The Most Thoughtfully Composed Photo: “Leaving Clinic in Engeye” in Edegaya, Uganda
(Dr. Anya Koutras, Associate Professor of Family Medicine, UVM/COM)

Produced by the Nuvance Health / University of Vermont Larner College of Medicine Global Health Program
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Participants of the global health elective at the Nuvance Health / University of Vermont Larner College of Medicine Global Health Program, including students, residents, faculty, and administrators, write reflections about what they’ve seen, felt, and thought each week. From clinical experiences to cultural insights, contemplative observations to investigative inquiries, each of these pieces has helped shape and define our collective Global Health Diaries. In this booklet, we share some of the pieces that have moved us most. We hope that these deeply personal accounts will incite a similar spirit of reflection in you, be it in finding aliveness in the contours of these stories or drawing from that of your own.
The Value of Sharing Stories

PHOTOS AND REFLECTIONS 2019

WRITTEN BY MITRA SADIGH
Writer, Editor, and Researcher at the Nuvance Health / University of Vermont Larner College of Medicine Global Health Program, and editor of the Global Health Diaries blog

Participants of the Nuvance Health / University of Vermont Larner College of Medicine Global Health Program, including students, residents, faculty, and administrators, write to reflect on what they’ve seen, felt, and thought each week during the course of their global health elective. From clinical to cultural insights, observations to inquiries, each of these pieces helps elucidate the humanity in medicine. In this booklet, we share a collection of pieces that have moved us.

As editor of Global Health Diaries, where these reflections originally appeared over this last year, I often ponder why we feel compelled to share our stories and absorb those of others. After poring over the moments held in this collection, I feel that perhaps in so doing, we feel affirmed in the shared qualities and experiences that define what it is to be human.

The stories in this collection retell experiences of deeply relating to new cultures, forging family connections with new individuals, and feeling home in new places. Experiences of questioning and reshaping our deeply held views. From a leprosy center in Thailand to a psychiatry ward in Uganda, mountainside in Tanzania to beachside in the Dominican Republic, they show us that despite our differences, we all understand pain, loss, illness, and vulnerability as we connect in shared suffering. We all understand compassion, acceptance, care, and community, as connected in shared love and humanity.

It is from this sacred place of shared humanness that we can care compassionately for each other.
I am 63 years old
If you asked me, I would say that I am happy
I have friends
A new family
A gate.

I pick mangoes with my neighbors
And we help each other cook meals
We play cards
And gamble with rambutans
Behind the gate.

We yell at the futbol players on the old tv during matches at lunch
And sit together as the sun turns the treetops to gold
I help some of the older residents walk home in the dark
And say good night when it gets late

Sometimes
Before sleep claims me
I remember my mother
And how she looked at the floor when my father told me I had to leave
I was 18
When I became a leper
And first saw the gate.

During the day I miss my fingers
And try to recall the ease of twisting a doorknob
But at night I remember her
And try to recall the feeling
Of my mother’s arms around me
On the other side of the gate.
This poem came to me after our visit to the Phud Hong Leprosy Community near our town in Thailand. It was an incredibly powerful experience to see how its members have adapted to life within their community. All the residents are elderly, as there have been very few new cases of leprosy in the region in the last couple of decades. Many members have been there for the past forty years, sharing with us stories about how they were isolated and cast out from their families and communities when they were first diagnosed. It is a disease with a terrible stigma, especially back in the 1960s and 1970s when many of the people we spoke with first contracted it.

For many years, members of the Phud Hong community were not allowed to interact freely with the surrounding town, and very few people came to visit them. Today, however, modern medication has eradicated the bacteria from their bodies and made them non-contagious, allowing them to come and go as they please. Many, however, have found that they still prefer life within their community compared to the outside world. I wrote this poem from the imagined perspective of an older member in the late 1990s or early 2000s when the community was still gated, and based on some of the testimony we heard during our visit.

In Thailand, the family unit comprises an extremely strong bond. Having that broken, as some members described to us, and being disowned by the very people that are supposed to love and support you unconditionally is something that really hit home for me. I first imagined rage and fury as the predominant emotions. But many members spoke of feeling an indescribable sadness rather than anger. Here, I’ve imagined what someone who has gone through this thinks about when they are alone with their thoughts at night, and the emotional rigidity of daytime gives way to the melancholy cover of darkness.
I excel at intellectualization. It is a fickle defense mechanism, allowing the observer to fully comprehend the situation in front of them without fully engaging in the emotional context. Throughout my medical training, intellectualization has aided me at many patient bedsides and through emotionally charged family conferences. I am reminded of many moments on neurology wards when a patient’s emotionally charged question was reinterpreted and deflected through a purely intellectual and biological lens. The disease process was stripped of its emotional and societal resonance and presented as a simple fact of life. My habit towards intellectualization even followed me into psychiatry, a field that fully embraces the nuances and significance of human emotion. It is much easier to intellectualize a difficult patient encounter with the Diagnostic and Statistical Manual of Mental Disorders (DSM) qualifiers or neuronal processes than it is to simply exist in a difficult moment and let in the anxiety and fear that often accompany it.

Even this introduction to my experiences at Butabika Psychiatric Hospital is intellectualization. It is my attempt to analyze and appreciate the defense mechanism that served me so well and yet has likely met its match. The human suffering that I recently witnessed has affected me greatly. Before arriving in Uganda, I imagined rough caricatures of what I may expect. Having been pre-warned that conditions in inpatient psychiatry are below what one would find in the United States, images of classic asylums immediately came to mind.

My conception of such places comes intellectually from history books or visually and culturally from films such as One Flew Over the Cuckoo’s Nest. Even given the challenging environment I imagined, I was unprepared for the visceral nature of my experience. Butabika is located about thirty minutes from the center of Kampala, Uganda. It is situated on a lush hill overlooking the tranquil countryside. The peaceful quality of the environment is perhaps a prerequisite given the scenes that often occur within its walls. Each psychiatric ward is a separate one-story building spread generously across the sprawling facility. Psychiatric patients are divided into child-adolescent, forensic, addictions, acute care, sick care, and convalescent (stable) care categories. The general physical upkeep and atmosphere of each ward varies dramatically. The acute male ward is my worst fears brought to life before my eyes.
The entrance gate is manned by a psychiatric patient dressed in the simple blue-green patient garb, letting his fellow patients enter or leave based on what appears to be whim. Within the walls, patients meander about in states of extreme psychosis and mania without any real attempt to intervene in case of conflict. Sanitation appears as an afterthought, causing the smell of human suffering to be fully entrenched in my emotional memory. Due to the limited security structure, walking around the grounds of Butabika means constantly running into patients in the acute throws of psychosis walking aimlessly around the grounds as though in a perpetual daze. The resulting impression is one of extreme despair and powerlessness. Due to resource constraints, the medications provided to such patients are restricted to first-generation antipsychotics that produce a wide variety of symptoms including repetitive motions of the limbs or face, drooling, and extreme sedation and lethargy.

Compounding this is the extreme lack of social work or societal support available to the patients here. Patients are often dropped off by family members in acute states of psychiatric illness and simply left to become wards of the state. Quantitative medical tests like thyroid levels, lithium levels, or computerized tomography (CT scans) are provided only if the patient can directly pay. Given that patients with mental illness are statistically likely to be less educated and more impoverished, this reality is criminally disheartening. In contrast to the patient-centered care preached in the United States, encounters at Butabika have often felt like paternalism come alive. Ward rounds can sometimes feel closer to tribunals in which medical decisions are decided and read aloud without direct patient involvement.

"Compounding this is the extreme lack of social work or societal support available to the patients here."

Amidst this environment, I have felt true despair of the variety that I cannot easily intellectualize away. I struggle to understand a system that, due to its resource constraints, treats patients in a manner to which I am simply not accustomed. My discomfort participating in psychiatric care at Butabika is immense and yet I wonder if my own standards are too unreasonable given the constraints on-the-ground. Am I justified in my fear and discomfort or am I simply “othering” another system? I have been questioning my emotions and feelings since beginning my time on Butabika’s grounds but have yet to find an answer. Yet maybe that questioning and understanding is unnecessary. By explaining away my feelings and concerns, am I simply looking for a way to intellectualize my anxiety? I am left with the hope that one day I will make meaning from my inpatient experiences in Uganda. Until that time, I will simply sit with the discomfort that I now feel.
I’ve heard people frequently ask why American children leave the house and move away so quickly. I’ve really been reflecting on this lately as I consider a location for residency and decide where I want to spend the next three to five years. I was once one of the “typical” American kids that rushed to be on my own at eighteen. I’m grateful for the independence I’ve gained, but my perspective on the support of family has changed. I now deeply value it. My Dominican family has been amazing.

In the house are Mami Marissa, Papi Jesus, and Wellington. Nearby in the next building is our sister Esmeralda, her husband Dandy, and the family’s first grandchild, their daughter Zoe. I see Esme and Zoe every day. Mami looks after Princess Zoe before and after school until Esme gets off work. The system they have built works very well.

Like any other three-year-old, Zoe definitely wants everything her way. She’s rather entertaining. I play with her often, watching her dolls die and come back to life after a fall from the mountain that is the dining room table. She’s quick to correct my Spanish and bribe me to play with her. Wellington is like any other brother: we see him when it’s time to eat. Jesus works as a school gym teacher and makes sure we have plenty of activities to engage in. He’s taken me on tours, introduced us to his friends, and sat down to carve out some “father-daughter” time with a beer. Just like any other parent, he worries when we are out and stays up until we arrive home, even though he attempts to act like he doesn’t.

Mami doesn’t speak much English but we have conversations through body language and the bit of Spanish I have picked up along the way. She takes pride in cooking our meals, arranging them just as she would in the restaurant she used to run. Marissa is a fantastic woman who treats me just like her own child. The love she shows every day is so genuine. I love that the house is filled with noise, as it makes me think of memories I’ve shared with my own family. I deeply appreciate the dynamic they share. No matter what everyone is doing, they all come home for lunch and dinner.
I think we often get so caught up in living that we don’t take the time to enjoy the people we are living with. Our host family took us in like their own. We celebrated Esme’s pregnancy with a gender reveal party attended by friends and family. I was traveling that weekend but I made sure to be there because she is my sister. We have different personalities but it works so well. Our birthdays are even on the same exact day! I wasn’t expecting to be so emotional about leaving. The bond we have built is solid, and the foundation set in stone. This family shows their love for each other in multiple ways and has gone the extra mile to make sure we feel this in every way. The experience with this family has grounded me and reiterated why being together is the center of a strong family.
Sexual and Reproductive Health Rights

Written by Florence Dibiase

University of Vermont Larner College of Medicine Class of 2019

“You should see the stuff they stick up there... I’ve seen coat hangers, sticks, and bicycle spokes.”

- A fifth-year medical student at Makerere University College of Health Sciences in reference to treating septic abortion patients

As a future Ob/Gyn provider, I maintain a strong commitment to the fundamental rights of women. Beyond her basic right to gender equality and respect, I believe in a woman’s right to accessing safe and legal abortion as well as deciding how many children to have and when. I want to provide these services as a doctor. Every woman has a right to safe, consensual, pleasurable, and fulfilling sexual relationships. She should have access to information and options for both contraception and safe termination should she require them.

Reproductive rights are hard enough to discuss in the U.S., especially in certain social circles, often sparking heated arguments and tense emotions. Multiple legislative efforts against abortion are proposed weekly in a variety of U.S. states, while other states work hard to protect these rights. President Trump is attempting to pass exemptions that can restrict women’s access to birth control. Last week, his State of the Union Address also referenced ending “late-term abortions,” a misleading term that was actually meant
to represent twenty-one- to twenty-four-week abortions rather than those in women about to give birth. Of course, it pleased anti-abortionists and kept the tension high. I digress. I recognize my opinions on these issues are strong—I will readily debate with those who disagree with me and fight for what I believe is right. That said, I am still assessing how to uphold these beliefs in the global health context.

Prior to coming to Uganda, I researched reproductive rights here on the Guttmacher Institute webpage. The birth rate is one of the highest in the world at 5.59 births per woman (2016). Unintended pregnancy is common, leading to high rates of unplanned births. Premarital sex is common, with more than one-third of women aged fifteen to twenty-four having had sex. One-quarter of adolescents age fifteen to nineteen have had a child. Modern contraceptive use remains low at twenty-six percent of married women and forty-three percent of sexually active unmarried women.

Abortion is mostly illegal in Uganda. The law makes an exception in the case of endangerment of a woman’s life, and in 2006, National Policy Guidelines were passed that further permitted abortion under certain circumstances such as rape and incest, HIV infection, and cases of fetal anomaly incompatible with life. That said, abortion laws are interpreted inconsistently by law enforcement and because of this ambiguity, medical providers are often reluctant to perform the procedure. In 2013, the abortion rate in Uganda was 39/1,000 for women aged fifteen to forty-nine. This translates to an estimated fourteen percent of all pregnancies ending in abortion. This rate is even higher in Kampala specifically, at 77/1,000 women.

The same study showed 12/1,000 women are treated annually for complications resulting from unsafe abortion. While maternal mortality is decreasing (it dropped from 684/100,000 live births in 1995 to 343/100,000 in 2016), unsafe abortion remains a significant contributor to mortality. The Ugandan Ministry of Health estimated eight percent of maternal deaths were due to unsafe abortion in 2010. Meanwhile, post-abortion care is estimated to cost nearly $14 million USD annually. Studies show that restricting access to abortion does not decrease its incidence, but merely makes it more dangerous and deadly for women around the world due to unsafe method use. It saddens me that we have inexpensive and safe methods to prevent unintended pregnancy and perform early terminations, but many women continue to die due to lack of access, implementation, social stigma, or other barriers.

I have now been at Kawempe General Hospital for three weeks. I initially carefully avoided the subject of reproductive justice altogether, determined to wait to ask questions until I gained a better sense of cultural attitudes. From the Ugandans I have met thus far – primarily the Okullo family and surrounding medical students on their Ob/Gyn rotation – religion is a vital component of life here. We pray with the Okullo family before most meals, and they regularly reference God. A few medical students have asked me if I am Christian. It is interesting to consider how the origins of Christianity and other common religions in Uganda came from Western influence when Uganda was under European rule. Western influence continues to be present today, in part due to lasting impressions from that time and in part due to the opening of the country’s borders during the initial HIV epidemic. I am trying to observe how this religious influence has been adapted to fit the realities of East Africa and shapes cultural values. I imagine this contributes significantly towards attitudes regarding reproductive rights.

I have not heard much regarding abortion in my work at the hospital. It has been difficult to tease out the attitudes of healthcare providers. When I have hinted at topics to medical students, it has not encouraged enlightening conversation. One cannot expect to learn all the nuances of a new culture in three weeks, especially with such personal topics. As I am a guest here still trying to understand cultural attitudes, I am trying to avoid asking potentially offensive questions surrounding the topic of reproductive rights.

This week, however, I attended a lecture titled “Sexual and Reproductive Health Rights.” I saw this on the schedule and felt curious about how it would go. The general format of lectures in the fifth year medical student class involves one or two students presenting daily assigned topics with facilitation by an attending. This lecture was given by a timid appearing male student who started with similar statistics to those I referenced above. The attending facilitator, a female physician, chimed in frequently. As the discussion
turned to abortion, I felt at times that the attending's attitude was very liberal, yet at times, I also disagreed with her views. When she asked whether abortion should be legal, the class mostly responded in the affirmative, which somewhat surprised me. The professor, however, stated that legalizing abortion would not be effective.

She proceeded to share her view that legalizing abortion would not make it accessible to the majority of women desiring it due to costs, stigma, and lack of willing providers. She spoke about South Africa’s abortion legalization and the country’s subsequent struggle with its implementation for these reasons. She clearly acknowledged the reality of the problem. I wrote in my notebook her statement: “the men who say abortion is illegal are the same men who get women pregnant.” She gave case examples of patients she had treated with septic abortion. One woman she treated had the procedure performed by a non-licensed medical person who probed so far into her abdomen that they went through the uterus and into the bowel, only realizing their mistake when they started pulling feces out of the vagina.

She argued instead for prevention through education of all women and access to effective contraception for anyone who becomes sexually active. She stressed keeping girls in school as a fundamental way to decrease the high birth rate, unintended pregnancy, and maternal mortality. This is a more realistic and achievable goal, she argued, given that even access to contraception and sexual education are contentious due to religious and cultural beliefs. One example cited was about the Ministry of Health being forced to revise its statement on providing contraception to adolescents, raising the minimum age from ten to fifteen. Another student contributed to the discussion by bringing up the lack of sexual education offered to children. I would love to discuss this with him if I can find an appropriate time and place.

This was my favorite lecture to date because it left me questioning how to establish a woman’s right to reproductive control in resource-limited and culturally prohibitive environments. I went into the lecture believing abortion should be legal everywhere, and I still maintain that belief, but I had not thought through all the logistical complications; the economics and cultural context in which laws operate. Of course I want women in Uganda to have access to abortion services if they want them, but maybe this lecturer is right? Perhaps the current situation is not sufficiently stable or developed enough to successfully implement such a law. This is a great challenge of any field or specialty within global health: when there are so many aspects of the healthcare system that require aid (in any form), how does one set an achievable and effective goal? Where does one direct efforts when one cannot address everything one would hope to?

When I think about the environment at Kawempe General Hospital, I wonder too how many women are not accounted for in the statistics I read. It is resource-draining and time-consuming to perform data collection for things like the maternal mortality ratio and illegal abortion rates. I imagine many people are not accounted for in the census. Many women never go to healthcare centers for antenatal care or deliveries. The scope of the problem is depressingly large. That said, understanding the problem through data is the first step. An estimate is better than no estimate, and small successes are better than no success at all.

With a ton of new international students arriving this week and flocking to the labor floor, I decided to explore gynecology a bit more having spent the majority of my time thus far helping with deliveries. I have been going to the family planning clinic, which is a much calmer environment but an equally valuable clinical experience. As I am considering family planning as a career focus, it has been rewarding to see this subspecialty through the lens of a Global South nation. With the start of the clinic, advanced nursing staff gives a presentation in Luganda about all the different contraception methods available. Then, women bring their blue family planning record cards to receive a particular method and/or cervical cancer screening. They use dilute acetic acid to identify premalignant/suspicious lesions of the cervix with referral to oncology if necessary for biopsy. The majority of women here seem to prefer copper intrauterine devices and implants as birth control. In helping with the insertion of contraceptive devices, I learned that while the Ministry of Health and Kawempe General Hospital are supportive of family planning services, women still fear stigma for using contraception.

“Make sure you can’t see it,” one woman told me as we placed an implanon implant in her arm. “I don’t want people to know.”
Kaysha Ribao with Ahja Steele, medical student at Ross University School of Medicine, and James Ssewanyana, primary clinician at ACCESS Life Care Center as well as Co-Founder and Deputy Executive Director at ACCESS.
The red dust is everywhere: on skin and clothes, in the car and the air. Despite the rain last night, today was particularly dusty as we partook in another Family Planning Outreach event. Although we started in the late afternoon instead of our regular morning start time, I began to understand why. It was the beginning of farming season, which means women work until late afternoon before returning home to complete chores. With farming composing their main livelihood, it was pertinent that we work around their schedules.

Communication is key to any event, and Ugandan social media includes loudspeakers and lively music. As we sat on the grass under the tree as our advertisement played in the small village, I spoke to Charity, a security guard at ACCESS who had joined us. She described her dream of becoming a nurse, and the reality that she could not afford the school fees, especially with five siblings. Costs (1 USD = 3,600 shillings) include 200,000 shillings for primary school, 300,000 shillings for secondary school, and 500,000 for university, not to mention the meager income for each family. She believes it is her responsibility to pass her dreams on to her younger siblings and support them in their endeavors. According to Deo, our driver, there is no such thing as loans in Uganda. It was then clear to me that there is no such thing as equal opportunity.
As I make my way through Paul Farmer’s Pathology of Power, things are starting to make sense. Poverty is essentially the cause of the injustices I observe, as a lack of resources pushes individuals to vulnerable situations in order to simply survive. Poverty excludes the poor from receiving an education, which is essential for finding a stable job and having an influence in the community. It leaves individuals malnourished, which renders them vulnerable to sickness and disease. The village children caught my eye as they ran around playing and taking care of each other with muddy bare feet, yellow snot, and dirty clothes that barely covered their thin bodies.

These observations make me feel helpless and frustrated. As a systemic issue, poverty requires a systemic solution. Poverty pushes the poor to the point of anger or despair, leading to political upheaval and eventually civil war. War brings on violence, which further exacerbates human rights violations—sexual assault, torture, displacement, and hunger. Deo explained that the war in Uganda left him orphaned, but that he was cared for by relatives, bringing meaning to the phrase “it takes a village to raise a child.” However, many others were not so lucky.
Untitled (Photo credit: Scott Mitchell)
Selected as Most Impactful Photo at the 2019 UVMCOM Global Health Day
Finding Home

WRITTEN BY RAY MAK
University of Vermont Larner College of Medicine Class of 2022

Where is home for you? If I had to pin a physical location, I would consider Southern California my home. Though I only lived there for four years in college, they were the best years of my life. I felt truly at home. For some, home isn’t defined by where you grow up, how long you’ve lived in a particular place, or where your parents chose to settle down. Rather, it’s measured in the love and safety to nurture your authentic self. For me, home is not held in a physical space, but within the circles of people I hold close to me. Home truly is where the heart is and unexpectedly, I left a piece of my heart in Thailand this summer.

Upon arriving at Walailak University in Southern Thailand, we were welcomed with open arms. Thai hospitality is incredible: there was always somebody to show us around and take us out for food. There is a culture of giving and looking after one another, even among strangers. For instance, as I was leaving a roast duck shop, one of the cooks ran after me to hand me a bag of mangosteens, a common tropical fruit in Thailand. Her generosity caught me by surprise, and I had done nothing to deserve it. I didn’t know how to respond at first. At a loss for words, all I could say was “khàawp khun krap,” or “thank you,” one of the few Thai phrases I picked up. Although not being able to speak the local language felt isolating at times, the kindness of strangers was touching. Walking into a restaurant near the university, a woman the students refer to as “Auntie” came out to greet us and take our order. As a Chinese-American, I grew up with a similar custom of calling everyone my parent’s age “Auntie” or “Uncle” even if we were not blood-related. In terms of student-professor relationships, I learned that it’s normal for students to text their professors, and even the dean of the medical school, whenever they need anything. The dean wants us to call him “Pee Menn,” meaning “big brother Menn,” implying that we are all family and here for each other despite the differences in our backgrounds and upbringings. It’s hard for me to imagine normalizing this level of comfort in the U.S. where I was hesitant to even email my college professors, fearing that I would be a bother and take up too much time in their busy schedules. There’s a sense of closeness and connectedness in rural Southern Thailand that doesn’t exist as prominently in the U.S. where things are more “everyone for themselves.”

Independence is valued in American culture, rendering it acceptable to settle down far from home. On the other hand, maintaining strong family ties is a common theme in Asian cultures. From speaking with Thai medical students, I found that they often feel homesick while studying at Walailak. However, one reason why many choose to study there is that the school strives to train doctors from underserved areas of Southern Thailand so that graduates can return to their hometown and serve the community they grew up in. To
cope with being away from home, students say that they treat their peers and mentors like a second family. As someone who found chosen family in college, I can deeply relate.

The summer before college, home was a foreign concept to me. My parent’s house was not the place for me to live as the person I wanted to be. When I told my parents that I was transgender, they expressed their disapproval and an already-difficult relationship turned into four years of estrangement after moving out for college. I remember sitting in my pediatrician’s office, trying to verbalize why living with my parents was becoming unbearable. Luckily, my doctor understood me and argued with them that there was nothing inherently wrong with me wanting to live as my authentic self. Though they didn’t listen, I found comfort in knowing that at least my doctor was on my side. To this day, it’s been a challenge to bring my parents along in my journey of transitioning.

Hearing the stories of patients at Phud Hong Leprosy Center, I saw how our experiences paralleled. It was less than a lifetime ago that leprosy was heavily stigmatized. Those afflicted with the disease became social outcasts, forced to leave home and quarantined to a leprosy facility. People believed that the disease was punishment for a horrible action in a past life. Leprosy patients were turned away even by friends and family. My heart wanted to leap out and pour the love that they had been missing through all the years, but it would have been too little, too late. Over the past few decades, effective treatment for leprosy has become available and our understanding of the disease has progressed significantly, but the debilitating effects on survivors still remain. They are left with varying degrees of facial deformities, muscle atrophy, limb amputations, and psychological trauma.
The most valuable teaching from this day was that it reminded me why I chose medicine in the first place. Among the many stories, one patient shared his surprise when one doctor in particular was not afraid to touch him and treat him like a human being. When the rest of society turned him away, this encounter gave him faith in the world as he knew he would be well taken care of. This is the kind of hope I want to give my future patients. I chose medicine to be a part of the change in healthcare for marginalized communities. Doctors are in a position to see how health touches the many aspects of a person’s life, and it is our job to treat the person as a whole. When a patient has hit their low point, I want to be by their side and fight for them to see better days just as my doctor did for me.

Presently, leprosy patients at Phud Hong Leprosy Center are free to leave and see their loved ones in the outside world, but many choose to stay because they are unable to reintegrate into society after the
years of trauma and rejection. Like physical scars, the emotional scars last forever. You can still hear the pain in their voices as they recount their stories. Despite the suffering, there was a beauty in how patients supported each other through difficult times and bonded over their shared experiences. As we toured their living space eating fruit off the trees that they tended to, I was struck by a community brought to life. This was home for them: a place to feel safe among chosen family that they could call their own.

That day, I found a struggle that resonated within me. I was immensely grateful for the opportunity to interact with these patients. I fell in love with their stories, their resilience, and their audacity to continue living and sharing their lives with people like me despite their unfortunate circumstances. These patients will continue to be an inspiration in my pursuit of medicine. I hope I can be just as inspirational and uplifting for others one day.

At the end of our rotation, we gave a presentation on our experience in Thailand to an audience that included the dean of Walailak and other school officials. I chose to talk about how my experiences being transgender allowed me to empathize with marginalized communities, and especially how our day at the leprosy clinic reminded me of my inner drive. I wasn’t sure what people’s reactions would be, but it felt like a disservice to myself and my audience to not tell my truths. I took a leap of faith based on the kindness and understanding that seems so deeply rooted in Thai culture. Afterward, several people expressed that they appreciated my presentation. The dean even hugged me, saying that I was very brave for sharing my story.

That was when it hit me: I had found a new piece of home at Walailak University, a place that has nurtured my soul and allowed me to grow into a better version of my true self. I was inspired to continue the generosity of others by paying it forward, connecting with others as if we were family, and unapologetically falling in love with inner strength. These are the lessons that I will carry with me for the rest of my life.
This week I met Anthony, not at the hospital or clinic, but beachside as I was enjoying a cold Corona and a delicious seafood paella. Although it was August, Anthony was selling heart-shaped Valentine’s Day-themed lollipops. I saw him go to each dining table one by one, only to be rejected what seemed to be nine out of ten times. When he reached my table, instead of just buying the lollipop for 25 cents, I asked if he was hungry and would like to join us for dinner. He was shy at first and politely declined the invitation, but eventually sat down and joined me after I said the food was entirely way too much for me to eat on my own.

I learned that Anthony is fourteen years old, lives with his mother and grandmother, and doesn’t know much about his father. I learned that he works twelve-hour days, from 9 am to 9 pm. I learned that he makes on average four USD a day, two-thirds of which goes to his family. I learned that right now he’s working a little extra because he has to buy school supplies since classes will begin shortly.

I learned that Anthony doesn’t want to sell lollipops his whole life. When I asked what he wanted to study when he grows up, he said dentistry and possibly photography. I encouraged him to follow his dreams and told him I was proud of him. In this short meal, I not only learned that Anthony was hungry but too shy to admit it, but I also learned about his life and personal struggles. He reminded me of the times when I myself went door-to-door asking people if I could cut their yard for a few bucks, as I needed new shoes before school started and this was my only option. I was also fourteen. Anthony is another constant reminder to value what I have. I hope everything works out for him.
January 1, 2019, I began to organize for my trip to Uganda. I ordered a few things off Amazon: bug spray, a safari hat, a small rechargeable fan, etc. I changed my Facebook cover picture to the Ugandan flag, which features a pattern of black, yellow, and red stripes that repeats twice, forming six equal horizontal bands with a grey crowned crane—the national symbol—at its center. Black for the people of Africa, yellow for the sunshine of Africa, and red for the brotherhood (color of blood) of the African people, through which all Africans are connected. The grey crowned crane is known for its gentle nature, with its raised leg symbolizing the forward movement of the country. I think of the gentle and soft-spoken nature of the Ugandan colleagues who have visited the U.S. The grey crowned crane must be a beautiful bird.
As I look out the window, I can’t believe my eyes and the plethora of activities surrounding me. There are people EVERYWHERE in Kampala: on the main streets, side streets, in stores, outside of stores—people sitting and laughing and doing laundry in a bucket, people cooking on small fires. Everyone is dressed superbly, whether in the city or in a village. Dress might be soiled from a day’s hard work in the village, but the inherent sense of style is beautiful to my eyes. The smells remind me of summer barbeques roasting marshmallows by an open fire. My eyes fill with tears. What a beautiful place!

Kampala is an exciting city! It’s alive and well and never sleeps, much like New York City. Roads aren’t paved with concrete but are rather packed with beautiful red dirt. Each business is lined in a tightly knit formation, all in a row, in brick buildings. Merchandise is laid out on handmade African mats, mannequins, or sometimes on the head of a very talented African man or woman. It’s all there! Cell phones, clothing, produce, meat, hardware stores, hair salons, furniture stores, supermarkets, places to eat, pharmacies, construction companies, night clubs, and even places to purchase coffins! A car clearly labeled “Driving School” makes me wonder how young men and women in the U.S. would handle driving on Kampala’s streets. The roads are full of matatus, with people packed from top to bottom and front to back, and boda bodas on which up to 4-5 people ride at once, and helmets worn only by the driver. There are little to no traffic rules, but people simply make it work without yelling, cursing, or honking.

During our stay in Kampala, we are hosted by two wonderful, caring, and loving families: the Okullos and the Lubogas. We are treated like kings and queens. Each evening, we are welcomed with a warm heart and honest gesture of “How was your day? You must be very tired.” “Welcome home” is an understatement to say the least. We are home in their homes, never feeling like guests or strangers. We are treated like family, and I quickly become fast friends with the women helping run the homestay. I wake up at sunrise one morning to the Muslim prayer. The only time I remember hearing this is on the HBO series “Homeland.” As I lay in bed listening, I remember to stay in this moment and appreciate how blessed I am to be on this journey.

In Kampala, we spend a considerable amount of time at the orphanage, Sanyu Babies Home. I look around and smile as we are all engaged with the children: holding and/or feeding an infant, wiping the runny nose of a toddler, throwing a ball to a child, or pushing as many toddlers on the swing as we can, remembering there are only three swings but ten to fifteen anticipating toddlers! I admire the mamas who care for the children every day. They are making such a difference. It’s hard to leave. I make a mental note to spend more time at the orphanage during my next visit.
Before going to Naggalama, a village an hour away from Kampala, we buy bread, rice, and soap to give as small gifts to patients during our palliative care rounds. These simple items, I learn later, are a luxury to many Ugandans. Palliative care rounds are eye-opening. The gifts are accepted with gratitude and happiness by the local community members we visit. Despite being very sick, they rejoice in our small gift as if they won a million dollars. I text my family to remind them how lucky we are, and to be kind to everyone. I encourage them to always help others and to open their hearts to them. I begin to notice the feet of Ugandans: just like mine but calloused from hard work. It helps me remember that we are all the same. On rounds, we are welcomed by four patients, most of whom are smiling despite their illness. I will never forget their faces and the compassionate care provided to them by the St. Francis Hospital staff.

In Nakaseke, a village two hours north of Kampala, we join members of the African Community Center for Social Sustainability (ACCESS) on community outreach rounds where we meet such happy, grateful people. One sings us a song about asking God to grant us anything we want in life. Another woman shows us the healthy piglets she is proud of raising. We visit two elderly women who remind me that all we need in life is friendship and love. We tease them, asking who is older, and even though I don’t understand the language, I can tell they are happy as they sit on the floor of their small, concrete home by a small cooking fire. I cozy up between the two women on the floor and wish I could stay longer. Life is simple; poor but simple.

Back home under the cold winter’s night, I look to the stars and remember. I think of the young girl paralyzed from the waist down lying on the concrete floor of her small home, and the enormous energy with which her smile filled the room the minute we entered. I think of the woman who sang to us in Luganda in her beautiful purple gomezi and her concern about her children’s reading since the solar lantern she had been given stopped working. I look at the stars and miss the two elderly ladies and the feeling of content that enveloped their home. I wonder if they are looking at the same star. The people of Uganda are certainly gentle human beings, much like the crane.
Sabino Canyon (Photo credit: Majid Sadigh)
Talk to Me (Photo credit: Keyvan Behpour of Kvob Photography)

Uganda (Photo credit: Albert Trondin)
Tis “the witching time of night,” Orbed is the moon and bright,
And the stars they glisten, glisten, Seeming with bright eyes to
listen— For what listen they?

(excerpted from “‘Tis the Witching Time of Night”)

Fortitude of the
Forever Flower
(Photo credit: Mitra Sadigh)
People take to the mountains for an assortment of reasons. For me, the mountains recall the words and cadences of the many poets whose lyrics I pored over in my life prior to medical school. Thus I would like to start with a quote from John Keats, who exalted Beauty and sought it out in Nature.

I start with these lines as they came to mind twice on Kilimanjaro. The mountain, despite its abundance and beauty, is also stark and isolating. Even as we may walk shoulder to shoulder, many of the moments on the mountain are experienced alone, as we battle our own fears and vulnerabilities.

This is particularly true on summit day, when you wake before midnight, throw on layers of clothing, gators, balaclava, and head lamps, in the frigid air and in the darkness, to begin the slow seemingly vertical ascent first to Stella Point and finally to Uhuru Peak. At this elevation, even the smallest action, opening a snack bar, readjusting a backpack, feels impossible. Every hard-earned step forward results in a sliding of two steps back, another discouraging blow at this unforgiving elevation. In the thin air, our minds play tricks on us, planting objects that are not present, blurring lines between dream and reality. Despite the bouts of despair that swell in the chest, if for one moment we break away from our own immediate experience to look beyond, we see the lights of the headlamps of the hikers in front of us, a sign of life, a gentle nod of encouragement. And that is often just enough to take in the fuller view, with eyes cast upward to that brightest night sky, teeming with stars, glistening above us.
These lines by Keats also call to mind the force of the Maasai people, the other tribe in addition to the Chaga, who escort teams up Kilimanjaro. Their strong, sure footing is further accentuated by a writhing dance and deep, monotone song that seems to originate from the earth itself. When our team intersects with theirs, this energy pulls our bruised spirits off the ground and compels us forward. And so we go, one step forward, two steps back, until we reach the summit and with bated breath, watch the fresh sun beams break into colors across the valley, into the pits of the crater, along the edges of glacial lakes. Many of us break into tears in an inextricable mix of exhaustion, gratitude, and incredulity—as if the earth has opened a new window into its core, and we are lucky enough to witness it.
But “the witching time of night” can be dangerous. We had passed him and his hiking team multiple times on the previous days. Standing or sitting off to the side of the trail, catching his breath, he always had a word or two of greeting for us. This time, he was crouched over in the middle of the trail, his hand to his chest, gasping. I immediately approached him and asked him, “Are you feeling okay?” With great effort, amid coughs, he replied, “No.” I bade him sit down on a rock, and performed a brief physical exam while my father knelt down beside him, and as with so many of his patients, holding his hand, while the other members of our team surrounded us. His oxygen level was extremely low, his heart rate high, and breaths short and shallow. When he coughed, he brought up frothy pink sputum. We already suspected that this young man was struggling with altitude sickness, but that final detail confirmed our suspicions that this was pulmonary edema—one of the most severe complications of altitude sickness, when the lungs fill up with fluid.

All the while, my father was speaking with him, learning about him. He grew panicked at the prospect that he was too sick to reach the final peak, his eyes swelling with tears as he begged us to help him continue. He told us that he had lost two of his closest friends recently, and that this climb was in honor of their memory. We all took turns reassuring him, comforting him, but it was not until he heard my father’s words that he finally understood that this was the end of the trail for him. “If you were my brother, my son, I would tell you that you must not continue. You will not be able to honor the life of your lost ones, or to inspire your friends and family, if you do not protect your own life. And right now, that must be your focus.” We learned the next day that he had made his way down with the help of his guide, and that he was out of harm’s way.

After basking in the sun reflecting off thousands’-year-old glaciers, we flee. This time, we slide down and ski through rocks that had only hours ago held us back, causing us to stumble and fall. Our lungs are soon flush with oxygen, our cheeks red, our fingernails pink.

And suddenly, we are back in the forest, where magic is as mischievous as the blue and colobus monkeys that prance and flirt in the canopy above our heads. Our eyes, which had shifted from the black of night to the blinding morning sun over a largely barren land, cannot absorb the volumes of visual data fast enough. Sagamore trees, olive trees, fern of all shades and textures, moss and vines hanging, clinging, climbing, create the backdrop for a thousand bird songs. At any given moment, with a simple turn of the head, we can see a world as lush as Shakespeare’s The Tempest.

I end now again with an excerpt from John Keats

Stop and consider! Life is but a day:
A fragile dewdrop on its perilous way From a tree’s summit.

(excerpted from “From Sleep and Poetry”)

Even as nature came to embody beauty, and with it, truth, it was also where Keats confronted his own mortality. As physicians, nurses and health care workers, we are privy to some of life’s most difficult moments, when our patients are prostrated by their fragility, illness, and pain. Before I began this journey
through the vistas of Kilimanjaro, I had lost my way. Somewhere in those ten years of medical training, the certainty of my role in this life was wavering. Like Keats, immersing myself in those peaks and valleys has humbled me in the face of my own mortality, and at the same time has invigorated me so that I can begin my work anew, at the patients’ bedside.

In our last view of Kilimanjaro from its verdurous base, we cast our gratitude to those majestic heights, with our feet sore but our footing more certain, our darkness revealed but our dreams united.
Sanctuary For Dreams (Photo credit: Majid Sadigh)
Paying It Forward

My overwhelming gratitude to the Global Health Program manifests in a strong desire to “pay it forward.” The program motivated me to develop the tools needed to help others in a meaningful way. After completing my medical training and specialty in neurosurgery in Russia, I had the fortune of participating in a six-week global health elective in Uganda just before applying for a residency in 2014. The elective was a transformative, eye-opening experience. Looking back, it not only helped me pass the forthcoming entrance examination but also gave me the courage to attempt it.

After undergoing the selection process and two-week pre-departure orientation, my colleagues and I landed in Uganda with a strong sense of mission: a responsibility to work hard and perform well. Though we initially felt as if we were submerging into an exotic dream-like world, we gradually awoke from dreams into reality. The program was multidimensional in every respect, involving an impressive scope of elements including curriculum and training in internal medicine, infectious diseases, biostatistics; entanglements with ethical issues and cultural interplay; exposure to a network of new people and ideas; novel perspectives of collaboration and teamwork; and pure professional development. I spent most of my time in the Neurosurgery Department of Mulago Hospital, but also visited Cure Hospital, a facility in Mbale that specializes in neurosurgical problems. Because neurosurgery is one of the most-needed specialties in the Global South, I want to use my skills as a specialist to contribute as much as I can.

The Global Health Program and the density of experiences it provides is a gift. My colleagues and I all feel that the only way of expressing our gratitude is to help those around us. The sense of responsibility we felt on the elective has carried over from the humanistic work we observed into the humanistic work to which we are now committed. That deep sense of connection drives us forward.
Classroom, Uganda (Photo credit: Majid Sadigh)

Untitled (Photo caption: Albert Trondin)
If you haven’t traveled and explored Africa it’s hard to describe how moving the experience is. During this trip I had the experience of dining with Bishop Tutu’s closest colleague — Tutu was in hospital — and talking with several people who were in prison with Nelson Mandela. Particularly poignant was a visit to Mandela’s grim cell on Robben Island Prison, where he spent 18 of his 27 years of incarceration. This poetic effort demonstrates that I was deeply affected. I wrote it while on safari in the Okavango Delta in Botswana, enjoying some of Africa’s infinite natural treasures. I named this poem after its beginning line instead of perhaps a more suitable “Coming Home to Africa.” As you may know, “dream time” is what the Australian Aborigines call “the time before time.”
In “Dream Time” all was Gondwanaland.
The ocean freshly born,
With every grain of life yet to emerge.
We were there, waiting – aimless,
No thought of time, or hope.
Eons set the land adrift as the Earth contorted,
Still groaning in its birth pangs.
At a pace only God could detect,
Land-forms drifted slowly apart,
Like pieces of a puzzle never again to be solved.
Sparks of life glinted in the sea,
A broth portending nothing, then.
Our continent rode the back of Africa
‘til we slowly parted ways.
Mare Atlanticus took shape between us,
An ocean-bottom seam tracing, even now, our historic unity.

Life had then begun on these and other land-arks
And in the sea surrounding.
God’s magic hand formed creatures long-forgot
That tried to gain a foothold on the spreading Tree of Life.
Upon the still slowly writhing ground of Africa,
Man’s first steps were heard an age ago.
With time, some men stayed in their verdant home,
And others wandered,
Following the horizon by day and the star-filled heavens at night.
And soon we’d reached the Earth’s extremes,
Or settled along the way.
Adapting, changing, resonating to God’s tones,
Forming a chorus of Mankind, singing together with all our hearts,
Rejoicing in the miracle of our life

And the Heaven-born miracle of our common birth,
And mourning the mystery of our individual death.
But could it be that this diaspora of epochs,
That drove us to explore unknown lands,
Was meant to cloud our memory of Africa, our birthplace?
Our souls took form here and never really left our home.
Our brothers and sisters who stayed in Africa today uplift our spirits.
Those of us who now visit our homeland to meet others who were
Here when our Mothers and Fathers lived long ago,
We are at once blessed by renewing our Brotherhood,
And cursed by knowing that Evil has too often
Broken our promise to God to rejoice in the common holiness
Of our human spirit.
We are among the fortunate, called home to meet our living ancestors,
To learn their names, to look into each other’s eyes,
To feel the bond in our differences,
And sense the throbbing of a single heart among us.
We, the fortunate, are forever changed by coming Home to Africa.
Flowers of Guatemala

Untitled (Photo credit: Jose Marquez)
He was a thin young man, only twenty-eight years old, but had probably experienced more than most do in a lifetime. He was shackled to the hospital bed with a visible sadness, confusion, and uncertainty of the future to come. Unable to communicate in English, he continued the solitude he had faced in the desert, but now in a sterile room with two Border Patrol agents present in body but with emotional distance. They waited, arms crossed in brown fatigues, guns at their side, exuding a seriousness centered on intimidation.

The consult was for bacteremia, MSSA – or methicillin-sensitive Staphylococcus aureus. The source was cellulitis of the leg caused by apparent multiple scratches and soft tissue injury. Cactus spines! Some of the broken-off thorns were still in his leg. The patient had been picked up by Border Patrol sometime earlier, crossing the vast Sonoran Desert to reach the United States of America. He had come all the way from Guatemala, a journey of two thousand miles. He had three young children at home, three flowers, for whom he needed to care. He had a desperate thirst to find a way to provide certainty and security for his family, and finding work in another country was the only choice.

His journey for a better life turned into a journey for survival. The scorching sun during the day and frosty moon during the night damaged his skin. He had survived several weeks in the wilderness, unable to shelter from the elements for very long. As his supplies ran out towards the end of his journey, he drank from puddles and troughs of animals. “For a better life,” he pressed on.

Close to his goal, however, he was spotted near the border. He ran with a pair of withering shoes eroding into his feet. Filled with a cold panic and fear, he ignored his exhaustion until his tired legs gave out. He fell off a small rocky ledge, crashing into thorny cactus and scrub vegetation. Waves of pain scoured his body as the thorns sliced through him. By this time, exhausted, he was almost grateful for the Border Patrol hand that picked him up.

Into detention he went, with chain-linked fences, cinder blocks, and fluorescent lights. He was ill from the journey, dehydrated and in need of hospital care. The skin and soft tissue injuries were significant and gave rise to a localized infection. Staph aureus, a master pathogen, invaded the bloodstream. Now he was febrile. The case was easy enough: intravenous cefazolin, ECHO to ensure no heart valve involvement, and localized wound care. But what would become of him? What about his family that he left behind? Now, there was no father to provide. The hope was fading like flowers in the desert.
African tulip tree flowers (Photo credit: Majid Sadigh)
Nostalgia (Photo credit: Majid Sadigh)
In Awe

Dr. Stephen Winter
Senior Consultant for the Nuvance Health Global Health Program

Medicine in a crowded hospital ward in a resource-constrained country can be emotionally overwhelming. Patients generally enter these hospitals with advanced diseases, often accompanied by severe comorbidities such as advanced HIV or malnutrition. Mortality rates are much higher than we experience in our home hospitals. During my visit to Zimbabwe two years ago, it was not unusual for two or three patients to expire or experience a severe event such as a grand mal seizure during the course of rounds on a single day.

As educators, we often worry about the potential emotional impact of such events on our medical students who rotate through these hospitals, especially early-year students who may have never witnessed the death of a patient, and set up systems to mentor and monitor them. But I think we rarely consider the emotional toll on trainees and young faculty at our partner hospitals who always seem to approach these situations with stoicism and acceptance of the local reality. Today, I learned that the reality is quite different.

As we discussed a patient at the bedside during ICU rounds, a nearby patient unexpectedly developed pulseless ventricular tachycardia. His Vietnamese resident jumped into action from rounds and lead successful CPR on the patient. She had cared for him over the past month after a fall left him with paraplegia from a high cervical spine injury. She left the unit to speak with the family and returned a few minutes later, barely holding back her tears. “The family wants to take him home,” she said – the local equivalent of hospice for a ventilator-dependent patient. “Why am I doing this? Half of my patients die. Maybe I shouldn’t be a doctor.”

Less than twenty minutes later, I received urgent text messages from another young physician with whom I was working that week, one of our Vietnamese Global Health Scholars who had worked with us at Norwalk that year. “Where are you? Can I talk to you?” We had been taking care of a young woman who had been unsuccessfully extubated four times in the previous two weeks. We developed a plan to extubate her five days prior, and she was doing amazingly well off the ventilator and planning on going home that day. But the night before, she suddenly coded and died under the care of a covering resident. My friend had come in that morning to face the distraught husband and try to provide comfort to the family. He too was fighting back tears, convinced that he had made a mistake that led to her death. When we met, he was clutching the multi-volume chart to show me a minor omission he had made in her care, certain that he was responsible for her death.

We often worry about our students undergoing emotionally fraught experiences, but who worries about the emotional distress our scholars and their colleagues must endure on a daily basis? Who worries about the repercussions of our mistaking their stoicism for lack of personal impact, as if they are somehow immune to bearing witness to so much suffering?
Together, we have discussed means of working through feelings of despair, helplessness, and blame that sometimes accompany our lives as doctors, and celebrated the many clinical successes from their skills as physicians. Yet I worry about these deeply compassionate young doctors who often lack an outlet for their own emotional distress as they minister to the distress of patients and their families. I wonder where these wonderful young physicians find so much resilience and inner strength. I am in awe.
From My Window (Photo credit: Majid Sadigh)
Sea Market, Dalian, China (Photo credit: Majid Sadigh)
2019

Photos and Reflections

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