E. Bailey GENERAL MEDICINE

Vietnam Elective Report
22nd April –24th May 2013

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My elective was based in Vietnam. Along with 4 other students I spent 2 weeks visiting clinics in the north west of the country and 3 weeks in a state hospital in Hanoi. Our first sights of Vietnam came as we drove from Hanoi airport into the city. The rice fields stretching out either side of the road, grazing buffalo and farmers in their traditional conical hats seemed quintessentially Vietnamese and gave us an initial insight into the beauty of the country.

As well as learning more about the culture and history of Vietnam I had four health related learning objectives for the trip:

1. What are the prevalent medical conditions that affect people in rural Vietnam?
2. How are the Medical services in Vietnam organised and delivered?
3. What can be done to reduce the spread of infectious disease in rural communities in Vietnam?
4. To learn more about how to provide public health teaching to people in another country – specifically breastfeeding advice.

After two days settling into Hanoi and exploring the city we met our guide and were taken to the Ho Chi Minh Mausoleum to visit the body of Ho Chi Minh. This was an interesting part of the trip as the Vietnamese people refer to their former leader frequently and an insight into his importance and the importance of the legacy he left behind helped us understand more about the politics and beliefs of the local people. Vietnam is still a communist country but in recent years the ruling government has begun to embrace more capitalist economic ideas and the country's economic and business districts had been booming until the recent economic downturn. Despite these changes banners holding communist slogans are liberally hung throughout the city and countryside and the beliefs of Marx and Ho Chi Minh are well respected.

After our visit to the Mausoleum we were driven for four hours along bumpy and unmetalled roads to the rural town of Mai Chau where the first part of our medical elective began. This town was predominantly home to Thai minority people, the population was 280000 and it housed one of the larger hospitals in the local area. The hospital had 200 beds and employed 100 staff members including 11 doctors. We were greeted by the medical director, Dr Cuòng, who told us about the hospital and local area. He explained how much of the equipment in the hospital and training of the doctors was provided by a Swiss NGO as funding from the government was limited. Throughout our time in rural Vietnam we were often told how the doctors felt that the provision of funds and equipment was diverted from the rural to the city areas and that many doctors believed working in the countryside was undesirable. As a result, Dr Cuòng explained that they required 30 more doctors to

adequately man the hospital but that they struggled both to fund and recruit this number to MaiChau. We were told that pay was lower in rural areas and that access to training and support was limited. It was also believed that it was common place for doctors in Hanoi to receive additional payments, described as bribes, from patients and their families to top up their income. In MaiChau the patients they treated were not affluent enough to provide additional money to the doctors.The act of providing addition money to receive a better service was described in all areas of Vietnamese life including healthcare, education and employment, we were told again and again how nepotism was rife and how people felt that this inequality had a detrimental effect on the lives of the poorer population.

While at the hospital we spent a day watching surgery, we were surprised (and impressed) to see the medical director perform a full day's extremely varied surgery including orthopaedic , gynaecological, and gastrointestinal. In the UK it is now very rare for surgeons to have such a broad set of operative skills with each instead performing only a very specific set of operations. MaiChau hospital had a range of departments including A&E, ITU, arenal unit with 3 haemodialysis machines, general surgical and general medical departments, a dentist and a herbal department. We were told that although reliance on herbal remedies is reducing there is still a great demand for this form of medicine along with a preference for advice from fortune tellers often before a doctor is approached.

We spent three days in Mai Chau before trekking to the village of Hang Kia. This was a small village with a population of 1500 Hmong people. This was a poor community with its own language and few Vietnamese speakers. Here we spent three days in the village clinic seeing patients with the help of both our Vietnamese and a Hmong interpreters. There were seven healthcare professionals working in the clinic, none of the staff members here were doctors but instead held a qualification gained from a college or university course which seemed to be equivalent to a physician's assistant in the UK. The scope of their abilities was broad and we witnessed them perform minor surgical procedures, dentistry, midwifery, epidemiology and both Western and traditional medicine. It was interesting speaking to the local people about their health beliefs and their experiences of living in this rural community. Throughout Vietnam we came across the strong belief that change in temperature and the weather was an importance cause of illness and we were told that visits to the clinic increased when the temperature varied. In this poor community healthcare was provided free of charge. If the clinic was unable to manage the health condition then the patient would be referred to Mai Chau for further investigation and treatment.

After three days in Hang Kia a 5 hour trek through tropical rain forests took us to our new homestay, a Thai stilt house surrounded by the rice paddies of Van Village. Van Village clinic served 2459 people from the local villages many of whom were the of the same Thai minority group who made up much of the population of Mai Chau. This clinic had one doctor in addition to a number of healthcare workers of the same background as those we met in Hang Kia. The doctor expressed some frustration at how limited his experience in the village was and how infrequently he was able to use the skills he had been taught at medical school. The distribution of resources in the clinics seemed counterintuitive at times, at Hang Kia the clinic had owed an ultrasound machine but had no one trained to use it, in Van village we met a doctor who was trained in its use but had no access to an ultrasound machine. Many of the healthcare workers told us stories of limited resources but it was impressive to see how skilfully they were able to manage patients with so few of the tools

that we take for granted in the UK. As with Hang Kia any patients that could not be managed in the clinic were referred to Mai Chau which was 30km away. In the rural clinics we were able to speak to the local women and to the healthcare professionals about the benefits of breastfeeding for the mother and child and learn more about the local breastfeeding views and practices. It seemed that although breastfeeding is common practice it is seen as a less desirable option than formula milk which is associated with wealth and increased weight in early years. We had to recognise the challenges of providing this form of public health advice in another language, via and interpreter, to people with a very different cultural background to ourselves and tried to learn as much as we could about the local community so as to make our suggestions as relevant as possible to their situation.

We left Van Village after 6 days and drove back to Hanoi and began a three week placement at the ThanhNanh hospital in the south of the city. This large state hospital provided care to poorer communities. The hospital had more than 400 beds and employed over 1000 health related staff. Here we were able to observe many areas of the hospital including laboratories, radiology, ITU, A&E, outpatient departments, paediatrics, obstetrics and gynaecology and general surgery. We were welcomed by all of the doctors and students and allowed to observe and speak to patients in many of the wards. The students took us under their wing and enjoyed practicing their English with us and allowed us to try out the few words of Vietnamese that we had learnedwithout laughing at us too much. Here we were able to learn a lot about the medical training of students in Vietnam, in many ways it was very similar to our own but in addition to studying the students were expected to do night shifts to help within A&E. As might be expected the medicine that we witnessed in ThanhNhan hospital was very similar to that seen in any hospital within the UK, especially within the very well-equipped and modern ITU department. The differences we observed related more to the personal care of the patients and the hospital environment. The wards were busy and mixed sex, there were usually about 8 beds to a ward and often many of the beds had two patient occupants. The patients were cared for and their food provided by their relatives. There were no curtains between beds and the doors to the wards were open and patients were often exposed without any attempt at privacy. This situation appeared to be tolerated well by the patients and we never heard anyone complain although whether they would have to us is debatable. In Vietnam it seemed that privacy may have been considered less important than it is in the UK so it was hard to determine whether or not these differences we observed were merely a reflection of a cultural difference rather than an indication of undesirable care.

The healthcare system in Vietnam is a private one, many, though not all, take out insurance and some communities, like those in Hang Kia and Van Village are provided with free healthcare. For other communities the insurance costs are subsidised to varying degrees, it appeared the level of support received was based more on region rather than personal income. Certain diseased are treated free of charge for all patients including HIV,mental health problems, malaria, TBand leprosy. Contraception is also provided free in many areas. We met some patients who had chosen not to take out insurance and instead were covering their own health costs; in Mai Chau we met a man who had just undergone an appendicectomy which had cost him 400USD, each night he spent in Mai Chau cost him 3USD. The price of beds in ThanhNhan hospital varied depending on the number of other occupants of the room and bed but appeared to be in the region of 10 to 50USD per night.

We saw a range of medical conditions while we were in Vietnam most of which were, unsurprisingly, similar to those we see regularly in the UK. Maternal health was a key issue, there is no two child policy in Vietnam but women are strongly encouraged to have only two children, and government workers who exceed this number of children may be demoted. Antenatal check-ups are provided and widely taken up. Women are provided with information about the benefits of breast feeding and maternal health. The healthcare workers described how they felt that women's rights were improving; in Van Village a poster detailing the "12 rights of the pregnant woman" was displayed in the consultation room. These included the right to receive a safe and confidential service, to be treated respectfully and a platform to voice their ideas, concerns and expectations. Women are given the right to choose the place and nature of their child's delivery including the right to choose to have a caesarean section.

The average age of marriage is lower in than in the UK and this is especially true in some of the rural communities where girls marry as young as 12. Sex outside of marriage was discouraged and few unmarried women requested contraception despite it being freely available and utilised by married women. The abortion rate in Vietnam is fairly high and although it was hard to be sure it seemed that the stigma attached to it was less that that often observed in the UK. Irreversible forms of contraception like sterilisation were also much more commonly performed than in the UK.

Child health is also a key government focus, unlike the UK where paediatrics includes children up to the age of 16 in Vietnam this label was only given to those under 6 years. We saw a great number of children being treated in the rural clinics and uptake of vaccinations was as high as 100% in the villages we visited, we were told that this figure was common for much of the country due to high levels of promotion though use of the loud speaker systems that line every town and village as a relic of the war time public communication system.

The spread of infectious diseases appears well contained in rural Vietnam. At one stage leprosy was common place but government targets for testing, containment and treatment have almost irradiated the condition. One area in which the spread of infectious disease could perhaps be controlled better is sexually transmitted infection. The lack of discussion of premarital sex and a reliance on mechanical and chemical forms of contraception rather than barrier forms mean that rates of chlamydia and gonorrhoea are rising in Vietnam. A discussion of the risks of unprotected sex and the benefits of barrier contraception may play a role in minimising this spread.

Throughout our time in Vietnam I was constantly struck by the beauty of the country and the kindness of all of the people that we met. The staff at all of the hospitals and clinics seemed incredibly grateful to us for having come to Vietnam and we tried to express to them how grateful we were to them for all of the support and teaching that they provided to us. In Vietnam it is hard to travel internationally, the barriers of money and visas mean that few people get to travel outside the country and even fewer get to visit the west. We were struck over and over again how lucky we were to be given this opportunity to explore another country and be allowed access to its healthcare system. I will remember my time in Vietnam extremely fondly and feel that it will help to shape my experience as a doctor. It has made me appreciate the opportunities, resources and equality our healthcare system provides and has also taught me how effective a healthcare professional can be when these resources are scarce and doctors must instead rely more on clinical acumen and experience.