OBS+ GYNAE

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Elective Report

I undertook a 5 week elective in the district of Kadodara, in the state of Gujarat in India. The hospital I was working in was primarily an obstetric and gynaecological unit. However, we also regularly saw paediatric cases and on occasion medical emergencies that I would have considered more suitable for a 24 hour accident and emergency department in a larger hospital containing doctors of multiple specialities.

I also had the chance to witness treatment in a government hospital, an ayurvedic hospital and a homeopathic centre. This meant I could make comparisons between the three and the privately run hospital where I spent the majority of my stay.

Objective 1 – Describe the pattern of disease or illness of interest in the population with which you will be working (Gujarat) and discuss this in the context of global health.

India is a vast country, with a population of 1, 198, 003, 000 people. The life expectancy at birth is 63 years for males and 66 years for females. The probability of dying under five is 66 per 1000 live births and the total expenditure on health as a percentage of GDP is 4.2%. This can be compared with the UK, where the life expectancy at birth is 78 for males and 82 for females, probability of dying under five is 5 per 1000 births and the total expenditure on health is 9.3% GDP.

Malnutrition is accountable for many diseases found commonly in India, for example, around 70% of adolescent girls are anaemic.

Communicable diseases, such as TB, multidrug resistant TB, polio, communicable childhood diseases and leprosy, account for around 38% of the disease burden in the country. Each year there are 1.8 million new cases of TB and more than 1.5 million people contract malaria. In 2005, more than 5 million people were living with HIV. Other infectious diseases such as dengue, JE (Japanese encephalitis), filariasis, kala-azar are also endemic.

In addition, a new group of diseases more commonly seen in developed countries are now on the increase in India. These are collectively termed 'non-communicable diseases' and include cardiovascular disease (CVD), diabetes mellitus, cancer, stroke and chronic lung diseases. These are thought to be emerging as a major public health problem due to an ageing population and changes in behaviour (such as increasing consumption of food from fast food restaurants).

Objective 2 – Describe the pattern of health provision in relation to the country in which you will be working (India) and contrast this with the UK.

The pattern of healthcare provision in India is very complex. There is a public sector which is funded by the government and there is also a private sector. The private sector can be further broken down into 'not-for-profit' sector, which includes

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chartable institutions, missions, trust and NGOs. However, this is a very small portion of the private sector.

Most of the private sector is in the 'for-profit' category and this not only includes those with formal qualifications but also a number of other practitioners and institutions. Those with formal qualifications may not necessarily be doctors of allopathic medicine as there are also universities and schools in India dedicated to producing Ayurvedic doctors and homeopathic doctors. The 'informal' sector comprises practitioners without any formal qualifications, such as the faith healers, bhagats, hakims, vaidyas and priests, who also provide healthcare.

There is a marked contrast when comparing the Indian system to the UK. In the UK, the government funded NHS boasts a level of quality of care that is not even achieved in many of the better private hospitals in Gujarat. Most of the government hospitals in Gujarat are so impoverished and facilities so lacking that even the poorest families will opt first for some form of private healthcare.

In the UK, a minority will opt to pay out of pocket for private healthcare. In India this is the norm and represents a significant financial burden on households. Compared to public expenditures on health in India, the private household's expenditure is around four to five times more.

Objective 3 – What cultural problems are encountered when trying to provide healthcare in India.

In India, the problems with overpopulation are apparent as soon as you step onto the streets. In Gujarat, there is another problem: the sex ratio is skewed in favour of boys. In 2001, the civil registration system (CRS) said that the ratio was only 883 girls per 1000 boys in the state. Traditionally, girls will stay with their in-laws after marriage, whereas boys remain with their own parents and are therefore able to care for them in their old age. As a result, boys are more valued and wanted by couples. The gender imbalance in the state is the result of this cultural belief and the subsequent practice of female foeticide and infanticide.

Sex determination by ultrasonography has been illegal in India for many years, but we still encountered many couples wishing for illegal sex determination. On occasion fertile couples would come to the clinic asking only for advice on how to get pregnant with a boy or how to ensure the pregnancy they were carrying would be born male. We also encountered countless women who presented with complications after they had tried to self-terminate their pregnancies.

Objective 4 – To improve my clinical and communications skills in obstetrics and gynaecology

The main spoken languages in Gujarat are Gujarati, Hindi and English. One of my main goals was to be able to take a good medical history in Gujarati, something which I have struggled with previously. By the time I finished my 5 week placement, I was much more fluent in Gujarati and I think now I will be more confident not only when

communicating with patients in Gujarati, but also more culturally aware – something which cannot be obtained by simply attending language courses.
I was also able to vastly improve my clinical skills under the supervision of the lead consultant.