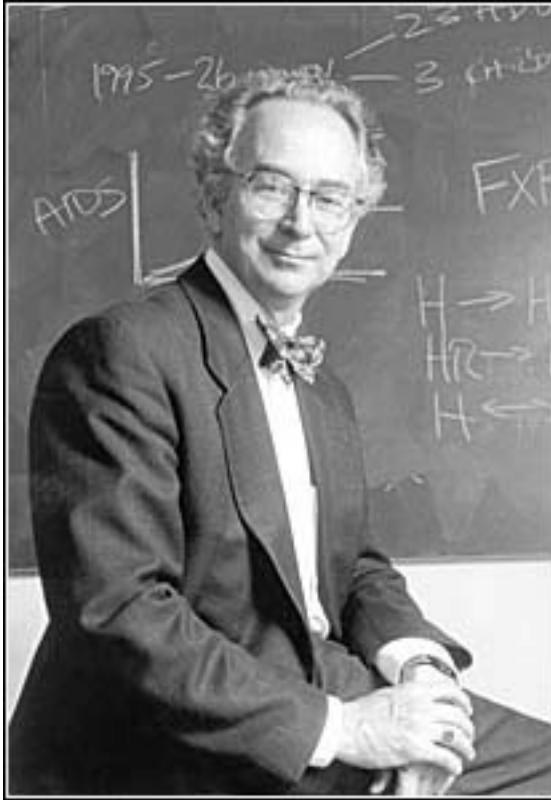


“The modern human rights framework can provide a new movement of health professionals with the necessary instruments and modes of action to uncover and act upon the societal foundations for disease, disability, and death.” Jonathan Mann
(*Health and Human Rights*, 1996: 2/1, 4)



Jonathan M. Mann, 1947 – 1998

Jonathan Mann was a world-renown researcher and champion of human rights. He received his undergraduate degree from Harvard College and a degree in medicine from Washington University School of Medicine. Following medical school, he worked as an epidemiologist in New Mexico for the U.S. Public Health Service and the New Mexico Health Services Division. He then returned to Boston and Harvard, earning an MPH from the School of Public Health.

Dr. Mann joined the school's faculty in 1990 as professor in epidemiology and international health. In 1993, he was appointed the first François-Xavier Bagnoud professor of health and human rights and founding director of the François-Xavier Bagnoud Center for Health and Human Rights. During much of his career, he focused his intellect and skills on developing international strategies that

would reduce and prevent the spread of AIDS. He founded and directed Project SIDA, an AIDS research initiative in Kinshasa, Democratic Republic of Congo. In 1986, Dr. Mann founded the World Health Organization's Global Program on AIDS.

His experience with AIDS policy drew his attention to the link between human rights and health. He was particularly interested in the impact of health policies on human rights, the health effects of human rights violations, and the inextricable connection between promoting and protecting health and rights. It was his suggestion that began the commencement tradition of presenting every HSPH student a copy of the Universal Declaration of Human Rights.

Dr. Mann died on Wednesday, September 2, 1998, in the crash of SwissAir flight 111 bound from New York to Geneva, where he was to attend a World Health Organization conference. He was 51. His wife, Mary Lou Clements-Mann, also perished. She had been a visiting professor of international health at HSPH during 1997.

“How great a loss was the death of AIDS researcher Jonathan Mann . . .?” asked the *Village Voice* in an article that went on to quote Peter Piot, executive director of the United Nations AIDS program: “I'm convinced that if someone other than Jonathan had been the first director of Global Programme on AIDS, the whole response to the epidemic would have been different.”

Program

Opening Remarks

Barry R. Bloom

Dean of the Faculty and Professor of Immunology and Infectious Diseases in the Department of Population and International Health at the Harvard School of Public Health

Introductory Comments

“Jonathan Mann’s Legacy: A Vision in Action”

Stephen P. Marks

François-Xavier Bagnoud Professor of Health and Human Rights at HSPH and Director of the François-Xavier Bagnoud Center for Health and Human Rights

Jonathan Mann Lecture

“From Doctors without Borders to Patients without Borders”

Bernard Kouchner

Former Minister of Health to the Government of France and UN Special Representative for Kosovo, Cofounder of Médecins sans Frontières and of Médecins du Monde

Respondent

Paul Farmer

Maude and Lillian Presley Professor of Medical Anthropology, Codirector of the Program in Infectious Disease and Social Change, and Founding Director of Partners In Health

Bernard Kouchner, MD, is a physician and humanitarian who works tirelessly to develop and provide medical interventions in areas where none exist. His ongoing campaign has been to introduce the “right to intervene” into international law and UN practice. In 1971, he founded Médecins sans Frontières (the 1999 Nobel Peace Prize recipient) and served as its president through 1979. From 1980 through 1988, he was president of Médecins du Monde, an organization he also helped found. On behalf of these organizations, Dr. Kouchner traveled extensively to most of the troubled areas of the world, including Afghanistan, Vietnam, and countries throughout Africa, the Middle East, South America, and the Balkans, organizing humanitarian operations. He has also made significant contributions to the governments of France, most recently as Minister of Health. In that capacity, Dr. Kouchner established partnerships between hospitals to provide low-income countries with anti-retrovirus treatments to combat AIDS. In 1999, UN Secretary General Kofi Annan appointed Dr. Kouchner UN Special Representative for Kosovo, a post he held until 2001. He has authored numerous books—most recently *Le Premier Qui Dit La Vérité* (R.Laffont, 2002). He has received several human rights awards, including the Dag Hammarskjold Prize and the Prix Europa and is *Doctor Honoris Causa* from several universities, including Sarajevo and Pristina. Dr. Kouchner is currently a professor at Conservatoire Nationale des Arts et Métiers in Paris.

From Doctors without Borders to Patients without Borders

presented by

Bernard Kouchner

at the

Inaugural Jonathan Mann Lecture on Health and Human Rights

March 6, 2003, Snyder Auditorium, Harvard School of Public Health

I.

Mrs. Ida Mann, Mr. Aaron Mann, Dean Bloom, Monsieur le Consul Général de France, Professor Stephen Marks, Professors of the Schools of Public Health and of Social Medicine, Ladies and Gentlemen, Dear Friends:

This afternoon, I have the privilege of delivering the Inaugural Jonathan Mann Lecture. This is a distinction that I regard as an honor and, in some ways, a reward.

At this particular moment, I can't help but think of Albina du Boisrouvray, who continues the never-ending fight for human rights, of her son, François-Xavier Bagnoud, and, naturally, of Jonathan Mann.

What would Jonathan Mann have said upon seeing us gathered here in his honor? For all of the friends he made in the worlds of health and of human rights—multitudes of unknown people on each continent thank him—he also made a few waves. Or should I say strong opponents? It seemed a foolhardy project indeed when Jonathan ventured to mix the two concepts of public health and human rights. Jonathan was a pioneer, like so many of the men and women I see before me now, who, in their respective fields, transformed the world of health—or of healthcare, which is not the same thing. But the pioneer knows that, in taking the lead, one often becomes a target. The first lesson learned, from Doctors without Borders and, much later, from Kosovo and the UN system: *No success will go unpunished*. I am reminded of this lesson as I look out into the audience and see my good and lovely friend from Pristina, Dr. Vosa Debruna, who was Minister for Civil Society and Human Rights in our provisional government.

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The first time I saw Jonathan Mann was at an international conference on AIDS sponsored by Doctors of the World and AIDES (the French and now international NGO created just after the death of our friend the French philosopher Michel Foucault). Why do I now speak of Doctors of the World instead of Doctors without Borders? We had created this new association in 1981 with all of the historic founders of Doctors without Borders, which had been founded ten years earlier, in 1971, because we could no longer disregard what the newcomers called “politics.” Just as a marriage experiences what they call the “seven year itch,” so Doctors without Borders became restless around the ten-year mark.

My life can be seen as a permanent struggle between humanitarianism and politics, and between medicine and politics. For example, we were eager to go to the South China Sea, to rescue those who were fleeing Vietnam and who were drowning en masse, sometimes after being pirated and raped. How many boat people died in the Chinese Sea? Nobody knows. Tens of thousands, undoubtedly. And it is always important to know who died killed by human violence. The survivors have the right to know, as it is written in Protocol 1 of the Geneva Convention under the auspices of the ICRC. We had chartered a first hospital ship—six more would come—that turned out to be very useful. Her true name hinted at utopia: “The Isle of Light.” Docked at the island of Poulo Bidoung, we gave on-board medical and surgical care to more than two thousand patients. Was this about politics or public health? Our detractors, all of institutional medicine, and, alas, some of the newcomers to Doctors without Borders, snickered, saying that we had no right to take care of these refugees, who were under the authority of Vietnam and not to the French Doctors! What were we doing there? As students, we had been opposed to the Vietnam War, and this was a reverse prolongation of that sentiment. Without naming it, we were chasing after human rights. It was 1979 and 80. That year, Jonathan Mann was encountering a similar kind of problem in Zaire.

But since I am not here today to write a novel, let's return to the Paris conference. I didn't know about our common and different approaches when Jonathan Mann entered our meeting room in the year 1987, his light-blue eyes shining and a bow tie at his collar. I liked the light in his eyes but was wary of his bow tie. I was wrong. But in my country, bow ties were only worn by those we called “Mandarins,” the most conservative professors of medicine. For all of those in the audience wearing bow ties, I beg your forgiveness. I often harshly judged these academics. But they, too, judged me severely. Much later, I had become and remained Minister of Health for nearly ten years, and I got used to working with them. In growing older, we made steps toward each other. In the beginning, they called us “Doctors without Diplomas,” “the hippies of medicine on the road to Katmandu,” and scoffed at our work. They were proud to

take care of *their* patients. *I am not sure that this possessive—my patient—is a guarantee of proper medical attention.* Second lesson learned. Patients belong to themselves, and have a particular relationship of confidence with a doctor. We wanted to be close to the patients of others in countries without health facilities. We wanted to take care of all the patients in the world. Our eyes were bigger than our stomachs. Jonathan Mann's were too. We all remain rebels.

When he entered our meeting he was still head of the Global Programme on AIDS of the World Health Organization. Although he was in agreement with our practices, he was taking a different path toward human rights.

I remember what Jonathan declared to us that day, in 1987, words that profoundly changed our view. Sophia Gruskin was there. We had been turned toward developing countries and we still are, but what Jonathan said about AIDS forced us in France to embrace what Michel Foucault called “the outcasts,” (“les exclus”) and the idea of free and anonymous medical consultations. The French Doctors returned to France. Michel Foucault would say that a society can be judged by the way it treats its outcasts.

Jonathan also demonstrated the importance of the epidemic in Africa (The estimate at the time was that five to ten million people were infected.) and spoke for the first time of the beginning of the illness in Asia. He insisted on education and information to fight against HIV. Above all, he declared that the strategies against the epidemic must include human rights, that patients should give their informed consent to be tested, that discrimination should be eliminated, as should the practice of quarantine, and that other attitudes would be a risk to public health.

He explained that the epidemic was not the leading public health problem at the time, but that it would be soon, and that the whole world had to mobilize, as the UN system did for the first time, around a health issue. He also insisted on the social aspects of the epidemic, which were, for him and for us, fundamental.

III.

I am a doctor of the generation that emerged too young to be able to participate in a war that had invented the holocaust. The encounter with politics, with human rights, with barbarianism, imposed itself on us. I had always preferred impartiality to neutrality. Third lesson learned: *Neutrality is often complicity.* I wanted to be a doctor, like my father Georges, most likely to imitate him because I admired him, but also to fight against the savagery of men—in my eyes, the first harm to public health. War, suffering, poverty, bombs, napalm, gas chambers: Tracking the cause while relieving pain, is this not the heart of medicine? What's more, my country was giving itself to a war in Algeria made even more brutal by the fact that it

was without a solution. Born from within this particular generation, the Doctors without Borders movement can be explained in this light. The “right to interfere” runs counter to the rule of non-intervention in international law, and yet it becomes necessary to respond to massacre and oppression of minorities. *But first, we doctors must fulfill our “duty to interfere,” one sick person after the other.* Fourth lesson learned.

Were we the first to embark on this mission in 1970? The international strategy of interference had been established some years before by Amnesty International. Theirs was a moral interference. Amnesty International sent letters across borders to murderers and dictators who imprisoned and tortured people because of their beliefs. With Doctors without Borders, Doctors of the World, Partners in Health, and Physicians for Human Rights, it was the health providers themselves, engaging in physical interference, who crossed borders—often illegally—to respond to the call of the suffering. We did not behave like colonialists. We only responded to complaints. We arrived only on request. But we were listening carefully to the clamor of the world. We stood on permanent call. We were concerned by the unhappiness of others. Today, before you, I would ask: Who is responsible for the suffering of others? *We all are.* A fifth lesson learned. I cannot help but think of the Iraqi population. Who is listening to them now?

I would like to name the members of the Biafra-Nigeria team, those who were at the start of this adventure, who were the pillars of Doctors without Borders, which received the Nobel Peace Prize in 1999. Six doctors: Maximilien Recamier, Minor Eysen-Hernandez, Vladan Radomon, Patrick Aberhard, Pascal Grellety Bosviel and myself. Two students who are now university-professors: Olivier Dulac and Jean-François Bernaudin. A nurse: Francis Dechatre. Of course, many others came, but I'm thinking of these few because on these first and second teams, faced with an immense task, we felt quite alone. At the time, we didn't know how far our dream would take us.

Those of us who were already being called the “French Doctors” were feeling the shock of discovery. We were confronted with the cruel reality of poor countries, we discovered sick people who seemed to have been forever abandoned to solitude and death. Fresh out of school, coming from our highly efficient hospitals, and used to excess in medicine, we were confronted with the ravages of lack. Lack of means, lack of food, lack of work, lack of hope. We hadn't learned how to care for these kinds of pathologies and we were cruelly lacking in elementary medicines and equipment. We were discovering the misery that had been the daily lot of people for centuries. People would come to us with hope and we, the French Doctors as they called us in Biafra, the doctors of the future, couldn't do much to help them, apart from improvised war surgery in our community hospital in Awo-Omam.

In the evening, we would be delivered dozens of wounded soldiers and civilians whom we would sort according to a system we had developed. Our first priority were those soldiers who had a chance to survive, at the expense of those whom our feeble reanimation and surgery capabilities would never be able to save. I can still see the look on the faces of those whom we would abandon to certain death. But, after all, we were doing what we could. As for the soldiers, it was their job. Those who were healed would return to the front. It was war, it was life.

The civilian men, women and children that planes would machine-gun the streets or bombard on village steps would also arrive to us in bloody bunches, according to the dictates of fortune. We would treat them as well as we could. The luckiest would return to their villages, sometimes only to come back to us again after an attack. It was life at war. At that time, civilians were the armies' favorite targets (10 percent of victims during World War I; 90 percent in Bosnia).

Doctors without Borders was born in our minds of the suffering of children. We improvised a pediatric hospital in an elementary school called Santana. Louis Schitly and Daniel Tarantola were in charge. The tiny patients were suffering the consequences of malnutrition: marasmus and kwashiorkor. We discovered disease in them and we improvised a treatment that seemed miraculous. Once treated, the skinny-limbed, big-bellied children would come back to life within three weeks, like dry plants that had finally been watered. They would then return to their villages. But the Nigerian army's food blockade continued, and the children would return to us two months later. We had to start all over again. The third time they would come to us, the treatment would become innocuous, and they would all perish, so light, so frail, in our hands. What was to be done? As volunteers of the International Committee of the Red Cross, we had each signed an agreement saying we would not reveal what our work had permitted us to see. We were impartial: we gave the same medical care to Nigerians, Biafrans and mercenaries. The alimentary blockade was used as a weapon in contempt of the Geneva Convention. To give medical care and to keep quiet, to give medical care and let children die, burdened our good consciences. For me, it was complicity. Neutrality led to complicity. The French, Norwegian and Italian doctors came together and decided that the protection of our patients was the most important thing and that we should speak out and organize an international press conference. The French team was not worried, but in a hospital to our north, the Yugoslavian team and English nurses were assassinated.

The duty to interfere was born. We spent ten years repeating it all over the world, from Africa to the Middle East, from Asia to the Balkans, from Central to South America. Sometimes

words alone would suffice to change public opinion. And only public opinion could transform the politicians into activists. *We invented the “law of outrage,” which allowed us—occasionally—to protect patients.* Sixth lesson learned.

It was already politics. It was also human rights. Or are they the same thing?

Although it is not the subject at hand, I should say a few words about Iraq. I would like to address the suffering of the Iraqi people: Shiites, Kurds, Sunnis, Assyrians, Turkmens, they are calling us. They want to be rescued and liberated. Despite the fact that I hate war, and believing that there is still an opportunity for us not to go to war, I would like you to think about these people and remember that Saddam Hussein killed 500,000 of his own people in addition to those who were killed during the war between Iraq and Iran.

IV.

Doctors without Borders, Doctors of the World, Partners in Health and Physicians for Human Rights had a common characteristic. We all worked in the field, close to the people, treating them not as a mass but one by one, with our knowledge and our hands. Jonathan Mann was a specialist in public health, not a medical practitioner. He thought on a grander scale. We were different. Jonathan Mann was an intellectual and an activist, a key figure in humanism. He led us in the fight against global poverty and illness.

My friend Stephen Marks wrote a piece in 2001 called “Jonathan Mann's legacy to the 21st century.” I quote him:

“His greatest achievement was effectively sounding the alarm with unsurpassed passion and conviction to governments and international institutions that HIV/Aids pandemic called for urgent human rights-based responses, founded on solid epidemiological evidence...

Second he mobilized his closest colleagues to join and build a movement of health practitioners committed to human rights, this with Tarantola and Gruskin...

Finally he articulated his ideas in articles which are the lasting value due to the clarity of his expression, the significance of the issues addressed, and the infusion of knowledge of medicine and international affairs.”

I would also like to quote Sofia Gruskin and Daniel Tarentola, who were so close to Jonathan Mann from the start of his undertaking.

“The challenges posed in linking health with human rights are immense. There is, however, increasing evidence that public health efforts that respect, prospect, and fulfill human rights are more likely to succeed in public health terms than those that neglect or violate rights. Human rights and health are progressing, in parallel, towards a common goal that will never be

fully realized. Yet, together, they project a vision and an approach that may fundamentally and positively improve the lives of people everywhere in the world.” Dr. Jennifer Leaning, who wrote a moving tribute to Jonathan, also carries on this tradition at the FXB center and, like me, goes to the hot spots of the world to bear witness and bring help.

In his last book, *Pathology of Power*, Paul Farmer, International Chair of the Collège de France, a man who works with his hands close to the poorest of the poor in Haiti and other places and a man I feel very close to, wrote, “Medicine and public health, and also the social sciences relevant to these disciplines, have much to contribute to the great, often rancorous debates on human rights. But what might be our greatest contribution?” Are we, doctors, the “natural attorneys of the poor?” asks Rudolph Virchow. Paul Farmer answers that a “health angle’ can procure a broader human rights agenda in unique ways. Medicine and public health benefit from an extraordinary symbolic capital that is, so far, sadly underutilized in human rights work. No one made this point more clearly and persistently than the late Jonathan Mann.”

And Paul Farmer goes beyond AIDS to reach tuberculosis, malaria and all the diseases of poverty.

Jonathan Mann said that the accomplishment of the goal of public health, based on epidemiology as its fundamental science, necessitated the transformation of society and the disappearance of social injustice. The French Doctors maintained, along with Dostoevsky, that “all men are responsible for each other, and myself more than the others.” “We consider ourselves responsible for the pain of others, no matter who they are, where they come from or where they are going,” said Jacques Lebas, president of Doctors with the World, in introducing Jonathan Mann in 1987. Jonathan Mann and the French Doctors were close, we were similar, we were brothers, but we didn’t resemble each other. Had he been here, he would have helped us to imagine, to create and to take on the risk of Patients without Borders.

Here is the new adventure. To send doctors all over the world is magnificent. We must carry on. But this is not enough. It will take five, ten or thirty years, but we must imagine a world health insurance: Patients without Borders.

V.

Contagious diseases, viruses without borders and bacteria without borders lead us to treatment without borders and—finally—to Patients without Borders. It is not a slogan, but a necessity that is manifesting itself bringing with it a promise: hope without borders.

What are the priorities? First, AIDS. Allow me to remind you of a few facts and raw and frightening data. The AIDS virus was first reported in 1981. Twenty years later, the pandemic is responsible for some 22 million deaths, 15 million of which occurred in sub-Saharan Africa. We know that close to 50 million people carry the virus, and that they are found essentially in developing countries. Alas, in my opinion, these figures are underestimated. If we had more reliable statistics for China and India, the numbers would be increased by millions. According to the most reasonable calculations of the United Nations, if wealthy nations don't increase their efforts to fight AIDS, particularly through the Global Fund, the pandemic could kill 70 million people in the next 20 years. There is even talk of some 110 million stricken with the disease by 2010.

South Africa is one of the countries that contain the greatest number of HIV-positive people (one inhabitant in nine in a population of 45 million). For a long time, the South African government refused to treat HIV-positive patients. Botswana is second to South Africa. It is the most deeply affected country, with one third of its population infected by the virus. On the African continent, six percent of all children could be orphaned by 2010. The François-Xavier Bagnoud Association is working actively on an orphan alert and intervention. Some of these countries have nonetheless made progress in their fight against the disease: Uganda reduced the prevalence of the disease by about eight percent, down from 14 percent ten years ago. Along with Zambia and Senegal, where we started the twin hospital program between France and Africa, Uganda is one of the countries where people with AIDS united to demand treatment.

For treatment does exist, notably tritherapy. However, despite spectacular reductions in price, treatment remains too expensive for inhabitants of developing countries. We should focus our attention on this issue by making treatment available everywhere, gradually, of course. We will only be successful at preventing the disease if we treat people. Patients need a drop of hope and, of course, a vaccine.

AIDS, however, is not the only enemy. We must also attack poverty. In developing countries, over 800 million people don't nourish themselves well enough to remain in good health. They wake up every day with the sole quest of finding food, their principal activity. In these countries, 11 million children die before the age of five. Seventy percent are killed by diarrhea, malaria, respiratory infections, measles and malnutrition. The list is endless. Every year, 8.8 million people fall victim to active tuberculosis, and 1.7 people die from it, especially in poor countries. By 2020, 35 million more people could succumb to tuberculosis if nothing is done to reinforce prevention. Tuberculosis and AIDS are often associated.

Malaria also kills one million people each year, essentially African children. According to World Health Organization estimates, Africa's Gross Domestic Product would be 100 billion dollars higher if malaria had been correctly combated over the last 30 years. Can one combat disease with bare hands? Some have done it, some who are here with us today, like Paul Farmer.

One must always combat prejudice, egoism, *idées reçues*, racism. The dogma was the opposite. Among the establishment, the investors, the idea was that insuring health in poor countries was neither possible nor profitable. Some said, "How can we treat all of them? It's too costly. It's impossible." The long history of medicine answers clearly: we must start one by one, then thousand by thousand. Pasteur first vaccinated the young Joseph Meister against rabies, not all of the children in France. The opponents insisted, "How do you give health care to people who don't have roads leading to an existing hospital? Let's build them roads..." Structural reform and education were called for. Financial means were supposed to follow our Western canon. The International Monetary Fund and the World Bank were getting old. It was a grave error in Western, and some Africans', dogmatism. This explains why the creation of Doctors without Borders was a considerable political event, not only a charitable action. We were inventing another manner of looking, a different way of perceiving the economic and political evolution of the world. We were precursors. Unfortunately, some of my successors refused this analysis, seeing themselves as neutral, clean and apolitical Good Samaritans.

Finally, last year, a report by Jeffrey Sachs affirmed that investment in health would be profitable in the Third World. Jeffrey is a believer in controlled capitalism. He is a man of action. He says: "Let us first care for people with the means we have. Then they can build the road that will one day lead to the hospital, while those will one day work there educate themselves. It is up to the wealthy nations to begin, working in cooperation with poor countries and for a common interest." This is what we, practitioners, did with Doctors without Borders and Partners in Health. It took a long time to convince people, especially those who were in charge, like WHO, the World Bank, the International Monetary Fund and government leaders.

Patients without Borders: a world health insurance. It seems megalomaniacal. Everything needs to be invented. Here is a simple example: Between five and six million people die every year of diseases that are carried by water or atmospheric pollution. The green movement chose a slogan: sustainable development. Now it is time to act. Development starts in the health field, even if subscribers to the anti-globalization movement don't yet understand.

The task ahead is titanic, but we may be encouraged by the progress, albeit limited, we have made. Life expectancy has mainly increased for the six billion inhabitants of the planet,

reaching 66.4 years during the period from 1995 to 2000 compared with 59.9 at the beginning of the 1970s. Still, this average poorly obscures enormous disparities. In France, women live to the age of 83 on the average. During the same period, the mortality rate for children younger than five sharply decreased from 96 to 56 out of 1000. Since 1990, 800 million people have better access to water. Although famine decreased in certain countries, it would take 30 years to eradicate it at the current rate of progress. Famine is still a reality in Africa: what are we waiting for? If one wanted to put the poor on the same level as wealthy Westerners, it would take the resources of three planet Earths!

A world health insurance, combining the private and public sectors, is easy to say, but hard to do.

The results of the world summit that took place in Johannesburg in September 2002 are disappointing. Still, the fact that heads of state met with 60,000 participants is not negligible. The event will leave a mark. But the main problem to solve is before us: find the means to obtain the objectives set at the Millennium Summit of the United Nations in September 2000. The goal was reaffirmed during the Johannesburg summit: diminish the number of people suffering from hunger by half by 2015; cut the infant mortality rate by two-thirds; contain AIDS, malaria, and other diseases. These goals might remain only promises.

We must take care of such immense problems ourselves. A seventh lesson learned.

Wealthy nations cannot contribute new financial assistance without the agreement of their people. To give their consent, the people need to be informed participants. To assure health care for others, we need to change the mentalities of users of health care systems, both rich and poor.

A 1997 World Bank report spoke of a contribution of ten dollars per person per year in developing countries. Jeffrey Sachs increased that amount to 34 dollars per person for essential interventions, for prevention more than treatment. I remind you that we currently estimate that inhabitants of poor countries, who occupy the majority of the planet, spend as little as between three and five dollars per person per year on health care. Jeff Sachs admits that the least advanced countries could mobilize to gather 15 more dollars per person per year before 2007. The deficit that rich countries would thus need to make up for is 19 dollars. The idea that we must communicate that comes from AIDS is this: The planet of diseases no longer knows any frontier, any border. In protecting the poor, we protect the rich. Selfish, but effective reasoning. In the Sachs report, we learn that the essential interventions proposed should allow us to save about 8 million lives per year before 2010 in countries with low revenues. Jeffrey Sachs affirms that the donors will make a profit by 2015.

These are encouraging but terribly theoretical calculations. *Let us beware of economists.* Eighth lesson learned. As former Minister of Health, I know that health always costs more than expected.

In spite of these criticisms, I hold the Commission on Macroeconomics and Health's report to be very important.

Patients without Borders, world health insurance, how can we implement such a dream? How can we build it in practice? With which tools, under which latitudes, following which strategies, under which authority?

This is what I am working on here in Boston, where research groups are forming. This is what I will work on in ten days with the World Bank in Washington and in Paris for the rest of the year, as Chair of Health and Development at CNAM university.

We are not simply blindly navigating. We know what measures need to be taken so that everyone has access to basic public services. We know that it is necessary to create sanitation programs within development policy. We know what needs to be done to promote access to potable water and to reinforce the fight against disease, from AIDS to dengue fever. We know that we need to be able to rely on "clean" energy sources in order to reduce the diseases caused by fossil fuel. We know almost everything, except for how to convince people in the luckiest countries and give them a taste for the adventure of this century: giving all of the inhabitants of Earth an equal chance by loaning them money that they won't reimburse in cash, but in pride.

How will we proceed? Slowly, and with great humility. We are not megalomaniacs, even if the project is immense. I spoke about research groups and possible funding. We will work with business people and professionals who share our enthusiasm. We will begin in April with two days of brainstorming at the *Bureau national du travail* with the leaders of the International Association of Social Security. We will propose to begin with two countries, probably African, and one that is richer than the other. For the first time in public health, we will adopt the distribution methods of micro-credit banks. We will concentrate our efforts as much as possible on women and communities. I hope that our friends at the FXB Center—Steve, Sofia and Jennifer—and Partners in Health will be associated with our work. We will have to define the prevention and care package. *We will work systematically under the direction of national authorities, the prime minister and minister of health.* Ninth lesson learned. And it is important not to pretend to be able to do everything, even if the ideas are advancing.

Let us not forget that this combat was launched by Jonathan Mann while he was responsible for the fight against AIDS at the World Health Organization. Our Jonathan, who perished with his wife in the Swissair accident over the Atlantic, to whom we must forever pay

homage. He maintained, "Health is a human right, as is fighting against the diseases of the Third World." In the beginning, certain people laughed at his moving political vision of world health. Jonathan would have loved Patients without Borders. In our day, no one deserves to die of a curable disease because he is poor. Globalization, militant specialized associations and protests at every summit bear witness to the internationalization of health problems. Those who once said, "We must start a revolution at home," are now saying, "We must reach equality with others."

Alas, the word globalization carries a negative connotation. I know this and I understand why. But this will change. In creating Doctors without Borders, we were perceived as the "hippies of medicine." But that perception changed, and the Nobel Peace Prize came. I am confident. It is this optimistic vision of globalization that I wish to illustrate, its most visible and immediate aspects.

Globalization, anti-globalization: we must beware of these terms. Confusion and antagonism have lastingly and dangerously set in because we are unable to accurately define these terms. We will encounter great difficulties in trying to give the poorest of the world access to an acceptable life. Let us not ignore the difficulties: the combat will be long and militant.

The solutions brought forth by the anti-globalization movement are not always pertinent, I know. But I approve of their indignation, of their demands and their way of making their demands known, except for extreme violence, of course. I think they used me as an example. Certain diplomats have a hard time accepting this representation of civil society. France brought the impetus with the French Doctors. Our officials have not always understood the power of this movement. What did we do to change the way things were? We considered that however poor, however dirty, however uncultivated the human being before us, he or she was a patient, *my* patient, to whom I needed to give care. Then, soon after, we said that this patient was *our* patient regardless of borders and we transported the doctor to him.

VII.

This 6th of March, 2003, is, for me, a solemn day. As I was preparing this lecture these last few days, I remembered the faces of a number of doctors I met over the years. There were many, for the years were long. Allow me to sketch for you a few of them, without speaking of my closest companions, who made this adventure into a collective process.

I remember Doctor Okoyé, a Nigerian pediatrician. He was elegant and devoted to his work. He taught us his plant-based recipes that allowed us to care for starving children. He

once said to me, in the Biafra hospital, "Thank you for coming. But it's too late for us. It's always too late. Why do doctors always wait for sickness and death before intervening?"

I remember Doctor Ho. This thoracic surgeon was the director of the enormous Jiah Dinh hospital in Saigon in 1975 at the time the city was falling. He remained in the city, although he could have fled with the American helicopters who arrived like a black cloud in the sky. He lowered his head when the Northern soldiers came to arrest him. He said, "I've never been involved in politics." They took him to a camp. I found him in Poulo Bidoung and I begged him to come and work on our boat the "Isle of Light." He is now a general practitioner in the Silicon Valley. In Poulo Bidoung, he told me that I was wrong: If doctors don't engage in politics, others will do it for them.

I remember the fourteen-year-old Muslim boy we found in the Beirut neighborhood of Bourg Hamoud, whose spleen we removed because it had been struck by a bullet. I ran into him later on the street just as he was lifting his shirt to show his scar to a Catholic boy. The two laughed. It was the Catholic boy who had shot him.

I remember the dozens of wide-eyed children splayed out on the ground in a Somalian village, literally dying of hunger. I will never forget the emptiness I felt in my hands when I lifted one of them; he was so light.

I remember a Kurdish doctor named Jallal and a Dutch doctor named Carpenter. Both were members of the Doctors without Borders team, who died in 1975, tortured by the troupes of Saddam Hussein.

I remember a very young boy stricken with tuberculosis. A Salvadorian guerrilla who was coughing up his lungs as he prepared for battle atop his mountain against his own brother, who was a soldier of the Salvadorian army.

I remember many others.

I remember Jonathan Mann.

In 1994, in the book we devoted to humanitarian medicine, Jonathan Mann wrote a chapter on AIDS, public health and human rights. He concluded that "a new vision of health is offered to us based on human rights, world interdependence and solidarity. In an unexpected way, a pandemic brought us to the frontier of a new era in the history of health and our societies. The AIDS crisis has sounded the alarm bell, demonstrating the difference in the battle against AIDS and health between a veritable effort to profoundly change the situation and a superficial perspective. It is now up to us to assume our responsibilities, to be a part of those who dream

about what has never been done and say, aloud, with all of our confidence, science and solidarity, 'Why not?'"

Predictive medicine, gene therapy, and other medical sciences have been developed since the death of our friend, on September 2, 1998, accompanied by his wife, Marylou Clements-Mann.

I have often thought about the last few seconds of their lives. I am sure that they turned to one another and took hands.

Wherever they are, they must be happy to see us here together with a common thought for both of them. And also a thought for those who participated in the adventure, some of whom are here tonight.

I often spoke about Doctors without Borders and Doctors of the World with Jonathan. I often told him about our interrogations and our doubts concerning the "doctors of the ends of the Earth." His blue eyes would sparkle even more. He would remain quiet. Then he would speak about AIDS, exclusion and human rights. They were different words to express the same thing.

With the memory of Jonathan Mann in our hearts and minds, let us embark on a new dream: Patients without Borders. "Why not?" he would have said.