SOCIAL MEDICINE IN PRACTICE

# Rethinking responsibility in global health: a case from Ethiopia

*Bram P. Wispelway MD, MS*

**Abstract**

The social determinants of negative health outcomes in the northern Tigray region of Ethiopia have aspects both unique and common to poor regions of the world. Using personal experience from my global medicine clerkship, I explore the historical, global, and local factors that lead to the continuation of poverty, ill health, and distrust in government and health systems among the poor of Tigray. In addressing a specific social determinant of health, in this case the decision of patients to abandon care to avoid death fees, I show that an accurate conception of the problem must be preceded by a broad and deep analysis of historical structures and actors. I argue that the direct responsibility and indirect complicity of the West engenders an obligation to the poor that goes beyond charity or compensation toward creative solutions and structural changes.

I scanned the faces of physicians and nurses at our large referral hospital for alarm or explanation. The dedicated medical team carried on with their work, quietly accepting that our ward's sickest patient had vanished overnight. Shriveled by tuberculosis, the 20-year-old woman was due for another attempt with a frustratingly high gauge needle—the only size available—to drain the thick pus from her abdomen. After only three days of hospitalization, it was too early to assess the efficacy of the tuberculosis medications. But at the nadir of physician presence she had signed out against medical advice with two brothers determined to bring her the day's journey home. An American studying medicine in Israel, I had witnessed, prior to arriving in Ethiopia, even the most skeptical patients replace distrust with hope in health workers who might halt their suffering. But this woman's forsaking of care reflected larger structures than those represented by the caregivers, and helped me begin to understand my own connection to the chain of events leading to her disappearance.

For many, Ayder Hospital in the northern Tigray region of Ethiopia is a destination of last resort. After help is sought at local clinics and secondary hospitals, patients frequently present here with end-stage complications of infection, cancer, cirrhosis, and heart failure. So why would a patient abandon hope after making the long and arduous journey to reach the facility? After finding my patient's bed empty in the morning, I broached the subject with my attending, a youthful and empathetic clinician who had been a local shepherd until educational opportunity struck at age twelve. With some resignation, he explained that hers was not an isolated case among the very sick. If a patient expires at the hospital, the body must then be transported by an official vehicle with a set fee that is unaffordable for many. While there is a process to apply for a fee waiver, families often believe, probably with good reason, that the paperwork and meetings may lead nowhere or in any case delay their traditional burial ceremonies. Our patients could not afford to die in our care, and seemed to view the entire medical system through what physician and anthropologist Paul Farmer has called a "hermeneutic of suspicion."[1]

Certainly for the Tigrayan peasantry, forced to concede death in order to secure humanity through

**Bram P. Wispelway. MD, MS**
Department of Internal Medicine, Brigham and Women's Hospital, Boston, MA, USA
Email:bwispelwey@partners.org

**Submitted:**
**Revised:** 5/24/2014
**Accepted:** 7/14/2014
**Conflict of interest:** None
**Peer-reviewed:** Yes

their funerals, such an affront only affirmed their distrust in government institutions, of which Ayder is one. While medically irrational, this decision to forego care seems reasonable after considering the historical legacy in which the nighttime decision was made. While we from the West often think of mass poverty as a historical accident or the function of impersonal long-ago events, those in poverty are more likely to claim that wrongs have been done *by* human beings *to* human beings. There is little hesitation in assigning responsibility. As my attending stated bluntly, "[i]n recent times we have been suffering. War, famine, disease: we don't deserve this. We are being held in poverty." The agents of injury are often both obvious and indirect, and require an analysis that is both historically deep and geographically broad.[1] In the case of Ethiopia, which faced extensive peasant famines during the 1970s and 1980s, the West shook its head and wagged its finger at the country's leadership. It was easy to point to the full storehouses that continued to serve up tables of plenty to the nation's elite and to the aloof dictators and military men who sought to protect their interests and global image.[2]

But in examining the indirect forces, we often find links to rich and powerful governments that have financial and military connections to the countries "held in poverty." For example Israel, where I attend medical school, in 1983 sold Ethiopia's ruthless communist regime, the Derg, US $20 million in weapons and spare parts that had been captured by the Israeli Defense Forces in Lebanon. Hoping to secure an ally as well as the immigration of Ethiopian Jews, by 1985 Israel was providing military training and advising for the Derg despite the fact that no official relations existed between the countries.[3] That same year, when Ethiopia was well into its worst famine in recent memory, the United States and other Western countries initially balked at providing food aid due to the country's communism. When aid finally arrived, it was strategically blocked by the Derg to further punish the politically troublesome region of Tigray, which is culturally linked to adjoining Eritrea, then a rebellious province of Ethiopia.[4] By the end of 1985, a million people were dead.[5]

Israel, concerned about the possibility of a less-than-friendly Eritrea declaring independence, and undeterred by the intentional mass starvation and murder of the populace, increased its military aid in the post-famine years. Anti-Derg revolutionary leader and subsequent prime minister of Ethiopia, Meles Zenawi, concluded in 1990, a year before the regime finally capitulated, that it "would probably have fallen by now if it had not been for the Israelis."[6] While the Derg's leader, Mengistu Haile Mariam, is at this moment living comfortably with government protection and support in Zimbabwe, his regime is now recognized for orchestrating what Human Rights Watch has called "one of the most systematic uses of mass murder ever witnessed in Africa."[7] A harrowing museum in Addis Ababa has been opened to remember the thousands of political opponents who were tortured and murdered during what has been dubbed the Red Terror.

In the ensuing years, life has continued to be difficult for the poor of Tigray who, in addition to experiencing steady rates of HIV, tuberculosis, and malaria, suffer from one of Sub-Saharan Africa's highest burdens of neglected tropical diseases.[8] Food security and economic mobility continue to be elusive for many in the region. The end-stage illnesses and patient disappearances are painful reminders that in settings of global poverty as well as in wealthy but unequal countries, it is often not enough to treat the patient in front of us. These extra-medical factors that neutralize the promise offered by our good will, our knowledge, our drugs, our surgeries—what about them? They require something extra, and this starts with asking the right questions about what has gone wrong.

Inevitably, the inquisitor is led to a decision of whether to join the poor in following the trail of connections and naming responsible parties even, and especially, when it becomes uncomfortable. After this is the need to move beyond good intentions: actively engaging our role as citizens with at least some say in the foreign policy and economic decisions of our own governments, as well as using our creative potential to alleviate suffering via non-governmental channels. If German philosopher Thomas Pogge is correct that rich countries and global neoliberal policies are directly linked to the continuing poverty and associated negative health outcomes of poor nations, then his conclusions—that this is an issue of justice as opposed to charity—should be taken seriously: "We must then at least compensate the global poor. Failing to do this, we would be harming them and profiting from injustice at their expense."[9] Paul Farmer has also claimed that it is essential to "see the conditions of the poor not only as unacceptable

but as the result of structural violence that is human-made", and that we privileged Westerners are implicated in its creation and thus its eradication.[10] Responsibility may be diffuse and complex, but reflective work in global health proves that its ostensible distance from Western experience is illusory.

Thinking of the young woman weightless with tuberculosis as she is carried out of the hospital by her two brothers, I can now see that my well-tended hands are not clean in the long and tortuous series of events that led to her disappearance. The challenge before me is the one set before the privileged: first, to embrace our responsibility, followed by the painstaking work of identifying the specific conditions and actors, domestic and global, that lead to poverty, human rights violations, suffering, and illness. Only then will upstream solutions become visible on both grand and individual scales. Witnessing the human toll of our collective indifference, we must move beyond the initial instinct—to pay the family's vehicle fee—towards actions that ultimately eliminate the conditions that put a price on her right to live.

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