

Global perspective Experiences as a UK trainee in the developing world

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Indonesia is a developing country with high levels of poverty and deprivation. There is a shortage of skilled birth attendants and in spite of some progress in reproductive health programmes in the last decade maternal mortality rates remain high. After taking up an RCOG/VSO fellowship I went to practise as an obstetrician/gynaecologist and medical trainer on a small island in Indonesia for a year. This article is an account of the challenges and rewards of this experience.

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Introduction

In February 2005 I returned from a one-year RCOG/Voluntary Service Overseas (VSO) fellowship. I was placed as an obstetrician/gynaecologist and medical trainer on the island of Sumba in eastern Indonesia at Rumah Sakit Umum Daerah Waikabubak (the public hospital).

Indonesia is a vast and heterogeneous country, comprising 17 500 islands inhabited by approximately 210 million people from 300 different ethnic groups. The country's 1997 economic crisis and negative economic growth have led to a growing disparity in wealth and access to services, along with rapid urbanisation over the last decade. In 2000 almost 50 million people, mostly in rural areas, were living below the official poverty line.¹ These economic circumstances, in addition to the levels of education and employment and the social structure in which people live, not only affect, but are affected by, their reproductive health.

Provision for obstetric care

Despite some progress in reproductive health programmes in the last decade, maternal mortality remains high at 307 per 100 000 live births.¹ The Government of Indonesia has targeted the four 'toos' that increase the risk of maternal mortality:²

- too young (less than 20 years of age)
- too old (over 35 years of age)
- too often (birth spacing of less than 24 months)
- too many (more than three children).

One or more of these factors is associated with 65% of pregnancies. Malnutrition affects 21.2% of women of reproductive age. As a consequence of this and endemic malaria, anaemia affects 51% of pregnant and 45% of postpartum women.² The number of births attended by a skilled provider is low (5% by doctors and 50% by midwives).¹ Traditional birth attendants known as 'dukuns' conduct 32% of deliveries. Some non-governmental organisations (NGOs) run projects to improve liaison between dukuns and village midwives but otherwise dukuns receive little or no formal training and do not form part of the Indonesian Government's strategic plan for reproductive health. Access to emergency obstetric care is limited by availability of qualified and competent providers. At least 30% of district hospitals do not have an obstetrician/gynaecologist² and 50% of villages do not have a village midwife.

These figures fail to demonstrate the dramatic regional variation between provinces on the relatively wealthy islands of Java and Bali and provinces on other islands.³ Sumba is a remote and extremely disadvantaged island with a population of 500 000. The island is linked to its neighbours by a twice-weekly plane and a weekly ferry (**Figure 1**). There are few medical staff: 0.9 specialist doctors and 3.0 midwives per 100 000 people (compared with 17.0 specialists and 23.0 midwives per 100 000 people in Jakarta).³ Doctors are discouraged from practising on the island by inadequate facilities, such as a lack of running water,⁴ and by better economic opportunities on other islands. In addition, the lack

Figure 1
The island of Sumba, Indonesia



of transport infrastructure and the poverty of the population mean that even where medical facilities do exist they are often inaccessible, particularly when complications occur, as the majority of women labour in their own homes (Figure 2).

The Government is trying to accelerate a reduction in maternal mortality by training village midwives to offer emergency obstetric care. The one year programme covers treatment of anaemia, management of normal labour, initial management

training. Once I arrived in Indonesia I spent six weeks learning the Indonesian language. Only a handful of people on Sumba speak English and I was expected to work and train in Indonesian. The VSO Indonesia staff based in Bali supported me. The RCOG provided a UK and Indonesian mentor but, given the communication situation on Sumba, I had virtually no contact with either.

My role as a volunteer was to work within the Government's initiatives and within VSO



Figure 2
A typical Sumban village

of eclampsia, suturing of the lower genital tract, treatment of haemorrhage by manual removal of placenta and bimanual compression, resuscitation in shock, treatment of sepsis and care of newborns, including basic neonatal resuscitation. Midwives are supported by generalist doctors in community health centres ('puskesmas') who are trained in basic obstetric emergency care. The Government plan also includes providing comprehensive emergency obstetric care in every district hospital by a fully trained obstetrician/gynaecologist. The antenatal initiative involves free provision of four antenatal visits, 90 iron tablets and two doses of tetanus toxoid to all pregnant women in a local monthly health clinic run by the village midwife.

Working as a volunteer in the developing world

Before leaving the UK I attended VSO residential courses in Birmingham covering issues such as adapting to life in isolated communities in developing countries, working in resource-poor environments and facilitating participatory

Indonesia's strategic plan to try and improve the reproductive health for women in West Sumba. Work has been carried out by VSO in the Waikabubak area for several years. Previous VSO volunteers in the hospital included a nutritionist and a nurse. While I was there a volunteer midwife from London was working 35 km away upgrading the skills of the village midwives in that community. VSO's preferred method of working is to use participatory techniques. The aim is to ensure that any intervention by the volunteer derives from the needs of the community and is, therefore, more likely to be successful and sustainable.

My counterparts (the only other obstetricians/gynaecologists on the island) were senior trainees from Bali sent for six to eight weeks on rotation. I quickly realised that, while working with these doctors was interesting and rewarding, they would all leave the island at the end of their rotation and return to practise in Bali. As a consequence I worked mainly with the hospital midwives, who

were permanent residents. They had no access to any continuing professional development as there was no bookshop on the island, no public access to the Internet and no culture of lifelong learning.

I started a nursing and midwifery library with my nursing colleague which contained donated books and materials. Using these resources helped the midwives participate in training (Figure 3). We generated a set of labour ward protocols and patient information materials and upgraded their skills, especially in emergency care. We introduced the use of the partograph for monitoring and recording of events in labour.⁵ We focused particularly on breastfeeding and tried to adhere to

Figure 3
Workshop for midwives on using the partograph



Figure 4
Colleagues at the hospital



the World Health Organization's 'Ten steps to successful breastfeeding'.⁶ I built strong relationships with my colleagues and it was extremely rewarding to influence and improve practice and empower these women (Figure 4). The hospital was regularly inspected by the local regional health inspectors and after the improvements in breastfeeding practice and the introduction of clinical protocols the hospital was judged the best in eastern Indonesia for maternal and child health.⁷

Culture and other challenges

My most significant challenge was learning to work in another language and within another culture. I found that, while I could contribute, I could not and had no right to change the culture of the island.

It was hard to accept a sense of powerlessness in the face of problems outside my control. I found it inexplicable that women would walk for a day to the hospital and subject their children to a vitamin A injection with a second-hand needle while ignoring the vitamin A-rich papayas dropping off the trees and rotting on the ground. It was heartbreaking when a family refused consent for a lifesaving caesarean section on the grounds that if they spent the money and the woman died anyway they would be unable to pay for the necessary and culturally extremely important funeral. Childlessness is socially unacceptable and seen as a sign of failure on the part of the woman. I will never forget the look of desperation in the eyes of a woman who came to the clinic when I questioned the safety and efficacy of her continuing with her prescription of clomifene, which she had taken continuously for five years. Prescriptions are seen as a vital part of any consultation and patients feel cheated and dissatisfied if they leave without one. I learned to try and find the reason behind a practice I didn't understand before assuming it was wrong. I had a tiny glimpse into how difficult it must be for overseas trained doctors starting off in the UK National Health Service.

I also found myself working outside the usual job description of an obstetrician/gynaecologist. I cleaned over 2000 viruses from the hospital's three computers, wrote a hospital formulary in Indonesian, ran a training session on the use of a donated defibrillator and was the official photographer for the hospital's marching team at the Independence Day celebrations.

My time in Indonesia gave me experiences in obstetrics and gynaecology I could never have had in the UK. It changed my way of thinking and challenged my personal and professional resources. I would recommend it wholeheartedly. Further details for prospective RCOG/VSO fellows are available on the RCOG and VSO websites.^{8,9}

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