



# Letter from Ethiopia

## The bridge-builders

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I was born in an ancient landlocked country in Northeastern Africa officially known as the Federal Democratic Republic of Ethiopia. Bordered by Somalia, Kenya, Sudan, Eritrea, and Djibouti, my homeland is famous for its varied landscapes and rock-hewn churches, revered as the original home of the coffee bean, and known for being the source of the Blue Nile.

With a population of 81 000 000 people, Ethiopia is the second most populated country on the continent—a challenging environment for medical professionals. There is 1 physician for every 100 000 patients in rural areas, and medical journals and textbooks are scarce.<sup>1</sup> Hospitals rely on outdated equipment and substandard sanitizing technology. According to the World Health Organization, nearly 90% of all expectant mothers in rural Ethiopia deliver their babies at home or walk many miles to ill-equipped clinics.<sup>2</sup> Life expectancy is 49 years for men and 51 years for women.<sup>2</sup> Strenuous efforts have been made, by both the government and non-governmental organizations, to improve the situation, and plans are in effect to create 11 new medical schools (8000 new spots) over the next 2 years.<sup>3</sup> But the shortage of doctors, nurses, and other health care

providers means an even greater shortage of qualified people to train them.

Even though Ethiopia is now relatively stable, it is still recovering from many years of civil war. After Emperor Haile Selassie was deposed in 1974, the country experienced a powerful wave of turmoil. My father managed to secure a position with the United Nations in 1976, which allowed us to leave the country. On top of saving our lives, this move gave me the opportunity to receive family practice and emergency medicine (EM) training in Canada.

To this day, Ethiopia faces complex socioeconomic and health problems. There are cultural barriers to providing optimal medical care. The number of people living with AIDS and HIV is a national problem, and rates of ischemic heart disease, diabetes, and stroke are rising.<sup>4</sup> With the country's rapid development of urban populations, industrial accidents and traffic accidents are increasing dramatically. In fact, authors of a recent *Newsweek* article said Ethiopia had the highest per capita rate of car fatalities in the world—190 deaths per 10000 vehicles.<sup>5-7</sup>

To compound the problem caused by the high rates of traumatic injury, EM as a specialty does not exist in the



Volunteer physicians from the Ethiopian North American Health Professionals Association teaching cardiopulmonary resuscitation

country and is not recognized by the Ethiopian Medical Association. The concept of time-sensitive care is new for physicians and nurses, who have not been trained to think in terms of the "golden hour." Further, Ethiopian emergency departments, or "casualty departments" as they are called, are poorly equipped and unprepared for disasters and rapidly emerging infections. Most patients are first seen by interns who have little training in triage principles or trauma care. Patients are later transferred to the appropriate specialists.

### A multinational alliance

I lived in many parts of Africa before settling down in Canada and completing my medical training. In 1999, I joined with members of the large professional diaspora community living in the United States and Canada to form the Ethiopian North American Health Professionals Association (ENAHPA). Along with many other physicians, dentists, pharmacists, and allied health professionals, I felt an obligation to help the country of my birth by improving health care in Ethiopia.

Today, one of the main goals of ENAHPA Canada is to develop an EM training program. I have been advocating this important mission for several years now, and during my most recent trip to Ethiopia I saw proof that diaspora-driven organizations can be effective bridges between developed and underdeveloped countries.

The current Canadian EM initiative involves providing continuing medical education (CME), as well as helping Ethiopian physicians who are potential leaders in the EM field study overseas. The initiative also involves publishing an ENAHPA-supported EM textbook for Africa, as there are currently no relevant texts that describe the unique challenges of practising EM in developing countries.

In May of 2006 and 2007, I helped coordinate groups of EM physicians, primary care physicians, and nurses from Canada and the United States who traveled to Ethiopia to provide CME for nurses and other hospital staff in Addis Ababa. The focus of the training was principles of advanced cardiac life support, triage, and acute trauma care. To guarantee maximum participation from health care providers, the training was scheduled to coincide with the annual meeting of the Ethiopian Medical Association.


In 2008, more CME was provided, this time by volunteer academic staff from the University of Toronto in Ontario and the University of Alberta in Edmonton and EM physicians and nurses from Stanton Hospital in the Northwest Territories. Health professionals and administrative staff from all over Ethiopia took advantage of the clinical presentations offered. As well, speakers from Uganda, Ghana, and South Africa attended meetings to share their experiences of developing EM infrastructures in their countries. These speakers alerted audience members to the need for private-public partnerships and a network of interested stakeholders to support the kind of EM initiatives proposed by ENAHPA Canada.

As a result of such advocacy, the Ethiopian Ministry of Health and the Faculty of Medicine at Black Lion Hospital in Addis Ababa are now making EM a priority. A technical working group is currently considering how to both develop a national EM system and provide the formal training programs needed for health professionals.

### Citizens of one world

A new world order emerged from the end of the Cold War, and the events of September 11, 2001, showed us how small the globe has really become. Based on my experiences in Ethiopia, I believe that Canadian-trained physicians are in a unique position to participate in global health projects. To heed the words of former Canadian prime minister Lester B. Pearson,

there can be no peace, no security, nothing but ultimate disaster, when a few rich countries with a small minority of the world's people alone have access to the brave, and frightening, new world of technology, science, and of high material living standards, while the large majority live in deprivation and want, shut off from opportunities of full economic development; but with expectations and aspirations aroused far beyond the hope of realizing them.<sup>8</sup>

Through ENAHPA, we have been able to help develop a better health care system in my once war-torn homeland. This opportunity to build on the indigenous abilities of my country's people has confirmed my belief in the necessity of global citizenship and the need for a global prospective on medical initiatives. 

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#### Competing interests

None declared

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