ANTE-NATAL CARE

Elective Report 2011

By Hussna Jahan

Introduction

I chose to go to Borneo Island specifically Sarawak Malaysia to carry out my elective. I wanted to go somewhere a bit more rural compared to the hustle and bustle of Whitechapel just to experience a different environment and a slower pace of life. We stayed in Kuching, the capital of Sarawak, a lazy town compared to London, the same description could not be used for Sarawak General Hospital. This is the largest hospital on Borneo Island, it has all the modern facilities and a much higher and quicker turnover. Whipps Cross used to confuse me, but that's a walk in the park compared to the size of this hospital. Cardiology was a shuttle bus away and a boat service was also available to provide medical services to the more rural regions where transport is an issue.

1. How does pre-natal management & obstetric complications differ in Malaysia (specifically in Sarawak) compared to the UK?

As I walked in to the labour ward I noticed that there were many junior house officers waiting around. In the UK FY1s are not as commonly found on labour wards and certainly not in that many numbers. We introduced ourselves and then were told that a birth was taking place and that we should go watch it. When we walked in to the labour room nobody asked who we were, all three of us were allowed to watch even though the patient was already surrounded by several nurses and midwives. We did not require consent and at no point were told to maintain confidentiality.

Over the next few weeks I noticed only few but significant differences between how labour itself is managed. Most women who go into labour come into hospitals to give birth. This service is provided for free in all government owned hospitals. There are no local birthing centres so for many this is the only option. Epidural is very rarely used as it prolongs labour which is not suitable practice for a hospital with such high turnovers. In the UK I have seen many patients asking for epidural and receiving it with ease, however none of the patients I had seen even requested for any extra analgesia unless they experienced a tear or required an episiotomy. Most got through it with Entonox along with pethidine which is also commonly used in the UK.

Caesarean sections are often indicated earlier thus reducing the number of emergency procedures compared to those carried out in the UK. Primagravida mothers with a normal vaginal delivery remained in hospital for 12 hours whilst multigravida mothers stayed for a maximum of 6. Patients with complications such as gestational diabetes, known Type 2 Diabetes Mellitus or instrumental deliveries were kept in for up to 48 hours. Most of the births we were allowed to watch were uncomplicated however when speaking to the senior registrars, they informed us that complications that commonly arise were similar to those affecting patients in the UK; pre-eclampsia, antepartum haemorrhage, preterm delivery, postpartum haemorrhage, maternal infections, low birth weight and stillbirth. Like in the UK life threatening conditions such as HELLP syndrome rarely occur.

2. What types of antenatal care are available in Malaysia as well as how the new mothers are followed up? How does this compare with PCTs in the UK?

This area is significantly different to the UK. Once the patient has confirmed their pregnancy, they are required to register with the Mother Child Clinic. They are given intramuscular tetanus injections and tested for HIV, VDRL and blood group. They are also tested for gestational diabetes and pregnancy induced hypertension. If such findings are positive, they are referred to antenatal clinic and followed up fortnightly.

Although this is similar in the UK, Nuchal scans as well as triple tests are offered so that couples are aware of any possible risks of conditions such as Spina bifida or Down's syndrome. They are then offered diagnostic testing and if the results are positive then they have the option of terminating the pregnancy. Abortion is illegal in Malaysia-although the government is considered secular the laws are heavily influenced by the majority Muslim population. Therefore a national screening programme which would make little difference to the outcome would be a misuse of capital and resources.

As already mentioned, recovery time in hospital varies for each patient. Mothers are then sent home and seen back at a community clinic four weeks later. In the UK a midwife pays home visits within a few days to ensure the mother is coping and the child is healthy. The level of support for new mothers is much less in Malaysia but this could be for a number of reasons. The turnover per hospital is very high; this would put a huge strain on resources especially as there isn't a PCT system put in place for specific catchment areas like in the UK. Malaysia has a two-tiered healthcare system where only the very basics are paid for by the government. General Practise throughout the country is privately paid for therefore any additional care in the community is often too costly.

3. What immunisations are provided for newborns & how are they followed up in School years

Every newborn baby is given Vitamin K like in the UK and a BCG vaccination-something which has now been restricted to babies living in high risk areas in the UK. Mothers are provided with a red book to monitor the child's progress and immunisations. In Malaysia they also have their own equivalent to the red book, a simplified leaflet that comes in pink or blue depending on the sex of the child. There is a growth chart monitoring weight, there are also some simple diagrams demonstrating relevant milestones and a list of immunisations required at each stage of the baby's life. The following table compares the immunisation programmes of the UK and Malaysia.

Age	UK	Malaysia
Birth	BCG if at risk	BCG, Hepatitis B
1 month		Hepatitis B
2 months	DTaP/IPV/Hib Pnemococcal	DTaP/IPV/Hib
3 months	DTaP/IPV/Hib Men C	DTaP/IPV/Hib
4 months	Men C Pneumococcal	
5 months		DTaP/IPV/Hib
6 months		Hepatitis B
9 months		Japanese Encephalitis
10 months		Japanese Encephalitis

12 months	Hib, Men C	MMR
13 months	MMR, Pnuemococcal	
18-24 months		Japanese Encephalitis
4 ½ years/preschool	DTaP/IPV, MMR	Japanese Encephalitis
13-18 years	DTa/IPV	

Since the introduction of Hepatitis B vaccinations, the rate of vertical transmission from mother to baby has dramatically reduced. I think this is an excellent idea and figures show a very cost effective one too. I personally feel this should be implemented internationally in both developed and developing countries although financially it may not be feasible. In the UK hepatitis B s only given to high risk groups or those exposed to risk prone procedures such as NHS staff. Another big difference is the Japanese Encephalitis which is restricted mainly to the Far East and South East Asia. TB is of a much higher incidence out there therefore a BCG is mandatory. The immunisations stop at pre-school age however boosters are available on private prescriptions.

4. To be able to adapt to a different environment & communicate with patients where language & cultural differences may be a barrier.

As much as I would like to say that I struggled and overcame many hardships to work in this environment, this was not the case. The system was very similar to the NHS. I found that it was the care in the community that was limited if people did not have a healthy income but the hospitals provided optimal service which could be compared to our very own NHS. The pace was a lot faster and turnover a lot higher. But Doctors were always keen to teach. I was able to communicate with majority of the patients and if at any point I had too much difficulty, an English speaking person was on hand to translate. Being a Muslim person myself living in the UK, growing up with both western and Islamic values meant I have had the best of both worlds, I could quite easily relate to the people and no cultural barriers arose.

Summary

My elective in Sarawak General Hospital (SGH) was fantastic. Although my objectives were geared towards O&G, I was able to explore other departments and see patients with signs so much more advanced to what I have been exposed to in the UK. For example on my first day I saw two births in the morning, then went down to A&E and examined a patient with advanced Meig's syndrome. There were several clinics and ward rounds we could join. Because SGH is a government hospital, people travel a long distance and often wait until they deteriorate quite dramatically before coming in. Although quite a sad scenario, it provides learning opportunities not often seen in more developed countries. They also let you muck in if you display enthusiasm and willingness to learn. The Doctors are keen to teach and will always point you to the more interesting cases. We soon became the locals and also explored much of Sarawak. I would recommend SGH as a great place to go on elective.