Destiny lies in a brown paper bag

Table 1: Comparison of health services and expenditure.

| Country                  | Reference year | Health expenditure as % of GDP | Health expenditure per capita $US '000 | Doctors per 1000 population (n) | Acute hospital beds per 1000 population (n) |
|--------------------------|----------------|-------------------------------|----------------------------------------|---------------------------------|---------------------------------------------|
| Australia                | 2003           | 9.5                           | 2.9                                    | 2.5                             | 3.6                                         |
| Indonesia                | 2003           | 3.1                           | 0.1                                    | NA                             | NA                                          |
| China                    | No data        | NA                            | NA                                     | NA                             | NA                                          |
| Japan                    | 2003           | 7.9                           | 2.2                                    | 2.0                             | 8.5                                         |
| Papua New Guinea         | 2003           | 3.4                           | 0.1                                    | NA                             | NA                                          |
| United Kingdom           | 2003           | 8.0                           | 2.4                                    | 2.2                             | 3.7                                         |
| United States of America | 2003           | 15.2                          | 5.7                                    | 2.3                             | 2.8                                         |
| Vietnam                  | 2003           | 5.4                           | 0.2                                    | NA                             | NA                                          |

Table 2: Indonesian and English translated words used in O&G scanning.

| Indonesian/English Scanning Instructions |
|------------------------------------------|
| freeze – diam / beku, unfreeze – tidak–diam, again – ulang, good – bagus |
| gel – jel, keep in middle – tengah, slide up – geser atas, slide down – geser bawah, measure – hitung, anterior – anterior, posterior – posterior, transverse – transversal, sagittal – sagittal, cephalic, breech – sungang, boy – laki laki, girl – wanita, pertanyaan – any questions, cervix – servix, fundus – fundus, placenta edge – ujung plasenta, previa – menutupi os, cord insertion – masaknya tali pusar, head – kepala, head circumference – lingkar kepala, falx line – garis kepala, CRL – jarak kepala bokong, spine – tulang belakang, heart – jantung, heart rate – denyut jantung, abdomen – perut, AC – ligkar perut, diaphragm – diafragma, kidney – ginjal, legs – kaki, femur – tulang paha, arms – tangan |

Your birthplace fate or fortune

What a privilege it is to have been born in Australia. My parents are third generation farmers and they and their ancestors lived in a small rural and farming community, Kyogle, on the Queensland and New South Wales border. The town has a fluctuating population. According to the census data from 2006, Kyogle’s population is approximately 4110.1 Kyogle Memorial Hospital, see image 1, was my birthplace in the mid-sixties. Despite the era, the hospital was well equipped with staff, equipment and a maternity ward. The maternity ward and operating suite provided skilled GPs with the resources to deliver babies at the hospital.

The western world has much to be proud about. Australia, when compared to other developed countries is a leader in health care. When we compare Australia’s investment into health care per capita of population and as a proportion of gross domestic product (GDP) (Table 1),2 our nation is the second highest investor in healthcare in the world. Although these data refer to 2003, they are the most current comparative data available and are profound statistics.

Indonesia by comparison

Indonesia invests just 3.1% of GDP. Comparatively, Indonesia has the lowest investment into healthcare of any country in the world. Understandably, in Indonesia, rural and farming communities are not equipped with basic infrastructure, such as a rural and district hospital. Rundown buildings, which were never intended to be used as health clinics, are used to provide basic healthcare to the rural population.

Trained doctors are also in short supply. As the data in Table 1 suggests, in Indonesia, the ratio of doctors per 1000 head of population is zero. However the true merit of this statistic...
can only be appreciated when the population of Indonesia is known. In 2011 the population was 242.3 million. Statistics, viewed through a prism of the total population, provide a sobering insight into the true level of under resourcing of doctors, health care workers and facilities in Indonesia. Moreover, for the Indonesian people, there is little respite from the liability and paralysing effects of these impoverished health care statistics.

Not to be deterred by the impact and tangible outcomes these statistics dictate on a population indiscriminately, these health care workers from the developed world continue to make an investment of their skills, knowledge and expertise into the health care delivery into Indonesian rural and remote communities. The workers are nobly trying to blunt the effects of an impoverished healthcare system on a population.

Ultrasound skill training in Indonesia

Dr Sue Campbell-Westerway has been teaching ultrasound scanning skills in Indonesia for at least the last 10 years. In February 2012, I accompanied Sue on an ultrasound skills teaching trip and so began the journey of a lifetime.

The purpose of the trip was to teach midwives and female obstetricians ultrasound scanning skills at two clinics in Indonesia. One clinic was located in Ubud and the other in Denpasar.

There was a language barrier to overcome. The full impact of this obstacle did not occur to me, until Sue handed me a list of English/Indonesian words we would need to use in our teaching session the next day. It was the night before our first clinic visit to Bumi Sehat in Ubud. On this evening, it was hot and humid and we were swatting and drinking hibiscus tea, to learn the common Indonesian words used in O&G scanning. We had a lot of fun stumbling over our words and our pronunciation became less stilted, over the course of the evening and during the teaching sessions. These words compiled by Sue, can be seen in Table 2.

The clinical setting – two different birth centres

During the course of our nine days in Bali we visited two contrasting midwifery and birthing centres. The first clinic was the Bumi Sehat birthing clinic at Ubud and the second clinic was based in Denpasar.

Robin Lim, a midwife and clinic director at Bumi Sehat was the winner of the CNN 2011 Hero of the Year Award. This award came with a prize of $US250,000. She plans to use this money to develop a new birthing centre. The plaque Robin Lim received and a CNN promotional image can be seen in Images 2 and 3.

Teaching goals and outcomes

The goals of our teaching classes were straightforward – keep it simple and teach the basics. We wanted to demonstrate in groups; how to survey scan a fetus and uterus, how to establish estimated fetal weight, presentation, amniotic fluid, placental site and fetal heart motion.

When we arrived at the teaching classes, there were pregnant women, waiting with anticipation, in a queue to be scanned. These women had travelled long distances and their babies ranged from 9 weeks to 37 weeks gestational age.

In the queue was a Japanese couple who spoke three languages and were fluent in English. Their previous pregnancy ended poorly with the woman giving birth to a trisomy 18 baby which died shortly after birth. The couple’s current 18-week pregnancy was being closely monitored by obstetricians at a major teaching hospital in Denpasar. The couple had travelled a long distance to the clinic to allow the midwives to practice scanning on their baby – why? Time and time again, we were to observe selflessness, generosity and kindness from the Balinese people and wider community, when they had so little.

However, we would still be scanning long after our clinic was due to finish. The midwives were keen to learn fetal biometry and fetal presentation and placental position. A group would huddle around a small ultrasound monitor and critique caliper...
It was hot in Denpasar. The temperature was at least 35°C. In one small room without ventilation, 10 midwives and obstetricians crowded around a single ultrasound machine to practise scanning. In an attempt to provide some relief from the oppressive heat, one small electric fan blew hot air around the room. Not to be deterred by the heat, patients who had travelled long distances would queue and wait their turn to be scanned by the Muslim midwives and the obstetricians.

**The anecdotal truths**

After the last teaching session in Denpasar, the teaching group shared a jug of heavily sugared iced tea. Drinking from glass jars, the group and some of the pregnant models shared some fascinating insights about midwifery and birthrates in Indonesia. First, the postulated and anecdotal, infant mortality rate beyond the capital cities in Indonesia is very high and exceeds the published statistics. This was attributed to most rural based mothers still giving birth in the fields and villages in Bali where there is currently no detection prior to birth of breech babies or placenta praevia. These pregnancies are destined to end poorly. A further insight gained from this trip was that a caesarean section costs $500 and this is prohibitive to most Indonesian couples. According to a report by the World Bank, 100 million people in Indonesia live on less than $2.00 a day.1

On the last day, the 90-minute return trip from Denpasar to Ubud was tinged with mixed emotion. Our teaching trip had equipped the midwives and obstetricians with skills they fastidiously modelled and competently executed. This was a tangible outcome evident to all in the teaching group. However, if the content of a cathartic group conversation I had been privy to was authentic, much work has yet to be done to improve birthing outcomes in rural and remote areas in Indonesia.

**Fund raising for Bumi Sehat**

In the aftermath of the global financial crisis, fundraising for third world countries and charities is proving to be difficult. At a presentation in October to the North Coast Group meeting of the Country Women’s Association (CWA), where approximately 80 CWA office bearers and local business and government leaders were in attendance, I was able to discuss the goals and objectives of our trip. Subsequent to this presentation, three pledges of money have been made to the Bumi Sehat Clinic. The money was pledged after a presentation that chronicled the social and health care statistics which impact on the Indonesian population. Some of the statistics included in 2011, there was a population of 243.4 million people and a birthrate of 18.1 per 1000.2 The official infant mortality rate in Indonesia in the reference years 2005–10 was 34 deaths per 1000 births, while in Australia the comparable statistic for the same reference period was five deaths per 1000 births.3 These statistics are contingent on all births and deaths being registered with the

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1. Nicholls, P. (2013). Fund raising for Bumi Sehat. *AJUM February 2013 16 (1)*.
2. Nicholls, P. (2013). Fund raising for Bumi Sehat. *AJUM February 2013 16 (1)*.
3. Nicholls, P. (2013). Fund raising for Bumi Sehat. *AJUM February 2013 16 (1)*.
relevant authorities. It is alleged by rural health care workers in Indonesia that babies born in rural and remote communities who die during birth are never registered.

In conclusion

The focus of this article has been to chronicle the skill teaching experiences that we undertook in Indonesia and to share an unique insight into some of the complexities which prey upon an impoverished health care system in a third world country.

There is an undeniable nexus between the fiscal prosperity of a country, fiscal and social justice policies and the prosperity of a health care system.

Our quest was simple, to equip a cohort of health professionals with scanning skills which allow the detection of placenta praevia and babies in breech presentation. With this knowledge, third trimester pregnancies can be managed more efficiently. This knowledge directly assists in the clinical management of pregnancies and deliveries. Notably, the midwives and obstetricians would try to turn breech presentation babies once identified on ultrasound. Likewise, pregnancies which required a caesarean section due to low lying placenta or placenta praevia could be allocated charitable funds donated to the Bumi Sehat Clinic and managed by Robin Lim. Many rural based midwives in Indonesia allege that if you cannot pay for a caesarean section to deliver your baby, you relinquish your baby after birth as payment for the surgery. The baby is then adopted out to a loving and prosperous Indonesian family, who pay for the surgery.

Destiny indeed does lie in a brown paper bag. I now know the significance of a bag which Sue handed to Robin Lim upon our arrival at Bumi Sehat Clinic. I knew the bag contained 5 million Rupiah as I had earlier witnessed the currency exchange of $500.00 Australian dollars. What was the value of this money in a third world country? Enough money to pay for one caesarean section, to save one baby’s life, destiny for one small baby changed. Your birthplace really does denote your fate and fortune.

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5 http://www.ausaid.gov.au/anrep/rep06/s2b.html#f13 (accessed 27/8/12)
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