think the world got messed up in the way it is messed up, by accident, you know, as opposed to through historical forces, very often the actions of very powerful people.

We can piece this together and see why, if we want to decolonize global health, we have to acknowledge extractive colonialism and extractive colonialism had a primary purpose, which was to extract riches from the top of the earth or just under it or human chattel. Right? That was the purpose. It was always clearly laid out there. And, what is the treatment for that illness? Well, it's reparative action, has to involve resource flows. So, when we talk about staff, stuff, space, systems and support for patients and our colleagues, we mean that in reparative terms. Now, others reject that. Other, others inside the reparation movement reject that. But, we don't see a lot of rejection of this pragmatic solidarity among the people we serve, who tend to cheer it on and welcome it as an appropriate response to the ills of extractive colonialism.

Patrick Fine: Who is rejecting that idea?

Paul Farmer: It's usually people in universities. Universities have formed, happily, I'm happy to say, have formed a hotbed of activism around reparations. But, you know, again, most of the people having strong opinions about this within universities are not themselves critically ill or injured. And, I spend a lot of time around people living on the margins of safety. That's what they always talk about in my experience: staff, stuff, space, systems and support. And, if it's about education, they talk about the same things. Right?

Patrick Fine: Yes.

Paul Farmer: Schools with electricity, schools where girls won't be the victims of predation. So, again these are real material things, which is why we need to talk in terms not just of solidarity but of pragmatic solidarity.

Patrick Fine: I love the concept that Partners in Health has advanced around the five Ss. So, you've mentioned them, staff, stuff, space, systems and support. Because I found in my own practice and I worked in the education system mostly. But, I found that I was advocating for those very five Ss and often countering the idea that a single intervention, textbooks or school building or teacher training would solve the problem. And, it was a tough argument, and I think it remains a tough argument to make that these single interventions are not going to achieve the objective of, say, more kids finishing school or of more people having access to quality health care.

You've got to consider the interrelated nature of these five basic components. I used to think of it like Maslow's hierarchy, that you've got these basic components. And, until you have those in place, there are things higher up in the hierarchy that you can't achieve.

Paul Farmer: Yeah. Well, you know, Patrick it's a bit of a cop-out. Right? It's not rocket science talking about staff, stuff, space, systems and support. How can a starved school system that doesn't have safe classrooms, enough teachers, supplied students, well-fed students? How can you have a proper public education system without staff, stuff, space, support, systems? And sometimes, you find out that the systems – you know, to me infection control is a system. Right? Systems engineers are right about all of that stuff and feedback loops. But, for a lot of the people we met in 2014, their idea of a well-functioning system was getting their paycheck maybe once every couple years.

Patrick Fine: Right.

Paul Farmer: I mean, you know, you learn things just by applying this blockhead – and I mean that – blockhead little formula, you know, because the staff, stuff, space, systems and support vary from place to place and time to time. Like, what we do in Rwanda in 2021 is not like what we did in Rwanda in 2004 and 2005. Right? Because the staff, stuff, space, support, systems changes over time.

Patrick Fine: Right.

Paul Farmer: And, that's true in West Africa as well. But, this desire to have a magic bullet, it must be part of our makeup, right, because again and again, we make that same mistake of thinking, well, this intervention is going to change everything when we know that's very rarely the case. A truly disruptive technology can change things, but even then it's usually not in the ways that it was built to change things.

Patrick Fine: I think the reason that we glom onto seeking some magic bullet or some transformative intervention is because it's just too difficult and intimidating to accept the kind of hard work and the long-term persistent effort needed to build a quality health system or a quality education system in a resource-poor environment.

In Liberia, you mentioned the health workers' and the teachers' idea of effective system was one where they got a paycheck, because they would have to travel for eight hours to a district health or district education office where they'd get a cash payment that usually had deductions from it. And then they had to travel back. So, you know, one advance that FHI 360 was involved in is we worked with the government of Liberia to introduce mobile money salary payments.

Paul Farmer: Yeah.

Patrick Fine: So, that teachers and health workers could get paid through their cell phone, through a mobile money. And, everybody got banked, so everybody had a bank account. And then, instead of having to travel hours to the district education office to get a cash payment, you got money into your account that you could then redeem from agents in the communities where you were working. Now, that was a huge systems improvement.

Paul Farmer: This is making me think of, you know, on the other side of the world, I was talking through a translator to a Navajo woman, through the translator, who was one of my colleagues, a community health representative. Her family had been there for millennia longer than mine, and she didn't speak English and she was elderly. And, for her to get her social security check or whatever check she was talking about, this fairly frail woman was being asked to leave her home, which is already without the kind of comforts – I mean there was no hot running water, for example – you know, was expected to schlep somewhere for hours and hours to get a social security check. I mean how could that reflect a concern for the frail elderly in Navajo?

And, we see the same errors, to attend to something like actually paying people. And, I was shocked, in spite of all that I've seen, when I realized that even a majority of the nurses that we met in Sierra Leone, working nurses, were not on the payroll.

Patrick Fine: Ah.

Paul Farmer: You know, they were hoping to be on the payroll. They'd been angling to be on the payroll for years. A number of them died by the way of Ebola without seeing their wish fulfilled. So, these things, if we can fit them under some bonehead category like staff, stuff, space, systems and support, it can help us attend to the material needs of those we're working for and on behalf of, and

with, and in partnership with. But, not to skip over the part where they say, oh by the way, you guys have a lot of things that we don't have and we need them to flourish.

Patrick Fine: Right. Paul, as you know the theme of the podcast this year is disruption. We've been talking about some disruptions. But I want to ask you, as a leading advocate for health and human rights, as a person who connects access to quality health to human rights and to the equity challenges we see in our world, do you think of yourself as a disrupter?

Paul Farmer: Well, I'm smiling a little bit, Patrick, because we've descended a far ways when we consider ourselves disruptive merely by saying, hey, you know, sick and injured people ought to have care and they ought to have insurance, and they ought to have a system they can rely on in times of danger and distress. Those just don't seem like they should be disruptive statements from a doctor in any case or a nurse.

Patrick Fine: Or a human being.

Paul Farmer: Or a human being. You know, someone who goes to a place like Senegal and sees immediately the promise and humanity of their new interlocutors. Right? I mean, I have that experience pretty reliably no matter where I go. And, it's a, it's a real blessing. Right? So, how would you not wish to take steps to protect those blessings? They're so obvious: staff, stuff, space, systems, support, and they're so obviously underfunded, whether in Navajo or in Sierra Leone.

Rwanda has done a much better job in really investing in its public care-delivery system. But, we have a long way to go in the United States and Sierra Leone and Liberia and lots of other places we work. And, if it's disruptive to say hey, you know, there are a lot of people who don't benefit from a safety net, and I'm reluctant even to fill in the blank, like, and they could be the source of the next COVID outbreak or the source of the next Ebola or whatever, I don't even think we should have to say that. We should say human beings need certain things to flourish, and here's what some of them are. And, we should disrupt ourselves in any way possible right now to make sure that they get those things that they need.

Patrick Fine: I completely agree with the points you're making. And, I also have a negative reaction against using security as the basis for doing what should be done, as if, well, these people are threatening us,

therefore we must act. When, in fact, we should be acting out of our collective sense of humanity.

But, I find that that argument, and I've made it in many different fora where I've argued that we're putting too much emphasis on security and not enough on just the moral imperative to treat people decently and to be part of a global community. Or, maybe it's not global. Maybe it's just part of the community that you live in. And, I, you know, I am often called an idealist or counseled that that's not going to generate the support required. That line of argument is just not going to resonate in terms of mobilizing public action.

Paul Farmer:

Not only is it not effective. It's so alienating. Right? I mean, this was the crux of the problem in West Africa in the early months of the Ebola epidemic. It was a control-over-care paradigm. And, it's the one that officials usually trundle out in response to these kind of epidemics. And not just Ebola and many epidemics.

So, inside that bubble, under that bubble, what do your listeners think it feels like? You know, they can probably easily imagine now they're the ones being controlled, washed, sprayed, counseled, buried in a resilient manner, etcetera, etcetera. And, it's not only frightening, but it's alienating. These people really don't care about me. They just care about protecting themselves. So, if you grow up intellectually and morally in a place like rural Haiti, you're going to hear things like that. And then, as time goes by, you're going to look back at the historical record and say, wow, yellow fever in San Francisco, cholera, AIDS in the United States in the early '80s. When has this control-over-care paradigm and this health security paradigm really strengthened our hand? And, I think it's much more rarely than we imagine.

Patrick Fine:

Well, how do you apply that to the current COVID pandemic? Because there's a lot of control-over-care.

Paul Farmer:

There's also a lot of giving up on control. The control-over-care paradigm is a very hard sell in the United States. It would be like saying here is our standard of care for Durham. It's a different standard of care for Chapel Hill. That's not going to fly, and there are strong reasons for that. We've tried that before, to have differing standards imposed as policy. It's failed. And, it failed, I would say, in West Africa as well. There we had a very obvious control-over-care paradigm. It was challenged throughout but usually by the afflicted communities and some caregivers, right,

some of them also unfortunately ill with Ebola. Right? In the United States, we've seen something very different during COVID. We've seen not a care-over-control paradigm – because care is always welcome – but a kind of containment nihilism, you know, where we're just saying we're not going to be able to do enough contact tracing, social distancing, mask wearing to make a difference. We're going to have to rely on antibodies and on vaccines.

So, that's kind of what happened in the United States. I think it's happening still. And, we really have not deployed the public health resources at our disposal consistently across the country, or we wouldn't have had the death toll this high.

Patrick Fine: Right.

Paul Farmer: So, it's been a different experience, but again if there's something that we can point to, it's back to your own analysis of education in a resource-poor setting. Right? You really need to look at the whole.

Patrick Fine: Well, the other thing in the U.S. is that we've politicized a public health response in a very exploitative way that has divided people instead of bringing people together to figure out what's the right solution. What do we need to do as a society to cope with a pandemic disease? We've seen it politicized in a divisive way.

Paul Farmer: Which, I have to say, didn't come as a great shock, but it was a great disappointment. Why would you politicize something like mask wearing? It's like saying reparations is a triggering term. Well, if that is required for us to move on to a better solution, then we'll have to risk it.

Patrick Fine: And see it not as a threatening action, not as an action that is harming you, but as an action that is actually in a way repairing you as well as repairing the, the communities that have been harmed over time.

Paul Farmer: That is a beautiful summary of Brian Stevenson's message from the equal justice initiative. I risk bringing it up toward the end because it's such a powerful analysis of the role that racism has played, but also his main point – and he's a disrupter in this way – is to undo that harm. And, he quite compellingly says, this is going to be healing for everybody.

Patrick Fine: Everyone.

Paul Farmer: Which is really the goal.

Patrick Fine: Yes. Paul, this year I've ended each episode with this question. What advice do you have for the next generation of public health practitioners or people working in human development?

Paul Farmer: One of them would be this advice that you gave as well. You know, you really have to stick with things for a while. But, then I also revealed my hand. We have no experience of applying ourselves assiduously to a health problem and not seeing it improve after sustained attention. So, that should be a good message to future leaders. This is a field, and I mean it broadly as you do, that is, is full of wonderful treats and surprises and deep satisfactions, but you have to stick with it. So, that's one thing.

And, the other and it's difficult to get your hands around this, but it may be less difficult for those coming up. And, that is that we have to be very careful of these mental traps that go along with paradigms and frameworks. Right? Are we sometimes setting our goals too low because we're feeding data about the GDP of the country, let's say, or into the current data, not the historical data into a kind of analytic framework that doesn't lead us in the right direction?

Meaning it would, say, do less and less for more and more rather than do more and more for more and more. Those are the biggest traps I think, these cognitive traps. And, and how do you get out of them? That's where disruption really comes in handy. That's why disruption isn't an entirely silly term when applied to these matters, because you do have to disrupt your own thinking very often.

And the way you did it is the way that I did it. You know, you go to a new place that you intend to set down roots, but you intend to learn from that place and from the experience of those who you're meeting for the first time and will meet again and again. I, I just have had my head cleared so many times by saying, okay, let's see what our Rwandan colleagues say or let's see what our Russian colleagues say or let's see what our friends in Navajo have to say about this. That's another kind of bit of advice for the upcoming generation. Don't deprive yourself of that diversity of views that you can only get by a radical inclusivity that our fields call for.

Patrick Fine: And, be prepared to disrupt your own thinking by trusting what your colleagues tell you. I can think of many times when my Ugandan or Senegalese or Basuto colleagues suggested a course of action that I just didn't think was going to work. But, I trusted them, and, in fact, it did work. It worked far better than, than what I imagined or had in mind. That's the kind of disruption, self-disruption to be in a sense courageous enough to trust your colleagues.

Paul Farmer: That's so, so much my experience Patrick.

Patrick Fine: This is a fantastic conversation. I want to just summarize your advice to the next generation, Paul. Be persistent. Don't give up. Keep at it. And then too, be bold. Don't let your own viewpoint or the scope of the challenges constrain your ambition about what can be accomplished.

Paul Farmer: Amen. If we go into situations looking not for cultural competence but cultural humility, then that generation, if they go in with cultural humility rather than some absurd notion of cultural competence, then I think we're in good hands. Some would have a hard time imagining how we might be in good hands given the messed up state of affairs we're passing on to this generation. But I'm full of optimism around this.

Patrick Fine: I am too. And I love concluding this conversation with that notion of cultural humility because, uh, just like trust, it's the foundation of building the relationships that allow us to progress as people. Dr. Paul Farmer, thank you so much for this conversation.

Paul Farmer: Thank you. It's been a real pleasure. Fastest hour in a long time. I hope your listeners like it.

Patrick Fine: They're going to love it.

And listeners, thank you for joining this conversation today. You can learn more by visiting the Partners in Health website, which is PIH.org. So, it's an easy website to get to. Please share this episode and share your thoughts and comments about this conversation with me and with Paul Farmer.

Finally, I just want to let our loyal listeners to *A Deeper Look* podcast know that next month, I'll be taping the final episode of *A Deeper Look* podcast before I retire. I'm going to be interviewed, and I'm going to reflect on what I see as the disruptions and the

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trends that are shaping human development and that are going to continue to shape the world we live in. I hope you'll join me then.

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