Day 1-:

After a long trip totaling over 20 hours of travel, I finally land in Mekelle. I am greeted by vibrant flowers growing along the airfield with a morning sky that was clearing from overnight rains. I make a quick stop at the hotel to drop off luggage, then make my way to Ayder Referral Hospital to start my day. I take a bijaj, also called a tuk tuk, which is a 3 wheeled coup that serve as a small taxi. Although all of the bijajes are blue, each driver adds some unique flair to their vehicle, ranging from stickers to faux fur lined cleanings.

I arrive at the hospital, which is situated on a large campus with a sprawling white main building, that at times has a maze-like quality. My first stop is the departmental offices for Obstetrics and Gynecology. Throughout the day, I have the privilege of meeting with the department heads as well as other administrators. Between meetings, I am able to visit the Gynecology ward and meet some of the residents. While on the wards, I was able to help ultrasound while the Ayder Gynecology team performed an MVA for safe abortion for a patient who had failed prior medical management. In Ethiopia, abortion services are legal for women seeking termination under certain circumstances (rape, incest, maternal health).

At the end of the day I make my way back to the hotel for some much need rest with my excitement about the week to come continuing to grow.

Day 2-:

The morning starts out earlier than anticipated thanks to the restlessness of jet lag. However, after a short stroll to small restaurant down the street that serves strong, notoriously delicious, Ethiopian coffee the sleepiness dissipated. For breakfast I have a spiced bean paste eaten with bread for dipping.

Once at the hospital, I make my way to morning report. Similar to our morning sign-out, a set of residents give a summary of each patient that they currently have admitted to the hospital with updates on their condition and plans for treatment. I note that differently from our sign-outs, there does not seem to be a summary document that holds the critical information for the patients on the service. However; when making rounds with residents they seem to retain an impressive amount of detail about each patient even without a “sign-out” sheet.

The gynecology ward is set up as a long hallway with multiple patient rooms, each room holding between 3 and 6 beds. One room is set aside as a boarding room for mothers with babies in the NICU. This room has 6 beds, but at times also has extra mats that are laid on the floor to accommodate more mothers. The rooms all have windows, most of which are open to let in fresh air. There is a dedicated procedure room, which I had seen the day before, equipped with an ultrasound machine. There is also a chemotherapy room where cancer patients are able to have medications administered. When talking with the residents, they tell me that there is a high prevalence of cervical cancer that is sent to Ayder. They also tell me that routine cervical surveillance is still not accessible to many in the region.

In the afternoon, I planned to meet with the nutritionist for the hospital; however, one of the women she works with was not feeling well, so I am invited to meet them in the emergency room. The ER is on the first floor, and, not unlike so many emergency rooms in the United States, it is busy. There are patient beds lining the halls and an abundance of movement between rooms. I find the triage room where I meet the nutritionist and her cook who is sitting

on a bare stretcher. The room is filled with patients arranged on stretchers, wheelchairs, and ordinary chairs. The nutritionist informs me that they are waiting on a blood pressure cuff, as there is not one available in the emergency department, someone has gone up the ICU to borrow one. No blood pressure cuffs in the emergency room? The mantra I have heard so many times "vital signs are vital" comes to mind. How can you properly triage a patient without knowing a blood pressure? I think about our own Emergency Room that is often described as focusing on an underserved urban population, yet usually has a disposable blood pressure cuff that stays with each patient for the duration of their ER visit. After a blood pressure cuff arrives, we are sent to the lab and radiology with a piece of paper with instructions for further work up. We wander across the hospital to these stops. The women I am with navigate expertly, as they are hospital employees, but I can't help but think this must feel overwhelming for the typical patient who is new to this setting. My concern must have been visible on my face, because the nutritionist leaned over and said to me, "Here, the goal is Everest, but they have no shoes." The statement resonated perfectly with what I was seeing; the best of intentions with bright minds hard at work, but a struggle to obtain some of the fundamental tools needed.

Between our stops and waits, we head up the burn unit. The nutritionist focuses her efforts on nutritional support for the burn unit; however, she also provides service to the rest of the hospital. She describes the challenges of providing adequate nutrition to sick patients in a setting where TPN is not available. She has set up a remarkable kitchen within the burn unit where she and a few other women prepare special meals that are usually rich in protein and calories for her patients. Her passion for her patients and community is palpable, and her innovative approaches impressive.

By the end of the day, I am tired and find a bijaj back to the hotel. I grab a quick dinner and head to bed mulling over the experiences of the day.

Day 3- Friday

I wake up feeling a little under the weather, but excited nonetheless. Today I am planning to spend the morning in the operating room with the gynecology team. I arrive at the hospital and meet up with the residents that will be scrubbed in cases for the day. There is a C-section and a radical hysterectomy planned. Before cases start, we grab coffee at the cafeteria window located in the pre op area.

The residents tell me that the c-section rate for their hospital is about 30%, a number that initially surprises me; however, when I consider that it is the regional referral center it seems to make sense. Similar to the United States, most postoperative mothers will stay in the hospital for 2-3 days. Unlike in the United States, most postpartum mothers will only stay at Ayder for 6 hours postpartum.

We head to the OR and I notice that the scrub gowns are all cloth. Those scrubbing in wear a plastic or rubber apron under their gown to prevent fluids from permeating the cloth material. As I stand to the side watching, I image how hot it must be under a stifling plastic layer. The OR is warm and there are windows along the wall, one of which is cracked to let the breeze in. The c-section proceeds following the steps I am so familiar with and a new little life emerges angry to be so abruptly separated from its mother.

We head to the next case, which is the radical hysterectomy. In the United States this is no longer a common procedure due to routine cervical screening. The patient is thin and her

anatomical landmarks are clearly identified. The surgical team works with the skill and efficiency; it is clear that this is a procedure they have experience with. I notice there is no ligasure, a tool that we often use for major cases in the United States. Each vessel is carefully identified and suture ligated. The patient does well and at the end of the case she is taken to a busy recovery room.

After cases, I met with a medical student to discuss implementing a survey based study to examine male attitudes about long acting reversible contraception, which I had already talked with some of the residents about. This parallels a project I am currently working on in the United States. We discussed the national health data that suggests most women in Ethiopia consult their husband/partner about their choice of contraceptives. Given this, I thought it might be interesting to see what the perception of the most effective forms of contraception are by the men that are making up half of the decision making dyad. Overall both students and residents seemed to be enthusiastic about exploring this topic further. I spent the remainder of the evening looking over literature and formulating plans for implementing this study in Ethiopia.

Day 4

I head into the hospital forgetting that it is the weekend; however, it becomes clear that there is a skeleton crew working with no scheduled cases. After some time I head back to the hotel and meet up with a group of Peace Corps Volunteers for lunch. After lunch we walk through the city and find our way to a market for some shopping. As we wander through the market, I am impressed with the volunteers' command of Tigrinya, the local language, and the way they engage with the merchants. We pick up coffee and a few other items. It is fascinating to hear about their experiences. Most of the volunteers are serving as English teachers in the Tigray region. We talk about gender roles and disparities that influence day to day life for their students. A few of the volunteers have extended their service commitment to continue to work with their communities. One of the has started to work with a non-profit organization started by a local woman called Dignity Period. The organization that provides adolescent girls in the region with reusable menstrual pads. She explains that in parts of the Tigray region many girls cannot afford underwear or disposable menstrual pads, so when they get their monthly cycle they often miss school while they are bleeding. As can be imagined, over the course of a adolescence this adds up to a significant amount of classroom time that these young women miss out on. Dignity period visits schools in the region where they host classes on puberty and distribute packs that contain 4 reusable menstrual pads and 2 pairs of underwear to each female student. They discuss how to care for and clean the pads, which are intended to last for 2 years.

In the evening we meet again for dinner, this time at a local cultural hall. We sit in ornately carved chairs around a low set table and are served a variety of traditional dishes with injara. There is live music performances that alternate between traditional songs with dancing and modern pop songs. I make note of the overall aura of happiness that circulates the room.

Day 5

It is my last morning in Mekelle and I am sad to think that this visit is already coming to an end. I head over to the hospital to meet with a team of 4th year medical students who are

interested in helping with research. We grab coffee together at a restaurant near the hospital. We discuss their potential role in a project about contraception and I give a talk on contraception and tier based counseling.

After our meeting, I head back to the hotel to pack. I walk down the street to get lunch and sit for while enjoying my coffee and reflecting on my trip. This visit served as introduction to Mekelle and has shown me that there are so many avenues to partner with the residents and faculty at Ayder. I have a number of projects that I am excited to continue to work on remotely form the United States, and am excited for my co-residents who are planning to trips here as well; however, I can't help but wish I could spend more time working directly with the team at Ayder.