REFLECTIONS OF MAPUTO

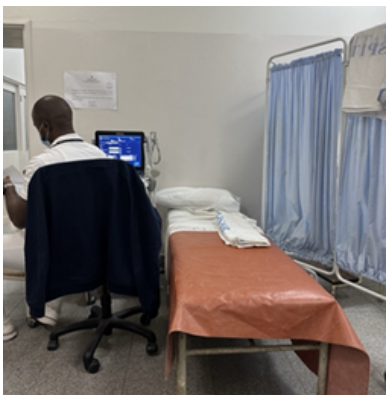
BY CASSANDRA HEISELMAN, DO, MPH

"Tell me and I forget. Teach me and I remember. Involve me and I learn." – Benjamin Franklin

It took many years and lived experiences to understand that things can be done for the right reasons but not with the intended outcomes. An ethnography I read in college set in the Middle East has always deeply stuck with me – a story about international aid workers coming in to build infrastructure, a bridge, to help with commerce and trade endorsed by the male village leaders. During the project, they took down an old, smaller bridge on the edge of town because 'why would you need that bridge anymore?'. What was culturally unappreciated was that women were not allowed out in public unless escorted by a male family member and that bridge served as the only means - a secret path - that allowed the women of the village to socialize and connect. The destruction of that small seemingly worthless bridge broke down the female social structure in that village. I never wanted to be those aid workers unintentionally harming a community I was hoping to help.

There are ongoing debates and arguments on what is ethical and sustainable international medical volunteering. While I had a lot of anxiety and nervousness that my unique set of skills and knowledge may not be what is needed in Maputo, the knowledge that these efforts were coordinated by Dr. Sierra Washington helped to assuage that fear and focus my energies. Our many preparatory meetings to discuss not just logistics but structured goals for my time in Mozambique gave reassurance that my impact would be a positive one. My goals were that of antepartum protocols and sonography. Dr. Washington had realized in her time at Hospital Central de Maputo that the placenta was a neglected topic – in its sonographic evaluation to look for things like previa or in the setting of a prior cesarean section and the evaluation of abnormal placentation (i.e. accreta). Secondly, the attending newly assigned to lead the antepartum unit, Dr. Benjamim Matingane, was interested in learning umbilical artery Doppler evaluation and management of fetal growth restriction.

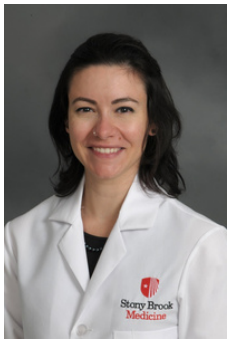
Dr. Washington and I made plans for lectures to the department and the residents on ultrasound evaluation of the placenta, accurate dating ultrasound, and fetal growth restriction. I spent my days working closely with Dr. Benjamin and the residents on antepartum, learning the flow of their unit and their needs. Dr. Benjamin and I, along with different residents and attendings, scanned together on their sono unit, finding many growth restricted babies with the many women admitted to the hospital for hypertensive management. I was able to show and teach in real time what absent and reverse end diastolic flow on umbilical artery Doppler assessment looked like and help create care plans for these women. Scheduled ultrasound visits were also set up for women with anterior placentas in the setting of prior cesarean deliveries, and we had great hands-on practice in placental evaluation.



Differences in culture, resources, and management were highlighted on rounds when we discussed management options for a patient at 25-weeks gestation with severe growth restriction and abnormal Dopplers. In Maputo, the top public hospital in the nation, the NICU is not able to resuscitate below 1000g or before 28 weeks. I learned a lot about what true viability means and the ability to sustain life outside the uterus without millions in resources. This highlighted the need to make a clinical protocol that works in resource poor settings. Dr. Benjamin and I worked on adapting SMFM's management guidelines for Fetal Growth Restriction for Hospital Central de Maputo to be presented to the department protocol committee later that year.

My overall experience was one of openness and welcome. From Dr.Washington opening up her home and sharing her day-to-day life with me to the wonderful people at the hospital – patients and physicians a like. Having someone like Dr. Sierra Washington, who is deeply committed to improving health outcomes for women in Mozambique but even more so committed to setting up sustainable learning systems that will continue long after she leaves, made the world of a difference with this experience. While my time in Maputo was short, it felt purposeful. I love knowing that Dr. Benjamin will have the confidence and skills to better assess and treat the growth restricted fetus on his unit. That he will be able to teach the residents the indications, skills, and evidence-based management plans for umbilical artery Doppler evaluation. It is a privilege to be part of the Global Women's Health Team here at Stony Brook and be supported by my division and department to improve health for Mozambicans. What we teach in Maputo will build skills for the current and future generations of obstetricians and will no doubt have long lasting echoes in the community.

REFLECTIONS FROM MOZAMBIQUE AND THE VALUE OF BILATERAL EXCHANGE



BY DR. AMY LASKY

"Exchange: the act of giving something to someone and them giving you"

So often "Global Health" is unilateral. With paradigms of learning extending from ONLY North to South. With residents and Faculty traveling ONLY from North to South. There is all too often a neo-colonial ethos in global health of "experts" from the High Income Countries traveling to save patients and teach professionals from Low Income Countries. We must work to abandon these notions and truly think about what bilateral learning can occur. With this spirit in mind- I went to Mozambique to BOTH teach and learn.

I went to Mozambican to teach:

When considering how I could contribute in Maputo, I was surprised to learn about the epidemic of excessive cesarean deliveries at Maputo Central Hospital in Mozambique. Dr. Washington and I discussed the need to implement evidence based practices to reduce cesarean delivery rates. The kiwi vacuum is a fantastic tool for this. In order to successfully and safely begin to implement Vacuum assisted delivery, a skilled provider would need to teach it. One of the reasons for my first visit to Mozambique was to introduce vacuum delivery to the residents and faculty there. Vacuum Delivery is a common tool here in the United States and the majority of OBGYN specialists are well acquainted with the use of the Kiwi vacuum so I was happy to go to Maputo and share my expertise. While I was there only briefly, I spent all three weeks on the labor and delivery ward and I was able to teach several residents at the bedside and introduce a protocol for vacuum delivery into the labor ward. The young residents were enthusiastic and quick to incorporate the new tool into their practice. We are now working on a grant to fund pelvic simulation models to assist in mainstreaming training in vacuum delivery. It is sure to take hold with Dr. Washington's sustained presence on the labor floor. I personally look forward to going back and I hope more faculty and residents from Stony Brook go to Maputo to reinforce the training we have started.
I also went to Mozambique to learn:

Women in America are demanding more choice in labor, and yet, Breech delivery skills are becoming hard to learn and master in the United States. It is often a logistic challenge to learn and implement new clinical skills once we complete residency and as we progress in our careers. In contrast, breech delivery is common practice in other areas of the world, including Mozambique. It has long been a goal for me to become skilled in breech delivery and I was thrilled to be able to learn this art in Mozambique and bring back my new skills to Stony Brook. While in Maputo I was able to perform a number of breech deliveries under supervision of confident and seasoned providers.

This quick yet intensive skills acquisition would not have been possible without genuine bilateral exchange between our two institutions. We are so fortunate to have this opportunity at Stony Brook to share our skills with health professionals in Maputo , and to learn from health professionals skills that can improve our patient care here at home. This was a truly equitable exchange of knowledge that I will carry with me as I continue to grow as a specialist in obstetrics and gynecology.

2023 MIGS CAMPAIGN TO MOZAMBIQUE

BY DR. XUN (JULIE) LIAN

I have had the privilege of traveling to Maputo, Mozambique two years in a row, both times for three weeks to collaborate with our OBGYN colleagues at Hospital Central de Maputo. The purpose of both trips was to teach safe surgical techniques in laparoscopy. I have participated in medical trips to underdeveloped countries in the past but this was different. In fellowship, I spent a week in Ecuador performing gynecologic surgeries with attendings. These cases were done with surgeons and a medical team (students, nurses, and anesthesiologists) from New York. We did not work with the local health community. I remember feeling like the trip was worthwhile but something was missing.

While medical missions to underdeveloped countries can provide much needed care, these programs do not always establish long term sustainable collaborations with local health establishments and professionals. What has been rewarding and unique about my experience in Mozambique is working with the physicians there and seeing the improvements in medical care and education that have occurred over time. We started with diagnostic laparoscopies on my first trip. These cases were mainly performed for infertility. The emphasis during these cases was safe laparoscopic entry and trocar placement. We also performed laparoscopic ovarian cystectomies and salpingectomies, with importance placed on adapting laparotomy skills to laparoscopic ones. The entire OR team was involved in order to provide safe and enhanced surgical care.

We performed more advanced laparoscopic procedures during my recent trip in June this year. In total, 9 hysterectomies, 11 cystectomies, 5 myomectomies, and 5 salpingectomies were completed. It was heartening to see the surgeons I worked with last year teach and perform laparoscopic cases, such as salpingectomies and ovarian cystectomies, with junior colleagues. If you can teach something, that means you know how to do it. This has significance – the surgeons will be able to routinely perform laparoscopy for patients with emergent conditions such as ruptured ectopic pregnancies and ovarian torsions, to the benefit of those patients. With continued collaboration and commitment, more advanced laparoscopic cases will be routine as well.

The successes of this global health program have been in large part due to the efforts of Dr. Sierra Washington and the collaboration between OBGYN faculty at Stony Brook Medicine and Hospital Central de Maputo. I am proud to be part of this endeavor and look forward to future partnership with Dr. Washington and colleagues in Maputo.

REFLECTIONS ON THE 2022 UROGYNECOLOGY CAMPAIGN TRIP TO MOZAMBIQUE FROM DR. ANDRE PLAIR

Arriving in an unknown airport was not new to me, nor was seeing a new destination for the first time. What was new were the things that I was set to do during my 3-week trip to Maputo, Mozambique. It was a unique opportunity to have a settled contact, ambassador, and colleague of Dr. Sierra Washington at the Central Hospital of Maputo and to have two dedicated attendings, Elenia and Emelia, that I would instruct in selected urogynecologic surgeries. A key emphasis in global health is the sustainability of one's impact and having the two astute learners with me for my cases was critical to being able to leave a lasting benefit. Dr. Washington and the rest of the team members of the "Urogynecology Campaign" (the term used at the hospital to refer to our collaboration) had worked hard advertising across multiple cities in Mozambique to have patients come for consideration for inclusion into the campaign. After initial preoperative screening we arranged to do a collection of vaginal prolapse reconstructive surgeries, colpocleisis surgeries, autologous fascial sling procedures, and repairs of chronic obstetrical anal sphincter injuries.

There were certain aspects of surgical care and instrumentation that we needed to work around. We had anticipated needing to bring certain sutures (some polyglactin pop-off sutures) with us for our trip, however, I did have to adjust my techniques for limited suture sizes, suture types, and a lack of self-retaining vaginal retractors. We even devised a system of tying silk sutures to the free-end of our uterosacral ligament sutures (which we eventually called the "Mozambique Technique") that would normally require a free needle (something that they did not have in at the hospital in Maputo) in order to pass it through tissue.

The realities of postoperative care in Mozambique was also a new learning experience. All patients stayed at least overnight to ensure appropriate care in the initial night of and day after surgery. This is due to many patients not having the ability to rest in a quiet room at home and to have access to strong initial postop pain medication. It dawned on me how much our ERAS systems assume an ability to recognize postop issues at home, have the mindset to seek medical care, and have access (reliable phone service or quick transportation) to responsive medical care. I was additionally informed that many patients won't have access to pharmacy-based (over the counter or prescription) stool softeners and so the use of diet-based bowel motility promotion was usually the only option. Additionally, the access to clean water for doing home Sitz baths or perineal washing was not universal and needed to be considered in postoperative instructions for perineal wound care.

In addition to medical work, I was able to enjoy aspects of life in Mozambique. We visited Macaneta Beach, a beautiful beach island off the coast of Maputo city. All of the people that I worked with in Maputo were kind and helpful in making the campaign a reality. They shared food and opened their homes to me. As an appreciator of good food, there is a lot of seafood available in Maputo due to its coastal location and the culinary highlights were delicious razor-neck clams at the Macaneta Beach restaurant and crab-dominant crab cake mixtures stuffed into shelled out crab shells (no heavy fillers there). After tough negotiations in the market place I brought home some very nice souvenirs for family as well.

Reflecting on my time in Mozambique, I feel that the people and hospital were appreciative, open, and cooperative to making the Urogynecology Campaign a success and to having further educational and collaborative endeavors in the future. There are numerous gaps in care and medical culture between the Mozambiquan practitioners and ourselves, but we are all medical professionals looking to improve and preserve the health of our patients and peoples. I think all parties are hoping for a continued relationship between the two hospitals and countries. This trip would not be possible without the support of our chairman, my division director, my urogynecology colleagues, and certainly not without Dr. Washington. Thank you for allowing me to make a small impact ripple in Mozambique.