These conversations are called Voices From The Field, and what you've just heard are two true voices from the field describing how they are working with our Ministry colleagues on improvements to the hospital in Ifanadiana District in Madagascar. I'm here to step back a bit, so we can consider how the hospital fits into the larger picture of the healthcare system and to look at things from more of a global perspective.

I feel like this is a particularly fraught time for taking a global perspective on anything. Certainly, events of the last few months with the COVID-19 pandemic have underlined just how interconnected we truly are as a global community. And I think it would be remiss of me not to touch on the critical dialogue that was kicked off in the United States last week following the tragic deaths of George Floyd, Ahmaud Arbery, Breonna Taylor, and too many others before them.

But how does that tie into a conversation about district hospital care in a rural region of Madagascar? If you bear with me, I'm going to try to explain how I think they're fundamentally related.

This webinar rounds out a conversation around the 3 different levels of healthcare that PIVOT supports in Ifanadiana District. We started a few weeks ago with a discussion of community health and the integral role community health workers (CHWs) play in linking remote communities to basic health services. Then, last week, we talked about the key role of primary care (or outpatient clinics), which can play an important preventive role so that people don't get so sick that they require hospitalization. And finally, today, we're discussing hospital medicine.

The topic of hospital medicine can seem somewhat sterile and foreign to people who haven’t spent their lives working in them hospitals like Jessie, Aina, and I have. But most of us have had the experience either of being hospitalized ourselves or of having been with a loved one while he or she was hospitalized, and during that time there's an incredible feeling of vulnerability – there's a real dependence on strangers in a way that is quite unusual in our normal day to day lives. So, I want each of you to take a moment right now and think about a time like that and remember what it felt like.

Now that you have that in mind as context – and since you’ve already heard some of what we are doing at PIVOT to support people during that uniquely vulnerable time – I want to take the discussion beyond the confines of a clinic or hospital. The provision of excellent hospital care is critically important, but it’s not enough in and of itself. It’s also our job to work with the
Government of Madagascar to make sure that those 3 different levels of the healthcare system (community, health centers, and hospitals) can all work seamlessly together. And I don’t think that’s something we think a lot about in developed countries, but it’s critically important that these systems can function together effectively in order for people to access the healthcare they need.

Why is this so important? Even the strongest community health program won’t survive if community health workers identify sick patients and accompany them to a dysfunctional hospital that can’t treat those people’s illness. Over time, the inability of those patients to receive appropriate care at a clinic or hospital discredits the work the CHW is doing, no matter how committed that community health worker may be and how strong their community-based program is. Similarly, when there are breakdowns in community-based care or primary care, people show up to a clinic or hospital with very advanced disease, often so severe that doctors and nurses can’t save them; and that, in turn, can discredit those facilities no matter how well well-equipped they are and how well trained the staff may be. We recently saw this in Ifanadiana when the community health program stocked out of malaria tests, children were not diagnosed and treated for malaria early on, and instead they children were showing up with severe cerebral malaria late in the disease course when it’s much harder to treat.

Sadly, due to challenges with insufficient human resources, inadequate training, broken supply chain systems, and crumbling infrastructure, in many places around the world hospitals are actually thought of as the place you go to die, rather than a place that saves and protects lives. I’ve worked in some of those hospitals and seen some of those clinics firsthand, and it’s devastating for those communities.

For those of us working in global health, I think there can be this false discussion around the need for education and behavior change in order to increase the utilization of healthcare services. It’s not that I don’t recognize the real value of health education, but I want to challenge the idea that is often promoted that the rural poor don’t know they need healthcare, so we need to spend millions of dollars of aid money to educate them about the need to seek treatment for their child who has malaria or to deliver their baby in a hospital.

There can be real challenges here that can be addressed with education, but in general, people know when they’re sick and they want healthcare, but it has to be affordable, accessible, appropriate and dignified. If it doesn’t meet these 4 criteria, which is the case for a large percentage of the world’s population, then no amount of behavior modification will lead to the changes in healthcare outcomes we seek.

And no woman, poor or otherwise, wants to deliver a baby in a broken-down building – sometimes quite literally on the floor – or take her child to be seen in a facility where there is a lack of trained staff and essential medicines. And for many people, those are the types of facilities we are “educating” women to deliver in and implementing programs to refer their sick children to.
Here is an example of what I’m talking about. This is a health center in the northern part of Ifanadiana District that PIVOT is not yet supporting, and this is the only option for women in the area to come to deliver babies or have their children treated for malaria, pneumonia, and diarrheal illnesses. I think most of us would agree we wouldn’t want to deliver a baby in a facility like this, and we certainly wouldn’t want to walk for hours to do so.

So what we’re doing at PIVOT is working in partnership with the Ministry of Public Health to improve all of these levels of care simultaneously, and also to help people move between them – via ambulances, stretchers, and other modes of transportation.

And this is where I want to bring the conversation back to what we’re experiencing in the US right now. As a result of the overwhelming outpouring of pain and anger that’s been provoked by the senseless death of George Floyd, a Black man in Minnesota, we are having a long overdue renewed dialogue around structural racism and social justice in this country.

What happened last week with George Floyd was an individual example of a fundamental violation of justice. Anyone who’s watched the video knows that. And here have been so many other examples just in the last few months. At the same time, the longstanding racial disparities
in general health outcomes in United States, along with the newly apparent racial disparities we’ve seen in outcomes for people with COVID-19 here over the last few months, are additional examples of structural racism and injustice. These challenges have, unfortunately, been with us for the last 400 years. On the global scale, those trends parallel the even larger forces of structural violence that plague countries like Madagascar in sub-Saharan Africa and in other resource-constrained countries around the world.

There’s a lot of focus on “aid to Africa” intermittently, and it typically focuses around the need for charity to poorer countries. And, while most people recognize the profound injustices that were inflicted on Africa and the African people during the colonial era, we don’t hear a lot about the ongoing structural violence that perpetuates these injustices. This image shows the roughly $30 billion of “aid” that flows into Africa each year, which pales in comparison to the $192 billion that is extracted from Africa in both legal and illegal ways. One can argue about the exact dollar amounts and the details contained in this figure, but the point is clear: there has been an exploitative and extractive relationship between Africa and many other regions of the world that has continued from the colonial era well into today.

Source: Health Poverty Action (2014)
My final point is that these seemingly unrelated inequities – what’s happened with George Floyd and other African Americans in the US, the way the COVID-19 pandemic has differentially impacted people of color in the US, and the stark inequities in healthcare in Africa – are actually all a part of the same process of structural violence and institutional racism that has been perpetuated for centuries. And it is because of ongoing structural violence and deep-seated inequities that women in rural Madagascar have to choose between delivering on the dirt floor of their home or the only marginally better broken floor of a health center like the one I’ve shown you.

Therefore, I think it is up to all of us to promote this dialogue around global structural violence in the same way that people are raising their voices about the structural violence happening here in the United States.