RESIDENTS ABROAD
Dr. Joe Wooley at Rosebud Indian Reservation, Dates: 03/12/18 to 04/18/18

I recently returned from my global health rotation on the Rosebud Reservation in South Dakota, where I worked with Indian Health Services. This was my first exposure to the Native American health care system, as my historical focus in global medicine had been in Latin America. However, I am grateful for the serendipitous path that led me to Rosebud because it was an eye-opening experience that will no doubt alter my career trajectory.

Native Americans are the lowest ranked demographic by almost every metric of health care status compared to other Americans. Barriers to accessible care and devastating social conditions have led to significantly truncated life expectancy and disproportionate disease burden. The community is plagued by high rates of incarceration, chemical dependency, and harsh economic conditions which lead to food insecurity and housing instability. The pediatric population is resultantly steeped in toxic stress that is reflected by poor nutritional status, low graduation rates, drug abuse, and alarmingly high rates of depression and suicidality. While this high risk community with limited resources is comparable to our other international sites, the precarious relationship to IHS as a representative of a government that has caused tremendous historical trauma to this community makes Native American health care a particularly demanding experience for non-native providers. It requires incredible intentionality toward cultural sensitivities and establishing trusting therapeutic alliances, especially since many do not seek routine care and are seen only for acute visits.

As the first UMN resident to rotate through Rosebud IHS in any official capacity, there was little framework for clinical duties or community experience. Ultimately, the majority of my clinical involvement was in the outpatient pediatric clinic where I worked a full schedule with 24/7 on-call responsibilities for ED consultations and admissions. However, due to extremely limited capacity of the hospital, both number of beds and inadequate resources to handle acuity, most children requiring hospitalization were transferred to outside hospitals. The nearest free-standing children’s hospital is over 3.5 hours away by ambulance, creating an incredible strain on the already limited resources. Additionally, the average commute to the hospital is over an hour, which is another barrier to care, with no public transportation and the majority without access to a car. The funding for preferred care referrals is annually determinate, so typically only level 1 priority (reserved for life/limb/sight threatening disease) is approved. This means that most referrals to pediatric subspecialists are not only inaccessible, but also unaffordable.

I was saddened by the level of disparity that has been allowed to persist within the confines of one of the wealthiest countries in the world. However, reflecting on the experience, I realized there had never been a time in residency when I felt more needed. The human capital need is overwhelming but strengthened the awareness that my efforts were vitally important to the child in front of me. I recognized that if I weren’t doing it, there may not be another to fill that void. Now that the veil has been lifted, I cannot ignore the health disparities in our own backyard and plan make Native American health part of my long term career plan. I am currently working to help develop Rosebud as a permanent global health site for our residency program with the hopes of providing similar inspiration to other residents.

If you are interested in the Pediatric Global Health Track or have something to add to this newsletter contact Emily Danich at edanich@umn.edu
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GLOBAL HEALTH TRACK
MONTHLY NEWSLETTER—MAY 14, 2018

Dr. Janice DeMello is visiting from Tanzania for the next month. Please reach out to her directly if you are interested in meeting with her. This would be particularly helpful if you plan to do a rotation in Tanzania. Please email her directly at janicedemello3@gmail.com.

Pictured: Dr. Julia Rubin-Smith, Dr. Steve Swanson, Dr. Saki Ikeda, Dr. Benji Katz, Dr. Janice DeMello, Dr. Steve Selinksy, Dr. Meghan Fanta

Publications:
Surgery For Saving Babies from ‘Water On The Brain’ Developed in Uganda
Endoscopic Treatment versus Shunting for Infant Hydrocephalus in Uganda

Chief's Corner—Note from Dr. Ife Ojo:

I returned to Minnesota on May 1st with my wife and daughter after an intense start to our year in Mbingo Cameroon. In some sense, the 15 weeks of almost continuous service seemed to speed by really quickly, but in other ways it felt much longer. My family and I have grown in many ways through this experience, and I am thankful that we were all able to serve together at Mbingo Baptist Hospital.

The Cameroon Baptist Convention Health Services (CBCHS) has a good thing going in that country. Their effort to provide high quality, low cost care through the CBCHS hospitals and health centers is very laudable. This is the first time I got a chance to experience some of the inner workings of a faith-based hospital. I was not aware of the important contributions of the CBCHS the first time I visited Cameroon in 2010, as part of a World Bank Group team researching how governments in Africa collaborate with the private health sector (including faith-based organizations). I spent about a week interviewing key players in the health sector and visiting private health facilities in Yaoundé and Douala. At that time, I did not realize the CBC was such a major player in Cameroon health service delivery. Sadly, the findings from our research, that more than 95% of people pay for their healthcare out of pocket remains true. In fact, many families are thrown into financial crises despite the lower cost of services provided through organizations such as the CBCHS. But from my time at Mbingo, I came to appreciate why many families either self-refer or are referred to the hospital for expert management. They are able to access the care without first providing a ‘deposit’ which is demanded in most other private hospitals. At the government hospitals, families have to purchase the medications used to treat the patients. Let’s leave the conversation about catastrophic health expenditures and the role of health insurance for another day.

It was humbling to be seen as an expert. I felt most out of my depths when children with complex neurologic conditions were referred to Mbingo to see “the pediatrician”. I do not consider myself an expert in the field of pediatrics by any means. So, it was very helpful to be able to pull together great brains in the pediatric sub-specialty services at University of Minnesota, as well as contacts through Dr. Slusher and the Midwest Consortium of Global Child Health Educators to help some of the Mbingo patients. Telemedicine access to these experts made the best possible care available to children in Cameroon without having to refer them further away from home. I hope to continue collaborating with the Mbingo Baptist Hospital pediatric department by being accessible as a resource or link to consultants for the pediatricians and residents that work there.

I remain grateful to the patients, families, chaplains, doctors, nurses, laboratory scientists, administrative staff, social workers, cleaners, and other helpers at Mbingo Hospital who enabled me partner with them to provide care to children during my time there. It was a blessing to serve with them for just a few weeks, and I applaud the work they all do on a daily basis despite the challenges. The Mbingo staff and volunteers are my heroes for the month of May!

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