ELECTIVE (SSC5b) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

Women's health in Rwanda is an area of many challenges but also many successes. Rwanda is one of the few countries to have achieved their millennium development goals target for reduction of maternal mortality from 1300/1000,000 live births in 1990 to 325 in 2015 - maternal mortality in 2015 was 320/100,000. This success is attributed to improved use of the maternal death audit and investigation into complications. Of the 320/100,000 maternal deaths in 2015 it was found that 72% were due to post partum haemorrhage or obstructed labor as these present the major challenges to safe obstetric care in Rwanda.

Obstructed labor is an area of global health priority due to its complication of vaginal fistula, a condition that affects 2/1000 Rwandan mothers annually. A fistula is an abnormal connection between two organs and in the case of vaginal fistula it is predominately the anus, bladder or both connecting to the vagina that results in the continuous leakage of urine and or faeces from the vagina leading to skin infections, kidney problems and even death if left untreated. Fistula is caused obstructed labor, where a woman cannot deliver her child by simple vaginal delivery (often due to a small and immature pelvis) and does not access timely obstetric care leading to the death of the child, its removal and damage to the woman's pelvic viscera. Fistula a much discussed topic because sufferers are often victims of stigma and social isolation, The WHO believes that the best treatment for fistula is prevention and therefore an education programme has been adopted in much of sub Saharan Africa, including Rwanda. This programme suggests fistula can be avoided by delaying age of first pregnancy, encouraging the cessation of harmful traditional practices and ensuring timely access to quality obstetric care.

In CHB fistula is discussed in hushed tones due to the awareness of social stigma and treatment is paramount. 80-95% of fistula can be managed surgically and women are managed conservatively in the first 3 weeks to encourage natural healing with wound cleaning and antibiotics. After this time surgery can be discussed. But the major sufferers from fistula do not come from the big towns such as Butare, they come from the countryside and make up 80% of fistula sufferers as they cannot access such care. For mothers to endure a long and agonising labor, to lose their child, have to endure the removal of the child from her body and then be left with a condition that leaves her shunned by her community which could be easily treated is a major issue and seeing women with such conditions is extremely saddening.

The management of post partum haemorrhage in Rwanda is much the same as the management in the UK though I have personally noticed many patients who suffer haemorrhage do so due to uterine rupture - a rare complication in the UK that I had never seen prior to visiting Rwanda. In one instance we were phoned by a district hospital who were desperate to transfer a mother for emergency C section whose uterus had ruptured leaving her fetus free and palpable in her abdominal cavity.

Rwanda's successes with regards to the millennium development goals are impressive, a reduction in maternal mortality of 77% between 2000 and 2013' and the training of over 1,000 midwives. Though it has far to go, Rwanda is one of the most improved sub-Saharan Africa countries and this can be partially attributed to the focus on progress that has become part of the national psyche after the horrors of the 1994 genocide which resulted in the killing of over 1million Tutsi's and the displacement of 2 million more. Rwanda has one of the few majority female senates in the world, has been named one of the least corrupt countries in the world by transparency international and has been awarded great sums of international aid due to their responsible spending. My opinion is that the difference in maternal healthcare between Rwanda and its neighbour Uganda is very much due to the change in this country after 1994.

The health system of Rwanda comprises 440 health centres, 48 district hospitals and 4 referral hospitals - all of which can provide family planning and women's health services. however, despite this coverage unfortunately there are just 35 obstetricians/gynaecologists for a population of 11,776522. In comparison the UK has 1506 for a population of 65.14 million and Uganda for a population of 37.5 million (all 2015). This shortage results in women still not necessarily having access to the care they need, evidenced by the number of women presenting for ante-natal care. Just 35% attended the government target of 4 ANC visits per pregnancy. However this is up from just 10% in 1990 and though the majority of women do not make all 4 appointments 95% of women will make at least one (up from 90% in 1992).

There are many reasons for this lack of specialists, partially because junior doctors are trained to perform C sections early in their career and partly because since the genocide are fewer doctors, both due to the initial genocide and due to the closure of the national university of Rwanda in the aftermath for 3 years. As my placement in Rwanda has been in a major teaching hospital it is promising to see that in the maternal health department, whist only a handful of consultants and trainees there are large numbers of medical students who have entered into medical training in the past few years. Each week 28 students rotate through the department, spending a week at the university hospital and a week at the district hospital in their 3rd year before returning for an extended placement in their final year.

My exposure to HIV/AIDS treatment in Rwanda was primarily the prevention of mother to child transmission of HIV and tackling this matter has been broken down to 4 essential components- 1) the primary prevention of HIV among women 15-49 years via safe sex education and the distribution of barrier contraception. 2) the prevention of unintended pregnancy in those women who are HIV+ by education and provision of contraception. 2)the prevention of MTCT via the WHO option B+ policy. 4) the extended provision of care to HIV+ women and their children.
In Rwanda the WHO policy of option B+ has been adopted by the MoH, this option was developed in Malawi in response to the WHO recommendation that low income countries adopt either their option A or option B policies. Option A is a better option for middle income countries and has therefore been adopted by countries like South Africa, but option B - a policy where all HIV+ mothers have their CD4 count tested and if it is below 400 put on ART for the duration of their pregnancy and infants given nevirapine for 6weeks after birth has been adopted by lower income countries. However, Malawi found that in the absence of reliable CD4 testing for new mothers it was simpler to place all HIV+ expectant mothers on antiretrovirals and to keep them on it for life. This policy has been adopted in much of sub Saharan Africa including Rwanda due to its simplicity, reduced need for testing and focus on maintaining the mothers health so that she may adequately care for her child. In Rwanda this policy has been widely successful, 93% of HIV+ women receive ART during pregnancy and despite 40-50,000 babies being born to HIV+ mothers per year transmission rates are as low as 1.8%. In CHB All mothers have their HIV status documented at antenatal appointments and those that are HIV positive are counselled about their test results and steps for protection of their children. Those who do not get HIV care are predominantly those from rural areas who do not present for testing or ANC and deliver at home.

As my placement has been in one of the four referral hospitals of Rwanda I have not gained as much exposure to the pressures of poor resources that might be seen in the smaller Rwandan hospitals however, despite this, there are still many examples of the small shortages in this country - patients must bring their own gloves for the staff to use when examining them and there has been more than one occasion where a patient has self discharged due to an inability to pay for their stay/treatment.

My objective of improving my medical french was not fully achieved as medicine is condcted in aenglish in Rwanda however my day to day french imoroved considerably.

Bibliography - all statistics WHO global health observatory who.int/gho/data/node.country.country-RWA