

Setting up a primary care STI detection and treatment service in Dili, East Timor

East Timor (Timor Leste) is a small half island almost directly north of Darwin, Australia. For many years it was colonised by the Portuguese, who pulled out of the country in 1975. After a brief period of independence the Indonesian army invaded and annexed Timor Leste. Thus began a 25-year rule of terror and repression. It is estimated that about a third of the population died during this time, mostly from famine.

After a UN sponsored referendum the country voted for independence in 1999. The Indonesians withdrew after an orgy of destruction and killing. When the UN peacekeepers finally arrived they found a wrecked country, with no government, health care or justice system. Seventy per cent of the infrastructure had been destroyed and the population was scattered and traumatised. Today, despite huge amounts of foreign investment and aid, Timor remains the poorest country in Asia with a life expectancy of 47 years and high rates of infant and maternal mortality.

Dr Dan Murphy, a doctor from Iowa, arrived in Timor Leste in 1998. Moved by the suffering of this kind, gentle people he set up a small clinic in Bairo Pite, a working class suburb of Dili. It soon mushroomed to provide care to up to 500 people a day and now contains a small inpatient ward, long-stay TB treatment facility, small maternity unit and dental room. The clinic is staffed by Dr Dan, an ever-changing assortment of foreign doctors and medical students, and 32 Timorese nurses, midwives and administrators.

I had always wanted to work abroad but was unwilling to commit myself to the year-long contracts required by most international NGOs. In 2005 I found some information about Bairo Pite clinic on the internet and decided to work there for 3 months. The time I spent there was interesting but terrifying. There was a

huge epidemic of dengue haemorrhagic fever and most of my time there was spent struggling to cope with desperately ill children. This time, in 2006, I wanted to get more involved in the running of the clinic. Specifically, I was hoping to try and install a new system for diagnosis and treatment of STIs.

From the moment I arrived I realised how ambitious my plans had been. Helped by the rose tinted spectacles of memory I had completely forgotten how incredibly disorganised and hectic life at the clinic could be. This time I brought my partner, Andy, a surgical registrar. As I proudly showed him round the clinic I watched his face fall as he registered the hundreds of patients waiting in the sun, the filthy lab, the piles of out-of-date drugs, and the boxes of random surgical equipment full of cockroaches stacked in the corner. I found my carefully planned pharmacy stock-take system fallen into disuse, the shipping container we had cleaned out again full of mouldy medical equipment, and the wards we had repainted covered in urine. That first night was one of soul searching for us, wondering if we had made a mistake by coming and whether we would be able to achieve anything at all.

The main problem with the clinic is, and had always been, lack of management. Luckily our arrival coincided with that of Liz, an experienced NGO manager on a 2-year volunteer placement. She quickly assessed all that needed to be done (lots) and, after taking a few deep breaths, we embarked on trying to make things run more efficiently.

The first step was to organise the pharmacy and medical stores. Several hot and humid days later the pharmacy was arranged in alphabetical order. A truckful of out-of-date drugs was driven round the city while we negotiated their disposal with various incompetent officials. A stock take was taken and

drugs which were low in stock identified and ordered. We began the long process of trying to teach staff members about how (and why) to recognise what we needed, and how to order it before we ran out.

We then turned to looking at the feasibility of our STI project. Alarico, the social worker, had been trained in voluntary counselling and testing (VCT) for HIV and was running regular groups with sex workers and those who had already been identified as HIV positive. We worked together with him to provide a system for referral between Alarico and the medical team. When we saw patients with symptoms suggesting an STI they could be sent straight to him for VCT, contact tracing, and advice about sexual behaviour. In the same way he could refer anyone from his groups directly to us with a referral letter. They could then jump the queue and come straight to see a doctor, without risking losing them to follow up.

As no diagnostic facilities existed at the time we were treating people empirically for STIs using the WHO formulas. The disadvantages of this are many. Firstly, there is no way of telling what you are treating. This means each patient taking a huge number of drugs. With a largely illiterate population the chance of understanding and compliance is low, and the more drugs prescribed, the more the chance of non compliance. Secondly, we had no idea of the epidemiology of what we were treating. These figures would have been useful for some of the NGOs working there at the time, and were required by us to assess need and plan further services

Luckily, our visit happened to coincide with that of Peter, an Australian Air Force lab official with a long history of involvement in Timor Leste. His team had put together a lab in response to the tsunami in Aceh, which was not required by the Indonesian government. After

weeks of negotiation with customs the equipment was diverted to us. Suddenly we had a gleaming lab full of state of the art equipment. Peter imposed a military regime of staff training and the lab became a source of pride to all. We discussed with him the feasibility of diagnosis of vaginal and urethral discharge. We worked out that although diagnosis of chlamydia was simply too complex it would be definitely within the lab's reach to do gram staining, candida and wet preps for *trichomonas*. He planned to start training for this once the staff had mastered the new equipment.

It was then that we started thinking more widely about women's health. It had long been Dan's dream to have a women's health centre at the clinic. This would provide antenatal care, gynaecological care and, one day, cervical cytology screening. The project had got as far as building a new simple building with four rooms but then stalled. Liz and I decided to revive the idea. We worked out what equipment we would need and wrote a proposal to USAID for funding. We realised that the project needed a dedicated manager and found the funding for this and began to write the job description.

This was when things started to collapse around us. In February 600 army members went on strike and were subsequently sacked. Demonstrations started occurring daily. The mood was tense. Every day families were packing up everything they owned into any form of transport they could find and heading into the hills. The clinic became deserted. Staff were terrified but still coming into work, only to find that transport would stop running and they were unable to return home or contact their families. The foreign staff, now dwindled to Liz, a British medical student, and me, spent much of our time stocking up the clinic with fuel and supplies and trying to

reassure our jumpy colleagues. Having lost everything in 1999 they were understandably terrified about losing everything again. The fear was palpable, and although expat life carried on much as normal, escape routes were planned and bags were packed.

At the end of April the demonstrations erupted into violence. For 3 days Dili resounded with sporadic gunfire, cars were burnt and windows smashed. An uneasy calm then settled and radio bulletins encouraged the residents to return to work and school. The people, however, were not convinced. Tens of thousands of refugees gathered in schools and churches. A few weeks later I had to leave. It was with mixed feelings that I set off, safe in my knowledge that I was returning to a comfortable, affluent, and predictable environment. I was leaving behind beloved friends and colleagues to face an uncertain fate.

One week later our worst fears were realised. Dili descended into violence and disorder. Australian peacekeepers are presently struggling to control gangs of machete wielding youths. Law and order has totally collapsed and an estimated 100 000 people are displaced from their homes, living in camps with little food and poor sanitation. Our clinic has turned into a refugee camp, our staff have had their belongings looted and their houses burnt down, some of them have simply disappeared. My heart aches for beautiful Timor and its lovely people.

In all, despite the sad ending, this was a wonderful experience. There are many frustrations and challenges in working in an environment like this but also many rewards. The relaxed attitude to time keeping, the different clinical priorities, the heat, the humidity, the dirt — all of these had the potential to drive us insane at times. But every frustration would be balanced out by joy. The Timorese people are wonderful — polite, friendly and warm

— never complaining despite their suffering. Watching a malnourished child start eating again, wading across rivers to visit dignified tribal elders with TB, being welcomed every morning by smiles and 'Bondia!' from patients and staff — all of these are experiences that will stay in our hearts.

My advice to anyone planning a similar project? Don't be too ambitious. Don't assume that your priorities and standards are the same as those of the country that you are working in. Remember that barriers to behaviour change can be enormous and, however hard you try to understand, you may never actually work out what they are! Make sure that your project objective is very fluid and do not be too disappointed if it doesn't go quite to plan. And, lastly, be incredibly adaptable, wear comfortable shoes and make sure, whatever the security situation, that you always have what you need to make a good gin and tonic ...

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