

By Dr Tay Siew Hua



Project Lokun Mission

In December 2007, Dr Duyi and myself joined a group of 14 medical students (M3s turning M4 – Weiming, Eugene; M2 turning M3s – Xinrong, Bernice, Tammy, Yuhui; Sean, Weiliang, Yian, Zhengkang, ROSS aka Raymond, Alvin, Chris, Aaron) from my alma mater, National University of Singapore, on a humanitarian trip to Cambodia. Our humanitarian trip, nicknamed Project Lokun, was pioneered by medical students. Dr John and Dr Priscilla Lim, both busy practising general practitioners, who have shown unwavering support for the student pioneers. Father Hernan Pinilla, a Catholic pastor working in Cambodia, has also given his kind assistance to facilitate the execution of the project.

UNDERSTANDING THE TURBULENT HISTORY OF CAMBODIA

Before we embarked on the trip, I read up on the history of Cambodia. Apparently, in the 1900s, Cambodia was a prosperous country and dubbed the “Jewel of the East”. The world famous Angkor Wat (built between the 8th and 13th centuries) epitomised the flourishing of arts during the era of prosperity. Unfortunately, under the Pol Pot regime (1975-1979), the Khmer Rouge communists murdered two million people, especially the well-educated people and destroyed the infrastructure of the country. Today, still haunted by its loss, Cambodia has been rebuilding its economy and exorcising the ghosts of its past. With 44% of its population under the age of 18, the country could potentially rely on its youthful population to propel its economy and develop its country.



Dr Tay enjoys her work as a doctor. In addition, she loves travelling and shares her personal reflections and adventures through her travelogues.

POVERTY IN CAMBODIA

According to UNICEF, 34% of its population lived at the poverty level, sustaining themselves on an income of less than 1USD per person per day. In Cambodia, we worked in the impoverished rural parts of the country – in Kampong Luon, Keo Mony Village and on a floating village.

OUR CLINICS IN CAMBODIA AND OVERCOMING LANGUAGE BARRIERS

During our week in Cambodia, we set up our clinic strategically at locations easily accessible to the Cambodians including the healthcare centre, a school and even a floating church in the floating village.

The medical students were very organised and multi-tasked as triage nurses and pharmacists. With their help, the clinic sessions ran smoothly. Within short notice of our arrival, we were surprised that the clinics were swamped with people. Our patients comprised of both Cambodians and Vietnamese. There were many displaced Vietnamese in Cambodia who were not granted any rights in Cambodia. The Cambodians spoke Khmer and the Vietnamese spoke Vietnamese language and a sprinkling of Khmer. In the clinics, Dr Duyi and myself relied on our capable translators to translate the history for us. Sometimes, we needed two translators to do double translation for us. As mentioned, many displaced Vietnamese people did not receive any education in Khmer and translation was performed from Vietnamese to Khmer and from Khmer to English.

BECOMING ACQUAINTED WITH DISEASES IN THE DEVELOPING WORLD

Many of the patients had poor access to medical care and attempted to seek consultation for all their chronic problems within one consultation session. It was not uncommon for patients to present with chest pain and backache which has plagued them for eight years.

Many patients presented with recurrent abdominal pain. We suspected that many of the medical conditions were due to the unsanitary living conditions. Clean water was not available in the rural parts of Cambodia. Only 17% of the population in Cambodia had access to adequate sanitation. People living along the Tone Lesap River bathed and urinated in the murky and smelly water. They also drank from the same river. Their clothes always appeared to be dirty. Scabies was a common affliction.

I was shocked to see many undernourished children – the weight of their average 6-year-old child was equivalent to the weight of an average 3-year-old Singaporean child. Malnutrition was common in Cambodia. 45% of all Cambodian children below the age of 5 had stunted growth. In the school, we routinely administered the students a dose of mebendazole for empirical treatment of intestinal worms.

In addition, mortality from drowning along the Tone Lesap River was high amongst toddlers. Unsupervised, these toddlers often crawled from their hammocks and fell from their house-cum-boats into the deep river.

For me, the trip opened my eyes to the state of poverty and squalor that existed in many impoverished parts of the world. I really felt fortunate that I was born in Singapore.

Amongst the adult patients, we identified patients with poorly managed diabetes and hypertension. Many of these people were not educated on the importance of treatment of these chronic illnesses.

During the clinic sessions, we also identified a few patients who were more ill and required referral to the hospitals. On one occasion, Dr Duyi encountered a patient who had an extensive ulcer over his thigh and leg. The ulcer was deep and burrowed relentlessly through his skin. Initially, with the appearance of such a deep ulcer, Dr Duyi suspected the patient to be a diabetic. The hypocount was normal and later, the patient grudgingly revealed that his wife has been diagnosed with AIDS. He has already been rejected treatment by a few village doctors. It dawned upon us that the deadly epidemic of HIV has reached the poor people in rural Cambodia. Retrospectively, the ulcer could have been due to non-tuberculous mycobacterial infection.

Upon enquiry, we also found out that philandering husbands were often responsible. Married Cambodian men often stayed out overnight and patronised the services of prostitutes. The submissive Cambodian women usually accepted their husband's infidelity as part of their lives and suffered silently. These women often became infected with HIV by their husbands.

THE BOLD VISION OF PROJECT LOKUN

I felt that unsanitary living conditions and poverty were the root causes for the poor nutritional status and prevalence of infectious diseases in Cambodia. Our students aimed to raise money to provide clean water for the people living on the floating houses. Father Hernan has been teaching the villagers more cost-effective agricultural methods. Hopefully, these measures would result in greater income for the people. In addition, Singaporean doctors and medical students would return every six months to conduct the clinics and provide public health education. The people would certainly benefit from learning about hygiene practices and about the prevention of HIV. Project Lokun has also hired a local doctor to monitor the clinical progress of the hypertensive and diabetic patients.

FRIENDSHIPS FORGED

During my brief trip, the vivacious medical students really impressed me with their altruism and enthusiasm. In less than 2/52 time after their return to Singapore, the M2s and M3s would be sitting for their pharmacology examinations and pathology professional examinations respectively. Yet, they still volunteered their time.

In addition, the Cambodian patients were glad at our presence, always thanking us quietly with heartfelt gratitude. In their torn and tattered clothes, the children always flashed brilliant smiles across their innocent faces. It seemed incongruous that the children were so deprived materially and yet they seemed so full of joy.

On the last night of our mission, Father Hernan hosted a farewell dinner for all of us. Beneath the starlit sky, we dined and chatted with our translators. Father Hernan gave each of us a gift of a Cambodian scarf and thanked us warmly. As a doctor, I certainly felt glad that I was in a privileged position to help the Cambodians who otherwise had poor access to medical care.

I would urge all doctors to contribute to this worthy humanitarian cause either by donating generously or volunteering your valuable time. Interested doctors could contact Peh Weiming (M4) at endless_waltz86@hotmail.com or 9752 6954. ■