ELECTIVE (SSC5b) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

For my elective, I chose to visit Kilimatinde and Mayoni hospital, situated in the Singida region of Tanzania. I wanted to experience healthcare from a different perspective and understand how both culture and environmental pressures influenced the provision of healthcare, specifically the influence these factors had on obstetric care and choices for women.

Within the maternity ward at Kilimatinde there were separate areas for antenatal and postnatal care with a separate room for labouring mothers. C -sections were carried out in the operating theatre. In addition to attending ward rounds and antenatal clinics, I was able to accompany the midwives and doctors on a medical safari, where vital antenatal and paediatric care was offered to tribes in rural areas. During these visits, malaria and HIV blood tests were offered to all members of the tribes, particularly expectant mothers. These testing regimes allow for improved control over the spread of bloodborne diseases, and allow for a quicker intervention with antiretroviral therapy following the child's birth, with the aim of reducing mortality rates and vertical transmission. The outcomes of these tests were recorded on a double sided piece of paper; the antenatal book. This meant that mothers were able to keep records of their antenatal care, and served as a way to also record the child's vaccinations and growth.

Back on the postnatal wards, the prevalence of HIV in pregnant women was actually lower than I had originally expected, we only encountered a couple of women every few weeks who had tested positive. This was surprising, given the attitudes to sex and condoms which we had seen; we were told by doctors that men preferred not to use condoms, and would often have multiple wives. I also found out that many women have children with different fathers and in general, sexual education was almost non-existent. However, antiretroviral therapy was offered free of charge to anyone who needed it. Pregnant women presenting with HIV + status were offered ART in an attempt to bring down their viral load, to try to both reduce vertical transmission and prevent post c-section sepsis (very common in HIV patients). Babies born to HIV+ mothers were started on ART immediately after birth for 8 weeks. We were told that in low risk cases (patients with a high CD4 count or low viral load) this was 100% preventative, but in high risk cases the rate of prevention was lower. As breastfeeding here is the best way for a baby to get their nutrition, mothers with HIV would breast feed their babies as often they have no other choice. I only witnessed two severe complications of HIV in mothers, one was a woman with untreated HIV who had developed cerebral complications, causing her to enter a mute state, and another woman who was experiencing wound infections and dehiscence post c-section.

There are different levels of hospital provision within Tanzania, some state funded and some private. Manyoni hospital has a higher level of government support as a district hospital, and therefore the services are subsidised. At kilimatinde, all tests, imaging, medication and ward admission had to be paid for. Previously the hospital was better funded and provided these services for free, but the government redirected money into larger district hospitals and so the smaller village hospitals had to start charging for services. Often patients were unable to pay for treatment. Healthcare for pregnant women and children under 5 was free. Within Kilimatinde and Manyoni, GPs were largely replaced by outpatient care within the hospitals. Patients needing follow up, new case presentations and those requiring medication would all visit the doctor at the hospital, and from there it would be decided if they needed admission or if they

could be sent home. This also functioned as the emergency department. The three doctors working at kilimatinde worked at all hours of the day, coming in when patients presented. Many patients were lost to follow up, and often they presented very late, with extreme signs and very unwell. Both hospitals seemed to run in a similar manner, treating who and what they could and referring what they couldn't onto the city hospitals. There didn't seem to be an appointment system, patients would just show up on the day and be seen by a nurse and doctor. This led to long waiting times for patients, especially when the specialists from the bigger city hospitals came to visit.

Antenatal care was sparse compared to the UK. Some pregnant mothers would be tested for HIV, malaria and anaemia throughout gestation, with very few coming in for scans or check ups. Very few women were able to tell you how many weeks along they were. In rural regions, such as Dabia, the mothers would receive monthly abdominal examinations from the flying doctors and would be offered folic acid or iron supplements. This low level of antenatal care meant that we often saw cases of birth defects and stillborn babies that were not picked up on antenatal scans, and mothers often required blood transfusions due to anaemia following childbirth. The most interesting cultural difference in regard to antenatal care was the decision of the pregnant mothers to eat termite soil to promote fertility and foetal health, in lieu of taking the iron supplements. In Kilimatinde, pregnant mothers would stay in the maternity unit for up to 1 month before giving birth, as many women travel from far away to avoid giving birth at home or on the roadside. Tribal women would often opt to have their babies at home supported by wise women. Most women chose to give birth naturally; c sections were only done in case of emergency. When done, they were done with vertical incision to aid in quick birthing of the baby and the only anaesthetic available was ketamine. One tribe, the Kuri tribe, will never have a c-section or even an episiotomy in case of obstructed labour, as this is seen as weak. During labour, no one except the mother and the midwives are allowed into the birthing room. Interestingly I saw no husbands around the maternity ward at all, compounding the idea that husbands do not play a big role in child raising, instead working to provide for the family. Women who had given birth at the hospital would stay in the hospital for 24 hours or 7 days for natural births and c-sections respectively. Each day, the health of the mama and baby would be checked, including uterine tone, any wounds, presence of lochia and availability of breast milk. There was no NICU ward and the babies were wrapped in kitenge and on the mothers beds.

During my time at kilimatinde, there were only a couple of burns patients within the burns unit, and by my second day there they had been discharged which meant I was unable to get involved in their treatment. I was however able to learn about their unique way of managing burns; banana leaf. As banana leaf is abundant here in Singida, it is a unique problem to the ever present problem of resource scarcity. By stripping and sterilising the leaves, they are able to utilise them as cheap and effective wound dressings. The banana leaves offered a wide range of benefits, from anti-inflammatory properties to possessing a soothing ability and promoting skin healing, allowing the hospital to successfully treat burns at a low cost.