OBS + GYNAE

Elective Report: San Ignacio Community Hospital, Belize

Shahbaz Singh Kang

Ha06239@qmul.ac.uk

Dates: 9/4/2012-15/5/2012

Supervisor: Dr Guillermo Rivas, Bishop Martin Drive, San Ignacio, Cayo District, Belize

Objectives:

1. What are the prevalent obstetric complications in Belize? How do they differ from the UK?
2. Outline how labour is monitored and managed in Belize. How does this differ from the UK?
3. How does the prescribing medications in Belize compare to that in the UK. Are drugs prescribed safely?
4. How does the delivery of clinical medicine vary differ to that in the UK? Is there any difference in how doctors communicate amongst themselves and with their patients?

1. Belize is an island of just over 300,000 people. Roughly 40% of people live in poverty. In 2005, 134 out of 10000 mothers died, with eclampsia responsible for almost two-thirds of such deaths. Eclampsia is the most prevalent obstetric complication in Belize, whereas in the UK it affects roughly 0.05% of pregnancies. During my time with Dr Rivas, I witnessed how hypertension in pregnancy was treated to tackle the problem of eclampsia early on. Patients are given anti-hypertensive medication early, as a prophylactic measure for the development of such complications. Labetalol was prescribed to patients, as it would be here. Furthermore, the patients' blood pressure was constantly being monitored and such patients were admitted immediately for continual observation.

   Postpartum haemorrhage is also a commonly experience complication in pregnancy. Whilst at San Ignacio, I have noticed that mothers aren't given Vitamin K injections, as they do in the UK. As healthcare is free in the region, lack of funding is probably why this was not offered and would explain why Postpartum Haemorrhages are more common in Belize.

   Another problem in Belize is the rate of HIV. In some areas of Belize, the rate of HIV is as high as 8% of the population. Therefore, pregnancies affected by mothers infected with HIV are relatively common. Whilst at San Ignacio community hospital, measures similar to those in the UK were taken. Mothers are provided with anti-retroviral treatment and were recommended to undergo elective C-sections, in order to reduce vertical transmission of HIV to their babies. However, owing to the

economical situation, such treatment regimes could not be provided to every single patient.

2. Whilst on the placement, I was fortunate enough to see how patients are managed on the labour department of the hospital. There was a vast difference in the level and regularity of care at San Ignacio hospital. In the UK, each mother has a midwife in charge of her care specifically. However, in Belize, there was only one midwife in the evening responsible for the ward. Fortunately, owing to the fact that San Ignacio is a small town with not many patients, she was not overrun with tasks whilst I was there, however she informed myself of situations where there has been too much to do.

   Despite the shortage of staff, the methods used to monitor mothers in labour are still similar to the UK. CTG monitoring of patients is utilised in the hospital, with mothers with high risk pregnancies were monitored more regularly. With regards to the patients with HIV, San Ignacio hospital did not have the services to provide them with the C-sections that they required; such patients were sent to the Belmopan hospital, over half an hour away.

3. At San Ignacio, I witnessed how medications were prescribed to patients. It was the duty of the junior doctor to write the medications in a drug chart, as with the UK. However, I observed that the doctors did not look up the medications and check interactions, with as much scrutiny as it is done in the UK. The drugs themselves are generally the same and are used in the same circumstances, as we do in the UK. The nurses administer the medications to the patients, with the senior doctors checking on the ward round and applying what changes are needed. I was not able to find or speak to the pharmacist at the hospital, in order to discuss their roles and the protocols of that hospital. Subsequently, I could not comment on how safely medications are prescribed and how common prescribing errors were.

4. Clinical medicine in Belize is not too dissimilar to that in the UK. Similar structures and frameworks are in place in Belize, as with the UK. Obviously, the amount of money involved in the healthcare system is far less in Belize and thus resources are limited. However, the multidisciplinary team and respect that professionals have for each other still rings true. All the staff at San Ignacio hospital were amicable with one another and were very effective at communicating with their patients. The level of communication between doctors and patients was not as extensive in the UK and patients did not seek to know as much about their healthcare as we do in the UK.

   Certain resources were also limited too. Whilst at the hospital, I spent some time working in the emergency room. One case that I remember was in the emergency department. One gentleman came in following a car accident and his head went through the windscreen. He came to have his wound sutured. I noticed that the

instruments were not sterile and suture kits came wrapped in cloth, as they could not afford sterile kits. Despite the obvious lack of funding, this did not affect the attitude and respect that the doctors and patients shared with each other.

In reflecting upon my time in Belize, I would like to sincerely thank Dr Rivas and his team and all the other doctors for this fantastic opportunity and the chance to observe how medicine is practiced in a completely different environment to London.