Dr. Paul Farmer

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I was lucky enough to make my first trip to Haiti almost 25 years ago. Haiti has been the best teacher I've ever had (and that's saying a lot).

Working there taught me several things: that all enduring, good work is done by teams (no doctor can be effective alone); that public health and public infrastructure is always important (even the biggest and most beautiful mission hospital cannot serve the people of an entire region, much less a nation); that community-based care, relying on village health workers is the secret to success for programs for chronic diseases, including AIDS and tuberculosis; that some services should not be sold, even for the tiniest price, because there will always be some who cannot pay these "users' fees," as they're called, and the ones who cannot pay are precisely the people we came to serve in the first place. These are also the people who are, often enough, hungry. There's only one treatment, we learned, for that affliction: food.

With these hard, if obvious, lessons came great success for small projects, but also a haunting doubt: Could quality (and comprehensive and complex) health services ever be "scaled up" in some of the poorest countries in the world? The very countries needing such scale up most?

Over the past decade, our work in Haiti expanded rapidly whenever we followed these principles: Over the past two years what was in 1985 a tiny clinic served, through the public sector and with the help of an army of community health workers, millions of Haitians. But still we had not scaled up in the conventional sense--nationwide.

We still work throughout central Haiti but have also worked in seven other countries, pursuing, along with thousands of others, two goals in tension: high-quality health care for the patient in front of us, but thinking, whenever possible, of the tens of millions more who need the same services.

The tension is still there, and scale up remains an elusive goal when comprehensive care is the deliverable. It's one thing to have a national vaccination campaign--easily enough done--but quite another to rebuild public infrastructure, offer care for maladies ranging from AIDS to obstructed labor (which requires, of course, a Cesarean section, which in turn requires electricity and an operating room and someone who can perform the

procedure), and to recruit and train that army of community health workers. It's hard, but not impossible. The potential health workers are there wherever there is rural unemployment; but they have to be paid if they're to dedicate most of their time to this important, lifesaving work.

In 2005, together with the Clinton Foundation and the Government of Rwanda, we were invited to two rural health districts counting close to half a million people. There were no doctors in these districts. "Can you scale up a Haiti-style project there?" they asked. We thought we could, and two years later I think we have.

Then came the tension, this time followed by hope and excitement: Could it be that in this small, mountainous nation of over 8 million people we could scale up a rural health model for all Rwandans, over 80% of whom live in rural regions? Why believe it possible there more than elsewhere? What was in Rwanda that had been missing or in short supply in the other countries in which we'd worked?

First, there was good governance, security and a great deal of what's termed "political will": that is, the *government* wanted these services to be available to all Rwandans. Second, although Rwanda is terribly poor, and recovering from a genocide, its economy was growing, not shrinking. Third, although our hosts, partners and funders had ostensibly invited us to rural Rwanda to do an "AIDS project," everyone knew that we were in fact there to do a comprehensive rural health model, and it was working. Fourth, there are many NGO partners with significant resources which, were they to contribute to this effort in rural regions, could help achieve these goals within the public sector.

After working all of my life in global health, I've been lucky to work on small projects that have grown; to have worked on specific efforts (such as the treatment of multi-drug-resistant tuberculosis in Peru) that have been scaled up nationally, in the public sector, by Peruvians.

But here in Rwanda, I'm wondering: Is this the country where a truly comprehensive health model can reach, in a reasonable amount of time, all of the rural poor of this country? If we can raise the money, which we must, I'm betting on Rwanda.

Dr. Paul Farmer, the Presley Professor of Medical Anthropology in the Department of Social Medicine at Harvard Medical School, is the founder of Partners In Health.

--Interviewed by Sonia Narang