

## Reflections on My Global Health Rotation in Uganda by Stephanie Peace

On my first day at Mbale Regional Referral Hospital in Mbale, Uganda, I toured the labor ward, which does an average of 680 deliveries per month. Most mothers labored outside, reserving the 6 beds in the ward for active deliveries and initial triage. I watched women present for evaluation, bringing their own cloth to cover the bed. Nursing and medical students, overseen by midwives and intern doctors, would evaluate the patient including Leopold maneuvers, cervical examination, and assessment of fetal heart rate, auscultated primarily with a fetoscope or sometimes with the unit's single doppler. As part of my tour, I met the charge nurse, Edith. After greeting me, she asked about a box stored in her office. "Doctor, do you know what this machine is for?" When we opened the box together, I saw an external fetal monitoring system, complete with fetal doppler, tocometer, automated blood pressure cuff, and pulse oximeter. Edith reported that the machine had been donated two or three years ago, but never used because they weren't sure how to use it.

During the two and a half weeks I spent at Mbale Regional Referral Hospital, I led multiple trainings with nurses, midwives, intern physicians, and nursing and medical students to show them how to use and interpret the external fetal monitors. We discussed fetal physiology, signs of fetal distress, labor augmentation, and how to triage the use of their single fetal monitor for the highest risk patients, such as those with a prior uterine scar or receiving augmentation with pitocin. At the end of each training, the machine was carefully boxed up and locked in the charge nurse's office for safe keeping.

There are many potential pitfalls in the practical application of global health, but I think the one most of us fall into is failure to recognize that global health is at its core an exchange. Too often, we view global health as provision of resources and knowledge from a high-income, high-resource location to a lower-income, lower-resource location. But the mere provision of resources—an external fetal monitor, for instance—doesn't ensure that they will be used, and education doesn't ensure that those resources will integrate into a different model of care. While I hope that the trainings I led will enable the providers at Mbale Regional Referral Hospital to use the external fetal monitor on high risk patients, I also understand the intricacies of incorporating the single machine into a busy ward with limited staff and even more limited space. Furthermore, the benefit of utilizing an external fetal monitor to predict fetal distress has decreased utility in a setting where an emergent cesarean section may take as long as two hours to prepare.

Nothing could have clarified this point more than the emergence of a global pandemic—the novel coronavirus, or COVID-19—during my rotation. When I left the United States, my state had just seen its first two cases, both travelers. Arriving in the airport in Uganda, I received a health questionnaire and was asked about a stamp from China in my passport, from a trip in 2017. At the hospital, people joked



about coronavirus, but given that there were no cases yet on the continent and that personal protective equipment (PPE) is already severely limited, life and medicine continued as normal. By midway through my rotation, the pandemic had reached the U.S. in full force and travel restrictions were being placed, prompting my early departure from Uganda. Now, the United States has surpassed all other nations for the total number of cases and the first few cases have arrived in Uganda, where health care providers still have a limited supply of masks and at least in the case of Mbale Regional Referral Hospital, no ventilators available for severely ill patients. High or low resource, we can all learn from each other as we develop public health strategies and medical therapies to manage this global threat.

The experience that I had working at Mbale Regional Referral Hospital strengthened my own commitment to global health work, including direct patient care, education, and advocacy. It made me grateful for the education and surgical training that I have received and for the well-equipped hospital in which I practice. I am also grateful, however, for the opportunity to have worked with and learned from the incredibly dedicated, hard-working, and resourceful physicians, nurses, midwives, and students at Mbale Regional Referral Hospital. Whether the external fetal monitor will stay safe in its box, locked in Edith's office, or become a part of the workflow on the labor ward, I don't know. What I do know is that the exchange of resources, information, and most importantly empathy is what makes global health truly global.