TB in Peru: How the Third Side Mobilized a

Global Response to a Burgeoning Health Crisis

Rebecca J. Wolfe[1]

In 1995, Father Jack Roussin, a priest from the Boston area, became seriously ill. At the time, Father Jack was fulfilling his life-long dream of living in Peru as a missionary and social worker. After returning to Boston to receive medical care, he was diagnosed with tuberculosis and given what was believed to be the appropriate medications. However, seven weeks later, Father Jack died from what was later identified as multi-drug resistant tuberculosis (MDR-TB). Father Jack died because the traditional antibiotics that are used to treat tuberculosis could not defend him against his particular strain of this infectious disease.

His death alarmed two Harvard doctors, Paul Farmer and Jim Yong Kim, both friends of Father Jack. Father Jack had provided Farmer with a place to live in his parish while Farmer was in medical school and later persuaded the doctors to expand their nonprofit organization, Partners In Health (PIH), to a community in Peru where Father Jack was working. PIH, started by the two doctors in 1987 to provide health-care to poor communities in Haiti, Peru, Roxbury, MA and Mexico, has a mission of 1) providing a "preferential option for the poor" and 2) working with the poor in "pragmatic solidarity" defined as a "commitment to struggle alongside poor people and against the economic and political structures that define and perpetuate their poverty and ill health."[2]

The organization's work is based on the belief that health care is a basic human right and that lack of money should never prevent someone from being treated. PIH works in partnership with local communities or "sister organizations" to provide health care to the community. The flagship project, Zanmi Lasante, is located in a town in the central plateau of Haiti. In this area, PIH has built

[1] Much of the information from this case study is based on personal experience from when I worked at Partners In Health from September 1995 until November 1997.
[2] From the PIH website: www.pih.org

and currently maintains a hospital, school, outpatient clinic, TB sanatorium, and a health education facility.

In Peru, PIH works in Carabayllo, a shantytown outside of Lima. This is an impoverished community whose access to affordable health care has decreased immensely since the privatization of the Peruvian health care system.[3] Together its sister organization, Socios En Salud (SES), PIH has organized and trained 80 health care workers to help treat residents of the community. PIH has also identified and created interventions aimed at removing the obstacles that prevent the residents of Carabayllo from receiving health care.

After Father Jack's death, Farmer and Kim traveled to Carabayllo and discovered an epidemic of MDR-TB in the community. What especially troubled the doctors was the fact that people were not being treated—clinics were turning the patients away. For example, Benedicta, a resident of Carabayllo, went to the TB clinic because she believed it was free when she arrived. She was told the national TB program would not cover the cost of her treatment and in order to be treated she would have to pay 10 soles. Benedicta could not afford the treatment and continued coughing and infecting others.[4]

The lack of treatment not only caused a problem for those afflicted with MDR-TB (i.e., they were not getting better), but also for those who were in close contact with those who were infected. TB is an airborne disease and therefore is quite contagious. Since most people in this community lived together in close quarters, infection spread rapidly among family members, leaving few if anyone within a family unit able to work in order to support the family.

In addition, it was unclear what the patients could do in order to access treatment. Here was a case in which the people had little access to the decision makers that were affecting their lives. How could the situation change? Through a network provided by PIH, the residents of Carabayllo were able to demonstrate the importance of treating MDR-TB.

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[3] Kim, Shakow, Bayona, Rhatigan & Rubin de Celis (2000)
[4] *ibid.*

Tuberculosis and Treatment

Tuberculosis is the world's number one cause of death—two million die yearly.[5] About one-third of the world's population carries the TB bacilli, but for most carriers, the bacteria remain dormant.[6] Five to ten percent of infections become active TB and each of these people then infects roughly another ten to 15 people.[7] Those who suffer from malnutrition or other diseases, such as HIV, are especially susceptible to active disease once infected.[8]

What makes TB particularly dangerous is that it spreads quite easily. The bacilli residing on the mucous membranes are spread through the air by a cough or a sneeze. Moreover, with global travel, it is difficult to contain. The ability of the disease to spread has made the containment and cure of TB a priority for many public health officials.[9]

To treat TB, patients need to take a series of drugs. To ensure the patients complete treatment, a protocol was developed called directly observed therapy, short course (DOTS) where health workers check in with patients every couple of days to make sure that people take their medication. The treatment takes approximately six months to complete. This treatment was found to be both effective in terms of cure rates and compliance, and was inexpensive. Because of the ease in administering and affordability of DOTS, WHO recommended that the DOTS protocol be used to treat tuberculosis in developing countries.[10]

However, DOTS is not effective when it comes to treating MDR-TB. MDR-TB develops when a strain of the bacteria mutates so that it no longer responds to certain antibiotics. Often this occurs because the patient does not complete treatment.

MDR-TB is especially complicated because not only does patient's strain of bacteria no longer responds to treatment within the patient, but also resistant disease is spread to other people.

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[5] WHO (2000)
[6] *ibid.*
[7] *ibid.*
[8] *ibid.*
[9] Donnelly (November 1, 1999).

When the newly infected patient goes to the doctor, he or she is automatically put on the DOTS regimen; the doctor does not know that the patient will not respond to the drugs. Consequently, the resistant strain is not treated correctly and continues to be spread.

Once MDR-TB is diagnosed in a patient, it can be treated with "second-line" drugs. However, these come with additional difficulties. The second- and third-line drugs that are used to treat MDR-TB are more expensive since the drugs are rarely prescribed and thus not profitable for the pharmaceutical companies.[11] Additionally, the second-line drugs have harsh side effects, which make the patients reluctant to comply with the treatment.[12] Third, since the drugs are not as effective as the frontline drugs, they must be taken for a longer period of time (18 months as opposed to six months for the frontline drugs).[13]

Because of these difficulties, WHO advised that MDR-TB could not be treated in resource-poor areas because it was not cost-effective to do so.[14] In addition, WHO believed cases of MDR-TB were rare and therefore concluded that not treating it would not cause much of a problem.[15] However, PIH disagreed with this analysis and decided to find a way to treat patients suffering from MDR-TB.

What PIH Did

What PIH doctors found when they went to Carabayllo was an emerging crisis—approximately 100 people in the community had MDR-TB and it was not being treated. In the opinion of Farmer and Kim, this was a public health crisis waiting to happen. MDR-TB had already shown its ability to cross boundaries. People visiting other Latin American countries had returned to the United States with MDR-TB. (Most documented cases in the US were related to travel.) In this community, the disease was devastating families—it was not uncommon to have multiple members of one family being

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[10] WHO (2000).
[11] Washington Post (August 17, 1999).
[12] *ibid.*
[13] Donnelly (February 25, 2001).
[14] www.pih.org

infected and it was unclear to what extent it would spread to other communities. Furthermore, it was a dangerous strain of the disease. Many of those infected were resistant to most of the frontline drugs, leaving few treatment options for these particular patients.

PIH first developed a protocol for treatment. Like DOTS, health workers would observe the patients take their medication, but instead of once a day, this was done two to three times a day, and instead of treatment occurring over the course of six months, treatment lasted 18 months. The new protocol also differed in two other important ways. One of the flaws with DOTS is that it treated patients with drugs to which the strain of bacteria was already resistant. This prolonged the period in which the bacilli were harming the patient as well as the period in which the patient could infect others. PIH realized that sputum samples from the patients should be tested immediately to determine which drugs to which the bacilli had built a resistance the appropriate drugs then prescribed.

The second difference in the new protocol was that patients received money for food and shelter. PIH had found that lack of access to food and shelter hindered compliance and cure rates. Malnutrition made the body more susceptible to the disease and reduced the efficacy of the medication. Additionally, lack of shelter made it more difficult for the health workers to track the patients.

Unfortunately, finding a way to implement the protocol was difficult. First of all, the second-line drugs were not available in Peru. Since WHO did not authorize the treatment of MDR-TB in poor communities, local pharmacies did not carry the drugs. Moreover, there were no labs in Peru that would test for MDR-TB and the drugs the patients were resistant to.

To overcome the testing issue, employees of PIH brought back samples of sputum from the patients when returning to the US. The Massachusetts State TB lab then tested these samples for resistance so that the patients could be treated appropriately.

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[15] Donnelly (February 25, 2001).

A more difficult problem was finding ways to pay for the drugs and transport them to Peru. In the US, the drugs were prohibitively expensive; the cost to treat one patient was between $10,000-$20,000.[16] Given this level of costs, PIH needed to find a million dollars to treat these patients—an amount larger than the organization's annual budget at that point.

The Peruvian Health Ministry was reluctant to provide the money; they were proud of their "first-rate TB program" and did not want negative publicity implying that their program was ineffective. Given WHO's proclamation that treating MDR-TB was not cost-effective in resource-poor areas, foundations were also hesitant to fund the project. Fortunately, a benefactor of PIH believed in the cause and bankrolled the medication—in the end giving three million dollars to treat less than 200 patients.

In the first two years of the program, PIH had an 85 percent cure rate, much higher than any TB expert predicted (most assumed 50 percent).[17] However, the results received little attention and it became apparent that the benefactor could no longer afford to bankroll the project. PIH needed to find other sources of funding for the project if it was to continue.

The Policy Debate

At about this point, PIH's financial difficulties became apparent to Howard Hiatt, a former dean of the Harvard School of Public Health and member of the PIH's board of directors. When the president of the Brigham and Women's Hospital in Boston informed Hiatt that PIH owed the hospital close to a $100,000,[18] Hiatt went to see Farmer and Kim, who presented their findings to him. Hiatt found the results "astonishing" and scheduled a meeting for Farmer and Kim with leading experts in worldwide TB control at the American Academy of Arts and Sciences (AAAS). At this meeting, PIH demonstrated to the experts who did not think MDR-TB was treatable in developing countries that it was in fact curable.

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[16] *ibid.*
[17] Donnelly (November 1, 1999).
[18] Kidder (2000).

Hiatt also suggested that PIH now look to the George Soros's Open Society Institute (OSI) for funding. OSI officials explained, however, that since they were just about to start a similar project in Russia they would not be able to fund PIH's project in Peru. Farmer realized that the project OSI planned for the Russian prisons was likely to fail since it was based on DOTS and did not account for MDR-TB. With Hiatt's blessing, Farmer wrote a letter to Soros with this information. Next, Farmer had an in-person meeting with Soros; as a result, Farmer was asked to become a consultant for the Russian prison project and Soros agreed to help fund the Peru project. Furthermore, Soros was able to mobilize the attention of the international community, including former First Lady Hillary Clinton and the World Bank.[19]

PIH, however, knew that the funding from Soros would not last long. While the drugs were so expensive, treating patients would be difficult for PIH and other health agencies attempting to treat patients with MDR-TB. The next step was to lobby the pharmaceutical companies to reduce their prices. All along, PIH had tried to convince the pharmaceutical companies to provide them with the drugs at a reduced price, but with little luck. Again with Hiatt's assistance and the strength of the data, Kim was now able to get the attention of the pharmaceutical companies.

Outcomes

Following the first meeting at the AAAS, a strategy based on the PIH protocol for treating MDR-TB, called DOTS-Plus, was endorsed by WHO and the new guidelines were published in conjunction with PIH and OSI in November of 1999. Just before publication, WHO also announced plans to fund MDR-TB pilot programs in Russia, Latvia, and Kazakhstan. This endorsement had a domino effect affecting the other issues. The pharmaceutical companies agreed to reduce the cost of the drugs by 90 percent. Now the cost to treat patients with MDR-TB was reduced to between $300-$4,000 from $10,000-$20,000 per patient.[20]

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[19] *ibid.*
[20] Donnelly (November 1, 1999).

In the fall of 2000, the Bill and Melinda Gates Foundation gave PIH $44.7 million to continue their work in Peru.[21] Also, the European Community Humanitarian Office provided $2 million dollars for a MDR-TB pilot project in a Siberian prison.[22] The WHO also has organized a "drug warehouse" to which the pharmaceutical companies will sell TB drugs at wholesale prices; nations that implement an approved TB program will have access to these medications.[23] On World TB Day 2001 (March 24th), the Bill and Melinda Gates Foundation announced that they would give $10 million towards this project.[24]

Analysis

This case is an example of how structural violence can be addressed. Carabayllo is representative of many poor communities around the globe where suffering would be preventable if only resources could be allocated differently. Moreover, this case is important because it is a rare example of how a latent conflict embedded in the system captures the attention of decision makers and precipitates a a solution on how to manage the problem. The inequalities embedded in the economic system produce this conflict—people who lack power do not have the same access to basic human needs, such as medical care, as others do. In this case, it is mostly geography—where a person is born—that determines whether they receive treatment. Typically, people consider cases of structural violence too difficult to resolve or manage since "it is impossible to change the system." Whether or not a change in the system occurred in this case is debatable, but it does show how people who seem to be powerless can affect policy.

This analysis consists of six parts. First, the conflicting parties and third siders are briefly described. Next, a deeper analysis of the Third Side and the roles they played is provided. The crux of the argument here is that the Third Side played the role of equalizer for the most part and other roles to a lesser extent. In the next section, I will comment on what roles were missing. The fourth

[21] Donnelly (July 28, 2000).
[22] Kidder (2000).
[23] Donnelly (February 25, 2001).

section examines how these different roles were coordinated and the fourth section analyzes the forces that allowed this issue to be put on the agenda and addressed. In the fifth section, the outcomes are evaluated and in the final section, lessons for other communities are presented.

The Parties

The parties included those in conflict and those who assumed third-side roles in an effort to resolve the problem. The immediate conflict was between the residents of Carabayllo—more specifically the MDR-TB patients—and the Peruvian Health Ministry over health care. This conflict was complicated by the fact that forces outside the Peruvian Health Ministry affected its decision about whether or not to provide treatment.

Additional conflicting parties (although less direct) are the pharmaceutical companies and WHO which bring the conflict to both the interorganizational and international level. The pharmaceutical companies Charge so high a price for the drugs that treatment in resource-poor areas is prohibitively expensive. WHO's policies stating that MDR-TB can not be treated in resource poor-areas because of expense and compliance concerns made it difficult for both public and private agencies to justify funding expenditures related to treating MDR-TB. Both WHO's policies and the pharmaceutical companies create a "chicken-and-the-egg" problem: WHO's policy stemmed from the cost of the drugs, but the drugs were so unprofitable (and thus expensive) because WHO did not endorse their use.

PIH's role as a third-side player is the focus of this case. For the most part, the story is told from the PIH viewpoint. This conflict finally received the attention of important decision makers because of PIH's diagnosis, treatment, advocacy, and lobbying efforts and their Harvard affiliation. On the ground, PIH worked with Socios En Salud (SES), its sister organization, which handled the day-to-day treatment of the patients. SES is also part of the Third Side since it works with PIH to

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[24] Reuters (March 24, 2001).

access treatment for the patients in Carabayllo. However, since PIH often acts as an umbrella organization for its sister organizations and for ease of presentation, I will subsume SES under PIH.

Two other third siders become involved later in the process. One is Howard Hiatt. His ability to call a meeting of worldwide TB experts and contacts with funding agencies and pharmaceutical companies provide Farmer and Kim with an audience of people who could influence public policy. The funding agency to which Hiatt directed PIH, the Open Society Institute, facilitated even greater access to world leaders, such as former First Lady Hillary Clinton. These two actors gave PIH access and the ability to influence both the pharmaceutical companies and WHO, as well as others.

Finally, this case raises the question whether an institution can play the role in the Third Side. Harvard provides contacts and legitimacy to PIH. However, no representative from Harvard is ever part of the process. It is unclear whether Harvard should be considered a third sider in its own right. In this analysis, I consider Harvard at network that helps mobilize action rather than a third sider itself, but this is a point that could be put up for discussion.

Third-side Roles

In this story, different people and organizations played the third side roles of equalizer, provider, witness, and bridge builder.

PIH, Hiatt and Soros for the most part played the role of the "equalizer" in this conflict. Rarely do poor communities in developing countries have access to decision makers, especially decision makers in the international arena. Through these actors the people in Carabayllo had their needs addressed.

A common predicament in conflicts in which there are power disparities between the parties is that parties with greater power have little understanding of those with less. For one, since more powerful parties have little dependence on the less powerful, they have few incentives to pay attention to them. For example, powerful parties have more control over their environment than

weaker parties and therefore can act with little regard for them. Second, weaker parties are less likely to vocalize their needs. Finally, even if powerful parties understand the needs of the less powerful, they still have few incentives to address their concerns; weaker parties have few tools to influence decisions emanating from holders of power. It is difficult for the needs of relatively weak parties to get on the agenda and even more difficult for their needs to be addressed—a characteristic in situations of structural violence and latent conflict.

What PIH, Hiatt and Soros did was to provide access to the decision makers. By themselves, it is unlikely that the residents of Carabayllo would have been able to influence the Peruvian Health Ministry and even more unlikely that they would have been able to communicate with WHO and the pharmaceutical companies. Through connections with these third-side actors the needs of the people of Carabayllo were heard and addressed.

The first equalizing force was PIH. PIH equalized the power between the residents in Carabayllo and the Peruvian Health Ministry and WHO in two ways. First, they provided treatment. PIH had the access to resources—money, drugs, labs, etc.—through their benefactor that made treatment possible. Without the ability to provide treatment and subsequently vouch for its efficacy, obtaining additional resources to treat MDR-TB would have probably been even more difficult than it was. People began to pay attention to the issue only after Farmer and Kim were able to publicize the results of their clinical work.

Also by providing treatment to the residents, PIH helped them to become less dependent on the Health Ministry and on WHO, thereby freeing them to fight against the system. Moreover, by demonstrating that WHO's assumption regarding treatment of MDR-TB in resource-poor settings was incorrect and that Peru's TB program was failing in important ways unnecessarily, the residents were able to gain some power relative to these decision makers--publicity surrounding the agencies' failure to treat threatened to become a public relations nightmare. Therefore, both WHO and the Peruvian Health Ministry had to listen.

The second mechanism that allowed PIH to play the role of an equalizer was their Harvard affiliation. As professors at Harvard Medical School and clinicians at the Brigham and Women's Hospital, both Farmer and Kim possessed credibility and legitimacy. All too often, many lobbying efforts (such as those for AIDS drugs now) are led by nonmedical professionals with little data to support their demands. It was difficult to dismiss PIH's efforts on this basis since these physicians had the credentials that allowed them to make these claims. Their status, legitimacy, and credibility also became associated with the residents of Carabayllo, as PIH acted as their representative in subsequent policy meetings.

PIH's affiliation with Harvard also gave them access to influential people in the medical establishment. The most important of these connections was Hiatt, the second third sider to play an equalizer role—this time between PIH and the decision makers (Peruvian Health Ministry, WHO, and the pharmaceutical companies). Until Hiatt saw its results, PIH had a difficult time influencing decision makers with little other incentive to listen. PIH was, after all, a small nonprofit in Cambridge which, at that point, was not directly involved in creating public policy. Only through Hiatt's ties was PIH able to get their treatment results into the hands of worldwide TB experts (including officials at WHO) who could evaluate the results and make appropriate recommendations. The meeting that Hiatt called at the AAAS proved to be a turning point; policy makers were given conclusive evidence that MDR-TB could indeed be treated in resource-poor settings. Additionally, Hiatt's contacts with funding sources (i.e. Soros) provided PIH with funds to at least temporarily continue the Peru project and as well as access to more influential programs dealing with similar issues.

The third and quite influential third-side player was George Soros and his Open Society Institute (OSI). By joining forces with OSI, PIH immediately gained power. Considering Soros's influence on the world stage, especially over former-Eastern-bloc nations, it became more difficult for policy makers to ignore the findings and recommendations of PIH. Soros twas able to put this issue on the agenda of former first lady Hillary Clinton and subsequently the World Bank. Finally, people were paying attention to the unnecessary suffering of the MDR-TB patients in Carabayllo and

realizing that others were probably suffering from MDR-TB. Unfortunately, these others did not have a PIH to care for them.

To a lesser extent PIH, Hiatt and Soros also played the role of provider. In sharing their knowledge and resources, they helped the residents of Carabayllo meet their basic needs. PIH was a provider to the residents of Carabayllo by treating the patients and alleviating hunger. Soros acted as a provider by funding PIH's work in Carabayllo.

PIH also acted as a provider by sharing knowledge and data regarding MDR-TB treatment with the Peruvian Health Ministry and WHO. By providing information to these organizations, PIH encouraged them to change their policies, and also stimulated Soros' project in the Russian prisons. This action by PIH may also be seen as part of the teacher role. However, given Ury's conception of teacher in his typology—someone who imparts the skills to handle conflict—I believe the type of information exchange described above fits more firmly under the role of provider.

PIH assumed the role of witness in speaking out against the lack of treatment of MDR-TB patients in Carabayllo and then getting help from others. Moreover, during his visit to a Russian prison, Farmer alerted Soros that there were already indications of an MDR-TB outbreak in Russia.

According to William Ury's definition, bridge builders are members of conflicting groups who develop relationships across conflict lines. In this case, there are no bridge builders strictly speaking, since there is no direct interaction between the residents of Carabayllo and the decision-makers. In this case, a chain of contacts finally linked the residents of Carabayllo to WHO and the Peruvian Health Ministry. PIH connected Carabayllo to Harvard and Hiatt; Hiatt connected PIH to world TB experts, WHO, and Soros and Soros connected PIH to a wider network of projects, funders and policy makers working on the MDR-TB problem world wide.

Third-side Roles Absent

Five third-side roles were largely absent in this case: arbiter, mediator, healer, referee and peacekeeper. One reason why these roles were absent was that for the most part this was a latent

conflict. There was no open hostility between the residents of Carabayllo and the Peruvian Health Ministry or WHO. Of these roles, only the healer is likely to be utilized when there is no open conflict. Given the medical nature of this case, a healer role seems appropriate, but in third-side parlance healers are those who mend injured relationships, not bodies. In this case it is unclear if the parties considered their relationship to be injured; if they did, it is unclear whether the relationship was repaired.

The roles that did not emerge in this case are most relevant to disputes that are recognized by both parties who are working together to resolve it (with arbiters or mediators) or, in the case of overt (referee[25], peacekeeper). In this case, once WHO recognized the issue, it became willing to work with PIH and Soros to establish guidelines and did not need a third party to help them through that process.

Coordination of Roles and Actors

For the most part, the third siders in this case played overlapping rather than complementary roles. The addition of Hiatt and Soros did not expand the number of roles played, but rather, expanded the capability of PIH to fulfill the roles they were already fulfilling.

At the same time, the roles that were played complemented one another quite successfully. The roles of bridge builder and provider, for instance, boosted the role of equalizer. The contacts and coalitions between Carabayllo, PIH, Hiatt and Soros gave Carabayllo and PIH leverage with the Peruvian Health Ministry, WHO and the pharmaceutical companies. Without PIH's provision of treatment to the patients in Carabayllo with treatment, the patients would have remained dependent on the Peruvian Health Ministry.

[25] PIH might be seen as a Referee, since they influenced the change of the rules by WHO, and changing the rules is one of the behaviors of a Referee. However, I would argue, again, that under the conception of the Referee role by Ury, the Referee changes the rules with regard to how the parties interact. The change of the guidelines did not change how the parties interacted, rather the change of the rules aides in providing for the parties. Hence, I put this action under the Provider role.

It is interesting to note in this case just how the third-side functions interacted. Through a very unusual combination of personal and organizational networks, that to an extent were self-organizing, PIH was able to coordinate an effort to address issues of structural violence. PIH's membership in the organizational network of Harvard Medical School provided them access to Hiatt and a personal tie developed between the three doctors. Hiatt's status at Harvard, in turn, provided him with ties to a greater network of influential people in the medical establishment and funders. It was Hiatt's tie with Soros that gave PIH the greatest amount of leverage. Given Soros's network as both a businessman and a supporter of democratic reform in Eastern Europe, he influenced a vast and diverse set of people and organizations.

Mobilizing Events and Forces

Three events stimulated action in treating MDR-TB in Carabayllo. The first was Father Jack's death which led Farmer and Kim to investigate whether others in Carabayllo were infected with MDR-TB. They uncovered an epidemic that they felt compelled to treat.

The second was the meeting that Hiatt organized for PIH to present the PIH data to worldwide TB experts, publicizing the results of the treatment program in Carabayllo, and forcing policy makers to recognize that MDR-TB could be treated in resource-poor areas.

The third event was Farmer's meeting with Soros. By demonstrating to Soros that the OSI project in Russia would fail, Farmer was able to acquire some funding, but more importantly, this meeting led to an alliance between Soros and PIH that subsequently made it possible for the issue of MDR-TB treatment to get worldwide attention.

A further mobilizing force in this case was globalization. Globalization is often seen as a force that hurts the poor—i.e., companies move into into poor countries where they can pay low wages, are restricted by few labor and environmental regulations and do not feel compelled to give back to the communities. However, in this case, the connection between health problems in Carabayllo, Peru and prisons in Russia via Boston, Massachusetts shows just how the

internationalization of a problem stimulated action. Not until PIH was able to demonstrate that the epidemic of MDR-TB in Carabayllo was not an isolated problem did the world community feel that it was important to treat the disease. As a result, globalization became a positive force for the Third-side.

Outcomes

This case shows clearly how the Third Side addresses a conflict—specifically a latent conflict. The outcomes were indeed significant: PIH received funding for their work in Peru through the Gates Foundation. Other monies have been allocated to treat MDR-TB in other areas, especially in eastern Europe. WHO changed their guidelines for treating MDR-TB and the pharmaceutical companies lowered their prices making treatment affordable.

This case also provides an example of a solution that benefited all players--WHO, Peruvian Health Ministry, the pharmaceutical companies and the MDR-TB patients. A combination of WHO endorsement of the drugs and the lowering of prices by pharmaceutical companies made it possible to treat patients.

Although the case was a successfully resolved the immediate conflict—treatment of MDR-TB—the larger question of structural violence was not addressed specifically. Whether this case will have an affect on the alleviation of structural violence is still an open question.

Lessons

In many ways, this is case is unique. The residents of Carabayllo had the advantage of the "Harvard" connection, something most impoverished communities do not have. Besides the value of forging such partnerships, what else does this case bring into particularly sharp focus?

The Importance of the Equalizer Role

When there is a power imbalance, it is difficult for parties to communicate. It is especially hard for the more powerful party to even know what is going on with the weaker party. In the Carabayllo case, third-side involvment helped balance the power thus facilitating communication. Less powerful parties tend to use protest or even violence to "equalize" power. By allying themselves with other powerful parties (Harvard, etc.), the residents of this small Peruvian community were able to address the power imbalance without using tactics which often escalate a conflict, at least temporarily.

Building Bridges with other Communities and Globalization

It was difficult to get others to listen to PIH when the MDR-TB epidemic was seen as an isolated instance in a small shantytown outside of Lima. By emphasizing that this communicable disease posed a potentially serious international epidemic, PIH laid the groundwork for a global effort. The bridge between Carabayllo and Russian prisons through PIH and Soros was a catalyst for this response. This case shows that leveraging the interconnections between communities may push people towards action.

Interconnections between Third-side Roles

It is doubtful whether any one of these roles played in isolation would have produced the above effects. For example, the bridge builders' construction of the coalition between PIH and Soros also supported PIH's role as an equalizer. Understanding the connections between these roles allows for more strategic use of third-side roles and more successful outcomes.

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