Too Poor to Stay Alive

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A physician’s observations

My observations on health issues in poor countries are from the point of view of a mother, a paediatrician and, in mid-life, a student of public health. I accompany Jeff often and we frequently take our kids to developing countries, and did so from when they were infants. Acquaintances often question the prudence of taking our children to countries with such high prevalence of diseases and low quality of medical care. But Jeff deflects such concerns by pointing at me, saying that he travels with his kids’ paediatrician. This is my first and only, albeit unofficial, role in health issues in poor countries. So before I became interested in public health, I was in charge of my family’s private health.

Over the years of travelling to poor countries, I have gotten the mother/doctor bit down to a science. I mean that quite literally. I keep up with the medical literature on infectious diseases. I read the CDC advisories of latest outbreaks and latest recommendations on travel precautions. Accordingly, to keep my family safe I have, over the years, shot them up with the following immunizations:

DPT booster
Polio booster
MMR boosters
Hepatitis A series of 2 shots
Hepatitis B series of 3 shots
Yellow Fever
Meningococcal vaccine every 3 years
Typhoid vaccine every 3 years
Malaria prophylaxis for each and every trip
So far, this list, which provides short-term protection for my family, already costs over $500 per person which, my in-house economist informs me, is above the average yearly income in sub-Saharan Africa and many other places in the world.

But, being a doting mother and an obsessively compulsive doctor, I do not stop at this expense. I always travel with the following medical paraphernalia and pharmacopoeia:

Insect repellant
Fansidar – in case we get malaria in spite of prophylaxis, since in a lot of places malaria is resistant to currently used anti-malarials
Ciprofloxacin – the antibiotic that became a household name in the Anthrax scare, but we use it for traveller’s diarrhoea or, frankly, when one of us gets a fever and I do not know the cause (misusing the antibiotic in this case is better than going to some clinic, usually woefully understocked and understaffed)
Syringes and IV antibiotic in powder form
Lomotil
Antiseptic ointment
Antiseptic solutions – for hand cleansing since most bathrooms consist of a partitioned hole in the floor without plumbing and without hand-washing facilities.

When we stay in Africa, we drink only bottled or boiled water; we eat only cooked food. We adhere to the dictum: ‘boil it, peel it or forget it’. Whenever we deviate from this mantra, we pay dearly for it, for about two days. Whenever one of us gets sick, I triage. Sometimes I take care of it; sometimes, as when it was an eye emergency, I made an international phone call to my colleague at a hospital in Boston; and when one of our children needed surgery, I practically had the surgery done via an international phone call.

So now, juxtapose this scenario of maternal care with that of my counterpart: a mother in Africa. My most recent experience in Africa was in January 2002. We went to a small village in Malawi, near Lilongwe. We sat on mats in the dusty centre of the village watching the village women give us a warm welcome consisting of singing while performing a dance, miming their chores in the fields. The villagers were mostly older women and their grandchildren. We became painfully aware of the missing generation. Each woman had a story about her dead husband, dead sons and dead daughters lost to AIDS. The grandmothers frequently had seven to nine children to take care of, feeding