THE UNIVERSITY OF ALABAMA AT BIRMINGHAM

International Medical Education

Medical Student Enrichment Program
University of Alabama at Birmingham School of Medicine

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Student: Kendall Snellgrove, MS4
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You've Eaten What? - When Pediatric Medicine Crosses Borders and When it Does Not

As a future pediatrician, I found it considerably amusing that adults in Zambia's southern province often use an afternoon greeting that roughly translates to: "You've eaten what?" If you add emphasis and an element of surprise to the end of this greeting, it transforms into a question that I have rhetorically asked many of my young patients in the States: "You've eaten WHAT?" From snail shells to Legos, their pet poodle's feces to household cleaning agents, the items that kids deem to be edible can be surprising. And, as anticipated, I discovered that kids eat strange things in Zambia too. So, when I would hear this greeting, "Mwalya nzi?" casually exchanged between 'grown-ups' asking about their friend's lunch, I couldn't help but laugh at how this question is better suited for pediatrics and how applicable it is on a global scale.

When traveling, I enjoy appreciating the similarities and differences between my culture and the culture I am visiting. This past month found me mentally constructing a Venn diagram of Birmingham, Alabama and Macha, Zambia from the perspective of a soon-to-be pediatrician. Apart from the certainty that kids will be kids despite what country they live in, including their ingestion of strange and dangerous items, I was surprised to see that pediatric medicine in Zambia and Birmingham shares much in common. Primarily, kids get better. In Macha, this was demonstrated by the 1 kg baby girl born tremendously early. Her abdomen distended to an unnerving level by day 3 of life, heralding a dismal list of possible diagnoses. But with little to no intervention, she got better by the time she was 2 weeks old.

I also found that Zambian and American stigmas exist in very similar ways for particular diagnoses. I met a Zambian woman who, as a young mother, had transmitted HIV to her child because she was in denial of her own illness. I will likely always retain the pain of watching her cry with regret as we explained her now teenage son's condition. He had irreversible hearing loss and lung scarring due to the delay in his treatment. HIV diagnosis and treatment is often the same in the United States – denied, hidden, and stigmatized, even within the pediatric and adolescent population. A final similarity was found in the discussion concerning the allocation of resources. Much of pediatric medicine emphasizes prevention, both in America and Zambia. This philosophy may be prudent for the masses but can leave outliers at risk – as is the case in routine screening and vaccinations. But this model often solicits an important question: "Am I treating the 99 and forgetting the 1?" How do you allocate resources to pursuing that one patient that falls through the cracks of the health care system? Like in Birmingham, this is a question that is equally troubling for Zambian doctors. Regrettably, none of us have a great answer.

In many ways, pediatric medicine crosses borders, even oceans. But the differences between Birmingham and Macha better defined this experience. First of all, while we both discuss how to allocate resources, the affluence of resources in these two settings are dramatically different. The blatant lack of resources in Macha was startling. Basic radiography was down for the majority of the month and the only other imaging modality was ultrasound. Labs were extremely limited and water in the area, including water for the hospital, only ran for an hour two times a day. For most patients, you rely solely on your stethoscope and your brain. My conclusion is that this gap in resources may be the cause of another gap between American and Zambian medicine – the gap in child mortality. In 1975, 50% of Zambian children died before they reached the age of 12. Although this percentage has drastically declined by 2019, the truth remains that many Zambian children die of preventable causes. This creates a ripple effect that is heartbreaking. In my month there, most mothers refused to name their children while in the hospital. When I asked one of doctor why, he said, "Mothers don't want to recognize their baby's personhood until they can bring it home alive." I later learned that many people in Macha believe that children do not have a soul until the age of 5 or 6, which led to many more difficult discussions with patients and Zambian healthcare providers. By the end of the month, I had written down several more differences: gender roles, the earlier transition of adolescence to adulthood, perceptions of ethnicity, and more.

Yet, it was the disparity between Birmingham and Macha's resources and child mortality that I found the most frustrating. To add even more frustration, I had been expecting these differences.
Upon reflection, it was not the surprising way pediatric medicine transcended cultures that was the most impactful aspect of this month abroad. Instead, the foreseeable differences were ultimately the greatest catalysts for change. Although these catalysts involved tragic realities, I am extremely grateful for the way I was transformed throughout and by my time in Macha, Zambia.

Kendall Snellgrove