Taking the family to East Timor

Carolyn L Beckett

How did I come to be in East Timor? That is the exact question I asked myself upon arriving in Dili, the national capital, with my husband Ben, our 2-year-old son Oscar and 6-month-old daughter Chloe in tow. It was very hot and humid and there was a real threat of a looming dengue epidemic from Indonesia. My anxiety for the health of our children was in no way eased when, a few days after our arrival, an Australian expatriate asked, "What sort of a place is this to bring kids?".

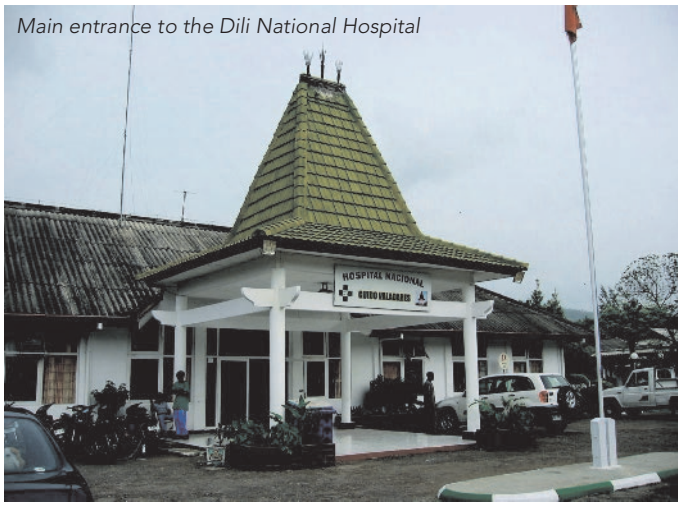
I had been aware of a program coordinated by Eugene Athan, an infectious diseases physician, whereby Australian physicians could work at the Dili National Hospital. As an infectious diseases physician with an interest in medicine in developing countries, and having been assured of the political stability of the country, I put up my hand to go. Ben was able to take time off work to care for our children. After many months of planning, multiple vaccinations, and reassuring family and friends of our safety and wellbeing, we arrived in Dili in late January 2004.

The Dili National Hospital is run by the East Timor Ministry of Health. The hospital medical staff consists of overseas visiting specialists, Indonesian emergency department doctors, and Timorese resident doctors working on the wards and in the outpatient department. There are no locally trained specialists — a major limitation to the long-term goal of having an autonomous Timorese hospital.

I worked on the women's medical ward for 2 months. While not arduous, the work was emotionally draining. In my first week, there were three postpartum deaths due to presumed sepsis. Like anyone, I found this difficult to deal with, but being there with my family, and still breastfeeding Chloe, made it even harder. My emotions were fuelled by the thought that one family now consisted of a husband without a wife, and four kids without a mum. The harsh reality of the estimated maternal mortality in Timor (around 800 per 100 000 live births) is that this family circumstance is not uncommon.

Despite Portuguese being the official language, the majority of Timorese people speak either Tetum, Indonesian, or one of 16 indigenous languages. As my Tetum capabilities were limited to pleasantries, I relied heavily on certain hospital staff to interpret for me. Needless to say, taking an adequate history and communicating with the patients and hospital staff proved to be a challenge — like a combination of charades and Pictionary. The language barrier became even more difficult towards the end of my stint, when a Chinese medical team arrived that included doctors, a nurse and a translator. They had spent 6 months learning Portuguese, which, despite the best of intentions, was of no practical use to the majority of people at the hospital.

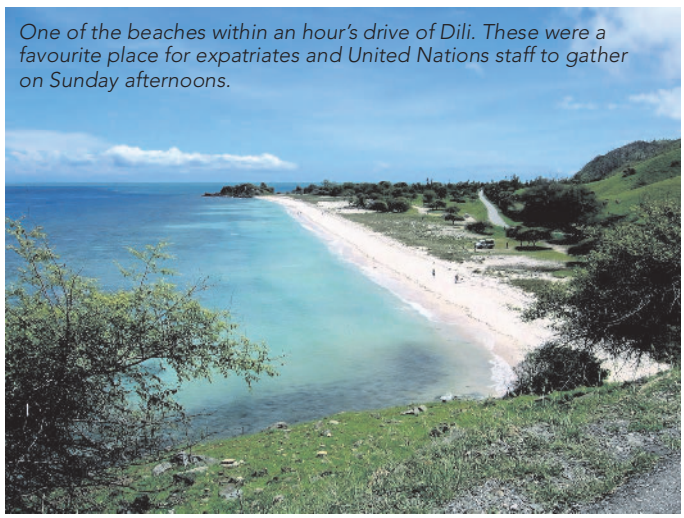
The hospital was serviced by hospital and national laboratories that performed basic testing, which was intermittently available and of variable standard. Malaria films were regularly performed, with frequent positive results. Biochemical tests, including tests for urea and creatinine, were not available during my stay. Minimal microbiological investigations (including tuberculosis smears, and serology for HIV, hepatitis B, hepatitis C and syphilis) were available. Pathology specimens were sent to Australia, with a 6–8-week turnaround time. The major medical problems I encountered at the hospital included tuberculosis, malaria, renal failure, heart failure, thyroid disease and hypertension. As all patients had varying degrees of malnutrition, I kept them in hospital for as long as possible, knowing that the hospital would provide nutritious meals.



Main entrance to the Dili National Hospital

Of concern was the lack of a single positive sputum smear test for acid-fast bacilli during my stay. For whatever reason (be it deficiencies in collection, transport, processing, laboratory technique or reporting), all sputum smears were negative. Aware that this could not be accurate, I introduced antituberculosis therapies in patients for whom there was a high suspicion of tuberculosis based on clinical features and x-ray results. Of greater public health concern was the lack of mycobacterial culture and sensitivity testing facilities. A national tuberculosis control program has been established to monitor patients during treatment, but some patients did not complete their therapy and it is unclear whether drug resistance is a problem.

It was hard to believe we were only a 1½-hour flight away from Australia. Drug therapy options were limited to an essential drug list; however, even these, at times, were unavailable. Although we



One of the beaches within an hour's drive of Dili. These were a favourite place for expatriates and United Nations staff to gather on Sunday afternoons.

Infectious Diseases Department, Box Hill Hospital, Box Hill, VIC.
Carolyn L Beckett, MB BS(Hons), FRACP, Infectious Diseases Physician.
Reprints will not be available from the author. Correspondence: Dr Carolyn L Beckett, Infectious Diseases Department, Box Hill Hospital, Nelson Road, Box Hill, VIC 3128. Carolyn.Beckett@boxhill.org.au

had previously worked in Africa, we found it difficult to comprehend that the national hospital of one of Australia's close neighbours could have such limited resources.

Despite their many hardships and difficulties, I was touched by the loving nature and strong sense of family among the Timorese people. They were very receptive to us as a family, but we certainly raised some eyebrows. For starters, I was working while Ben stayed at home with the kids, which many locals found amusing! Ben spent most of the time fighting off malaria and dengue-carrying mosquitoes and keeping the kids and himself cool by whatever means, including a staple diet of ice-cream for the kids and beer for himself. During weekends off, we were able to hire a car and explore many beautiful parts of the country.

Having spent only a short period of time at the Dili hospital, I was grateful for the welcome I received and the warmth of the hospital staff. Upon leaving, I felt I had contributed to the health of my patients, and yet had a deep sense of sadness because it seemed that the healthcare system may worsen before it improves.

So, were we foolish to take our kids to Timor? On the contrary — we believe that we took them to a place full of caring, loving and welcoming people who deserve the chance to live a better life. ❑

A two-year placement in the Solomon Islands

Rosalie Schultz

I wanted to work somewhere exotic, experience a different lifestyle and contribute to health advancement in a developing country. So I was delighted when Australian Volunteers International offered both me and my partner, also a doctor, a 2-year placement (February 2002 to February 2004) in Makira Province, previously the Eastern Solomon Islands.

Life in the Solomon Islands

The Solomon Islands have a subsistence agricultural economy. Of a population of 450 000, 85% live self-sufficient lifestyles involving small-scale farming, fishing, fetching water, cooking on wood fires, building and weaving. Outside events, even major ones like terrorist attacks, seem far away.

Life on fertile volcanic soil surrounded by the Pacific Ocean maintains Solomon Islanders in good health. They work hard physically and enjoy a diet rich in fruit, vegetables and fish. However, they increasingly seek to supplement their traditional diet with rice, flour, canned meats and instant noodles.

Healthcare in Makira Province

The major causes of death in the Solomon Islands are infectious diseases and perinatal conditions.[1,2] HIV/AIDS has not yet had a significant impact there.[1]

Makira Province, with 33 000 people, had no doctor working either when we arrived or when we left. Kirakira, the provincial capital, has a small hospital with 86 beds — plenty for patients, with spare beds for relatives. Coping with the hospital's unreliable medication supply was a challenge — sometimes it was well resourced, while at other times we struggled to manage, using the most suitable medication available at the time. People suffered for want of paracetamol, and died for want of oxygen. Nurses helped us manage patients with malaria, tuberculosis and congenital syphilis, as they knew more about managing these conditions than we did. The most common diagnoses of the 2322 patients admitted during our stay are shown in the Box. There is a national referral hospital in the capital, Honiara, where we could refer patients we were unable to manage in Kirakira.

Common diagnoses of patients admitted to Kirakira Hospital (excluding admissions for childbirth), Jan 2002–Dec 2003

Discharge diagnosis*	Infants	Children 1–5 years	Children 5–15 years	Adults	Total
Malaria	45	77	81	336	539
Skin infections, abscesses, cellulitis, carbuncles, impetigo	12	37	32	129	210
Trauma	0	9	37	82	128
Pneumonia	48	29	9	27	113
Gastroenteritis	11	17	0	13	41
Osteomyelitis, pyomyositis, septic arthritis	0	3	13	21	37
Tuberculosis	2	1	3	17	23
Cancer	1	0	0	19	20

* Not mutually exclusive.

Together with specialist eye, reproductive health and tuberculosis/leprosy nurses, I established a program of touring the 34 clinics in the province to provide support to clinic staff and treat patients. Most clinics are in coastal villages, accessible by aluminium dinghy and outboard motor. As the villages may see no shipping for months, people must be totally self-sufficient. Clinic nurses manage most cases of malaria, pneumonia and gastroenteritis that are not managed at home. Under national policy, every village should be within 3 hours' walk of a clinic, but the country's economic situation has not enabled this policy to be fully implemented. Nevertheless, the patients I saw while touring were in remarkably good health. Common referrals to me were for back pain, hip pain, and dysmenorrhoea. It was difficult to advise the staff in the clinics

Centre for Disease Control, Northern Territory Department of Health and Community Services, Alice Springs, NT.
Rosalie Schultz, MB BS, MPH, Coordinator.
Reprints will not be available from the author. Correspondence: Dr Rosalie Schultz, Centre for Disease Control, Northern Territory Department of Health and Community Services, PO Box 721, Alice Springs, NT 0871. rosalie.schultz@nt.gov.au

that had no supplies and no means to transport patients. Australia is currently funding the purchase of solar-powered two-way radios for each clinic (radios must be solar-powered because supplies of consumables are unreliable).

Trauma and related infections

Skin and soft tissue infections, abscesses, joint and bone infections, and pyomyositis were common in Makira. These infections may be occupational hazards of subsistence farming, but young children and even neonates were affected. We drained copious amounts of pus under ketamine anaesthesia, but, unfortunately, we often had no suitable antibiotic treatment. We treated many cases, including osteomyelitis and septic arthritis, with oral doxycycline, erythromycin or chloramphenicol.

There were about 12 motor vehicles in Kirakira, and the first-ever motor vehicle accident happened during our stay. A passenger in a utility tray was crushed against another vehicle. He fractured seven ribs on one side and nine on the other. We had no intercostal catheters to manage the haemopneumothorax, no intubation facilities, and no resources to evacuate him. Yet, amazingly, he survived with analgesia, oxygen, intravenous fluids and basic physiotherapy ("Hold your chest and blow hard!"). His high level of physical fitness, as a subsistence farmer, most likely saved his life.

Non-communicable diseases

Non-communicable diet- and lifestyle-related diseases that are major causes of morbidity and mortality in Australia are only beginning to reach rural Solomon Islanders. We saw mouth cancers among betel-nut chewers, and liver and cervical cancers. Diabetes manifests with peripheral vascular disease, and hypertension with stroke. No myocardial ischaemia was diagnosed during our stay.

Challenges and rewards

The general standard of health and health services, despite the country's economic difficulties, highlights the fine personal qualities of the people. Nurses continued working during periods when they were not paid. I recall one nurse who visited the hospital on a day when she was off duty. Noting that no nurses were working, she went home, put on her uniform, and returned to cover the day's shift.

The village of Gupuna, Ugi Island, farewells our touring team.

As there was no stationery provided for health services, people carried exercise books for their health records. Patient-held records provide continuity of care from village health workers to visiting overseas specialists, and also give patients ready access to the information.[3]

We spent a memorable 2 years in the Solomon Islands, proving to me that overseas volunteer work is enriching and rewarding. It provides an opportunity to support colleagues in countries where healthcare staff are difficult to recruit and retain.

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