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Maternal and Child Health in Northern Tanzania

During the placement at Huruma Hospital in Rombo District, Kilimanjaro Region, Tanzania I spent much of my time experiencing child and maternal medicine. Although some aspects of this type of medicine are similar to that of the UK, some aspects differ. HIV prevalence is 5% is Sub-Saharan Africa according to the World Health Organisation (WHO). In 2012, of the 1.2 million people living with HIV in Tanzania, 48% of cases were women and 15% were children. This compares to 98,000 people living with HIV in the UK during the same year. The most common cause of HIV in children is mother to child transmission, and for this reason HIV is one of the most important issues in maternal and child health in Tanzania. The Kilimanjaro region of Tanzania is forward thinking, providing Provider Initiated Treatment and Counselling (PITC), which attempts to reduce stigma around HIV and promotes everyone knowing their HIV status.

As well as HIV, many illnesses in maternal and child health are similar to the UK. Like the UK, pre-eclampsia is a major issue in Tanzania. Maternal blood pressure is monitored during antenatal checks in Tanzania, with women being encouraged to have at least 2 antenatal checks, and if complications arise, more antenatal appointments are arranged. In young children, the major illnesses are infections, mainly pneumonia, tuberculosis and viral infections. Besides tuberculosis, the illnesses are similar to the UK. Fractures are a major issue in Tanzania, with many surgical paediatric cases being orthopaedics. This is due to a combination of road safety, diet and difference in fracture management.

Organisation of Health Services in Northern Tanzania

In Tanzania, healthcare is organised mainly by the government, but some hospitals have religious affiliations as well. Huruma Hospital is funding by the Tanzanian government as well as the Catholic Diocese of Moshi. Due to the World Health Organisation's Millennium Development Goals, maternal healthcare and health care for children under five years is free. Although an excellent, the practice isn't quite as good. Due to poor resources in the hospitals, women coming into hospital to give birth need to bring basic supplies, such as sterile gloves, with them

In Tanzania, there is also a health insurance scheme. There is the basic insurance which can be bought through the government, which means there is still a fairly large cost to the patient while in hospital. Those who can afford it pay for private healthcare and go to private hospitals for care. A hospital about 20 minutes' drive from Huruma charged 50,000 Tanzanian shillings for a normal delivery and 250,000 Tanzanian shillings for a caesarean section.

Tanzania healthcare differs from the UK in that there are no general practioners in the community. Tanzania has dispensaries which generally do not have doctors, but have clinical officers. They can give advice and sell prescriptions. There are also smaller health centres for the less critically ill patients and hospitals such as Huruma for more ill patients. Huruma can also refer to larger referral hospitals such as Kilimanjaro Christian Medical Centre, 50 kilometres away, for more specialist care if needed.

Public Health Measures in Northern Tanzania

Due to the large prevalence of HIV in Tanzania, Northern Tanzania has started to educate the general population on HIV. It has tried to rid society of stigma, introducing Provider Initiated Testing and Counselling (PITC), which attempts to test all patients admitted to Huruma Hospital. It also aims to test all pregnant women at their initial booking appointment. The aim is that by educating the general public, it can allow those who are infected to seek treatment and educate others of the risks of infection and how to prevent becoming infected.

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Another public health measure in Tanzania is for children. There is a Children's and Maternal Health Clinic, where mothers bring their children. It aims to assess breast feeding and growth, as well as immunizing the children at the appropriate ages. The aim of the clinic is to decrease early childhood mortality and to improve the health of children as well, trying to stop preventable illnesses.

Reflection on Medicine in Northern Tanzania

My time at Huruma Hospital was beneficial to me as both a professional and as a person. The hospital had a friendly and welcoming environment which meant that settling in was a quick and relatively easy process. The doctors were all friendly and willing to teach. We were intent on doing mainly paediatrics and obstetrics and gynaecology, but decided to experience some general medicine as well. It was possibly one our best decisions. The consultant on the medical ward was very knowledgeable and keen on teaching, but also keen on enabling us. Through the guidance of Dr. Kiwelu we were able to start by using our clinical skills to recognise signs and diagnose patients. Slowly over a couple of weeks were able to step up our responsibility, first making management plans and discussing them, then learning to tailor these plans to the medicines available in Tanzania. Eventually, in our final week of placement at Huruma Hospital, we were leading ward round, with a doctor or nurse as our translator and us making all the important decisions.

The 6 weeks at Huruma Hospital were a difficult journey at times. In one of our first weeks, we came across a young man who was very unwell. We recognised he was unwell, but there was a lack of urgency from the staff on the ward. We were trying to get him oxygen, antibiotics and a few investigations, however we were being told we were over-reacting and that he was not as ill as we thought he was. To appease the doctors 2 stayed with the patient, while one continued on ward round. The two that stayed to look after the patient attempted to get fluids, oxygen, antibiotics, and investigations. When we were eventually moved from the ward we had to accept that we had put a plan in place and hope that we would get some answers. When we came back for ward round the next day none of our investigations had been carried out and he was still without oxygen and fluids, we eventually pushed and got some fluids and antibiotics. Unfortunately the patient passed away later that day. We found that too little was happening too late for many patients. There was a lack of urgency in acute care, which after several weeks we realised was down to the lack of resources in the acute medicine setting. It was found that once a patient was dying, there was not much they could do, so people would accept that a patient was dying and leave them to pass away. This mentality will stay with me for quite a while, and I am glad to be returning to practice medicine in the UK where we have the capability of caring for the acutely unwell patients.