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My experience in Manguzi, South Africa centered, for the most part, on women's health care and on the role of gender in health and society. I spoke with Fleur Ackermans, a physician from Holland who moved to Manguzi with her husband. In addition to her generalist training, she completed additional training in Maternity and Surgery, which made her a great resource for questions related to my future as an OB/GYN. We spoke a great deal about the role of women in society, and in particular about a patient we had who seemed to be in a coercive and possibly abusive relationship that we were unable to help. She told me that she encounters this relatively often, and is often frustrated with both the society's acceptance of these kinds of situations and the lack of resources available to victims of domestic violence.

We also spoke about teenage pregnancy, contraception, and family planning. Her perception is that for many women in Manguzi, having a child is both a badge of honor and their perceived purpose in life. For these reasons, many pregnant teenagers are not upset that they are having a baby at such a young age, are unable to finish school, and have a significant other who may not stay around to help take care of their child. For the same reasons, many women are not interested in contraception, especially among those who have not had any children – the idea of delaying childbearing does not make sense to many patients. Finally, the desire to have a large family sometimes conflicts with safety concerns as women age or have had dangerous deliveries. In Manguzi, the physicians do not feel comfortable performing more than three c-sections on a patient. Consequently, patients are encouraged to attempt a vaginal birth after they have just one c-section, but

after two patients may only have c-sections. This creates conflict when women have a c-section for their first birth and can only have three children. For many women, they do not understand why we would encourage them to limit their family size, and very much would like to take on the risk of an additional pregnancy when this could potentially be very dangerous for them.

My most profound clinical experience was not one moment or patient, but a general theme of my clinical experiences. Particularly on labor and delivery, it was interesting to see the different ways that problems are dealt with in Manguzi and in the US, and the different amounts of concern displayed about various problems. In Manguzi, the concern about infection risk in labor and at the time of c-section is much different than in the US. In part because of the high rate of HIV, but also because of sanitary issues, physicians are much more hesitant to rupture a woman's membranes to speed up her labor because of the increased risk of endometritis or chorioamnionitis. In the US, we prioritize moving labor along, and trust that if women develop an infection we will be able to treat it effectively.

Conversely, there are things that we monitor obsessively in the US that are checked less frequently or not at all in South Africa. Group B Strep swabs, which are performed on every pregnant woman in the US, are not routinely done in South Africa, and women who are GBS positive are not given prophylactic antibiotics during labor. Finally, it was interesting to me how many things were actually quite similar, but modified to be done in a more resource-poor setting. Concern for pre-eclampsia is high in South Africa, but they do not have the resources to place every pre-eclamptic woman on continuous monitoring, so they focus more intently on fetal kick counts, maternal

symptoms, and blood pressure and hook patients up to the monitor twice daily to assess for fetal well-being.

Repeatedly, I had cultural experiences regarding gender and the role of women. Many surrounded the role of the female patients in their homes and families and the roles the wives of the male patients played in taking care of them while hospitalized. In addition, I had my own experiences with expectation of me based on my gender. For the most part, patients and nurses seemed to believe I was a doctor because I was both white and wearing a stethoscope. On labor and delivery, one nurse I had worked with repeatedly noticed my engagement ring and asked if I was married. I told her I was getting married in May, and she asked where my husband was. I told her he hadn't come with me, but was in Kenya at the time. Her response was to ask me if I was worried that he would find another woman while I was away. When I told her I wasn't worried she was surprised, but said it must just be different in the United States. I told her that would be considered very shameful in the US, and she said for men in Manguzi, there is no shame in taking a second woman if your wife is away or unavailable. She scoffed and was upset, but said this is the way that men are. In many ways, this experience was similar to others I have had in developing countries – issues with gender politics are universal, and often very pronounced in these kinds of environments.

I have always planned to travel and work in developing countries as a part of my practice. My fiancé studies development economics, so he travels frequently to India and parts of Africa for his research, and likely always will, so we imagine that eventually we will be able to travel together and I will be able to practice medicine in the area where he does his research. This elective in particular helped me think more about what that might

look like. From a practical standpoint, knowing so many couples who had moved from European countries to Manguzi and seeing how they lived their lives and made the adjustment helped me think about what this would be like for us. The practice setup in Manguzi also gave me a lot to think about in terms of how I might practice in a developing nation. All of the physicians at Manguzi Hospital are generalists, and all are responsible for seeing all types of patients, but with the kind of training I will receive in OB/GYN in the US, I think I'm unlikely to feel comfortable practicing like that once I have completed residency. For that reason, it may make more sense for me to try to visit a slightly larger city where there are some specialists so that I can do what I know best. It may also make sense to visit rural hospitals as a visiting GYN and simply operate on patients culled by the physicians there and scheduled to have surgery on my visit. Regardless, seeing how these things work in Manguzi gave me much better perspective on what my future international medical work might look like.