Reflections on Experiences in Rural Uganda

Misty Richards, Marc Freiman, Stephanie Van Dyke, and Neil Gray discuss the ethos behind the setting up of the Engeye Health Clinic in Ddegeya Village, Uganda

Religion, wealth, and power are among the principal causes of human conflict. Religious, nationalistic, and ethnic ideologies are frequently exploited to facilitate the dehumanization of another people, allowing violence to become an acceptable option. Frequently, migration is both a contributor to, and a result of, such conflicts. The influx of a new people into a region often leads to conflict over land, resources, and political power, particularly when accompanied by significant cultural, religious, and/or ethnic differences. Conversely, prolonged or significant conflict frequently creates a strong impetus for migration, as people abandon their homes in search of a security. Hence, conflict and migration are linked in a vicious cycle.

Healthcare is often compromised in situations of migration, particularly ‘forced’ migration due to conflict or natural disaster. The absence of stability frequently makes simple medical conditions life threatening. Migrants often have diminished legal standing, and may be unable to access or afford the health resources of the host country. Even if healthcare personnel are available, they will often lack an understanding of the migrant population’s language and culture, leading to significant barriers in care. In conditions of instability, continuity and follow-up usually suffer, which can have a substantial impact on the morbidity and mortality of chronic illness.

As medical students, we are preparing to practice medicine, and will inevitably be called upon to treat patients across national boundaries - whether our patients are migrants to our homeland, or we travel to another country to help patients there. Medicine is not merely black and white and is largely governed and regulated by public policy. Understanding this, in order to practice the best medicine possible, we must firmly understand the rules and regulations of the land. We are the gatekeepers who try to keep the path towards good health accessible, while policy makers build the gates and therefore dictate their unique properties.
In essence, healthcare workers across the globe must embrace that healthcare is not mutually exclusive from matters involving religion, power, and money. In fact, in order to become the most effective physician possible, one must grasp that the practice of healthcare is often regulated by the patient’s culture and religion, the rule of law, as well as the forms of payment and health insurance that exist within a region. Accepting that people will travel and live in foreign lands, accepting that nations do have control over all people within their territory, and accepting that medicine is often made a commodity by governmental powers, what can we as healthcare workers do to stimulate positive change?

Anytime migration occurs across cultural boundaries, the issue of cultural assimilation arises. In the cultural lore of the U.S., there is an old metaphor, that our country is a ‘melting pot’ in which people of diverse backgrounds become one. The implication is one of complete assimilation - the melted ingredients lose their shape and individuality, to become a homogenous liquid. But is this truly desirable? Is it even possible? A more recent take is the ‘vegetable stew’ - the ingredients are combined, but each of their individual uniqueness is preserved. Should one stir the pot, and try to promote assimilation? Or is it better to promote the retention of culture, at the risk of intercultural discord? Although simple, these metaphors have value in thinking about approaches to immigration.

The real control over the melting pot is not always dictated by stirring or the lack thereof, but more realistically determined by the contents of the pot. If the people migrating to the mainland refuse to integrate and adapt to the local culture, then no amount of stirring will facilitate a smooth transition. If the locals are not accepting of foreigners, then coagulation will inevitably prevail. The goal is not to strip people of their identity, but to enrich them with experiences of new and different cultures. This idea served as the catalyst to the creation of the Engeye Health Clinic in Ddegeya Village, rural Uganda. After experiencing the extreme poverty and lack of health care in this little village as an English teacher, Stephanie Van Dyke decided that learning English was probably low on their priority list. Instead, she decided that the real problem was access to medical treatment, especially when many of the villagers suffered from chronic diseases requiring diligent attention. Keeping this in mind, Stephanie decided to use all of her grandmother’s inheritance to build a medical clinic right in the heart of the village. The villagers were dying of treatable conditions and had never, and would never, receive the medical treatment they needed. It was her hope that the Engeye Medical Clinic would empower the villagers to seek better healthcare, though she was careful not to force the Western philosophy of medicine upon Ugandan culture. Ultimately, it was Stephanie’s goal to create a clinic capable of providing comprehensive treatment specific to the needs of Ddegeya Villagers without the possibility of boiling over. She hoped lighting the match would be enough to facilitate peaceful mingling within the melting pot.
The Engeye Health Clinic officially opened its doors during April of 2007. In the midst of her second year of medical school, Stephanie and her Ugandan partner, John Kalule, were able to organize the construction, staffing, and logistics of this first medical mission. Nothing short of a miracle, Stephanie and her team of 12 United States medical students, physicians, and nurses were able to treat close to 1,000 patients in Uganda in less than 2 weeks. Ugandans traveled by foot from as far as 10 miles away to receive medical treatment. Observing high rates of malaria, peptic ulcer disease, hypertension, and osteoarthritis, it became clear that the people were in need of constant health care supervision. Though the team from the United States had initiated a gallant effort, what could be done to continue the momentum? Once the Americans returned home, who or what force would sustain the chronic healthcare needs of the villagers? What new problems or issues would arise?

Religion. Power. Money. Healthcare. We are faced with these four words yet again while attempting to transform the Engeye Health Clinic into a self-sustaining medical facility. We needed to empower the villagers to feel proud of the Engeye clinic, as it was intended to become a part of their community. In order to do this, we needed to embrace the local culture, which meant understanding religious beliefs (which affected their use of birth control as well as explained unique markings from the shaman on their abdomens), we needed to understand that shillings were few and far between in the village, and that healthcare was a brand new concept altogether. Ever cognizant of cultural differences, Stephanie worked diligently to ensure that the clinic folded nicely into Ddegeya Village in an effort to demonstrate respect and sensitivity towards the villagers. Again, she carefully introduced Western practices of medicine into the melting pot and watched as it simmered.

The departure of the Americans from the Engeye Health Clinic of Ddegeya Village was bittersweet. As the bus overflowing with “Mzungus” (Luganda for “white person”) left the clinic, villagers waited patiently in lines that wrapped around the clinic in hopes of receiving medical treatment. They did not know that the
The bus full of Mzungus would not return to the clinic for another 8 months. As the Americans watched the clinic become smaller and smaller in the distance, they began to wonder if their 2 weeks of volunteer work had truly helped the villagers or merely reinforced a false association between healthcare and foreigners.

Stephanie and the Engeye team were determined to break this potential association and, more importantly, wanted the villagers to have access to healthcare any hour of the day. In the first step towards sustainability, two full-time Ugandan nurses were hired to work at the clinic. Since this day, the Engeye Health Clinic has received a steady stream of patients and has become a trusted establishment in the village. Moreover, in a second move towards sustainability, each patient pays a negotiable 2000-shilling fee and in turn receives a medical book documenting their diagnosis and treatment, as well as any medications that they were given. Ideally, the patient would bring this back to the clinic if and when they return as a way for the healthcare worker to monitor their past medical history. Furthermore, the 2000 shillings goes directly towards restocking the medical supply. Taking great pride in this medical book, some villagers place this amongst some of their most valued garments that are only worn for the most special of holidays. Through embracing local customs and religion, empowering the villagers by creating a reasonable fee-for-service paradigm, and providing a central medical establishment, the Engeye team was headed down the right path - the path reinforcing that migration and cultural immersion may have initiated the healthcare movement, while good old-fashioned hard work from locals would have to sustain it.

Starting from two steps in the right direction, the Engeye team has made significant progress towards our final goal of sustainability. Recently returning from our second medical mission in November of 2007, we were able to reach many milestones. In summary, we established electricity at the clinic via solar panels, tested the water and soil for potential contamination, used malaria quick-tests on all patients symptomatic for malaria, conducted a minor needs assessment of the villagers, as well as treated close to 300 people in less than a week. Though we have much more to do, we are excited at the progress thus far and pleased that the villagers seem to be embracing the clinic. Furthermore, the most recent group of volunteers represented a greater variety of disciplines as well as geographic regions in the world; in total, there were 3 medical students from New York, 2 medical students from Rwanda, 2 engineers from California and Florida, as well as 2 public health specialists from California. Though our backgrounds are a bit different, we all came to Uganda with the common goal of leaving the clinic a bit better than we had found it.

We were especially excited that the two medical students from Rwanda joined us on this medical mission. They came to the Engeye Health Clinic to learn how to build a medical clinic from the ground up. It is their intention to return back to Rwanda to build a clinic specifically designed to combat malnutrition in their community. This exemplifies what we hope is a growing trend: instead of trying to leave their country to live and practice medicine in a more lofty environment, these students wanted to collect as much information as possible to stand on the front lines of their home country to fight for good healthcare. No one can blame a physician or nurse seeking a better life for themselves and their families by moving abroad, but the cost of this ‘brain drain’ to the quality of health care in developing nations, particularly in rural settings, is enormous. While having volunteer medical personnel from developed countries is certainly helpful, the only real long-term solution is to facilitate the training and retention of medical expertise from amongst the people it is meant to serve. To see young physicians-in-training with the commitment to
remain where they are most needed is deeply inspiring.

The practice of cross-cultural medicine has never been more necessary than it is today, as people migrate and travel throughout the globe. Working across political, cultural, and language boundaries inevitably leads to difficulties and misunderstandings, but also opportunities. We at the Engeye Health Clinic have learned what boils down to one word: perspective. Armed with a clear and realistic perspective, the Engeye Clinic has been able to begin to meet the needs of its patients, restore pride in a poverty-stricken village, realize our shortcomings in hopes of resolving them, and nurture the blending of two very different cultures in a slow-cooking vegetable stew. The Ugandans and Americans have worked together to accept and understand each other’s cultures, relinquish preoccupation with power and pride, and work towards a self-sustaining enterprise in Ddegeya Village. It is our hope that others will approach global medicine with the intention of leaving things a bit better than how they found them.

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This entry was posted on Monday, February 18th, 2008 at 10:47 pm and is filed under Perspectives, Articles. You can follow any responses to this entry through the RSS 2.0 feed. You can trackback from your own site.

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