

The Adventure of Helping Abroad: Experiences Providing Health Care in Ethiopia

Interview with Jeffrey Panzer, MD and Erin Mc Carville, MPH

Jeffrey Panzer (JP), is a former Thomas Jefferson University Family Medicine resident. His wife, **Erin McCarville (EM)**, is a public health specialist. They are currently working in rural Ethiopia and documenting their experiences on their blog: <http://erin-jeffinethiopia.blogspot.com/>.

What was your motivation for pursuing this type of work? Is this the first time you have been involved in providing health care overseas?

JP: After college, I taught English in rural Costa Rica for a few months, which sparked an interest in international work that hasn't died down since. During medical school and residency, I did short-term stints in Honduras, Ecuador, Jamaica, and Guatemala.

In Costa Rica, I was shocked at the disparity between the developing and developed world. I realized how much I had taken for granted all the opportunities afforded to me throughout my childhood and young adulthood. It felt like I had opened my eyes for the first time to many realities of the world. From that moment on, I wanted to help others witness this disparity. At the same time, I've been striving to determine a way to be more than just a learner and observer in the developing world and work towards helping close the gap between the two worlds.

EM: Jeff and I both attended Pomona College in California. I received my Masters in Public Health from Johns Hopkins University. I have worked in Washington, DC for the US Senate as well as for the National Academy of Sciences and the Institute of Medicine. Most recently, I worked as a grant writer and public health non-profit manager for a the Health Promotion Council under the Public Health Management Corporation (PHMC) in Philadelphia.

What kinds of expectations did you have before you arrived in Ethiopia? Did you have any training or preparation for what you would encounter as a provider of health care there?

JP: Ethiopia sits between Sudan, Somalia, and Eritrea – all areas of current conflict. I expected to feel more unsafe and more like I'm in some estranged foreign land, but I really feel at home here. Medically, I was worried about being the only technical “doctor” for a population of 130,000 people, and that my skills would not be up to par. The best preparation that I had was my month in Guatemala during residency where I cared for patients in a resource-poor setting.

Tell us about the clinic you work in. How is it funded?

JP: We work in a clinic called Chiri Health Center. It is in the southwest part of Ethiopia, about a ten-hour drive from the capital Addis Ababa and a four-hour drive from the closest city. The health center has a unique managerial structure – it's a government health center, but most components are managed by an NGO (non-governmental organization) called Lalmba that's based in Denver. Lalmba pays for the American volunteers to work here (between 4-5 people at any given time), pays for the majority of the 40-person Ethiopian staff (managers, guards, cleaners, pharmacists, etc), and pays for most medicines and supplies. The government pays for our nurses and lab technicians. Some medicines for TB, HIV, malaria, and malnutrition are provided for free through large aid organizations such as USAID, World Health Organization, and UNICEF.

Describe the actual physical environment of the clinic you work in.

JP: The health center has two main buildings. The first houses our labor and delivery room (with two laboring beds) and our inpatient rooms, which consist of a main room (with 7 beds), a malnutrition room (with 4 beds), and an isolation room (with 3 beds). In spite of our cleaners' best efforts, the cleanliness of these areas is far from US standards. There are no sinks to wash your hands between

patients, so I'm often left with a choice— touch the patients and risk spreading diseases between them, or not to touch them and miss some physical exam findings while seeming like a cold, uncaring foreigner. The second building has 5 outpatient exam rooms, an injection room for vaccines and family planning, and a treatment room for dressing changes and emergencies.

What one change would enable you to function better or improve the lives of the patients/community?

JP: The one change that would most improve the lives of the community would be a better public health system. If there's one thing I have learned being here, it's that there's a difference between *do-good* work and *feel-good* work. I'm reminded of what the doctor who oriented me said: “There will be some scary medical problems where you don't know what to do and that's OK.” We're not here as a band-aid; we're here to put systems in place to vastly improve the public health. This is about the solution as opposed to the band-aid method. When you watch a tuberculosis patient gain 5 kg over the first two months of their therapy, you feel good about yourself and the work you do. But when public health work is done well and tuberculosis cases are prevented, for example, no one knows. The challenge to doing good international work is ensuring that the work you are doing is truly helping the community and not just making you feel better about yourself.

What are the most common types of ailments, injuries, and diseases that you see in the clinic?

JP: We see a huge variety of adult, pediatric, and obstetric patients. The most common disease causing hospitalization in children is pneumonia. We also see a large number of malnourished patients, either with severe wasting from calorie deficiency (marasmus) or swollen from protein deficiency (kwashiorkor).

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They usually spend two weeks in the malnutrition ward. We see an overwhelming amount of tuberculosis, which frustrates me. It is a completely treatable disease yet continues to ravage the population of countries like Ethiopia. We also see many acute diarrheal illnesses, intestinal parasites, gastritis, arthritis, skin infections and abscesses, malaria, typhoid, and other tropical diseases. We have antenatal clinic twice per week, and do many deliveries and other obstetrical procedures.

Was there anything that surprised you?

JP: We do see a large number of machete wounds from fights, especially on market days when lots of home brew is consumed in town.

What motivated you to create a blog and document your experiences?

EM: We started a blog to inform friends and families about our experiences here. But we soon realized that the blog was reaching a wider audience as co-workers, extended family, and friends-of-friends began to follow along. As a result, we adjusted the blog topics to make them more interesting and thought-provoking to a wider audience—discussing bigger-picture topics related to living and working in a developing country. We hope that these posts offer opportunities for thought and dialogue among our friends, family, and readers.

Your blog poignantly illustrates some distressing experiences where you had to “let go” and accept the impending and inevitable death of a patient. You describe this as a learning experience because you are trained and conditioned to “save” and never give up. Describe how these experiences might change your perspective or change you as a clinician.

JP: I’ve definitely changed my perspective of death since being here. I’ve learned to say to myself that I’ve done everything reasonable for this patient, and I’m more ready to face death as a possibility than I ever was in the US. What’s interesting is that I don’t think a CT scan or MRI would help these people much. In the US, I can only imagine how many tests would be run on some of these patients. And yes, their outcomes would be better for the most

part. But mostly, their mortality rates are high because they waited too long to come in to the clinic, which is part of what I mentioned above – if our public health system (including having well-trained community health workers) was more functional, many of these deaths could be prevented. The main disadvantage in not having any radiology here (we don’t even have an x-ray) is that we are forced to over-treat. But in the end, most patients go home healthy.

I’ve also changed my perspective on health. In the US, there is an expectation that if someone gets ill or dies it is someone’s fault (sometimes the doctor). There is always a potential lawsuit. Without any threat of medical malpractice here in our corner of Ethiopia, I’m sure there is a certain amount of carelessness that leads to errors and that’s a huge negative. But there is also not an expectation of good health regardless of the scenario that may lead to the skyrocketing healthcare costs in the US. I do believe that these experiences have changed me, but I worry that how I practice medicine will quickly revert when back in the over-litigious environment of the US.

On your blog, you wrote a very provocative essay, *What is Good Aid?* What concerns you the most about the way aid is distributed to underdeveloped countries?

JP: I think development work is much harder than people think. Many of us in the US sit in our comfy couches and watch documentaries from the third world and ask ourselves how we can help. I think that’s a good thing. There’s obviously a disparity and a need to address it. However, the first question I would tell others to ask themselves is not how they can *help*, but how they might *hurt* the situation if they try to help. Development dollars are a huge part of the economy of many of these developing countries. They have the potential to do a great good, but also the potential for much harm.

In *What is Good Aid?*, I described the perverse incentives for health professionals to attend trainings. Through this *per diem* system (where they get paid at their job back home and also get paid to be at the training), Ethiopians expect payment for participating

in their own continuing education. Instead of paying to go to a conference like physicians do in the US, the conference pays them to be there. Certain diseases, such as HIV, seem to have more funding than others, allowing incentives to be that much more obvious.

How does this directly impact the clinic where you work?

JP: In our health center, I work with 7 nurses. We see more than 100 outpatients in a day. In addition, we supply daily medication to our TB patients. We care for up to 10-14 inpatients, including severely malnourished children. We have antenatal clinic twice per week. We see HIV patients in a confidential room. We have emergency traumas and deliveries on a near daily basis. Without much warning, 3 of our nurses will be taken away for sometimes as long as a week for a training. So, our number of nurses shrinks by nearly 50% and with it, our capability to care for the population and work towards our public health initiatives. And this type of occurrence is common.

Erin, describe some of your responsibilities as the Public Health Director.

EM: Lalmba’s public health programs are still in the early stages of development. As Public Health Director, my job is to establish long-term goals and objectives for Lalmba, and to implement programs and services that will meet these objects. In particular, we are currently establishing education programs to address malnutrition, sanitation, and TB. We are also instituting community meetings to engage villages in public health projects and we are training government community health workers. Additionally we are conducting outreach to remote communities to vaccinate and screen for infectious disease.

What has been your greatest challenge?

EM: The most challenging component of this work is to maintain preventive health services as a community priority in the face of countless other pressing needs. All too often, public health work is underfunded, or undervalued as a community service. It is therefore easy to argue that more funding and investment in public

health programs is needed, but funding is just one important piece of the public health puzzle.

Are there particular needs that you feel need more attention and funding?

EM: I would argue that, specifically, smart investment is needed in developing and replicating community-based best-practice work. Country

or region-wide public health projects often fail to understand the local needs and cultural nuances that impact the implementation of public health programs locally.

What have you enjoyed the most?

EM: It is necessary to know a culture and community thoroughly in order to

deliver public health services most effectively and efficiently. It is for this reason that I appreciate my work with Lalmba – an organization dedicated to truly understanding and working with the communities which we serve. ■

For more information on Lalmba visit:
<http://www.lalmba.org/>