Charlie Marriott

Barts & the London SMD

ELECTIVE REPORT

Kilimatinde Hospital. Tanzania
Monday 7th April to Thursday 8th May (including weekends)

1. What is the provision for women's healthcare in rural Tanzania – an extremely resource poor setting – and what are the barriers to accessing services? In particular, I hope to understand the difference in all stages of maternal care (ante-, peri- and post-natal) between a developing country and that provided by the NHS in the UK?

Access to healthcare in Tanzania depends largely on location (rural versus urban settings) and financial standing. Patients must pay for treatment, although this is often subsidised either by the government, or charity in hospitals run by the latter. Certain healthcare provision is available free at the point of access: ante-natal care, childhood vaccinations and HIV/AIDS monitoring and treatment. There is no primary care provision beyond the outpatient's clinic at hospital. Many attempt self treatment with products bought from pharmacies (usually without prescription) or with traditional medicine.

Tanzania is in some aspects a progressive African nation in terms of women's rights and quality of life: education is compulsory up to the age of 15 (although not always achieved) and at least 30% of any one party's seats in parliament must be occupied by women. Life expectancy in Tanzania at birth for women is 60.5 (WHO country data, 2011). Many markers of women's health and well-being however remain relatively poor. Maternal mortality per 100,000 live births is 460 (UNICEF report) and women in Tanzania have a lifetime risk of dying in pregnancy and childbirth of 1 in 38. Three critical factors contribute to this high rate of death: delays in seeking access to medical care, inadequate transportation and delays due to poor staffing and resources at healthcare settings. Women in isolated rural locations are particularly likely to be exposed to these risks.

Certainly in the area served by Kilimatinde, women present very late for medical and antenatal care. Some families also find it difficult to afford treatment and so attempt self treatment at home. Four children died in hospital from severe malaria during my elective period. It is possible that earlier presentation may have prevented these deaths.

As mentioned previously, the standard and availability of healthcare in Tanzania is highly dependent on a woman's financial status and location. Nowhere is this more apparent than in antenatal care. While affluent women in urban settings such as Dar Es Salaam can expect much the same standard of treatment as us in the West, there are pockets of women across the country who have no access to antenatal surveillance. Either location or access to funding for transport precludes them from accessing any of the services available. Kilimatinde Hospital, for example, runs medical safaris to take clinical and nursing staff to visit women in their villages. Here basic checks such as symphysis-fundal

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height and fetal heart rate (via fetoscope) are about all that can be managed. For women who are able to present to hospital however I was actually very impressed by the standard of antenatal care. Women undergo much the same battery of testing as at home: Hb, blood group, HIV status (including the women's partner) and urine screening. The main difference here unfortunately is the lack of routine ultrasound.

Perinatal care has been the part of my experience here at Kilimatinde which has shown the most marked differences between here and the UK in the standard of care available. In summary, little equipment is on hand, no pain relief is available and labour is often prolonged. Caeserean sections are done here but much later than would be performed in the UK, although the indications are identical. Despite all of this, there have been no maternal deaths during my time, no major morbidity (e.g PPH or fistulae) and the only neonatal death of which I am aware was probably not preventable - a uterine rupture through previous lower segment scar with late presentation. I think care had improved and death rates declined since certain measures such as active management of the third stage and neonatal resuscitation training have been introduced.

One thing I was shocked to see was episiotomies being performed without local anaesthetic, especially since it is always given post labour for suturing. Several women I saw who had been bravely silent during the rest of labour screamed when this was carried out. When I enquired about the lack of anaesthetic the response was that sometimes an episiotomy is performed in an emergency and there isn't always time. At labours I've attended since I have tried to encourage the staff to introduce lignocaine prior to making incisions if an episiotomy is looking likely.
Describe the difference in management of expectant mothers with infectious diseases where little diagnostic equipment is available.

2. Describe what types of health services are available to women in rural Tanzania. How do women access them? Which are the most frequently used? Which are not and why? How does this differ from the UK? If possible I would also like to investigate how this differs from urban Tanzania, e.g. Dar Es Salaam.

Besides maternity care, there is very little specialist health services available to women in this part of rural Tanzania. Most women present to hospital with the same conditions as men and children: malaria, diarrhoeal disease and trauma. Women also commonly suffer from anaemia, due to repeated malaria infection and poor nutrition. Treament with iron supplementation can be obtained from the pharamacy. In extreme cases, blood transfusion is used. The transfusion service has been in place in Kilimatinde for just over a year. Prior to its introduction, the only blood products on offer were those donated by relatives and cross matched.

Women can however obtain contraception free of charge at Kilimatinde and is strongly encouraged by staff at the hospital. There remains a great deal of pressure on women to have large families but for those willing and able, family planning is obtainable. Many women opt for the Depot injection as it does not require daily pill administration and is not affected by concurrent illness.

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Other services that we would consider standard in the UK such as cervical cancer screening and sexually transmitted infection testing are not present. In addition, women do not have any access to a regular physician for general health check-up such as weight, blood pressure or assessment for chronic disease. Usually, healthcare is only sought in the face of acute illness. It should be mentioned however that the incidence of chronic age related disease such as diabetes, hypertension and heart disease is very low. The few cases that I have seen here – including two instances of congestive cardiac failure – have been end stage. There is little awareness that patients are unlikely to show much improvement and that medicines must be taken long term. Counselling patients is difficult even without the added challenge of the language barrier.

3. Describe the difference in management of expectant mothers with infectious diseases where little diagnostic equipment is available.

By far the most common infectious disease during pregnancy here is malaria. One episode of malaria carries a high risk of miscarriage: over one in three during the first trimester. Even if pregnancy is not terminated, the infection can further complicate pregnancy through maternal anaemia, fetal infection, low birth weight and preterm labour.

Diagnosis of malaria is an area of expertise at Kilimatinde. Anyone presenting to hospital with a fever is automatically screened for the infection with the Malaria Rapid Diagnostic Test that screens for the malaria antigen. Blood films for the parasite are also readily available.

Beyond malaria, diagnostics are limited to basic blood and microbial investigations: urinanalysis, full blood count, sputum and stool microscopy. There is no culture available. Most women are treated empirically with the antibiotics accessible and supportive care.

4. Improve my clinical skills and judgement in history taking, examination and diagnosis, especially with regard to maternal healthcare. Assuming I do ultimately pursue a career in women's health, I would at some point like to work for a charity or NHGO in a resource poor setting. I expect that this elective would be good preparation for this kind of project.

I hope that this elective has improved my clinical skills, certainly in terms of examination. History taking was challenging as the majority of patients spoke no English and my consultations required staff to act as translators, who themselves have varying degrees of capability. The opportunities to better my practical skills however have been numerous. I delivered my first baby in my first week on maternity and have done many per vaginum examinations during labour. Even my knowledge of basic procedures such as abdominal examination to detect fetal lie and presentation has improved through practice. I am also now reasonably competent with a fetoscope. Overall I feel better

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placed to deal both with labour in the UK and in resource poor settings should I choose to do further work in the future.

In conclusion, the elective has been nothing short of eye opening. I couldn't have imagined before I came just how different it would be and I very much hope it has improved me both as a clinician and as an individual. I would like to thank Dr Uggi and everyone at Kilimatinde for making us feel so very welcome here and we hope we have been of some use during our stay.