PERINATOLOGY

SSC 5c Elective Report

Perinatology in Nigeria

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Introduction

Even before joining the medical school, I knew I wanted to be a Paediatrician. It was during the first two years at medical school however that I realised paediatrics is a rather diverse speciality, and in the UK it is quite separated from obstetrics despite the obvious overlap. This is mainly due to the very specific medical and surgical knowledge required for obstetrics compared with neonatology and paediatrics. My academic tutor at the time suggested the career option of Perinatology. However, this is not a recognised speciality in the UK. In fact many doctors, juniors or consultants alike, had never heard of Perinatology let alone think it a necessary or even sensible career option. I sensed that others thought it was too much hard work, too complex, too much of a risk to be sued. I was not disheartened though. I knew that I wanted to be able to deliver babies but also care for them, to combine the surgical side of modern medicine with the holistic approach needed to assist pregnant women and help them raise healthy children which does not often require medical intervention.

But how can I combine obstetrics, neonatology and even paediatrics into one "super speciality" in the UK if such a career is not even recognised? This question formed the basis for my elective, but it took me three years to fully realise this.

Whilst president of the Bart's & The London Afro-Caribbean Society for the 2007-2008 academic year, I helped organise an event for our members called Inspire, which had medical and dental professionals as guest speakers. One speaker that had a profound effect on me (other than the highly inspirational Prof. Fortune) was Dr Femi Olaleye. He is the CEO of WISH For Africa, a charity based in Nigeria which delivers primary healthcare and improves the quality of obstetric and gynaecological healthcare in poor communities.

From that moment on I knew I would spend my elective in Nigeria.

3 years later I got in touch with Dr Olaleye and began the task of planning my elective, securing finances for my stay and formulating my objectives.

This report will summarise my elective experiences along with outlining the four objectives I had for my elective, two for the medical school and two personal ones.

Elective Summary

The aim of my elective was to gain more experience in obstetric, neonatal and paediatric medicine in a foreign country and consider how I can combine my interest in three of those specialities in to a job description in the future.

I arrived in Nigeria on Friday April 8th and was brought to the hotel I was to stay at which was close by to the Olowoora Primary Health Centre (from now on referred to as the OPHC). I spent the weekend there since it was the first of three election days on the Saturday of that weekend.

On the Monday I had the opportunity to be introduced to staff and facilities at the OPHC and continued with arrangements to have a working phone for the rest of the day.

By the Tuesday however, despite me being well enough to start my day at the centre, I diagnosed with malaria by the afternoon. I took advantage of the bout of ill health and used it as an opportunity to learn about the disease. I am now much more familiar with the signs and symptoms, along with advancements in treatment and efforts made by the Nigerian government to lower the occurrence of the disease.

My clinical time at the OPHC were spread of day, overnight and weekend duties which helped me assess how people use the service. Since the OPHC is open 24hrs a day, patients can come in whenever they like. It was interesting to see that, just like in the UK Emergency departments, patients are less likely to present when there is something big happening, be this a football match, the Royal Wedding, or political elections.

The OPHC has two consultation rooms, a treatment room, a two bed and three bed wards, a medical dispensary, a delivery room and an onsite laboratory for basic investigations. I spent time in each location, learning about the duties of all the staff and to observe how patients are seen too. I got to attend antenatal clinics and assist with antenatal assessments and examinations, I treated wounds of patients how had recent accidents and assisted in deliveries. I also took histories from patients, examined and wrote up an appropriate management plan for them.

Compared with my GP experiences at the beginning of my final year at Medical school, a larger proportion of patients are made up of infants. In addition, a very common presentation for patients, regardless of age is that of cough and rhinitis, with a common addition of swinging pyrexia and joint pains. This generally leads to a diagnosis of malaria which is promptly treated with combination therapy of artemether and lumefantrine.

Since many of the more advanced investigations and even basic imaging are chargeable to the patient, it is common for doctors to have to rely on instinct when diagnosing and treating patients. It was refreshing to watch this change in patient management and it is something which has encouraged me to gain as many new experiences as possible in order for me to be the best doctor I can b

I enjoyed my experiences immensely and would advise many students to come here in the future.

MBBS Objective 1
What Obstetric and Neonatal health issues affect Nigeria compared with the rest of the world and the UK?

Obstetric healthcare in Nigeria, like in any country, is of great importance since childbirth is still the biggest killer of women despite it not being a disease in itself. Neonatology is just as important as there can be many problems during labour or with the newborn.

There are numerous diseases and complications which are the same anywhere in the world, such as post partum haemorrhage, foetal distress, or Down's syndrome. However, there are some issues which are more of an issue in Nigeria.

Sanitation is not as big a problem as one may presume. Surgical equipment is always sterilised, gloves are worn, and clinical areas are constantly cleaned. However, the heat providing optimal temperature for microbes along with the water containing so many microbes means that it is easy for women have get infections. The biggest infection issue I have noticed that can complicate pregnancy or effect newborns is malaria. It is extremely common here, virtually as common as the flu in the UK. The WHO and the Nigerian Government have worked hard to encourage quick and effective treatment for malaria, even in the poorest of communities.

Along with other routine antenatal drugs such as folic acid and iron, mothers are given prophylaxis treatment for malaria.

Sickle Cell disease is prevalent in Nigeria leading to most couples having their genotype discovered in order to conclude the possibility of having a Sickle Cell baby. Sickle Cell disease is disorder of haemoglobin where there is a replacement of glutamic acid for valene in the beta chain of haemoglobin. When red blood cells become deoxygenated, they adopt a crescent moon or "sickle" shape which can lead to red cells getting trapped in the smallest of blood vessels causing bone pain and leading to microvascular damage to numerous organs, the main places being the lungs and spleen. These later become the loci for infection during a sickle crisis which can be brought on by an infection, stress, cold weather, or an unidentifiable cause. Sickle Cell in itself can complicate the pregnancy if the mother has a Sickle crisis which can cause premature delivery. The nature of foetal haemoglobin prevents sickle cell babies from suffering symptoms of sickle cell disease when delivered until all foetal haemoglobin is replaced by the sickle cell variant.

For newborns and older babies, malnutrition becomes a serious concern. It is not uncommon for babies to given tea, reconstituted milk powder or some other beverage despite the WHO's recommendation that babies be exclusively breastfed for at least the first 6months of life. After this time, they are commonly given carbohydrate rich but protein lacking foods such as instant noodles or various grounded root vegetables and cereals.

MBBS Objective 2
How is Obstetric and Neonatal health issues managed in Nigeria compared with the UK?

Healthcare in Nigeria is not just delivered by the medical industry, but also, to a lesser but significant degree, by natural healers, spiritual leaders and sadly even by charlatans.

A vast number of Nigerians are very religious and so rely on spiritual support in times of trouble, including labour. . It is also not uncommon to hear women mention that previous deliveries were at church because it is free. Most Nigerians are also superstitious, resulting in many using herbal medicines to cure illness. Because of these two additional sources of healing, the role of the doctor and modern medicine on the whole can be diminished.

During one of the antenatal clinics I attended at the OPHC, I spoke with a pregnant lady who explained her previous pregnancy with twins who were delivered at her church. Her labour lasted 14hrs with the first of the twins being delivered at approximately 9am. The second twin was then delivered still born at 5pm, 7hrs later. Two years later, the first twin died. She whole heartedly believed that if she had delivered in a hospital she would have died as well. Her explanation for this is that her pregnancy was the victim of a spiritual attack. There were other women who told me similar stories.

There are many people in the community who are not trained but are still "providing" healthcare, which is quite clearly a dangerous practice. Even some experienced nurses and matrons are treating and caring for pregnant women and newborns without the knowledge of doctors despite their being a need for modern medical assistance.

National and local government along with healthcare professionals have accepted the aforementioned points and so now try to work in churches and other places of worship for free, or at least train up members of the church so that safe health care can be provided. Even at the OPHC during antenatal classes religious songs are sung to help bring the religious aspects of the patients' lives to the clinic so they feel more secure.

Antenatal classes are of great importance here as a low household income very commonly coexists with a low level of education. Many women, even though who have had babies previously need to be taught a great deal about pregnancy, labour and how to care for a newborn.

The cost of healthcare makes it difficult for healthcare to be delivered efficiently as explained later in this report. Because of this, there are many complications of pregnancy and conditions of the newborn which need to be treated when they could have easily and preferably been prevented.

Personal Objective 1
How does Obstetric and Neonatal medicine combine to make Perinatology a viable career option?

I thoroughly enjoyed my time working at the OPHC. It was a refreshing compromise between primary and secondary healthcare since it was primary healthcare provided for 24hrs with the possibility of having some inpatients that only required basic observations and medical support.

Therefore, it was easy to conclude that becoming a GP with a special interest in obstetrics and paediatrics is quite a good option. It would be necessary to specialise in obstetrics for a little while first however in order to gain experience.

Other options available to me include working abroad. In places where the patient/doctor ratio is very wide, doctors need to take on more responsibilities in order to provide adequate care to their patients. This is the case at the OPHC where doctors are not just GP's, but are more than capable of managing a delivery, even one complicated by a post partum haemorrhage. This simply wouldn't be in an option in health centres in the UK, since such patients would be managed in a hospital. However, with the shift in management of Primary Healthcare in the UK and the current trend in creating Polyclinics, the option of having deliveries in a Primary Healthcare Centre is not as farfetched as it used to be. It is something I must investigate further.

Of course the final option is to go into private healthcare and create my own centre which looks after mothers and babies. This option would require not only a lot of planning, but also a large financial investment, but the option still remains after I have been practicing for at least a decade.

Personal Objective 2
How do the issues of affordability and cost affect access and quality of healthcare in Nigeria?

The most important issue I discovered very quickly during my time at OPHC was that of poverty. The cost of a delivery at the OPHC is £30 is booked a month in advance, £40 if the patient presents late. In the UK, this cost would be considered trivial, even amongst poorer groups who are on income support. However, there are many people served by the OPHC who may only earn £30 a month. Many even less. Because of this, the cost of health care can be a huge obstacle to overcome.

To combat this issue, local Government in Lagos state and members of the Olowoora community created the OPHC which delivers 24hr services to all its patients. The most important thing to note about this OPHC is the fact it offers a unique insurance scheme which cannot be found anywhere else in Nigeria. They pay approximately £3.20 a month for a family of six which permits them to see the doctor, have some basic investigations and key medications for free. There is however a 20p charge every time they visit the Centre.

This is a huge reduction in cost compared to the £2 uninsured patients must pay or the £5-£10 for medication. For many of the patients, the insurance scheme is the literal difference between sickness and good health

Teaching hospitals tend to be cheaper than general hospitals, sometimes by 50%. This is somewhat reflected in the quality of service though, since a patient can stay in the waiting room for literally hours before being seen, if they are seen that day at all. This is not so much of an issue for pregnant mothers or newborns since they are prioritised. However, this is very common knowledge amongst individuals hence why they would be already discouraged to the hospital.

Private practices are by far the most expensive alternatives with deliveries costing around £2000 which includes accommodation for a few relatives and meals. The mother is allowed to stay for at least a few days as well, compared with the simple 24hrs which is usually permitted at other locations.

The quality of the service doctors can provide is generally very good since medical training is of a high quality. The problem that is found in the hospitals and indeed at the OPHC is that of low levels of staffing. It is not uncommon to have around 70 patients visit during a 9am-5pm day shift which is around a patient every 7mins. All these patients are to be seen by one doctor. This number does not include any pregnant women in labour or any other inpatients.

Doctors are vastly overworked in Nigeria compared to the UK and it is difficult to assess precisely what negative impact this has on healthcare other than the fact that patients have to wait longer to be treated.

If the insurance scheme was replicated across Nigeria, more money directed to pay for more doctors to work and more financial support given to the poorest in the country, the quality of healthcare in Nigeria could increase profoundly.

Conclusion

My time in Nigeria has been very eventful. Despite a lot of negativity expressed by many people, including from Nigerians, about me coming Nigeria to have my elective, I have learnt that Nigeria can indeed be a safe, friendly and exciting place to live and work in. Adjustments need to be made to ones constitution which takes around a week or so, but when they are made, one can really appreciate how wonderful a country Nigeria really is.

I look forward to coming back in the future as a more experienced doctor and to make a significant impact in the healthcare of people.