



Supporting Palliative Care Across the Globe

“MOST OF THE HISTORY of medicine was palliative care,” according to Mark Stoltenberg, MD, MA, a faculty member of the Division of Palliative Care and Geriatrics at MGH. Before the dawn of modern medicine, much of healthcare was not actually curative. “We couldn’t fix, or cure or anything,” Stoltenberg continues. “We didn’t have safe surgery. We didn’t have antibiotics.”

Over time, scientific advancements and improvements in technology changed the face of medicine. In 1948, Cicely Saunders, a British physician, founded the first official hospice care center, re-introducing an explicit focus on end-of-life care to medicine. The World Health Organization (WHO) took the next step and recognized palliative care as its own specialty—separate from hospice care—in the 1990’s.

“Palliative care is focused on a response to suffering for any patient with serious illness,” Stoltenberg explains. “It’s meant to maximize and support quality of life, for both patients and their families.”

For Bethany Rose Daubman, MD, an attending physician at the Division of Palliative Care and Geriatrics at MGH, this means palliative care offers a unique interdisciplinary approach to medicine that extends beyond individualized medical care.

MGH recently announced Daubman and Stoltenberg as co-directors of the MGH Global Palliative Care Program. Together, they have spent several years building palliative care partnerships in Belize, Chile, and in Jamaica. These partnerships have primarily focused on creating context-specific palliative care guidelines and training local clinicians in palliative care delivery.

Daubman’s journey to palliative care took what she would call a “backwards” approach.

“I was in Med school at a really young age and was really burned out,” she explains. “I was focusing on research and basic sciences and couldn’t feel that human connection.”

Her search to rediscover human connection in medicine led her to a job playing harp for hospice patients. As a trained concert harpist, Daubman had experience playing for crowds of all sizes, but she quickly found playing for hospice patients to be different.

(continued on last page)



Mark Stoltenberg, MD, MA, (left), and Bethany Rose Daubman, MD, (right), Co-Directors of the MGH Global Palliative Care Program

The Toll of COVID-19 on Health Workers

OVER THE LAST YEAR, at least [17,000 health workers](#) have died from COVID-19. A July 2020 investigation found that workers in 63 countries faced shortages of personal protective equipment (PPE) even as they treated COVID-19 patients. These shortages combined with the inequitable distribution of COVID-19 vaccines—low-income countries have [vaccinated 1.9%](#) of their populations—means that health workers in low-income countries face greater risk of infection and death than those in high-income countries.

“This pandemic has not really been easy for health workers in our city [Mbarara, Uganda],” Stephen Asimwe, MBChB, MS, DrPH, Program Director of the Mbarara University of Science and Technology (MUST) Global Health Collaborative

(GHC), says. “It has strained the health sector significantly, even

reducing the healthcare workers that would be attending to other issues. And there are other effects we are beginning to learn from health workers: their children not going to school, others losing loved ones, and even some of us who have lost very close colleagues.”

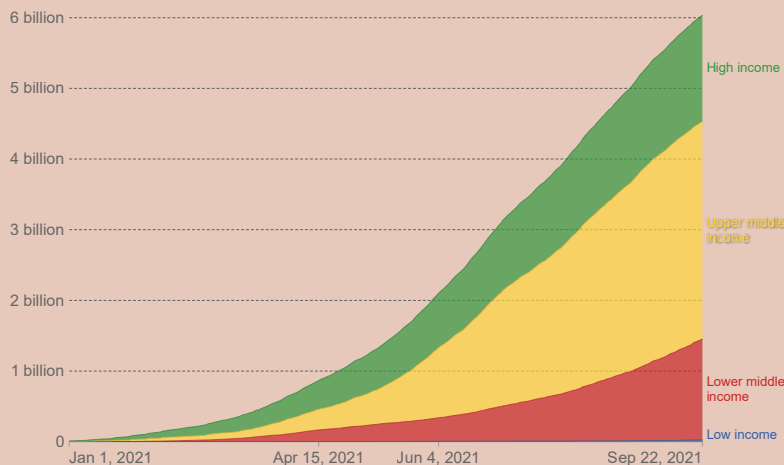
In July 2021, Carol Orishaba, RN, a nurse at Mbarara Regional Referral Hospital (MRRH) passed away after an extended battle with COVID-19. Less than a week later, Dr. Moses Ndema, a clinician in training at MRRH, passed away from the virus as well. Over the

past three months our staff—both in Mbarara and Boston—have mourned these losses.

(continued on last page)

COVID-19 vaccine doses administered by country income group

For vaccines that require multiple doses, each individual dose is counted. As the same person may receive more than one dose, the number of doses can be higher than the number of people in the population.



Source: Official data collated by Our World in Data, World Bank

OurWorldInData.org/covid-vaccinations • CC BY



Building Nursing Capacity through Relationships

MARY SEBERT, RN, MPH became a nurse 36 years ago. In this time, she has served in a variety of roles, including clinically in hospitals and disaster settings, as a nursing coordinator, as a nursing educator in Uganda, and, currently, as the Director of the MGH Global Nursing Program.



Mary Sebert, RN, MPH, Director of Global Nursing

Pressed on why she chose the profession, Sebert recalls her grandmother's premonition. "I think my grandmother led me to nursing," Sebert starts. "When I was 14, she said that I was going to be a nurse and I actually never really thought about it. Then I went to college and, somehow, I came out a nurse." She spent the first half of her career working domestically before entering the Peace Corps, which sent her to Romania for four years, in the early 2000s. She later decided to work with the Peace Corps again, this time partnering in Uganda with Seed Global Health—an organization devoted to the development and education of health workforces across the globe. After arriving in Uganda in 2013, Sebert embedded herself in Mbarara University of Science and Technology (MUST) as an educator, training nursing students while building relationships with the local staff, faculty, and trainees.

This work with Seed brought Sebert in connection with the MGH Center for Global Health (CGH) for the first time. Through Seed, Sebert worked with CGH's newly developed Global Nursing Program, under the leadership of its founder, Pat Daoust, RN, MSN.

When her time with the Peace Corps and Seed ended, Sebert knew she wanted to continue her career in global health. "I moved to Boston to continue working with Uganda, particularly, and work on the programs that we started for the MGH Global Nursing Program," Sebert says. "Now I find myself as a director of the Global Nursing program, which was a complete surprise."

Today the Global Nursing Program has supported 50 MGH nursing fellows and trained or graduated 1,325 Ugandan students through its work. In her time with the program, Sebert has helped launch the Masters of Critical Care Nursing Program in Mbarara, conducted leadership courses for international colleagues, established midwife training in Lira, Uganda, and helped build up nursing capacity in Native American reservations in Pine Ridge, South Dakota.

One former global nursing fellow is Sophia Harden, RN, a MGH intensive care nurse who in 2016, responded to a need in wound care training for nursing staff at MRRH by spending eight weeks in Mbarara, Uganda.

"I was sent over there to do clinical work, classroom didactics, to work in the surgical ward with the nurses, and to try to innovate new methods of burn care," Harden recalls. "There was such a lack of resources."

Over the course of eight weeks Harden helped successfully innovate new, context-specific methods of burn treatment and helped support and educate several students in the surgical ward. However, upon returning to Mbarara she found the longest lasting impact of her initial work was the relationships she built with the MRRH staff.

Relationships have always defined the history and success of the Global Nursing Program: those between Sebert and fellows, between fellows and the students they train, and between nurses and patients. Through them, the Global Nursing Program continues to support global colleagues despite COVID-19 disruptions. For Sebert, this has meant finding creative ways to connect with colleagues virtually and pivot her skills to support pandemic responses both locally and globally alongside the MGH Global Disaster Response and Humanitarian Action program.

"I've built relationships wherever I go," she says. "They're super important and I try to be supportive in them."



Sebert, RN, MPH, alongside (left to right) Grace Nambozi, PhD, MSN, RN/Midwife, Harriet Nabulo, RN, MSN, and Esther Beebwa, RN, MSN.

Global Health Grand Rounds Relaunch Alongside Brigham and Women's Hospital

THE MGH CENTER FOR GLOBAL HEALTH and Brigham and Women's Hospital (BWH) Division of Global Health Equity have joined together to create a joint Global Health Grand rounds series. This new series combines both department's former grand rounds series and hopes to bring together a wider community, connecting experts and partners from both institutions.

Global Health Grand Rounds brings together a multidisciplinary community of global health practitioners dedicated to learning and sharing ongoing efforts for global health equity. The series allows for presentation and discussion of recent advances and best practices in global health related to clinical care, nursing, research, and medical education.

The course directors include MGH Global Health's Executive Director Louise Ivers, MD, MPH, Global Medicine Director Geren Stone, MD, DTM&H, and Global Nursing Director Mary Sebert, RN, MPH as well as Associate Chief at Brigham's Division of Global Health Equity Joseph Rhatigan, MD.

The conference will be held the first Tuesday of every month at 8 AM EST, beginning November 2nd with Simukai Chigudu, MBBS, MRes, MPH, MSc, DPhil, Associate Professor of African Politics & Fellow of St Antony's College at Oxford Department of International Development.

Find out more about this and future events on our website:

<https://globalhealth.massgeneral.org/events/>

Responding in Haiti

A **7.2 MAGNITUDE EARTHQUAKE** was recorded in Haiti on August 14, 2021. The USGS estimates that the shaking zone affected more than 2.1 million people. The earthquake caused at least 2,207 deaths, 12,268 injuries, and 129,929 houses damaged or destroyed. Many local hospitals were very quickly overwhelmed.

The earthquake preceded Tropical Storm Grace which generated flooding, heavy rains, and strong winds on August 16 and 17. Recent crises such as the COVID-19 pandemic and political instability also impacted earthquake response efforts. The country is still recovering from the 7.0 magnitude earthquake that struck the country in 2010, killing over 200,000 people and injuring many others.

In response, Louise Ivers, MD, MPH, MGH Center for Global Health (CGH) Executive Director, arrived in Haiti on August 18 to work with local partners such as Health Equity International's St. Boniface Hospital (HEI/SBH). HEI/SBH's response efforts include treating injured survivors, delivering medical supplies to affected clinics and hospitals, and beginning preparation for mobile clinics.

Global Disaster Response and Humanitarian Action (GDRHA) has also dispatched two teams to support HEI/SBH, the first including Lindsey Martin, NP, Director of GDRHA, and Russell Demailly, RN, a MGH operating room nurse, and the second including Mary Foley, CRNA, Department of Anesthesia, Critical Care and Pain Medicine, and Kayla Quinn, NP, Orthopaedic Oncology. GDRHA has also supported deployments by Tom Monaghan, a member of MGH Biomedical Engineering, and George Dyer, MD, surgeon in the BWH Department of Orthopedic Surgery.

CGH also continues to support the Ministry of Health's National Laboratory and Epidemiology Department in their surveillance for disease outbreaks in the region.



Russell Demailly, RN, an MGH operating room nurse, (left) helps a patient into a transport helicopter near Fond-des-Blanc, Haiti

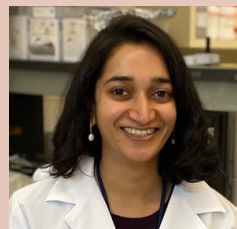
AWARDS & HONORS



MGH Center for Global Health Associate **Adeline Boatin, MD, MPH**, earned a Pilot Innovation Award from the American Association of Obstetricians and Gynecologists Foundation. The award promotes and encourages the development of early investigators from under-represented minority groups to conduct research in the field of obstetrics and gynecology.



Internist at the University of Witwatersand, **Teresa Sumy Thomas, MB BCH, MMed**, begins her residency at the MGH after being awarded the 2020 Discovery Fellowship. The Discovery Fellowship is awarded annually to one specialist in South Africa to conduct a year of clinical observership and research at MGH. Dr. Sumy Thomas is an internist focusing on endocrinology at the University of Witwatersand in South Africa.



MGH post-doctoral infectious disease fellow, **Sushmita Sridhar, PhD**, was awarded the first CGH Research Development Award, designed to support investigators who are beginning careers in global health research. The grant is The grant will support her ongoing project "Genomic and phenotypic characterization of invasive *Klebsiella pneumoniae* in Bangladesh."



COVID-19 Treatment Center at Mbarara Regional Referral Hospital in Mbarara, Uganda

COVID-19 Treatment Center Opens in Mbarara

ON JULY 1, 2021, Mbarara Regional Referral Hospital (MRRH) opened a COVID-19 Treatment Center designed to expand the hospital's capacity to care for patients with COVID-19. Construction began on [April 1, 2020](#) and today, has added 60 full isolation beds to the hospital's capacity.

Global Health Collaborative (GHC) Program Director Stephen Asimwe, MBChB, MS, DrPH, and Program Manager Annet Kembabazi, steered the collaboration that created the center. The treatment center was built with support from [Build Health International](#), the First Mile Program, the Uganda Ministry of Health, MRRH, Mbarara University of Science and Technology, and the Mass General Center for Global Health (CGH).

The center's opening came amid a significant third wave of COVID-19 infections. While many areas across the globe were reporting decreasing COVID-19 cases and deaths at the beginning of the summer, Uganda and other countries on the African continent were experiencing surges. Ugandan officials reported a 2,800% increase in cases from May 13 to June 13.

An MGH Global Disaster Response and Humanitarian Action (GDRHA) team [dispatched to Uganda on June 24](#), to assist in the country's response to a third wave of COVID-19 cases. The team, staffed mainly with critical care nurses, offered support in three main areas: direct clinical support in the COVID-19 treatment unit, operationalizing the CTC, and training clinical staff.

"Fortunately, the cases have started coming down which gives us a breather right now," Asimwe says. "Hopefully, we will get this behind us as our vaccination numbers keep going up."

Global Health Award Season

THE CGH WILL SOON BEGIN accepting nominations for Global Health Service Awards and applications for the Medical Education and Innovation Development Award. There are three Global Health Service awards: the Global Research and Innovation Award, the Excellence in Global Health Education and Mentorship Award, and the Global Disaster Response and Humanitarian Award. The Medical Education and Innovation Development Award provides \$20,000+ in funding and is designed to support early-to mid-career healthcare practitioners who are involved in global education healthcare delivery and innovation. Further details can be found on [our website](#).

—Palliative Care

(continued from first page)

It was very challenging and an incredible honor to be invited into patients' homes as they were dying, as they were feeling sick, as they had symptoms," she says. "To be able to offer music therapy and be present, witnessing the suffering and offering music was incredibly transformative to me. Palliative care is such a natural fit for me because the boundaries between what's considered strict medicine and other parts of the patients' life disappear."

Palliative care's ability to dismantle the boundaries between medicine and a patient's whole wellbeing also attracted Stoltenberg. After receiving a BA in religion as an undergraduate student and studying bioethics in medical school, he began to focus on questions about suffering alleviation and the need to focus on the entirety of a patient, leading him to palliative care.

Upon joining the MGH Palliative Care Division, Stoltenberg and Daubman worked with Eric Krakauer, MD, PhD, attending physician at the MGH Division of Palliative Care & Geriatrics. Krakauer had been working to improve palliative care across the globe, collaborating on programs in places such as Vietnam, Russia, and South Africa.

Stoltenberg's first experiencing delivery global palliative care occurred in 2015 in Belize, working alongside a local anesthesiologist. "I spent a month with [Dr. Beatrice Thompson] in Belize in 2015," he says. "At the end of her shifts, she would go see as many home patients as she could in the afternoons, and that's what she's been doing for 10 years. We saw one patient that lived two and a half hours outside the city. She finished her three o'clock shift, had been there since 7:00 AM, and drove two and a half hours to bring two or three bottles of morphine for a patient that lived out in the countryside almost on the border of Guatemala."

Similarly, Daubman's work with the Lakota Nation in South Dakota also

revealed the great lengths many need to take for palliative care services and the harmful outcomes of not having local treatment.

"Even within our own country, there are so many incredible health disparities and so many generational traumas. [For example], It's a cultural value for Lakota American Indians to be born on their land and die on their land," she shares. "[Without local palliative care resources] they are not even able to be home on their lands to be comforted and supported by their communities but have to be in a hospital 300 or 400 miles away where they aren't able to engage any kind of culturally congruent end of life practices."

Recently, a [Lancet Commission project](#) found that palliative care standards improve patient outcomes, reduce suffering, and do it at relatively inexpensive costs. However, implementing palliative care programs is still a work in progress—although the WHO declared palliative care a right all health systems must work to offer patients.

"The vast majority of unnecessary suffering that's occurring in the world right now is in low- and middle-income countries," Stoltenberg says. "There are far too many millions of people suffering from symptoms and psychosocial suffering that is treatable with inexpensive interventions."

"Globally, palliative care has to evolve and be nimble enough to meet the specific needs of whatever the population and audience is," Daubman adds. "It's also limited by the resources that are available. There aren't enough palliative care doctors and nurses in the U.S. There certainly aren't enough palliative care trained specialists globally."

Now, as they take the helm of the MGH Global Palliative Care Program, a collaboration with the MGH Center for Global Health, the duo hopes to coalesce a community of advanced practitioners to close gaps in palliative care delivery and share and apply the lessons learned from their global partners.

"There are so many people across MGH doing incredible work globally that we want to synergize with," Daubman proclaims. "Integration and synergy are a huge part of our mission."



Bethany Rose Daubman, MD, and Mark Stoltenberg, MD, MA, (bottom right) with colleagues in Kingston, Jamaica

—Healthcare Workers

(continued from first page)

Orishaba was a 15-year veteran of MRRH and Mbarara University of Science and Technology (MUST). She practiced as a nurse in a clinical capacity at the hospital and also worked on several trials and research programs, including a landmark PrEP study and with MGH Global Health Research Collaborative member Mark Siedner, MD, MPH, on a cardiovascular research study. Described as a team player, Orishaba was a vital member of both clinical and research operations in Mbarara.

Ndema was a newer member of the MRRH and MUST community. He was a clinician in training, tirelessly offering himself in clinical settings where staff was needed. He was a clinical officer and recipient of a MGH Center for Global Health (CGH) First Mile scholarship which provided him the financial support to train and practice medicine. His death shocked and disheartened the community that he had dedicated his young career to serving.

Both of these deaths came amid a COVID-19 second wave that struck Uganda, and other countries on the African continent. Uganda's COVID-19 case count surged from May to June. On June 13, the country reported 2,800% more COVID-19 cases than it did on May 13. This third wave peaked on July 5, when the country reported 855 confirmed deaths and a 7-day average of 144 deaths. The rise in cases came after over a year of diligently working to control COVID-19. Though initial measures such as lockdowns and social distancing stalled the spread of the virus,

numbers began to rise globally. At that time countries in the global north began to institute mass vaccine campaigns, while many others struggled to procure vaccines, leading to sharp increases in virus cases and deaths and a demand for greater global vaccine equity.

"The first thing is to increase advocacy for access to vaccines," Asimwe explains. "Then the second part is more personal protective equipment. Then training in the new protocols of how best to manage COVID-19. And finally, continuous medical education and updates on COVID research to counter the negative infodemic that came with the pandemic."

In February 2021, members of the CGH community penned an [open letter](#) to US President Joe Biden and leaders of pharmaceutical industry calling for global vaccine equity.

However, seven months later, the distribution of vaccines has continued to be inequitable: with projections that many low-income countries will not reach substantial vaccination levels [until 2023](#).

"We miss [Orishaba and Ndema] so much," Asimwe says. "We don't want to get a third wave because you never know who it will affect. And at this stage, where our vaccination rates are less than 2% nationwide, we can't risk having another wave hit us. Most likely health workers will be the ones affected."



Our thoughts continue to be with the families of Carol Orishaba (left) and Moses Ndema (right)

Share Your Work with the MGH Global Health Community

If you have an idea for a future newsletter or would like your global health related work featured please email globalhealth@partners.org