This summer, I had a wonderful experience due to the generosity of the Hassenfeld family and CURF. I undertook research and managed to work at a pediatric and maternity ward as means to achieve my main goal of reducing infant mortality. To figure that out, I undertook a two-step process. Firstly, I investigated the effectiveness and sustainability of the cold chain. I found that most clinics in Matabeleland originally used gas powered fridges but have since shifted to using solar powered fridges which is cost free. The gas refrigerators were not removed and are used as standby in case of malfunction. In Hwange, they also have telecommunication powered refrigerators, however, the challenge is, in case of a power cut, most of the boosters are located in higher terrain areas which are further from the clinic. So despite the free energy and the sustainability, someone will have to go over to the booster to connect the fridges, which introduces transport costs. These are most effective in areas where the booster is at a walking distance to the clinic. I visited some of the storage facilities for the vaccines and saw the temperature charts. The facilities are backed up with a generator which has an auto switch. The temperature charts is recorded twice daily to maintain the correct temperatures in each room and fridge. This way abnormalities are noted within 24 hours.

In all the clinics I visited, most of the children were up to date with their vaccinations, so I embarked on a phase of the project that required me to interact with the mothers and doctors. I did this while pre- med shadowing at pediatric and maternity wards. When I spoke to the mothers and doctors I found that in most cases the poor socio-economic status of a family affected the health of the child. For example, a young mother would not give her baby a balanced diet. The baby would then be susceptible to infections and come to the hospital. The mother would be advised by the doctors on the best way to accommodate the baby’s diet and would also be given a prescription for treatment. The mother would come for review but without giving the child the necessary medication because she could not afford it. Diarrhea also contributed to a large number of admissions to the clinics because of hygiene, and some children who were older than 6 weeks when the Rota- virus vaccine was introduced did not receive the vaccine. Taking note of the bias of the winter season, most babies were also susceptible to pneumonia. Overall, in my interaction,
I felt that the goal of reducing infant mortality is achievable. In most cases parents were committed to their children’s health but lacked funds. If this issue can be addressed the goal will be closer than it is now.

The experience was valuable to me because as I shadowed the doctors, I got a good perspective on what lay ahead as a pre-med student. The results from my research made me realize the various loopholes in the field and the areas which need to be worked on to improve infant mortality. I was especially impressed with how the cold chain has been managed to make sure that every child is immunized and even delivered to the remote areas using mobile clinics. I figured through collective action and unity, no problem is without a solution. I walked away from the experience, open minded, grateful and ready to make the change.