Medical Mission to a Border Hill Tribe Village

by Dr Michael Yee Jenn Jet, MCFP

Dr Michael Yee, private GP and currently enrolled in Fellowship Programme 2003 describes his experience in organizing a medical mission to the hill tribes in Northern Thailand.

Fellow colleagues in his fellowship class debated the merits of short-term medical missions. Short term medical missions, while able to bring hope and good cheer to the villagers as well as the mission team participants, may not meet the wider healthcare needs of the villagers. General consensus was that improving the level of healthcare among the remote hill tribes required a much larger scale effort involving government intervention, large financial resources, human resource commitment, political stability and resolve.

It may be more useful on a small scale to focus on health education and training the local villagers on public health measures. However participating in such humanitarian trips certainly play a part for the current generations of family doctors to be exposed to the needs of the rural population and is an enriching experience.

Night Clinic during a black-out.

REPORT ON MEDICAL MISSION

INTRODUCTION

With support from my church, I was tasked with setting up a medical clinic at the mission house in Northern Thailand and to study the longer- term medical needs of the Lahu people at Mae Gone Village north of Chiang Mai. We were there from 26-29 March 2004. The team of ten consisted of 1 team leader, 1 doctor and 7 support staff. The medical clinic was part of a previous identified need and a new phase in the long term commitment of the church to improve the living conditions of the Lahu people.

Lahu Village, North of Chiang Mai, Thailand

SETTING UP A RURAL CLINIC

Advanced preparation and adequate training was key to a good experience setting up the clinic.

There was manpower projection and logistics of purchasing medications, medical equipments, custom clearance and the actual setting up of physical structure. I was also involved in doing prior research to the culture and health needs of the Lahu people.

BACKGROUND AND EPIDEMIOLOGY

Mae Gone Village is a foothill village situated along the Mei Ping River. The Lahu people were originally hunters from Yunnan. They have since settled into a lifestyle involving shifting cultivation and animal husbandry. The prevailing religion is animism and believe in one spiritual being with 30% Christianity. The spiritual dimension forms the Lahu people's basic concept of illness.

The age of the patients encountered at our clinic were biased towards children with equal representation of males and females. The shorter life expectancy also skew the population to the younger age groups.

The distance needed to travel to reach the clinic also potentially excluded the elderly and expecting mothers from accessing the clinic.

DISEASE PATTERNS OBSERVATIONS

Dental health was noted to be generally poor. This could be due to the lack of chlorination or fluorination of the water supply or the lack of dental hygiene practices. Thyroid problems form an unusually large proportion of endocrine diseases due to the inherent lack of iodine in the diet of a hill tribe villager lacking in seafood. Simple use of iodinated salt and seaweed in the diet might help eliminate the problem. Lifestyle diseases like hypertension and diabetes mellitus, although less common compared with Singapore, was encountered even in the remote countryside at Mae Gone Village.

There was a fair number of cases with vague complaints which could be explained by the lack of previous health knowledge of the villagers, the free service, and language barriers.

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PITFALLS

TB and malaria were known health problems. In the region, opium production and trafficking is also an issue. The aggressive introduction of cultivation and animal husbandry techniques could inadvertently introduce new soil and zoonotic diseases.

HYGIENE ISSUES AT THE CLINIC

Food, water & sanitation was satisfactory at the mission house, American missionary groups having earlier done much of the sanitation works. Tap water was clean and safe for washing and bathing. Drinking water was via portable bottled water.

Food was handled hygienically in a dedicated centralized kitchen. Sewage system was centralized and clean with modern flush system. Piped methane gas was used from recycling pig's manure. Vector control was well maintained with mosquito netting in the mission house and little sign of mosquito breeding. This was also the dry season and hence more conducive to our clinic project.

LEARNING POINTS

The primary care rural clinic was useful as a point of direct personal contact with the population to help with rapport building and identify specific and changing healthcare needs of the villagers. The clinic was generally well received by the villagers, despite our limitations. Village leaders indicated that they wanted us to return to set up future clinics. The medical mission team truly enjoyed the warm hospitality of the villagers who showed their appreciation by food & small gifts.

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Further reading:

- Anthony R Walker. The Lahu People, An Introduction.
- Lessons, achievements and challenges, Oxfam Programme Impact Report August 2003
- Fong PH, Medical Missions, SMA News Feb 2004 36(2). http://www.sma.org.sg/sma_news/3602/personally_fph.pdf
- Maria Munoz. In this Border-town Dilemma. Medical Economics May 2004.
- AAFP March Board 2001, Cultural Proficiency Guidelines.