OBS+ GYNAE

I undertook my elective placement at The Western Regional Hospital, Belmopan, Belize. Belize is a country in Central America that is very culturally distinct from the rest of the region in that it is more Caribbean, more ethnically diverse and is English speaking. Belmopan is the administrative capital of Belize; Belize City however is larger and is where more advanced medical services are based.

Western Regional was a small hospital, but had Maternity, Trauma, General Medical, Emergency, Paediatric, Dental and some Psychiatric services. There was also a Public Health department.

I spent the majority of my time in Obstetrics & Gynaecology, but was also lucky enough to spend time at one of the few remaining Psychiatric inpatient facilities in Belize, and within General Medical outpatients.

Overview

According to the WHO, Belize has a population of 307, 000. As of 2007, life expectancy at birth was 71 for males and 76 for females (compared to the UK at 78 for males and 82 for females). The most common causes of death for men are circulatory (26.5%) injuries (21.9%) and cancer (9.7%). For women circulatory (36.6%), cancer (12.6%) and diabetes (7.7%) remain the most common causes of death. 3.3% of Belize's GDP is spent on health compared to the UK's 9.3%.

The health system in Belize is funded both privately and by the state. Not all medications are free, and certain treatments or procedures require payment, however it was not clear how this was defined or calculated.

The hospital, although clean, had basic facilities and, although highly skilled and dedicated, not enough members of staff. Very few patients were admitted, only the very unwell, elderly or very young. There were six inpatient wards, where all sexes where kept separate. Beds were old and mattresses of poor quality, therefore pressure sores were common. Patients with low haemoglobin levels or infections were nursed in side rooms, but infection control was not adhered to as strictly as in the UK. Sterile gloves were only used when absolutely necessary, aprons were not routinely used. I do not recall seeing widespread use of alcohol gel or washing hands after seeing patient (unless they had been extensively examined or had a procedure) and doctors wore white coats, up to the sleeve, usually only changing when soiled.

Objectives.

1. Describe the pattern of disease/illness of interest with which you have worked with and discuss this in the context of global health

The main focus of my elective was Obstetrics and Gynaecology. Belize has a maternal mortality rate of 94/100,000 (WHO 2003) compared to 12/100,000 in the UK. 16 out of 1000 live births will result in death under the age of 5, more than 3 times that of the UK. I wanted to observe the ante natal

care provision in this country, and was encouraged to see that according to the WHO, in 2006, 94% of pregnant women were seen by a health professional at least once before they gave birth. It goes without saying that this figure may be inaccurate for a number of reasons.

The ante natal clinics I attended were, like the UK, for high risk patients only. However whilst in the UK it is largely a risk management protocol, with many women going on to deliver with no problems. In Belize, many of the women had chronic, poorly controlled hypertension, resulting in many women with pre eclampsia .At least once every clinic a patient would be booked in for an emergency caesarean section the following day. The hospital had an ultrasound machine, but technicians were only available on Tuesday and Thursdays, for all patients. If more urgent imaging was required patients were sent to Belize City, otherwise US scanning on pregnant women was not routine.

The clinics were busy and chaotic. Apart from me and the consultant, there was often a registrar and a healthcare assistant in the same small, stuffy room. Heavily pregnant women waited in the often very hot waiting area to be seen, often waiting several hours. Whilst patients were very knowledgeable about their conditions and their medications, they were poorly compliant, often resulting in the consultant telling them off. The doctors here had a much more authoritative role, often being blunt with the patients.

Every woman had a fundal height measurement and the foetal heart rate measured with a Doppler, which was usually performed by me. I was also encouraged to perform vaginal examinations on these women, which I was not entirely comfortable with as we had been strongly advised against this during my O & G placement in the UK. Shortage of gloves meant the doctor examined with one hand.

Alongside this I spent time in theatre observing emergency caesareans. I was extremely lucky to do this as a shortage of scrubs meant that students were not always permitted in theatre. The theatre set up was very similar to that of the UK, but the equipment was older. WHO theatre checks were not taken where each member of the team introduces themselves and role prior to each procedure). Emergency sections tended to take place due to pre eclampsia or foetal distress. The surgeon made vertical midline incisions on all the women, which he said was for speed. Deliveries were quick, and the staff were highly skilled. However, a paediatrician was not in attendance, as with in the UK. A midwife crudely assessed the infant at birth – no formal APGAR scoring was taken or recorded. On one instance, when an infant required resuscitating, the anaesthetist did this.

Another one of my objectives focused on cervical screening. I was told there was no formal cervical screening, and this was performed opportunistically at public health clinics. Women were offered a smear test if they had any relevant symptoms or were seeking family planning advice.

Public Health and education was evident throughout the hospital. Posters everywhere educated patients on everything from breastfeeding to how to cope with depression. A mobile health clinic travelled into the rural communities to treat patients twice a week, and another specifically for HIV/AIDS patients and TB sufferers.

I spent time in general outpatients, which operated much like an NHS walk in centre where patients were seen on a first come first served basis. The hospital operated a sophisticated online patient

record system, which appeared greatly at odds with the basic and run down facilities of the hospital. All patient info was stored electronically, all information from consultations was entered, drugs prescriptions and investigations were ordered on the system and follow up appointments were booked. The doctors found this very time consuming as information had to be logged for each patient before the next was seen. Whilst I was able to clerk, examine and shadow prescribe medication in these clinics, I spent a lot of time logging patient information for the doctor when the clinic was busy. T he hospital administrator was very proud of the system, but I couldn't help question if the money and time spent on the system could be better used on facilities and patient care, especially when you consider at one point they ran out of blood collection bottles to measure a full blood count, and if a patient needed a blood transfusion, a family member had to donate.

The most interesting placement of my elective was the afternoon spent in an inpatient psychiatric facility. Belize has made great efforts to abolish psychiatric institutions and manage its patients in the community. There are 3 psychiatrists in Belize, operating mainly administratively. The bulk of care is provided by the 19 or so psychiatric nurses in Belize, who are coming up to retirement age, whilst no new nurses have been trained in this specialty. The facility was new and well facilitated, with bright airy rooms, attentive staff and activities on hand for the residents. It was not unlike the psychiatric wards I had spent time in as a student at Mile End Hospital. The main difference was that these patients were not going to be released back into the community. We were told rather matter of factly that these patients would be there until they died, and some of them appeared to be in their thirties. Rather than being treated and rehabilitated as we'd first assumed, these patients were deemed incapable of caring for themselves and admitted to the unit. This unit was the only one of its kind in Belize. This facility summed up my experience of healthcare in Belize. We met dedicated and highly skilled staff who wanted the best for the patients, only to be frustrated by the facilities available to them, which is perhaps a consequence of poor allocation of resources.