EDITORIAL

A visit to Maputo

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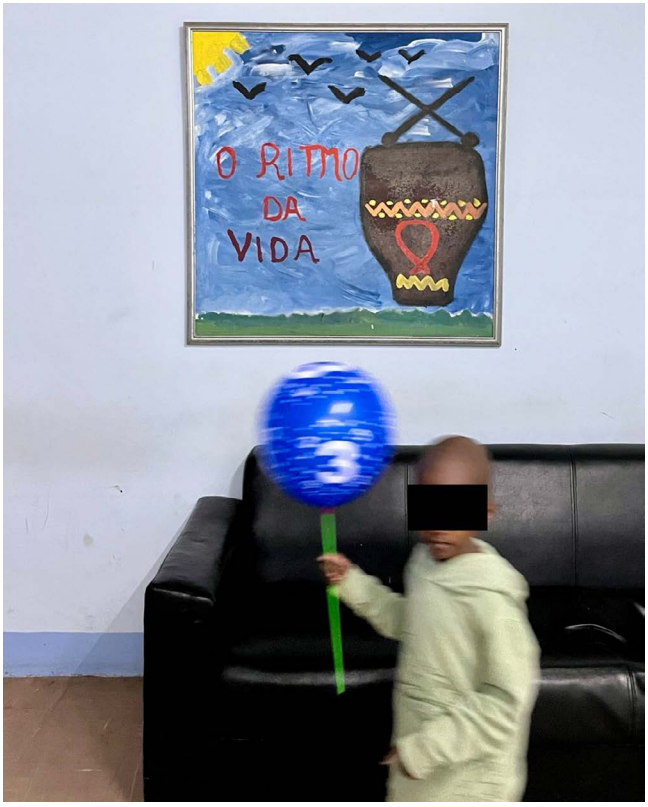
"I like to spend some time in Mozambique
The sunny sky is aqua blue
And all the couples dancing cheek to cheek
It's very nice to stay a week or two"

Lyrics from "Mozambique" by Bob Dylan, 1976



Twenty past six and it has been dark for an hour already. We have just arrived to see the patients for tomorrow's theatre list after finishing our TURP workshop at the private clinic. The single audible fluorescent tube in the corridor of the paediatric ICU at Hospital Central de Maputo (HCM) disturbs the otherwise quiet ward. Down the corridor I catch a glimpse of a ventilated head injury child being prepared for transfer. "Transfer to where?" I ask myself. Hopefully to the theatre complex, on the other side of this 1 500 bed Art Deco hospital complex spanning a whole city block in the centre of the capital. We find the ultrasound machine we came looking for and negotiate with a young nurse to take it next door, where there is an empty treatment room. The mother and child train in tow.

Little Angelika (not her real name) is the first patient for ultrasound: a quietly confident three-year-old with smiling eyes from Beira, 1 200 km to the north. Referred with UTIs and a single kidney, a subsequent CT scan showed a multicystic grossly hydronephrotic right kidney with a very dilated (presumed) renal pelvis down to a distal tortuous 5 cm diameter ureter. A mere 3 cm multicystic dysplastic sliver of a kidney is present on the left and her eGFR is already only 24. We are hoping to gain more information from the ultrasound in order to advise her mother on possible treatment options for the little girl. The familiar little Sonoscape A6 ultrasound has seen better days, but nevertheless leaves us with a presumed diagnosis of an obstructed megaureter, although we are yet to somehow exclude reflux and an atypical PUJ obstruction.

We plan a cystoscopy and on-table cystogram but a C-arm is not available. We debate with the local paediatric surgeon whether we should intervene at all. The socioeconomic circumstances offer no aftercare once she is discharged. A cutaneous ureterostomy may prolong the right kidney's function, but a wet child leaves everyone unhappy. Perhaps a definitive ureteric reimplantation is a better option, despite the risks. The parents are counselled by the local surgeon and the child is offered surgery whilst the visiting paediatric urologist from Cape Town is in town, and the mother leaves to discuss the news that her little girl may die young with the rest of her family. We wonder what other the surgeons visiting from Australia, Brazil, Portugal and the USA would have advised. Maputo has seen a steady stream of outreach missions in the past.

The next patient comes in for his bedside ultrasound: Samuel is a 14-year-old boy admitted with creatinine of 554 umol/l. He is catheterised and the urine looks terrible. Given our lack of Portuguese, we struggle to establish whether there is a history of voiding dysfunction. Our bedside ultrasound shows bilateral stones with a staghorn on the left side. We start antibiotics and ask for a CT scan to be done the next morning. There is no chance of endoscopic management for him: only open nephrolithotomy or nephrectomy. Neither of his parents have a government or civil service job, dashing any chance of applying for extra-ordinary government funding to have his medical care in the private sector or abroad, where endoscopic treatment is available. While Prof

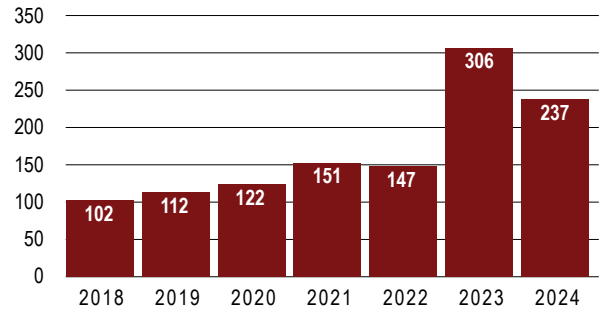
Lazarus explains to the mother what can be done and what cannot, I struggle with the gravity of a diagnosis of renal failure in this setting. The local surgeons are keen to operate.

After performing an ultrasound on our third patient, a three-year-old with Prune-Belly Syndrome, we make our way back to a ward with a desktop computer to review images, but despite the modern PACS software, the internet connection lets us down. We retire to the hotel for the night. On the slow drive home, strong rhythms float from the establishments along the Avenida Eduardo Mondlane, named after the founder president of the FRELIMO party.

The HCM, originally known as Hospital Miguel Bombarda, was inaugurated in 1942 during the height of Portuguese colonial rule. It was the crown jewel of colonial healthcare infrastructure, serving the Portuguese elite and colonial administrators in what was then called Lourenço Marques. The decision to build such an impressive facility was in part a response to growing international criticism of Portugal's colonial practices at a time when other European nations were liberating their colonies. The hospital exemplifies Portuguese colonial architecture of the time, and follows modernist principles with Art Deco and even Bauhaus themes, adapted to the tropical climate. The extended verandas, high ceilings and large windows allow cross-breezes and protect against direct sunlight. There are courtyards and landscaped gardens with many trees and lawns between the buildings.

After Mozambique gained independence in 1975 following a decade-long armed struggle led by the uniting FRELIMO party, the hospital was renamed Hospital Central de Maputo. The new government faced immediate challenges managing a complex healthcare facility while dealing with the mass exodus of Portuguese medical professionals, comprising nearly the entire skilled healthcare workforce. The young nation's socialist approach to healthcare and attempts to expand medical services to previously underserved populations proved difficult. The tumultuous post-independence period, marked by a 25-year-long civil war, devastated healthcare infrastructure and drained resources. During this period, HCM became one of the few functioning tertiary care facilities in the country. Although the hospital's evolution reflects the colonial legacies and post-independence ideals, the contemporary socioeconomic realities of this economically struggling nation are evident here. What is less clear, is the lack of resources in the rest of the country.

Our recent South African connection with Maputo urology dates back to 2002 when Prof Johan Naudé spent a year in Maputo after he retired from UCT. He trained one of the local general surgeons, Dr Igor Vaz in Urology. (Read the book Making the Cut in South Africa: A Medico-Politico Journey by Johan Naudé, RSM Press, 2007). Dr Vaz continued to train urologists in Mozambique and is the Mozambique College President (they write the COSECSA exam, see https://www.cosecsa.org/accredited-hospitals-2/). He is, however, better known internationally for his work in the obstetric fistula field, where, amongst other achievements, he heads up his own non-profit which perform six missions yearly throughout Mozambique. (See https://focusfistula.org.mz) The graph below shows the number of fistula surgeries performed annually in the "COVID-19 era", when elsewhere surgical numbers were dropping.



Focus Fístula em números

Today, the HCM serves as the principal referral hospital in Mozambique's public healthcare system and the country's main teaching hospital. Despite its prominence, the hospital faces significant challenges with ageing infrastructure, overcrowding, equipment shortages and maintenance difficulties.

The facility has approximately 1 500 beds and offers the most comprehensive range of medical specialties available in Mozambique, but significantly lacking when compared to South Africa. There has been no radiotherapy available in the country since 2019. There is no nuclear medicine. There is no resectoscope.

Currently the HCM has five urology consultants with varying levels of involvement, all also working in private practice. They have 11 residents (of which two are currently abroad in Portugal and Brazil respectively on self-funded training). The hospital employs around 4 000 people, with 677 doctors in 2019. It is estimated there are

approximately 200 specialists working at the HCM. The trainees earn relatively well (about R26 000 per month) and generally do not have to do extra work in the private sector. The cost of living is lower, and although a litre of petrol is R6 more expensive, mobile data is less than a third of the price of that in South Africa. Due to the lack of operating time and equipment at the HCM, they spend about 30% of their time assisting the consultants in private clinics, allowing for an apprentice-type learning model.

We head back to COOPMED private clinic, located in a residential street, just off the main Avenida bordering the HCM. Here we are told that there are 37 gynaecologists working in Maputo but only five urologists. Of those, only three urologists offer TURP. Endoscopic equipment is available but the imported well-known brands are prohibitively expensive. Most urologists set up a small theatre within their consulting rooms (which are mainly converted houses in the city) and use equipment from China, imported at a fraction of the price.

More concerning is the lack of endoscopic training and experience among the young urologists. The current trainees, in their fourth and fifth year of urology, have not had training in basic endourology. BPH is managed by finasteride, with or without an alpha blocker, and open simple prostatectomy, either via a Millins or Freyer's approach. Bladder tumours are managed with partial or complete cystectomy as most tumours are squamous, not urothelial in nature. Endoscopic stone management is non-existent: there is only one (private) hospital in Maputo with a 30W Holmium laser, and the hospital fee for stone removal is in excess of R150 000. It was against this background that the leadership of the small private clinic COOPMED, partnered with the Urology Department of HCM to arrange a workshop to teach TURP skills. It is an excellent example of industry involvement, with all major stakeholders involved. Eight "trainees" attended, of which three were qualified and five in their last years of training. Dr Amâncio Pinto Oliveira represented the HCM staff. Over two and a half days the trainees

were able to observe and operate under supervision, gaining valuable experience to build on in future.

Training opportunities in South Africa are becoming more limited due to the steady decline in available operating lists. Trainee numbers have increased without a proportionate increase in teaching staff, further hampering our overloaded academic departments' ability to provide quality training. Recent healthcare budgets have not prioritised increased spending on government hospitals to improve the failing state health system, serving the majority of the population. Moreover, the current Health Ministry has failed to engage with clinicians on alternatives to the unworkable NHI plan (see https://progressivehealthforum.net/wp-content/uploads/2024/12/UHAC_Report_11December2024_vF.pdf). The morale of doctors is further undermined by ongoing freezing of posts, cancelling overtime contracts and lack of government accountability. (https://www.dailymaverick.co.za/article/2025-02-12-healthcare-coalition-proposes-pragmatic-reforms-for-sa-says-nhi-unworkable/). Whistleblowing against corruption can have deadly consequences (https://en.wikipedia.org/wiki/Murder_of_Babita_Deokaran) and lack of high level corruption convictions in South Africa has led to a sense of futility. In the words of poet and whistleblower Athol Williams: "To the gods of hope, faithfully we pray, Give tomorrow the hope we lost today."

I am grateful for the opportunity to travel professionally. It's not for everyone, but then again, you don't have to travel abroad to make a difference. A visit to Maputo allowed me to reflect on the differences between my working day and that of my fellow urologists in Maputo. We currently have a strong healthcare industry, a multitude of excellent healthcare facilities and eight academic units with a functioning training pathway to produce new urologists. The broken pavements and windows, chipped plaster and fading Art Deco pastel paint of these once great edifices are perhaps more evident in Maputo than in our South African government facilities, but it is obvious that we face the same challenges ahead. I have learnt about ingenuity and about being proactive in terms of improving both training and service provision. It may be time to revisit some old practices and explore some new avenues, to further enhance our urology training network in South and southern Africa.

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