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My learning objectives included the following

1) To try and establish key obstetric issues in Belize.
2) To appreciate and understand the manner in which healthcare is delivered outside the UK and outside the realms of the NHS
3) To appreciate the various treatment option and ethical issues pertaining to obstetric medicine Belize
4) To identify the main challenges of practicing medicine outside the UK and to try and overcome these challenges

I had the opportunity to spend 5 weeks in Belize in San Ignacio Community Hospital on the labour ward. I was able to witness a whole range of obstetric medicine as well as a general medicine that I was able to experience during on call with the senior registrar.

Belize is a small central American country sandwiched between Mexico and Guatemala. With a population of just 300,000 it presents with a unique set of medical challenges and issues. One of my main objectives that I set before heading out to Belize was to witness first hand the delivery of Medicine outside the boundaries of the National Health Service (NHS). By witnessing this different method of delivery of medicine I learnt a number if things.

During my elective in Belize I noticed a number of recurring obstetric issues that seem to be common. These included common problems, similar to those found in the UK, such as gestational diabetes and hypertension. A big difference between the countries was the average age of primigravidas. In Belize, women on average had their first baby at a younger age, the majority of women in clinics and on the labour ward were between the ages of 18-23, in fact the average age of the first pregnancy was 18. Additionally, women were having more babies in Belize that in the UK, on average a woman in Belize can be expected to have up to 7 children. The reason behind the bigger number of children, according to the consultant was due to the fact that the majority of the Belizean population are Roman Catholic. As a result of this, the uptake of contraception is also low in the country and despite family planning being free, very few women take advantage of this resource. This may also help explain the exponential and alarming rise of sexually transmitted disease in the country, especially HIV.

Firstly, I noticed that the extent and quality of antenatal care was vastly. The vast difference in the healthcare aimed at expectant mothers was striking. In the NHS, antenatal care is widely and diligently encouraged. Expectant mothers are encouraged to undergo several tests and key dates for ultrasound scans are discussed and arranged. This was not the case in Belize. On average, during my stay there, only 2 in 10 expectant mothers that I saw had any antenatal input. As a direct result of this I noticed that the patients seen in the labour ward presented with more complications. These include complications such as gestational diabetes leading to macrosomic babies and shoulder dystocia. Other complications included gestational hypertension potentially leading to the fatal condition of pre-eclampsia. As well as complications directly related to pregnancy, the lack of coordinated and concerted antenatal care has also led to an alarming increase in the rates of transmission of HIV. I noticed that this blood test was not routine test, this is despite the fact that HIV is endemic in Belize and spreading fast.

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On discussing this alarming lack of antenatal compliance with the consultant and senior registrar I discovered that the prime reason underlying this lack of care was due to cost. Unlike here in the UK, in Belize antenatal care is not included in healthcare costs contributed by the government, as a result, many families cannot afford to pay for antenatal care as well as the costs of obstetric costs incurred during labour.

The main ethical issue that I came across in Belize was one of contraception. I was shocked to discover that family planning is not a well received branch in Belize. However after having several conversations with patients I learnt that this was not due to a lack of knowledge of what family planning involved but because of religious beliefs and as a result this should be respected as I strongly believe that patient autonomy should be respected no matter what nationality.

There were a number of challenges that I faced during my elective. Of this one of the biggest ones in my opinion is the language barrier. Despite being an English speaking country, the hospital that I was based at was located in rural Belize and the majority of patients spoke Spanish, as a result when it came to taking histories, I found it challenging to communicate with my patients. To try and overcome this challenge I downloaded a translator application on my smart phone to try and assist me in communicating with my patients, and whilst this is not ideal and to truly be able to take a thorough history one needs to have a basic grasp of the language at least, the app helped me a little bit.

Another key challenge was the cultural difference between myself and my patients in Belize. This was particularly relevant when I was discussing that issue of contraception and family planning with the patients. I realised the importance of respecting my patients religious beliefs and understanding that this beliefs will influence the medical decisions that they take, and I had to respect these decisions thoroughly as it was by respecting, appreciating and understanding could I truly ensure patient autonomy.