

Chapter 4: Living Witnesses and Moral Agency

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What is today called global health has shape-shifted over several centuries, with roots in colonial medicine, missionary medicine, tropical medicine, and international health.¹ Whatever the differences in name or focus, these efforts have all been directed by Western(ized) bureaucrats, technical experts, or do-gooders reporting to headquarters in Western centers of power. Resources for these transnational health interventions—regardless if they are undertaken to promote civilizing, development, or humanitarian goals—circulate along the same routes and produce the same ends established by the West for its project of global colonization: to arrange the worldwide flow of goods, services, people, opportunities, and discoveries to promote the comfort, safety, and prosperity of the Western bourgeois class, while containing the diseases and risks to which the West might be exposed through the accelerated global extraction, exploitation, and circulation of people and goods.² With these power dynamics at the forefront of mind, a question nags at my conscience: is it possible for today's global health professionals from or trained in the West to work across lines of social power to relieve suffering without reproducing hierarchies of identity, knowledge, and power that have always exposed most people to danger and death in order to protect and promote the wellbeing of a small minority of others?

¹ Paul Farmer. Arthur Kleinman, Jim Kim, and Matthew Basilio, *Reimagining Global Health: An Introduction* (Berkeley: University of California Press, 2013), 61; Joia Mukherjee, *An Introduction to Global Health Delivery: Practice, Equity, Human Rights*, Second Edition (New York: Oxford University Press, 2021), 8–9.

² United for Sight, “Colonial Medicine: Colonial Conceptions of Health,” www.uniteforsight.org/global-health-history/module2.

This question is not only academic for me. It grows out of my work as a global health professional, which began when I joined the global health organization Partners In Health (PIH) in 2008, as Haiti Program Coordinator. I worked closely with Paul Farmer in Haiti through the 2008 hurricanes, the 2010 earthquake, and the subsequent cholera outbreak. The work involved climbing mountains in rural Haiti to check on patients; hosting patients from Haiti who traveled to Boston to deliver keynote addresses at a symposium at Harvard University; and meeting with UN delegations and multilateral funders in Port au Prince and New York. As a result of what I learned working alongside Paul and attending carefully to his writings, I have come to conclude that the answer is yes. It is possible to cross lines of social power to relieve suffering without reproducing dominating power circuits, provided that such action is not the exclusive purview of Western(ized) professionals. Moral praxis that transforms iniquitous power circuits must also include—as moral agents who cross lines of power to relieve suffering—people from communities that have been historically and systematically dispossessed. I am honored to contribute to this volume dedicated to Paul’s impact on theological ethics. My essay draws out insights on moral agency generated by Paul’s critical reflection and action in the field of global health equity.

Paul’s moral praxis was indelibly shaped by Latin American liberation theology. He brought it to bear in formulating PIH’s mission “to provide a preferential option for the poor in health care.”³ Paul took seriously the insights on agency put forth by his friend and founding figure of Latin American liberation theology, Fr. Gustavo Gutiérrez: “the theology of liberation represents the right of the poor to think” and the oppressed must be “protagonists of their own liberation.”⁴ As a result, a “preferential option for the poor in health care” for Paul and for PIH is not only a

³ Partners In Health, “Our Mission at PIH,” www.pih.org/pages/our-mission.

⁴ Gustavo Gutiérrez, *The Power of the Poor in History: Selected Writings* (Maryknoll, NY: Orbis Books, 1983), 90; Gustavo Gutiérrez, *Theology of Liberation: History, Politics, and Salvation*, trans., Caridad Inda and John Eagleson (Maryknoll, NY: Orbis Books, 2010), 67, 174.

preferential option for the poor to receive high quality health care from well-intentioned and well-trained professionals from communities that are better off. A preferential option for the poor in health care also means that people who face the dual burdens of poverty and disease must be preferentially engaged to design the interventions aimed at helping them. It is a preferential option for the poor to deliver health care to their own communities. PIH embraces this praxis by training and employing local community members to be providers of health care as community health workers, patient navigators, supervisors, and managers.

Paul lived out this moral praxis in contexts that appear markedly different, from rural Haiti to Harvard University to Rwanda to Sierra Leone and Liberia where the Ebola virus got a foothold in 2014. Though they might be disparate, the social conditions in these contexts are not divergent: they are generated by the same global power dynamics that channel resources to promote the life and wellbeing of some people and consign most people to struggle to survive. Paul insisted on holding together every place he worked. A slide show Paul narrated to accompany his Shattuck Lecture at the Annual Meeting of the Massachusetts Medical Society in 2013 illustrates this point:

All accounts, especially of difficult times, are partial, and my Shattuck Lecture, which is largely about AIDS, tuberculosis, and other chronic infections, is, of course, partial. It's a view from somewhere. That somewhere is largely settings of rural poverty in Haiti and Rwanda, but also of having trained in Harvard's teaching hospitals, where I still work to this day. That contrast experience has shaped very much my views not only on AIDS, tuberculosis, and other complex pathologies but on the topic of global health equity.⁵

⁵ Paul E. Farmer, "Chronic Infectious Disease and the Future of Health Care Delivery," *New England Journal of Medicine* 369, no. 25 (2013): 2424–2436, doi.org/10.1056/NEJMsa1310472.

Paul's life and work demonstrate that opportunities for creative and collective moral agency that aims to transform the world exist in every situation and in every place because there is, in fact, only one world.⁶ All life is connected.

In Paul's analysis, pandemic diseases like AIDS and COVID-19 give lie to the illusion that people inhabit distinct and separate social worlds.⁷ Since there is just one world, liberation praxis to transform it can begin where each one of us is. From anywhere, anyone can begin to make the critical connections necessary to shift perspective, change posture, and seek out the people most directly affected by social inequity by joining them where they are, or through persistent search for counternarratives authored by and with them. Every place can be the point of departure for critical reflection and action to understand the social, historical, and political forces which forged the iniquitous shape of the world and to channel energy and resources to redress what Paul has called these "steep grades of inequality."⁸ To begin a lecture at Vanderbilt University School of Medicine in 2018, for example, Paul recounted his more than twenty-hour journey from Sierra Leone to Nashville. Noting that this may sound exotic to his audience, Paul put up a slide depicting a map of the transatlantic triangle trade that trafficked millions of African people into slavery. "This is not the first time the US South has been connected to West Africa," Paul pointed out. He went on to give his lecture addressing the question "How does a university engage in [global health in] an ethically sound and meaningful manner?"⁹

⁶ Paul Farmer and Gustavo Gutiérrez, *In the Company of the Poor: Conversations with Dr. Paul Farmer and Fr. Gustavo Gutiérrez*, ed. Michael Griffin and Jennie Weiss Block (Maryknoll, NY: Orbis Books, 2013), 171–172.

⁷ Farmer, "Chronic Infectious Disease and the Future of Health Care Delivery," 2426.

⁸ Paul Farmer, "An Anthropology of Structural Violence," *Current Anthropology* 45, no. 3 (2004): 305–325, doi.org/10.1086/382250.

⁹ Vanderbilt University, "Dr. Paul Farmer Spends Day at Vanderbilt, Sharing Perspective on Global Health and Service," medschool.vanderbilt.edu/mstp/2018/02/28/dr-paul-farmer-spends-day-at-vanderbilt-sharing-perspective-on-global-health-and-service/.

For Paul, “restoring to such problems their full social complexity” is a key component of liberation moral praxis.¹⁰ Paul’s call to “resocialize the way we see ethical dilemmas” does not flatten but rather attends carefully to differences in social conditions.¹¹ In other words, Paul’s liberative moral agency is not unconditional action but rather action under all conditions.¹² For Paul, the work of critical reflection and action is never done until there is no longer any socially structured suffering; until no one dies of a treatable disease. Any one critical insight or action is important though insufficient in itself. Yet, each helps generate necessary momentum and shifts in perspective on the way to building a world that extends care and protection to all people everywhere. To exercise critical ethical action and reflection under all conditions is moral agency that moves beyond what is currently deemed possible.

As part of his liberative moral praxis, Paul presses for ongoing critical reflection that “challenge[s] the chicanery that leads us to forget that we are part of the same world.”¹³ The “we” is important here. In an internal “mindfulness memo” he wrote to the PIH staff, board, partners, and supporters in 2018, Paul questions the assumptions behind the oft-repeated phrase among progressive professional-class social justice workers that “we are working ourselves out of a job”:

I doubt the aspiration of “working ourselves out of a job” is the right one for a global confederation like Partners In Health. Do we want our trainees and 17,000 co-workers to work themselves out of a job? Or is it

¹⁰ Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor* (Berkeley, CA: University of California Press, 2003), 210.

¹¹ Farmer, *Pathologies of Power*, 210.

¹² I owe this insight to a sermon I heard by homiletics scholar Kyle Brooks, who preached that the incarnation of God in the person of Jesus reveals not unconditional love, but the presence of love under all conditions.

¹³ Farmer, *Pathologies of Power*, 211.

really a question of working more and more people into the sorts of jobs that are taken for granted in some of the places where we were born?¹⁴

If there is one world—riven though it is by social inequities so deep and wide they are more like gulfs separating worlds than gaps to be bridged—then where one is born ought not determine who can effectively participate in its repair.

Who Lives, Who Dies, Who Speaks, and Who Listens

PIH's commitment to heed the direction of its patients in order to understand and address together the social inequities that expose them to ill health and death is well documented in the accounts of PIH's first decades of work in the 1980s and 1990s in Haiti and Peru.¹⁵ Listening to patients led PIH to offer treatment for multidrug-resistant tuberculosis (MDR-TB) and HIV in communities facing and fighting poverty, when the reigning global health experts said it was naive at best and irresponsible at worst, consigning millions of people to die from treatable diseases.¹⁶ PIH ignored the Western experts and heeded its patients' aspirations for treatment. PIH's MDR-TB and HIV treatment programs were successful and changed the status quo in global health delivery. Now, even the experts advocate for MDR-TB and HIV treatment globally. But the fight is not over. With each new disease outbreak—cholera, Ebola—the reigning Western experts authorize prevention, not treatment or vaccination. And PIH fights back each time. PIH and its patients continue to expand what is possible in global health delivery, offering cancer care and surgical services to communities that had been clinical deserts. This transformation

¹⁴ Paul Farmer, "On Partnership and Accompaniment: Three Questions, an Example, and Three Suggestions," November 4, 2018.

¹⁵ Paul Farmer, *Infections and Inequalities: The Modern Plagues* (Berkeley: University of California, 2001), 45; Paul Farmer, *AIDS and Accusation: Haiti and the Geography of Blame* (Berkeley: University of California Press, 2006), 47; Farmer, *Pathologies of Power*, 149–150; Paul Farmer, *To Repair the World: Paul Farmer Speaks to the Next Generation*, ed. Jonathan Weigel (Berkeley: University of California, 2013), xxi.

¹⁶ Farmer, *Pathologies of Power*, 201.

in health care delivery is possible because people who have been written off by the dominant circulation of resources are consulted and considered as full agents in the effort to provide a preferential option for the poor in health care. The critical reflection of the oppressed is, as Emilie Townes calls for in *Womanist Ethics and the Cultural Production of Evil*, “included into the discourse—not as additive or appendage, but as resource and co-determiner of actions and strategies.”¹⁷

In summing up this moral praxis in conversation with Fr. Gutiérrez, Paul says “When we actually went out and did what we said we were doing, which was listening to the poor, we discovered that we weren’t listening enough. Imagine even after several years of reading and thinking, there’s still more you can learn about how to structure a program by actually listening to people.”¹⁸ Paul acknowledges how difficult it is to listen, “especially when the subject at hand is social suffering.”¹⁹ Despite difficulties, failures, and shortcomings, however, PIH still strives to listen and engage the people most directly affected by health care inequality as protagonists of their own liberation. They are key moral agents in the fight against the poverty that causes their suffering.

A relatively recent example is the Journey to 9 program, which began in Haiti in 2018 when the PIH team noticed that maternity patients were missing prenatal appointments, did not have clothes or blankets in which to take their newborns home, and did not return for a postnatal appointment. Haiti has the highest rate of maternal deaths in Latin America and the Caribbean, and the PIH team also wanted to increase the number of pregnant people who delivered in well-staffed and equipped health care facilities. The team asked the new parents what the barriers were for them to come to the health care center for prenatal visits, delivery, and postnatal visits. Out of those conversations, PIH designed a program which includes eight group prenatal appointments, one group postnatal

¹⁷ Emilie M. Townes, *Womanist Ethics and the Cultural Production of Evil* (New York: Palgrave Macmillan, 2006), 16.

¹⁸ Farmer and Gutiérrez, *In the Company of the Poor*, 166.

¹⁹ Farmer and Gutiérrez, 112, 9.

appointment (hence the name Journey to 9, as in making it to all nine pre- and postnatal visits), psychosocial support and counseling, community-based care, hospital-based services, and a kit that includes onesies, a thermometer, and other hygiene supplies.²⁰ At a graduation ceremony, participants can share their experiences of the program. Participants have noted that the group setting makes the experience more supportive and less intimidating for women from poorer backgrounds. One participant had delivered a baby in the PIH maternity ward before the Journey to 9 program was launched. She said the Journey to 9 program made it an entirely different experience when she delivered her second child—as if it were a new facility.²¹ Two thousand women have participated in the program. Since 2019, 95 percent of them have delivered in PIH health care facilities. By comparison, only 36 percent of pregnant people in Haiti give birth at a health care center. The PIH team has already expanded the program to another public hospital where PIH works in Haiti and would like to extend the program to other regions throughout Haiti. The PIH maternal health teams in Mexico and Peru expressed interest in replicating the program. In February 2020, Haiti’s Journey to 9 team traveled to Chiapas to help them adapt the program for patients living in Mexico and Peru.²²

Space to Bear Witness in the Academy

Paul and the PIH team heed the insights of people most directly affected by social inequity not only to direct the shape of clinical interventions but also make space for their participation in academic settings where the shape of the world is debated and framed. For example, Paul recounts participating in an HIV conference in rural Haiti in 2000, “attended

²⁰ Partners In Health, “Mothers and Babies Receive Long-Term Support Through J-9 Program in Haiti,” www.pih.org/article/mothers-and-babies-receive-long-term-support-through-j-9-program-haiti.

²¹ Conversation with the PIH Haiti research department, October 26, 2022.

²² “Partners In Health Annual Report,” 2020, 23, www.pih.org/sites/default/files/pdf/pih-annual-report-2020.pdf.

mostly by women living in poverty, several of them also living with HIV.”²³ The women raised questions to challenge global health’s reigning position that prevention is the best course of action in places with sparse medical infrastructure—a position supported with research conducted in low and middle-income countries by affluent Western institutions whose “ethical codes developed in affluent countries are quickly ditched as soon as affluent universities undertake research in poor countries.”²⁴ In another salient example, a PIH symposium on global health equity held at Harvard University in 2009 featured keynote speakers Adeline Merçon and St. Coeur François, PIH staff members in Haiti who had started out as patients.²⁵ Paul stood with them on the stage to translate their remarks from Haitian Creole into English.

In addition to devoting space on the dais, Paul devotes much space in his books for the people on the underside of dominant power to tell their stories and analyze the structural violence that targets them most grievously. Womanist ethicist Marcia Riggs’s conception of a mediating ethic helps identify one of the moral frameworks at play in Paul’s approach. A mediating ethic is a move toward justice that generates momentum in the face of a moral dilemma.²⁶ Imperfect and insufficient though it may be, it is moral agency that moves a community enough to perceive a new possibility it could not have realized in its former position. Paul’s move to include in his books the voices of the oppressed offering a critique of the socio-politico-economic structures that cause them harm is a mediating ethic that advances liberation praxis through the impasse of a moral dilemma: not hearing the perspective of the oppressed in the dominant discourse versus publishing pieces of their self-narrated stories in widely-read books written by Paul that circulate in his name.

²³ Farmer, *Pathologies of Power*, 198.

²⁴ Farmer, *Pathologies of Power*, 198–200.

²⁵ Partners In Health, “15th Annual Symposium Pushes Boundaries,” www.pih.org/article/15th-annual-symposium-pushes-boundaries.

²⁶ Marcia Riggs, *Awake, Arise, & Act: A Womanist Call for Black Liberation* (Cleveland: Pilgrim, 1994), 20.

In Paul's first book, *The Uses of Haiti*, Yolande Jean gets the first word. She frames and directs the book's examination of the long history of the United States' exploitative and extractive relationship with Haiti from her perspective as a refugee who qualified for political asylum in the United States because of the torture she endured under Haiti's military regime but who was detained at the Guantanamo military base and prevented from entering the United States because she was HIV positive:

Everyone in Haiti was always criticizing the American government, and I'd say "You're not there, so how do you know they really wish us harm?" They'd say, "but look what they did to us in 1915," and I'd respond, "But that was a long time ago; things have changed." And yet I've come to see that there hasn't really been any change. My experience on Guantanamo allowed me to discover that it was true—these things are their doing. I have no idea what we are to them—their bêtes noires, or perhaps devils. We're not human to them, but I don't know what we are. It's as if they see us as a part of the world born to serve as American lackeys. And that's just what's come to pass. They use us as they see fit.²⁷

Jean's critique is remarkable because too often structural violence limits the transmission of critical analysis by people on the underside of hegemonic power. "Haitian friends have commented on parts of [*The Uses of Haiti*]," Paul writes, "but all, with the exception of Yolande Jean, have asked to remain anonymous."²⁸ Structural violence—which Paul defines as "social arrangements that put individuals and populations in harm's way"—denies people on the underside of power public authorship of their own stories and critical analyses.²⁹ Paul and his Haitian friends resist in the best way they can, having Paul tell their stories under pseudonyms.

²⁷ Paul Farmer, *The Uses of Haiti* (Monroe, ME: Common Courage, 1994), 10.

²⁸ Farmer, *The Uses of Haiti*, 8.

²⁹ Paul E. Farmer, Bruce Nizeye, Sara Stulac, and Salmaan Keshavjee, "Structural Violence and Clinical Medicine," *PLoS Medicine* 3, no. 10 (2006): 1686, doi.org/10.1371/journal.pmed.0030449.

In drawing near to bear witness to his patients' stories, Paul does not instrumentalize them to justify his work and position as a Western physician-anthropologist. Rather, Paul shares the stories of individual people with their permission to indict the Western-dominated global circulation of knowledge, identity, and power that causes their local misery. Farmer makes a similar move in his latest book, *Fevers, Feuds, and Diamonds: Ebola and the Ravages of History*, as noted in Barbara King's review for NPR:

In this grim tale, it's a relief to read about the West African survivors of Ebola who work to help others rebuild their lives. The stories of Ibrahim Kamara and Yabom Koroma, Sierra Leoneans who endured sorrowful family losses as well as terrible illness, Farmer conveys partly in their own words. It makes for two gripping chapters.³⁰

In the dominant Western-centric discourse, Yolande Jean, Ibrahim Kamara, and Yabom Koroma are not viewed as moral agents or even—Jean makes plain—as human. In Paul's writing, however, they are the actors whose critical reflection and action address most effectively the major moral crises of the day: political asylees crossing oceans in rafts; HIV; Ebola. Farmer does not use the stories of Jean, Kamara, and Koroma as "local knowledge" to give authenticity to his scholarly analysis. Rather, Paul uses his position as a credentialed Western academic to make noticeable if imperfect gestures at including Jean's, Kamara's, and Koroma's critical action and reflection in the analysis of structural violence and global health.

Together, Farmer's, Jean's, Kamara's, and Koroma's liberating praxis helps shape a new moral agency. This moral agency is marked by transgression of the roles assigned by the colonality of knowledge, power, and identity. Though the era of formal colonial governance is mostly over,

³⁰ Barbara King, "In 'Fevers, Feuds And Diamonds,' Paul Farmer Breaks Down Assumptions About Ebola," *NPR.Org*, November 17, 2020, www.npr.org/2020/11/17/935337735/in-fevers-feuds-and-diamonds-paul-farmer-breaks-down-assumptions-about-ebola.

power still flows through the colonial project's circuits: control of the knowledge and resources necessary for world-building accrue primarily to professional-class, predominantly white, cis-gendered men from Western centers of power.³¹ Farmer refuses a binary construction of dominant moral agency that either takes total control of the critical knowledge and action necessary to transform the world or refuses to exercise any power to speak and act for liberation so as not to be labeled an oppressor. Instead, Paul makes the mediating ethical move to transgress the rigid bounds of the physician-scholar social position by reporting and heeding the analysis and direction of people most directly affected by the suffering he actively labors to relieve. Jean, Kamara, and Koroma boldly transgress the object-of-foreign-intervention social position by authoring a paradigm-shifting critical analysis of the global structure that placed them at risk of grievous violence and harm.

Implications for Theological Ethics and for the Current Moment

Paul's conception of moral agency—marked by Latin American liberation theology and lived out through the field of global health equity—offers theological ethics an approach for engaging positionality to open new lines of critical reflection and possibilities for action. In the communities where PIH works and within the pages of Paul's books, patients assume authorship to interpret the complex reality of their lives and the global forces that shape them. Paul and his patients exercise moral agency that troubles the roles they inhabit in the Western hierarchy of identity, power, and knowledge. Paul and his patients exercise the liberative potential of their respective social positions to relieve suffering and to shift iniquitous power imbalances together: PIH patients' use their position on the underside of power to name the social conditions and structural barriers that block their ability to exercise their rights and reach their potential;

³¹ Nelson Maldonado-Torres, "On the Coloniality of Being," *Cultural Studies* 21, no. 2/3 (2007): 261.

Paul uses his position as a credentialed Western physician and scholar to marshal resources to redress the social inequities PIH's patients and staff identify; and they do so without becoming immobilized by the reality that in a system as rife with social inequity as the current global order, any action can only be partial and imperfect. Though Paul and his patients do not suddenly escape or destroy these roles, they show that the identities defined by iniquitous social conditions do not essentially or ultimately circumscribe human critical thought and action.

As I write, Haiti is facing one of the most difficult moments in its recent history:

a steadily deteriorating security situation over the past 15 months, which has worsened dramatically in recent weeks. Gang violence, protests, roadblocks, damaged communications infrastructure, and fuel shortages pose grave operational and logistical challenges for the team at Zanmi Lasante, as PIH is known in Haiti.³²

In October 2022, a new cholera outbreak emerged in Haiti. I have heard people who have supported humanitarian and development projects in Haiti for decades say that they will no longer donate to projects in Haiti because of the instability. Paul's moral praxis—committed to critical reflection and action under all conditions—helps chart a way forward. The current conditions are no excuse to give up. Liberative moral praxis in this moment demands critical reflection on the historic, geopolitical, economic, social, and structural root causes of Haiti's current crisis, which are directly related to the wealth and security that Western powers enjoy. Though Haiti is only five-hundred miles from Florida, it feels like a world away from the United States. Paul would remind us that it is not.

Liberative moral praxis also demands action that heeds the direction of the people most directly affected by social misery, and that shifts resources to address the social conditions that put the majority of people in harm's

³² Partners In Health, "With Instability in Haiti, Doors Remain Open at PIH Facilities," www.pih.org/article/instability-haiti-doors-remain-open-pih-facilities.

way. PIH is doing all of these things, as described in a recent article on its website. With the weight of all that the members of PIH team in Haiti are bearing, I want to quote them at length to communicate their depth of analysis, of resolve, and of spirit:

PIH believes a solution to the current nationwide crisis must be led by Haitians, and likely with the support of the international community. But our focus remains on working with ministries of health, not politicians; looking at histories, not the news of the day; and engaging in accompaniment and strengthening of equitable, high-quality health systems.

Zanmi Lasante is of course not just an organization capable of emergency response. It is a Haitian organization, led and run by Haitians. It works with and through the Ministry of Health, serving to bolster that institution's capacity to deliver quality health care to Haitians. Since 1985, it has only grown bigger and better, despite all sorts of political and environmental challenges. Its residency programs now train tomorrow's leaders. In short, it is a sterling example of how to aggressively chip away at a deep, deep problem—namely, a history of oppression that has resulted in a galling lack of modern medical care in the country—through solidarity, accompaniment, and providing a preferential option for the poor.³³

Paul would be proud.

Paul's liberation praxis interrupts dominant assumptions about whose and which formulations of moral agency effectively diagnose, alleviate, and prevent social misery. Paul's embrace of Latin American liberation theological praxis is a mediating ethic, not a moral absolute. "A preferential option for the poor and accompaniment and structural violence," Paul writes, "are not the only good ideas out there, but rather remind us of work yet to be done."³⁴ Paul's life and work demonstrate that moral agency which produces movement towards social justice is possible for anyone in

³³ Partners In Health, "With Instability in Haiti, Doors Remain Open at PIH Facilities."

³⁴ Farmer and Gutiérrez, *In the Company of the Poor*, 134.

any social position. In Paul's moral calculus, there is too much ground yet to gain for anyone to make any excuse not to take part in the work to transform the world together.



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