

Sallie Thieme Sanford

Sallie Thieme Sanford is an Assistant Professor at the University of Washington School of Law, with an adjunct appointment in the University of Washington School of Public Health. She received her B.A. with honors from Brown University and her J.D., Order of the Coif, from the University of California at Los Angeles.

She began her legal career as a law clerk for The Honorable Robert R. Beezer of the United States Court of Appeals for the Ninth Circuit. She then served as an Assistant Attorney General representing the University of Washington Medical Center, Harborview Medical Center and the UW's health sciences schools and research centers. Professor Sanford has been active on the board of the Washington State Society of Healthcare Attorneys and recently served as its president. Professor Sanford's research interests focus on health care delivery systems, health administration law, Medicare and Medicaid, comparative health law, and medical and administrative ethics.



TEACHING HEALTH LAW IN RURAL ETHIOPIA: USING A PEPFAR PARTNERSHIP FRAMEWORK AND INDIA'S *SHANBAUG* DECISION TO SHAPE A COURSE

Sallie Thieme Sanford*

I.	INTRODUCTION	487
II.	HARAMAYA UNIVERSITY	488
III.	OVERVIEW OF THE COURSES	490
IV.	<i>SHANBAUG</i> AND MEDICAL DECISION-MAKING.....	492
V.	PEPFAR PARTNERSHIP FRAMEWORKS AND POPULATION HEALTH	495
VI.	SOME PRACTICAL OBSERVATIONS	499
VII.	CONCLUSION	501

I. INTRODUCTION

In April 2011, I taught a month-long intensive health law course at Haramaya University College of Law in rural eastern Ethiopia. Given the burgeoning interest in global health law, I suspect, and hope, that others are considering teaching similar courses, whether as visiting or resident faculty. This essay attempts to ease their course preparation workload. I will describe how I used two recent documents—India's 2011 *Shanbaug* decision¹ and Ethiopia's 2010 PEPFAR Partnership Framework²—to shape the course. Both of these are worth consideration for use in a variety of health law and policy courses based in low-income countries with rapidly expanding health systems. Some aspects of my experience might also be helpful for other foreign teachers.

The *Shanbaug* case offers a useful introduction to various issues of law and ethics in individualized medical decision-making. It involves the publicly prominent case of an Indian woman who has for nearly four decades met “most of the criteria for being in a permanent vegetative state.”³

* Assistant Professor of Law, Adjunct Assistant Professor of Health Services, University of Washington. I am grateful to Joan Altman, JD, MPH, for her fine research assistance, to Christopher Sanford, MD, MPH, for his invaluable insights, and to my colleagues at Haramaya University and the University of Washington for their helpful comments. And, of course, to Richard Wentzell, JD, Ph.D., for facilitating this great teaching and learning experience.

1. *Shanbaug v. Union of India*, Writ Petition (Criminal) 115 (2009) (India Mar. 7, 2011), available at <http://judis.nic.in/supremecourt/chejudis.asp>.

2. Five-Year Partnership Framework in Support of the Ethiopian National Response to HIV/AIDS 2010-2014, U.S.-Eth., Oct. 27, 2010, available at <http://www.pepfar.gov/documents/organization/154198.pdf> [hereinafter “Ethiopia PF”].

3. *Shanbaug*, slip op. at 14.

In legalizing and setting forth procedural guidelines for what it termed “passive euthanasia,”⁴ the Supreme Court of India surveys medical decision-making law from a number of jurisdictions and explicitly considers its applicability to India’s legal and cultural contexts.

As of January 2012, nineteen countries and two regions have entered into PEPFAR Partnership Frameworks.⁵ These documents propose a variety of country - or region-specific health policy reforms. Studying these proposals could focus discussion on the law’s potential role in promoting population health in a given country. In addition, depending on the school’s location and the issues of academic interest, a Partnership Framework could provide an opportunity for timely problem-based learning in conjunction with affiliated health sciences faculty, policymakers, or local advocacy groups.

I found that these documents helped shape an engaged class, and hope that others might take them far beyond what I did. My use of them in a short seminar at Haramaya University can be considered a beta test. I also mention here some other resources that helped me prepare for this law class and also for School of Nursing classes I taught during the same visit. Finally, I offer some of the lessons I learned as a first-time foreign teacher not accustomed to a campus with hyenas.

II. HARAMAYA UNIVERSITY

With a population of more than 80 million, Ethiopia is the second most populous country in Sub-Saharan Africa. It is a low-income country with a real per capita income of \$232 United States dollars a year and nearly 40% of the population living below the international poverty line of \$1.25 a day. It is also one of the least urbanized countries, with more than 80% of the population living in rural areas.⁶ Although Ethiopia has made gains in a number of health-related indicators in recent years, its health status and system indicators remain low. Life expectancy is 53 years, and the infant mortality rate is 77 per 1,000 live births.⁷

Haramaya University, formerly known as Alemaya University, is one

4. *Id.* at 41–45.

5. For a current list and links, see *Partnership Frameworks*, U.S. PRESIDENT’S EMERGENCY PLAN FOR AIDS RELIEF, <http://www.pepfar.gov/frameworks/index.htm> (last visited June 4, 2012).

6. Ethiopia PF, *supra* note 2, at 6.

7. *Id.* at 6–8. By comparison, in 2010 the United States life expectancy was 78.7 years of age and the infant mortality was 6.14 per 1,000 live births. See Sherry L. Murphy et al., *Deaths: Preliminary Data for 2010*, 60 NAT’L VITAL STATS. REPS., Jan. 2012, at 6, 9, available at http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_04.pdf. A nice interactive website for comparative health status and systems comparisons is available at *Which countries are faced with a ‘critical’ health worker shortage?*, GUARDIAN, Jan. 17, 2011, <http://www.guardian.co.uk/global-health-workers/interactive/infographic-mortality-rates-health-workers-uk-us-world>.

of Ethiopia's oldest, having been founded in 1954 as an agricultural college on the shores of the now extinct Lake Haramaya.⁸ The 1,500-acre main campus is located in Ethiopia's Oromia region, the least populated area of the country. In addition to the academic buildings, sports facilities, housing and cafes for the approximately 17,000 resident students, faculty, and staff, the spacious campus features crop fields, greenhouses, poultry barns, and livestock, including camels.⁹ The university has expanded significantly over the years to include, among its many programs, colleges of law, nursing, medicine, and public health.

The College of Law ("HU Law"), founded in 2002, offers a five-year LLB program and will graduate approximately 140 students in 2012. Ethiopia is a civil law country, with some elements of common law based on precedent, as well as interaction with customary and Sharia law.¹⁰ In 2012 the law school plans to publish its first law review and begin an LLM program. Its current dean is University of Washington Law School ("UW Law") graduate Richard Wentzell, JD, Ph.D. HU Law and UW Law now have a number of other academic alliances, furthered by a memorandum of understanding signed in 2011.¹¹ For example, the two schools are collaborating on a Land Tenure Institute to help develop and improve rural land law and policy, and have exchanged students and faculty.¹²

Haramaya University's rapidly expanding colleges of medical and health sciences are located 15 kilometers away in Harar, just outside the walls of this ancient Islamic city. The Health Sciences College was founded in 1996, and now includes schools of nursing and midwifery, public health, environmental health and laboratory technology.¹³ The Medical Sciences College, which will graduate its first class in 2013, recently assumed management of the nearby 200-bed Hiwot Fana Hospital and its associated clinics.¹⁴ The medical school class to graduate in 2013 includes 60

8. See *Welcome to Haramaya University*, HARAMAYA UNIV., <http://www.haramaya.edu.et/> (last visited Jan. 12, 2012). For a fuller understanding of the University's history and roles, I am grateful to President Belay Kassa, Ph.D., and to the recently opened on-campus museum devoted to Haramaya's history.

9. In all of its programs, including distance and summer learning, approximately 31,000 students were enrolled in 2011. *Id.*

10. The GlobaLex website is one helpful resource for summary information on the legal systems of a number of countries. *Tools for Building Foreign, Comparative and International Law Collections*, GLOBALEX, <http://www.nyulawglobal.org/Globalex/> (last visited May 18, 2012).

11. See 64 UW L. ALUMNI MAG. 37-40 (Fall 2011), available at http://issuu.com/uwschooloflaw/docs/uwlaw_magazine_fall2011?mode=window&pageNumber=38.

12. *Id.* See also Catherine O'Donnell, *Law Students from Ethiopia Learn as Part of Nation Building*, UW TODAY (Dec. 2, 2011), <http://www.washington.edu/news/articles/law-students-from-ethiopia-learn-as-part-of-nation-building>.

13. Thanks to Health Sciences College Dean Biftu Geda and Nursing and Midwifery School Head Dereje Meaza for their helpful introduction to these programs, and gracious assistance throughout the visit.

14. College of Medical Sciences Dean Takaba Abdosh, MD, provided a personal tour

students; the class of 2017 has 220.¹⁵ The nursing school has seen a similar rapid expansion across its programs.¹⁶ HU's Harar Bulletin of Health Sciences published its inaugural issue in 2011, with an edition focusing on HIV/AIDS research.¹⁷

After participating in a HU Law conference in 2010, I was invited to return and teach a course or courses for law and health sciences students. My husband, Christopher Sanford, MD, MPH, was also invited to interact with the medical school and hospital.¹⁸ Our sons Nate and Henry, then twelve and ten, came as well, and attended the local public school.¹⁹

III. OVERVIEW OF THE COURSES

Ultimately, I ended up teaching separate courses on the two Haramaya campuses in April 2011.²⁰ The "Seminar in Current Health Law Issues" included eighty-three upper-level law students, met twice a week, and required two papers and two quizzes. It was intended to provide an overview of current legal issues involving individual medical decision-making and also of the role of the law in promoting population health. I shaped this course around Ethiopia's Partnership Framework and India's *Shanbaug* decision, both of which are discussed below. In the nursing school, I taught an "Ethical Issues in Health Care" module to eighty first-year nursing students and facilitated classes with upper-level nursing students. These sessions coalesced around small group discussions of hypotheticals I drafted based on medical literature,²¹ a nursing textbook,²² and discussions with

of the hospital and research offices, as well as useful information about the program.

15. Email from Health Sciences College Dean Biftu Geda, Jan. 15, 2012, on file with author.

16. *Id.*

17. HARAR BULL. HEALTH SCI., http://www.haramaya.edu.et/index.php?option=com_content&view=article&id=427&Itemid=211 (last visited June 10, 2012).

18. Chris has a relevant background, being a family practice doctor with a specialty in travel and tropical medicine as well as appointments at the University of Washington School of Medicine and Department of Global Health. He also is one of the founders of the East Africa Diploma Course in Tropical Medicine. This 12-week program, which had its first full session in 2011, is based in Tanzania and Uganda. A number of the student slots are reserved for African physicians, who pay a lower tuition than the other students. *See About, E. AFR. DIPLOMA COURSE IN TROPICAL MED.*, <http://www.tropmedafrica.org/> (last visited June 2, 2012).

19. The Model School is located on campus and encompasses grades kindergarten through twelfth grade. The principal, Basha Haile, teachers, and students were very accommodating and helpful, with English teacher Solomon Beshahwred facilitating arrangements. Our boys joined the seventh grade, the year in which most instruction begins to be in English rather than in Amharic or Oromo.

20. In May 2011, UW Law Professor Patricia Kuszler, JD, MD, taught the same group of law students a follow-on course focusing on quality regulation in health care and international medical research standards. She also taught similar material to nursing students.

21. A good source for links to this type of medical and bioethics literature is ETHNOMED, www.ethnomed.org (last visited June 6, 2012). This University of Washington website contains medical and cultural information about immigrant and refugee groups.

22. SALLY HUBAND ET AL., *NURSING AND MIDWIFERY: A PRACTICAL APPROACH* (2006).

faculty.

Throughout the law school class, I frequently referred back to an exercise from the first day. After a brief introductory lecture, I had the students break into small groups to discuss and prepare written responses to two questions without doing any outside research. I told them that the group members did not need to all agree on their responses. First: regarding health care or health care law, what does Ethiopia or the Oromia region do well? Second: what aspect of health care in Ethiopia would benefit from more or different regulation?

In response to the question as to what Ethiopia or the Oromia region does well, many of the groups listed the use of health extension workers. Ethiopia has been recognized for extensive and effective use of health extension workers, generally women from the community who receive a year's training in basic primary health care needs.²³ Other common responses included: mainstreaming HIV/AIDS treatment; constitutional recognition of a right to live in a healthy environment; expanded vaccination services; abortion laws; and improved maternal care.

In response to the question as to what aspect of health care would benefit from more or different regulation, the most common response was better regulation of the quality of health care providers, including traditional medicine practitioners. Use of traditional treatments is common in Ethiopia, particularly in rural areas, and sometimes raises concern about safety and efficacy.²⁴ Other common responses included: greater access to primary care; prohibition on harmful practices such as female genital cutting; stricter abortion laws;²⁵ more rural health care facilities; and effective regulation of environmental impacts on health.

On their written responses to these questions, I asked the students to write the names of each member of the group that developed them. Where the responses tied into the topic of a subsequent class session, I was then able to ask specific students to elaborate. This technique seemed to encourage students to speak up (and also to help me better pronounce Ethiopian names). A similar exercise with the nursing students worked much less well. With the nursing students, I did this as an individual, not group exercise; and I made the mistake of telling them in advance that I would not be

This textbook is specifically designed for use in low-income countries.

23. See, e.g., Wairagala Wakabi, *Extension Workers Drive Ethiopia's Primary Health Care*, 372 LANCET 880 (2008). The head of the U.S. and U.K. governments' aid programs have recognized the Ethiopian Health Extension Program as offering potentially "game changing" lessons in the fight against international poverty. See Press Release, Embassy of the United States: Addis Ababa, Ethiopia, International development leaders hail Ethiopian health extension program (Sept. 21, 2011), available at <http://ethiopia.usembassy.gov/pr-2011/international-development-leaders-hail-ethiopian-health-extension-program-september-21-2012.html>.

24. See, e.g., Richard M. Hodes, *Cross-cultural Medicine and Diverse Health Beliefs: Ethiopians Abroad*, 166 W. J. MED. 29, 29 (1997).

25. The prominence of "abortion laws" as a response to both questions probably was related to an on-campus debate on the topic that was scheduled for the following week.

grading their responses. Most of the law students, I later learned, had assumed that this was a graded assignment.

IV. SHANBAUG AND MEDICAL DECISION-MAKING

One challenge in teaching about legal issues arising in the context of medical decision-making is that many of the prominent cases and statutes have arisen in regions with extensive medical resources and a significant cultural focus on individual autonomy.²⁶ How relevant is that body of law in regions with limited medical resources? How applicable is it to regions with a broader focus on family or group affiliations? As health systems expand to provide a higher level of care to more people, many questions are likely to gain prominence: to what information are patients entitled?; if a patient lacks decisional capacity, who should decide?; when may medical care be withheld or withdrawn?; is physician-hastened death ever appropriate?²⁷ Any legal resolution of these questions is sure to be influenced by the cultural and medical context in which they arise.

Fortuitously, a few weeks before my Haramaya law class began, India's Supreme Court handed down its decision in the publicly prominent end-of-life case involving Aruna Shanbaug.²⁸ The Court begins its opinion with the statement: "we feel like a ship in an uncharted sea, seeking some guidance by the light thrown by legislations and judicial pronouncements of foreign countries[.]"²⁹ This 110-page opinion includes a survey of cases and statutes from several jurisdictions on patients' rights of self-determination, surrogate decision-making, withdrawal of care, physician-assisted death, and active euthanasia. It explicitly considers their applicability in India's cultural and legal context.

The *Shanbaug* case includes a compelling factual background. In 1973, while working as a nurse at King Edward Memorial Hospital (KEM) in Mumbai, Ms. Shanbaug was brutally assaulted and strangled with a metal dog leash by "a sweeper" whom she had chastised for stealing food intended for the stray dogs utilized in the hospital's dog lab.³⁰ Ms. Shanbaug sus-

26. See Robert H. Blank, *End-of-Life Decision Making Across Cultures*, 39 J.L. MED. & ETHICS 201 (2011) (discussing limitations of the current focus on "western practices and values" and summarizing findings of a study of end-of-life policies in twelve countries, including Kenya and India).

27. See, e.g., *id.* at 211 (discussing the "surge in requests for assisted suicide because of the AIDS epidemic" in Kenya).

28. In January 2012, a number of news reports from India were still available on-line. See, e.g., *Aruna Shanbaug case: Supreme Court rejects euthanasia plea*, NDTV, <http://www.ndtv.com/article/india/aruna-shanbaug-case-supreme-court-rejects-euthanasia-plea-89894> (last updated Mar. 7, 2011) (reporting decision and showing nurses' reaction in streets around the hospital where Ms. Shanbaug resides).

29. *Shanbaug v. Union of India*, Writ Petition (Criminal) 115 (2009), slip op. at 2 (India Mar. 7, 2011), available at <http://judis.nic.in/supremecourt/chejudis.asp>.

30. *Id.* at 2-3.

tained severe brain damage. She has been largely unresponsive and almost completely paralyzed for nearly forty years, occupying the same bed all the while at KEM Hospital. Based on testimony from a team of three Court-appointed doctors, the Court concluded that she meets the key criteria for being in a persistent vegetative state.³¹

The KEM staff is described in the opinion as devoted to her care. All the student nurses are introduced to her and told that “she was one of us.”³² The independent physicians’ report cites as evidence of exceptional nursing care the fact that in thirty-eight years Ms. Shanbaug has not had even a single bed sore.³³ She is painstakingly spoon-fed mashed food, though in 2010, while she recovered from malaria, a naso-gastric tube was also used.³⁴ Pinky Virani, a right-to-die activist who wrote a book about Shanbaug’s situation, petitioned for an end to the feedings, arguing that Ms. Shanbaug is “virtually a dead person” and that not letting her “die peacefully” is causing her unnecessary pain and violating her right to dignity.³⁵ Ms. Shanbaug’s family has not been involved in decades and declined to participate in the case.³⁶ KEM strongly objected, arguing that its staff is effectively her family, and they want to keep caring for her.³⁷

In resolving the case, the Court looked not only to Indian law, but also to that of other jurisdictions, predominantly in high-resource countries.³⁸ For example, it considers the scope of patients’ rights to consent to medical care and to refuse care, referencing, as do so many U.S. cases, *Schloendorff v. Society of New York Hospital*.³⁹ The Court goes on to consider the general role of surrogate decision-makers where the patient lacks decisional capacity.⁴⁰ It contrasts the “substituted judgment” standard favored in the United States, with the “best interests of the patient” standard favored in other countries.⁴¹ Much of the decision concerns the legal and ethical distinction between “active euthanasia,” or physician-hastened death, and “passive euthanasia,” or a withdrawal of life-sustaining care; India’s stat-

31. *Id.* at 4. Citing conflicting evidence, the Supreme Court appointed a panel of three independent physicians to examine Ms. Shanbaug and file a written report. The Court then requested that the physicians provide a clarifying report explaining the first in non-medical terminology and also appear before them to answer questions and to screen a current DVD of Ms. Shanbaug. *Id.* at 5, 17.

32. *Id.* at 9.

33. *Id.* at 8, 27.

34. *Id.* at 10–11.

35. *Id.* at 3–4.

36. *Id.* at 24.

37. *Id.* at 25–29.

38. See generally *id.* For helpful background to India’s law in this regard, see Sushila Rao, *India and Euthanasia: The Poignant Case of Aruna Shanbaug*, 19 MED. L. REV. 646 (2011).

39. *Shanbaug*, slip op. at 66, 81 (citing *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125 (1914)).

40. *Id.* at 24, 36–37.

41. *Id.*

utes and Constitution are parsed and contrasted with “death with dignity” legal frameworks in the Netherlands, Washington State and elsewhere.⁴²

Pending enactment of a law by India’s Parliament, the Court’s opinion in *Shanbaug* allows “passive euthanasia” (withdrawal of medical care) from an incompetent patient in certain circumstances. Those circumstances include the irreversible nature of the patient’s vegetative condition, and the court petition by an appropriate surrogate (typically close family, but possibly a friend or physician) stating that continued treatment is not in the patient’s best interest.⁴³ The *Shanbaug* Court further requires review by independent medical experts and judicial approval. These procedural safeguards are “necessary in our country as we cannot rule out the possibility of mischief being done by relatives or others for inheriting the property of the patient.”⁴⁴ The Court goes on to reference George Bernard Shaw’s play “The Doctor’s Dilemma” and Robin Cook’s novel *Coma*⁴⁵ in expressing its concern that a surrogate’s decision to withdraw care might be impacted by India’s substantial income variation, as well as “the low ethical levels prevailing in our society today and the rampant commercialization and corruption” that includes unscrupulous physicians.⁴⁶

In the case at hand, the Court concluded, the appropriate surrogate is KEM, and its staff wishes to continue providing curative care (in the case of a malaria bout for example) and regular care (the feedings). Thus it denied the petition.⁴⁷

I assigned an edited version of the *Shanbaug* decision as the first assignment in my Haramaya Current Issues in Health Law Seminar. For the next several sessions, it became a touchstone for our discussions about patients’ rights, the role of surrogates, and end-of-life decision-making. In one exercise, the students considered which of Ethiopia’s civil and criminal codes would have any relevance to the case. They discussed the tension between legal standards supporting a patient’s right to make informed medical decisions and cultural values that disfavor direct sharing of bad medical news.

In another exercise, the students reviewed general bioethics principles and discussed how they were expressed by India’s Supreme Court. One interesting discussion centered on the role of culture in informing legal and practical standards as to who should speak for an incapacitated patient. What is meant by “close family”? The students also considered the “best

42. *Id.* at 45–87.

43. *Id.* at 99.

44. *Id.* at 101.

45. *Id.* at 102. For an interesting discussion of the Court’s use of literary references, see Frank Pasquale, *Why Narratives Do (and Should) Matter in Bioethics*, HEALTH REFORM WATCH (Mar. 10, 2011), <http://www.healthreformwatch.com/2011/03/10/why-narratives-do-and-should-matter-in-bioethics/>.

46. *Id.* at 101.

47. *Id.* at 99–100, 108.

interest” of the patient as expressed in the cases cited by *Shanbaug* and how that standard or the “substituted judgment” standard could be applied to Ms. Shanbaug’s situation.⁴⁸

The students voiced thoughtfully mixed views on the equity issues raised by the case. Many expressed admiration of the exceptionally high level of nursing care Ms. Shanbaug received. Some of those students joined others in arguing that it was not a good use of resources in a country where so many struggle to access basic care. Furthermore, for a typical Indian in her situation, wouldn’t lack of access to hospitalization or inability to pay for its continuation be determining factors in her case? This question led to a lively discussion about the appropriateness of personal connections in facilitating medical treatment. Ms. Shanbaug has occupied a hospital bed for nearly forty years not because an explicit government policy or because of her great wealth but apparently because of a personal connection with the hospital nurses and their sense of obligation to her.⁴⁹

The first of two required papers, due at the end of the second week, was about *Shanbaug*. This paper was to be no more than five pages and include three sections: issue; Ethiopian context; and assessment. For the issue section, students were to describe the main legal issues before the India Supreme Court and its resolution of those issues. Next they were to describe their understanding of the current state of these issues in Ethiopia, with reference to at least one source outside of the required readings. As specified in the syllabus, the students were free to work collaboratively to uncover these additional sources, which could be statutes, regulations, cases, commentaries, health practice guides, medical journal notes, news articles or popular media depictions from Ethiopia or another African country.

Finally, they were to present their opinions about the *Shanbaug* case and its relevance or lack of relevance in Ethiopia. As to this last section, I was pleased to see a range of well-articulated views. In the middle section, the additional sources were not as illuminating or varied as I had hoped. Although I had deliberately allowed a range of sources, I had not anticipated the research challenges. The students had only a few days to do this research, computer access is limited, and the Internet was down most of the time. Ethiopia’s civil and criminal codes became the default additional source material.

V. PEPFAR PARTNERSHIP FRAMEWORKS AND POPULATION HEALTH

For the second half of the Haramaya Law class, I planned to focus on

48. For a very good discussion of these and other comparative health law issues, see TIMOTHY STOLTZFUSS JOST, *READINGS IN COMPARATIVE HEALTH LAW AND BIOETHICS* (2d ed. 2007).

49. Indeed, according to Rao, *supra* note 38, at 655, the KEM staff objected to efforts to move her elsewhere to free up the hospital bed.

the role of the law in promoting population health, ideally with some specificity as to Ethiopia. In a timely bit of symbiosis, in the fall of 2010 I was part of a multidisciplinary team from the University of Washington that was in the planning stages of a project related to the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) in Africa.⁵⁰ The project centers on the health policy reforms identified in PEPFAR Partnership Frameworks (PF).⁵¹ And in late October 2010, Ethiopia's PF was signed, setting up the possibility of problem-based learning related to some of its provisions.⁵²

As of January 2012, there are nineteen country-specific PFs and two regional PFs.⁵³ Each PF begins with data about the country's health indicators and health systems, both as to HIV/AIDS and also more generally. This section could be part of a short introductory summary for a health law course. The policy reforms detailed in these PFs include both specific and general proposals. Malawi's, for example, states that its Ministry of Health "expects to . . . chang[e] 'anonymous' reporting to 'confidential' reporting in order to permit a name-based referral system."⁵⁴ This sort of specific proposal lends itself to discussions about confidentiality, mandatory reporting rules, and roles of public health agencies, as well as processes for changing legally enforceable standards. Swaziland's includes a goal of "improv[ing] the status and rights of women, people living with HIV and AIDS (PLWHA) and other vulnerable groups."⁵⁵ This sort of general proposal invites discussion about the role of human rights and anti-discrimination laws in promoting health.

The PFs involve a number of common policy areas. These are human resources for health, HIV testing and counseling, laboratory standards, or-

50. The project has since been funded as a cooperative endeavor with the Centers for Disease Control (CDC), the United States Agency for International Development (USAID) and Futures Group, a global health consulting firm. It aims to support the advancement of health-care related policy and law reforms identified in the PFs. As an initial phase of this multi-year project, in 2012 we will collaborate with in-country partners to host regional workshops focused on monitoring identified health policy reforms.

51. PEPFAR began in 2003. PEPFAR's 2008 reauthorization shifts the program's focus "from an emergency response to promoting sustainable country programs." This second phase of PEPFAR includes Partnership Frameworks ("PFs"), "5-year joint strategic framework[s] for cooperation between the [United States government], the partner government, and other partners to combat HIV/AIDS in the country through technical assistance and support for service delivery, policy reform, and coordinated financial commitments." *Partnership Frameworks: Introduction*, U.S. PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF, <http://www.pepfar.gov/guidance/framework/120513.htm> (last visited June 10, 2012).

52. Thanks to Amy Hagopian, Ph.D., for this suggestion.

53. For a current list, see *Partnership Frameworks*, U.S. PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF, <http://www.pepfar.gov/frameworks/index.htm> (last visited June 10, 2012).

54. Partnership Framework Document to Support Implementation of the Malawi National HIV and AIDS Response, U.S.-Malawi, May 18, 2009, at 6, available at <http://www.pepfar.gov/frameworks/malawi/index.htm>.

55. Swaziland Partnership Framework on HIV and AIDS 2009-2013, U.S.-Swaz., June 4, 2009, at 3, available at <http://www.pepfar.gov/frameworks/swaziland/index.htm>.

phans and vulnerable children, and nondiscrimination. These areas will not reflect the full gamut of public health law issues of importance to a country. But—if the PFs are to be meaningful—they should reflect country-specific areas of concern and possible change.

For some PFs, there are now related Partnership Framework Implementation Plans that address issues such as prioritization, implementation options, barriers to change, and evaluation criteria.⁵⁶ Does a guideline need revising? A regulation adopted? A law enacted? Are there stakeholders with a particular interest or expertise in the area? Are there government agencies with particular responsibility? What are the barriers to change? How will priorities be identified? How will progress be monitored and evaluated? These issues and more can be addressed in the implementation plans. Taking a broader approach in an academic setting, the PFs and related implementation plans lend themselves to consideration of the efficacy of legal enactments and international declarations in actually supporting health system and health status improvement.

Ethiopia's PF includes proposed legal and policy reforms aimed at "addressing [Ethiopia's] HIV epidemic, as well as [supporting the Ethiopian government's] commitment to the broader health needs of its people."⁵⁷ The reforms are grouped into four broad categories: prevention; quality care, treatment and support; health system; and health governance. An extensive course could be built around these topics.

I assigned an edited version of Ethiopia's PF for use in four class sessions and for the second paper. We began with the Ethiopia PF overview sections and considered generally how the HIV/AIDS epidemic in Africa has impacted key areas of health law and policy.⁵⁸ In the following class, we considered goals of universal access to primary care and of a national insurance system as expressed in Ethiopia's PF.⁵⁹ These topics were enlivened by a discussion of how private payments enter into ostensibly free health care. A Tanzanian newspaper article provided the springboard by

56. *Partnership Framework Implementation Plans*, U.S. PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF, <http://www.pepfar.gov/guidance/framework/120732.htm> (last visited June 8, 2012).

57. SUMMARY OF THE HIV/AIDS PARTNERSHIP FRAMEWORK WITH THE GOVERNMENT OF THE FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA, U.S. PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF 1, <http://www.pepfar.gov/documents/organization/154220.pdf> (last visited June 4, 2012).

58. For a helpful overview in this regard, see Peri H. Alkas & Wayne X. Shandera, *HIV and AIDS in Africa: African Policies in Response to AIDS in Relation to Various National Legal Traditions*, 17 J.L. MED. 527, 527–29, 538–43 (1996) (discussing laws of more than a dozen countries, including Ethiopia).

59. Regarding health insurance systems in other African countries, see generally João L. Carapinha et al., *Health Insurance Systems in Five Sub-Saharan African Countries: Medicine Benefits and Data for Decision Making*, 99 HEALTH POL'Y 193 (2011) (discussing characteristics of different types of health insurance systems and comparing programs in Ghana, Kenya, Nigeria, Tanzania, and Uganda).

citing a study that bribery was common in that country's hospitals.⁶⁰ Several students related anecdotes that for non-emergency care or for a family member to stay with a hospitalized patient, payment might be expected, if only to the facility's guard. While anecdotes are low-grade data, this discussion did help focus consideration on the role of the law in ensuring "universal access," however that is defined.⁶¹

We next studied the Ethiopia PF sections on the patient counseling and treatment experience, with particular emphasis on issues of confidentiality. How can statutory or regulatory standards appropriately encourage testing, ensure confidentiality, and also protect third parties? In this class session and in their papers, several students expressed strong and divergent views on appropriate legal standards for partner notification.⁶²

Finally we considered the law's potential roles in workforce retention and regulation. Ethiopia is one of the fifty-seven countries recognized by the World Health Organization as having a health workforce crisis. As described in Ethiopia's PF, the country is one of many with a severe shortage of physicians and nurses; in 2010, for example, there were only 2151 physicians in the country, a ratio of about 2.72 for every 100,000 people.⁶³ This shortage is exacerbated by migration of health care workers to high-income countries and to administrative positions within non-governmental organizations based in Ethiopia.⁶⁴ My students were aware that shortages are particularly acute in rural areas, such as the region in which Haramaya University is located. They were also aware of HU's new medical school and the rapid expansion of the student body on the Harar campus.

The second paper, due at the end of the course, was about Ethiopia's PF. It was to be no more than five pages and include the following three sections. In the "issue" section, students were to identify one of the policy goals expressed in Ethiopia's Partnership Framework, explain the purpose of the goal, and, in general, the possible role of the law in its advancement. For the "Ethiopian context" section, they were to describe the current state

60. *Corruption Common in Hospitals, says NGO*, DAILY NEWS (Tanzania), Oct. 10, 2010 (on file with author), available at <http://dailynews.co.tz/home/?n=13702>.

61. Many of my students were well aware of the passage in the United States of the Affordable Care Act of 2010 and its controversial attempt to expand health insurance coverage in this country.

62. Useful case studies are collected in S.B. Odunsi & A.O. Nwafor, *Medical Confidentiality: Right of HIV/AIDS Patient and the Third Party Interest*, 16 LESOTHO L.J. 249 (2006) (with particular attention to ethical and legal standards in Nigeria, Ethiopia, and Australia).

63. Ethiopia PF, *supra* note 2, at 6–8. By comparison, in 2010, there were about 850,000 actively licensed physicians in the United States, a ratio of 277 for every 100,000 people. See Murphy, *supra* note 7; Aaron Young et al., *A Census of Actively Licensed Physicians in the United States, 2010*, 96 J. MED. REGULATION 10 (2011), available at <http://www.fsmb.org/pdf/pub-journal-census.pdf>.

64. See, e.g., Samuel Girma et al., *Human Resource Development for Health in Ethiopia: Challenges of Achieving the Millennium Development Goals*, 21 ETH. J. HEALTH DEV. 216 (2007).

of this issue in Ethiopia, with reference to at least one source from outside of the required readings. Finally, they were to provide their opinion regarding the scope of the issue in Ethiopia, possible ways the law might address it, and likelihood of success. As with the first paper, the outside research was not as robust as I had hoped; not only was the internet mostly unavailable, but an extended Easter holiday cut into class time.

Other articles in this *Indiana Health Law Review* issue discuss collaborative, problem-based courses involving students from law and health sciences schools in the United States. That sort of collaborative education could be fruitfully designed around many of the PF topics. Indeed, the original plan for my course was to include students from the Harar campus, but that proved to be too difficult logistically. Even if logistics preclude a multidisciplinary course, lectures from faculty in an affiliated health sciences school could help clarify some of the practical issues around the law and policy options. I certainly met faculty whose research interests dovetailed neatly with the topics we covered.

VI. SOME PRACTICAL OBSERVATIONS

There are several articles on the pedagogical and practical issues with foreign faculty teaching law in low-income countries.⁶⁵ In recognition of that body of literature, I will make here only a few practical observations about my experience as a white American accustomed to teaching at a long-established, urban law school with a new, technologically advanced building and an extensive law library.⁶⁶

First, I wish I had had a better appreciation of the resource limitations. An initial draft of my law course syllabus stated that the required papers were to be “double-spaced.” Law School Dean Richard Wentzell, JD, Ph.D, pointed out that few students had reliable access to computers and even fewer to a printer; papers are typically handwritten on unlined paper.⁶⁷ Despite this reminder about technology limitations, I persisted in a course design that prominently relied on the students researching the state of Ethiopia’s law on various issues.

When HU’s law library is completed and as internet access becomes

65. See, e.g., Peggy Maisel, *The Role of U.S. Law Faculty in Developing Countries: Striving for Effective Cross-Cultural Collaboration*, 14 CLINICAL L. REV. 465 (2008) (contrasting efforts from the “law and development” era with current approaches, with reference to several articles detailing professors’ experiences). See also Kirsten A. Dauphinais, *Training Countervailing Elite: The Necessity of an Effective Lawyering Skills Pedagogy for a Sustainable Rule of Law Revival in East Africa*, 85 N.D. L. REV. 53 (2009).

66. William H. Gates Hall, with its Marian Gould Gallagher Law Library, is located on the University of Washington campus in Seattle, Washington. See *Gallagher Law Library*, UNIV. OF WASHINGTON, <http://lib.law.washington.edu/> (last visited June 6, 2012).

67. There is a lot of eyestrain, I learned, in reading 166 handwritten papers, particularly by flashlight when the power is out.

more reliable and available, legal research should be easier. It still might not be easy, particularly in a short time-frame. In his article about "mistakes made and lessons learned" teaching securities regulation in Uganda, Stuart R. Cohen writes that he had not appreciated how hard it would be to track down the relevant legal authorities and that "one of the most appreciated byproducts of our course was a notebook that included all relevant statutes and regulations."⁶⁸

Second, and relatedly, it proved important to be flexible. University structures and processes were much more fluid than those at the University of Washington. To meet with the HU president, for example, one looked for his car next to the administration building and then sat in his waiting area until he was available. The composition, structure, and timing of my law and nursing classes shifted up until the last minute.

With the Easter holiday and other scheduling conflicts, a few class times had to be changed; this proved surprisingly easy where faculty and staff live on campus, bulletin board postings serve as effective communication, and nearly everyone seems to walk by the outdoor cafes at some point during the day. Although I had made an effort to learn about cultural issues that might impact teaching, I was continually learning new things. For example, for one class session all the women showed up but nearly all of the men were absent; I was told that a student's father had died, and as is customary, the student's same-gender classmates had gathered with him.

Third, having my family there enhanced the visit. My book-learning about rural health care in Ethiopia was made concrete by my husband's observations at Hiwot Fana Hospital and his discussions with physicians, medical officers, nurses, and medical students. What a "shortage of physicians" looks like is a medical officer seeing a couple dozen patients in an hour and making diagnoses based primarily on physical exam. What "delays in seeking conventional medical treatment" looks like is a toddler with a huge tumor on his back.

My sons' experiences at the local public school also helped my teaching. I had heard that the law students were most used to chalkboard lectures and that they were very good at memorizing. I appreciated that background better when Nate and Henry reported that their classes involved a great deal of copying from chalkboards into composition books and memorization. Among other differences from their public schools in Seattle, the Ethiopian teachers carried and sometimes used switches, the curriculum included several science classes, and the recesses were more fun, with intense soccer games.⁶⁹

68. Stuart R. Cohn, *Teaching in a Developing Country: Mistakes Made and Lessons Learned in Uganda*, 48 J. LEGAL EDUC. 101, 104 n.10 (1998).

69. Although there were several other foreigners on campus, ours were the only white children. On the campus as a whole, there were a number of faculty members from India, a few from the United States, and several Volunteers Services Oversees personnel from Com-

I never did see the on-campus hyenas, though Nate and Chris did on a walk at dusk through the agricultural fields. I did see the hyenas that come to one of the Harar gates each evening to be fed strips of camel meat the “hyena man” offers on a stick. The hyenas are skulking and mangy, with muscular shoulders and large jaws. Although I know faculty members and students who have fed the Harar hyenas, I refrained. The on-campus hyenas do not seem to require much accommodation beyond bringing livestock and pets in at night. In the days leading up to the Easter feasts, many goats were staked outside the HU apartments. At dusk they were walked inside and up the stairs, to spend the night bleating on apartment balconies.

VII. CONCLUSION

I would be interested to learn about the structure of other health law and policy courses in low-income countries with rapidly expanding health systems. As their systems expand, I expect that health law and policy will be an area of increasing academic and practical interest at a number of universities. There is certainly a burgeoning interest in the United States in global and comparative health law.

Perhaps my experience teaching at Haramaya University can help visiting or resident law faculty prepare similar courses. I certainly found that the *Shanbaug* case and Ethiopia’s PF helped shape an engaged course. The case, with its compelling factual background, surveys medical decision-making law from a variety of jurisdictions and considers its applicability to India’s legal and cultural context. The PF facilitates a shift in focus to the law’s potential role in supporting population health.

My limited beta test of these materials suggests that they successfully engage law students in considering important areas of health law and policy. Depending on available time and resources, they could provide a springboard to student investigation of the state of those areas, legally and practically, in a given country. The topics also would seem to lend themselves well to interdisciplinary collaboration with health sciences schools and, potentially, to linkages with lawyers, regulators or stakeholders involved in health policy reform. I look forward to hearing about courses like these.

monwealth countries. The Ethiopian children were well-versed in United States politics; one student asked Nate what he would do if Sarah Palin became president.

