

DEBRIEF OF A
SENIOR NURSE ADVISOR
SAIGON, VIETNAM
1966 - 1968
No. 30687

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The interviewee was first aware of the opportunity to go to Vietnam in December 1965, however she did not go to Washington for training until October 1966. She had a few weeks orientation and then four weeks language in Washington. She said she had difficulty because of her attitude and the manner of testing (written test and oral instruction). Once she got to Vietnam she did not use Vietnamese enough to keep up with what she had.

She did not know what her job would be until she arrived in Vietnam. Upon her arrival, she had a "warm welcome" which she considered important for anyone arriving in Vietnam for the first time.

The interviewee commented that many of the nurses who had training in the Asia Training Center thought the program was pretty good. One problem resulting from this was that the trainees got the impression that all the Vietnamese were like the ones that helped in the training.

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She recommended that the nurses working in hospitals learn Vietnamese. She gave the following advice for nurses going to Vietnam: Don't expect to set the world on fire, do expect obstacles, make evaluations before changes, don't start criticizing immediately, and be

innovative. The interpersonal relations are important. The interviewee cited two examples of the nurses using instruction as a means of building rapport with the Vietnamese nurses.

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The role of the American woman in Vietnam has not been fully explored. She mentioned that unfortunately there are not the best looking American women over there. She felt more thought should be given to the selection of those who go, since they represent the American women.

The nurses in the provinces got to know the Vietnamese much better than the ones in metropolitan areas like Saigon, DaNang, and Can Tho.

The interviewee noted the difficulty in making changes. She said that in the ten years American nurses had been in Vietnam, changes had been slow. One of the problems was that the Vietnamese were primarily concerned for their immediate families and did not consider the other people as individuals. Another problem was that the Vietnamese nurses would not follow suggestions of the Americans unless the medecin chef supported the request. There was a real concern on their part to follow the lines of authority. Even though the Vietnamese nurses were skilled and knew the right from wrong methods, they would always take the easy way out, unless there was discipline. Another factor was that the country was at war and this had caused a feeling of futility among the Vietnamese.

She conceded that some of the Vietnamese ways of doing things had practical reasons behind them. She gave as an example the use of mats rather than mattresses for hospital beds. The mats were what the Vietnamese were used to and they were actually easier to keep free of germs.

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The major role of AID/PHD was to work with the Ministry of Health. Throughout Vietnam there was a system of

national, regional, and provincial provinces which took patients from each of the respective levels. There were also a series of maternity wards and dispensaries.

In the hospitals there were paying and non-paying patients. The paying patients had a private or double room, whereas the non-paying were in a ward with 25-120 other patients.

The chief nurse was a position that was created within the last few years. Most of them were men, and when the draft call went up, there was a personnel shortage. Since most of them had not received any prior training, the Ministry of Health put on a two week training period. There was need for another one to be given, due to a high turn over.

The interviewee felt that the needs of the Vietnamese could be met by giving them the material. She felt that they would use what was given if they had the facilities.

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The U.S. has given elaborate equipment without regard to facilities, maintenance, and personnel to operate the equipment. She cited examples of X-ray machines and autoclaves that were not used because there was not enough electricity. Before equipment like X-ray machines be given, there should be basic facilities like running water and electricity.

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She said that there would be a cut-back on the number of nurses in the country, because a lot of the Americans were not being used. She said the number would be about 45. The roles of the American nurse based on the evaluations are as follows: 1) operate in a supervisory administrative role of nursing, 2) supporting American doctors, 3) supplying specialties (e.g., pediatric, surgical, physical rehabilitation nursing), 4) helping in hospitals that have schools of nursing.

PREFACE

The material contained in this debrief represents the personal observations, experiences, attitudes and opinions of the person interviewed. The Asia Training Center (ATC), the University of Hawaii, the Agency for International Development (AID) and the United States Government in no way approve or disapprove of the actions reported or opinions expressed; nor are the facts or situations reported verified.

The purpose of debriefing personnel returning from Asian assignment at the Hawaii ATC is to:

1. Provide AID with management insights suggesting alterations in current policies and practices and to identify patterns, trends and problems which, when analyzed, will provide guidance for future assistance plans and programs.
2. Accumulate new or updated information for an institutional memory, for fundamental research and for application to future development assistance programs.
3. Provide material for understanding the cultural framework of a country, and the dynamics of its mode of social change. And, as a correlate, to discover customs, mores, taboos and other relevant factors which affect interpersonal relationships between Americans and members of a host community.
4. Provide material suitable for instructional purposes.
5. Obtain information which will be of value--generally and specifically--to American overseas personnel in their future assignments.

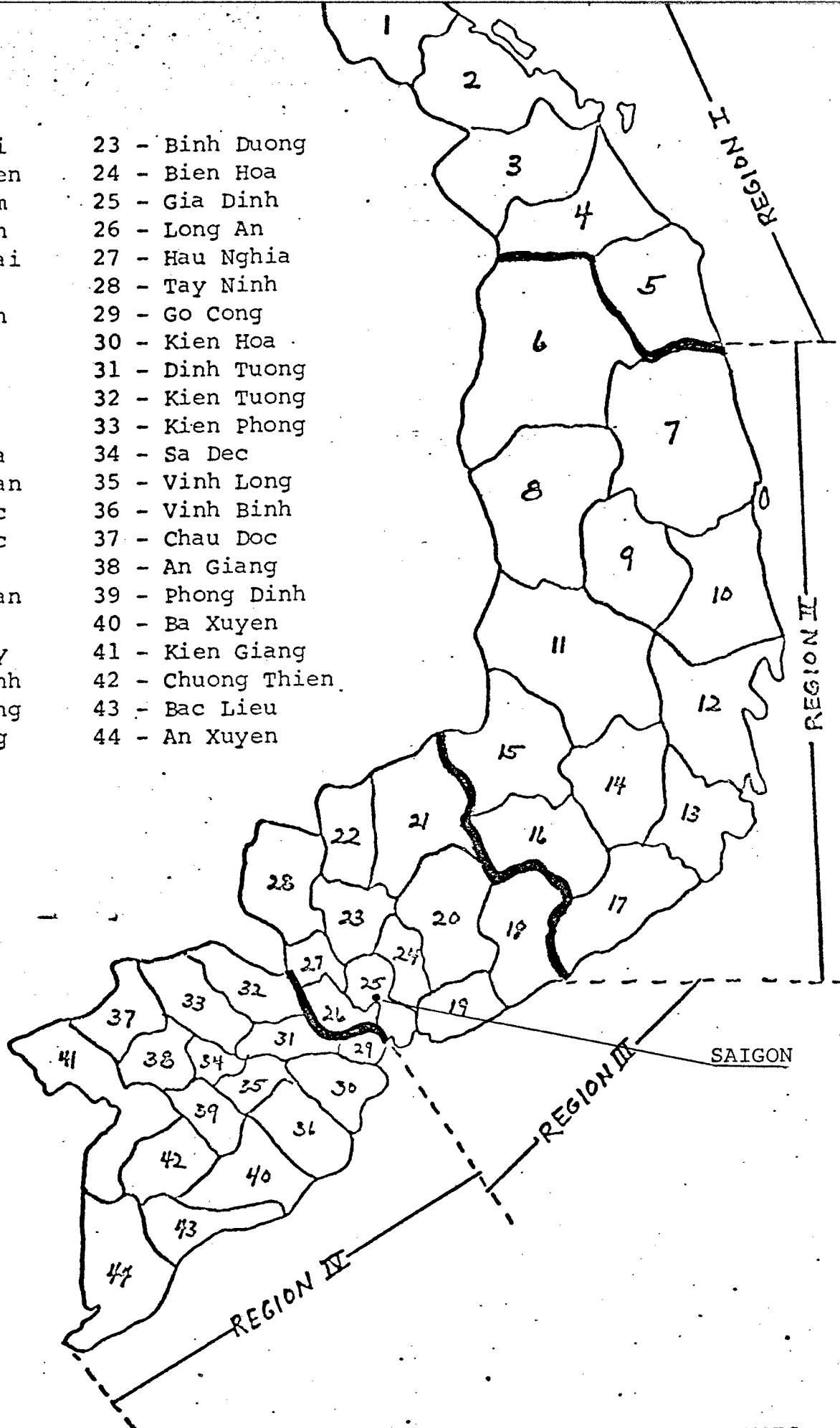
In order to obtain frank and open discussion, interviewees are promised that every effort will be made to prevent disclosure of their identity. For that reason, debrief reports are identified by a code number, unless explicit permission is granted to reveal identity.

In the event, for some legitimate reason, responsible persons desire additional information regarding material presented in this debrief, the ATC in Hawaii will attempt to contact the person involved to obtain the required information or establish

direct contact. Requests for additional information, or direct contact, should outline the reasons for the request and should indicate what use will be made of the information if obtained.

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| 2 - Thua Thien | 24 - Bien Hoa |
| 3 - Quang Nam | 25 - Gia Dinh |
| 4 - Quang Tin | 26 - Long An |
| 5 - Quang Ngai | 27 - Hau Nghia |
| 6 - Kontum | 28 - Tay Ninh |
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DEBRIEF OF A SENIOR NURSE ADVISOR

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1966-- 1968

Recruitment and Preparation for Assignment

I was originally approached by someone in the Red Cross. I received a telephone call asking me if I'd like to come to work in Vietnam. I said, "You're out of your mind." But, after further discussion, I said, "I would be interested in learning more about it." Right after that the recruitment team was in the city where I was and my application was given to them and I went down and talked with the people about it. This was in the early part of December, 1965. I decided that it sounded interesting and challenging. I was in the throes of looking for a new job at that time--something that was different from what I had been doing. I've always been interested in traveling and this happened to be an excellent opportunity to see a part of the world that I had wanted to see and didn't think I would be able to. I decided that I would give it a try.

At the time I had my initial discussion with them, apparently the whole concept of nursing advisory service in Vietnam was expanding and they were just beginning to hire general duty nurses. They talked to me about the possibility, primarily, of a regional supervisor position, but it was very vague and no real commitment of any sort was made as to what kind of position I would be holding when I got there. In the latter part of December, I had received word from Washington, via telephone, that they thought I could probably be able to report back to Washington in February; however, they had a few changes of rules and regulations, particularly about language. They had given me a language aptitude test; I can't remember now what my score was, but it wasn't as high as they had required for general duty nurses. We dilly-dallied around from December, 1965 until September, 1966 before anything concrete was offered to me and then I reported to Washington in October, 1966, at that time thinking that I was going to be functioning as a regional supervisor.

I had six weeks of training in Washington, D. C. There were two weeks of general briefing and orientation in terms of the country, the people, the conditions and what we should expect. It was pretty good. And, along with two other nurses, I had four weeks of language--I guess we were an experimental group of some sort. We did not have our language at FSI but at Lacaz Language School in Washington. I didn't learn enough language in the four weeks to do me any good; I think there were several factors effecting this.

In the first place, the other two girls who were in the group that I was in--there were three of us and an instructor--were a little bit more adept in the language than I was. Early in the four-week period I became hostile and I kind of withdrew for a while so I probably did a lot of damage to my own ability to learn the language. There were several things that made me hostile. One is that I thought the instructor was traveling more at the pace of the other two girls who were a little bit faster in learning than I was and therefore I wasn't learning. I think this created certain frustrations. Secondly--and I think this may be one of the major things--we were given to understand that we were only learning to be able to speak and that we weren't expected to learn how to read or write Vietnamese. Yet, each week we would have tests and much of the testing was based on our ability to write. In trying to learn the speaking of it I wasn't picking up the written portion of it well and I resented this; I felt that if they were going to test us on our ability to write Vietnamese then they should spend a little bit more time on it in class. But then, I don't have great language ability anyway.

In the second place, I didn't use my language once we came in-country, so the little bit I did learn didn't get applied right away and I managed to forget most of what I did learn in Washington. Since I've been in Vietnam I've learned very little. I know a few words and can understand some simple things but I haven't made any attempt, primarily because in the work that I'm doing I really don't need to learn Vietnamese and I'm basically lazy.

People talk about culture shock; to this day I believe that I suffered more culture shock in Washington than I did in Vietnam. I really didn't realize that life on the East Coast was quite so different. I think I had more culture shock in Washington because I wasn't prepared for it. I was expecting any and

everything in Vietnam; I had no really preconceived notion of what I was to expect. Things were different but then I was expecting difference. One of the things they stressed in Washington was that they couldn't tell me specifically what my assignment was going to be or where I was going to be going. I just was resigned to wait until I got to Vietnam before I would know where I was going as far as being in Vietnam was concerned. I had been told that possibly I would be going to II Corps as regional advisor, but there was no commitment on this.

I arrived in Vietnam in December of 1966, almost a year after my initial contact. I was met at the airport by the chief nurse and one of the other nurses and was given a very nice warm welcome, which I think was really good. I think this is very important that someone from the division itself meets the individual at the airport because you are kind of lost and don't know what's supposed to be done. This is sometimes rather difficult because of the poor communications system but, if at all possible, this is good.

I came in individually, so I was given a rather individualized orientation. First, there was a general orientation to the AID organization, structure and personnel processing. Then there was a two-day, at that time, orientation given by the personnel division that went over the overall AID organization--much of which was repetitive of what we had in Washington. Then there was a divisional orientation that was very good. It had been set up by the nursing branch and included introductions to all of the administrative personnel in the Saigon office. I was really given the feeling of being warmly accepted, of being wanted and made welcome. There were explanations given about what the program was and what they were trying to do, what the true goals were going to be and instructions. I thought this was very good. Within a day or two after I got there I was given my assignment and told that I would be based in Saigon. When I was told this, it was presented to me as if they were sorry they were going to have to keep me in Saigon. But this didn't bother me at all.

I have come in contact with many of the nurse graduates of the Asia Training Center, and their reaction to the training they had at the ATC, I think, on the whole was pretty good. Most of the nurses I talked to have spoken well of what they learned. I think, like any other kind of training program, individuals get out of it what they put into it as individuals. If they're

coming to Hawaii to the Training Center for a lark and a big vacation and just try to get through by the skin of their teeth, so to speak, that's exactly the amount of language they're going to learn. If they really apply themselves, there are many of the girls that do come out with a good speaking capability--I've been quite impressed. Their ability to speak fluctuates with how much they've been able to grasp or learn during the period.

My one criticism, and it's really not of the language school, is the contact that the nurses have here with Vietnamese gives them a very false impression of Vietnamese people. I think this is a difficulty for them when they get to Vietnam. Here they're living, associating and having contact with a highly educated group of Vietnamese people that have been exposed to Americans for a period of time, have been to America and have a much more Western way of looking at things than the majority of the Vietnamese. I think that they get a rather off-balance picture of what Vietnamese people are like. They have this idea that they have obtained from instructors here, and then they come to Vietnam and see the real Vietnamese that they're going to be working with and talking with and dealing with on a day-to-day basis; this is a rather difficult thing for them to adjust to sometimes. Several of the girls who've come back after having been in-country for a few months say, "The Vietnamese aren't like the ones we knew in Hawaii."

Suggestions for Nurse Advisors Going to Vietnam

Regarding language training, I think the nurses working in the hospitals very definitely ought to learn and need to learn Vietnamese. It's been a tremendous asset and the Vietnamese do appreciate any attempts to speak their language. I think they appreciate the fact that people make the attempt. They laugh a lot and have a tremendous sense of humor.

I would like to say some things to nurse advisors going to Vietnam. First of all, I would caution you not to expect to set the world on fire because you're not going to do it. You may have very good intentions and have the best motivation in the world to go and help somebody and to teach somebody some new techniques and different ways of doing something. Don't be

surprised and don't be too disappointed if you find many obstacles placed in your way. First off, before you make any changes, or even attempt to make any changes, make a pretty close evaluation of the situation that you're in. Like everything else, each hospital is different and has its own problems, its own solutions, and what will work for somebody in one place will not necessarily work for someone else in another place.

I also would say to remember one thing, the basic ingredient is human beings. As much as we like to believe that they're different or we're different, they still have some of the very, very basic human needs that each and every individual has. They have the need to be needed, they cry tears, they feel pain, they have all of the human needs that we have. Remember this and try to get over the concept of the cold Oriental mind or the Oriental way of doing things--forget about this.

Don't go into a hospital and immediately begin to criticize; these people realize that there are many things lacking, particularly in those instances where there are Vietnamese who have had some contact with a Western hospital or an American hospital. They realize what's missing in their hospital but they're doing the best they can as they see it, in the situation with which they are faced. They've lived with this situation--they've had a lot of people that have come from time to time to try to tell them how to change things, what would be better to do, and how it would be better to do it; they're proud of what they have, so don't come in and start criticizing right off the bat. Look for the good that you can find and build upon this. Win the confidence of the people you're working with and let them know that you care about them as people. I've seen this happen when I've been in hospitals with American nurse advisors. The patients will stop the American nurse and ask her for things or they will ask her something about a wound or a dressing. They ask the American nurse because they know that the American nurse will do something about it--get the doctor or help take care of it if at all possible. This is not always true if the patient calls the Vietnamese nurse.

Another thing I think I would say, is be content with little gains; if one morning the porter picks up the broom and starts sweeping the floor without you telling him to do it--you know you've made a step forward even though it may not be very much.

If you come in some morning and the Vietnamese nurse has started taking morning temperatures without you being there to prod--this is good. This is advancement. If they are pouring medications--without you telling them--for each dose during the day rather than pouring all medications at one time in the morning for a 24-hour period--be happy, don't try to set the world on fire.

The most important thing, and I think perhaps this is one of the areas where we have somewhat failed in our recruitment of nurses, is individual ingenuity--being creative to work with what you have or to think of new ways to do things. This is one of the most important attributes that a nurse can have. Unfortunately, most of the American nurses are too used to having rules, regulations, and all modern equipment with which to work. Individual initiative and the knowledge of how to improvise becomes a tremendous asset, and nurses who are willing to look for these avenues get a great deal more satisfaction from their experience. Now whether this ability can be developed or not, I don't know. I think creativity is something that we have or we don't have.

There is something that I think might be helpful here at the ATC. I don't know whether any emphasis has been placed on this in the past, but I think one of the most satisfying experiences that the majority of nurses have had is the relationship they developed with Vietnamese nurses in the hospitals in teaching English classes. Up to now we have paid little or no attention to this aspect of the activities of the nurses. If they have become involved in teaching English, fine. They use their own resources to obtain material and set up their classes. However, so many of our nurses are involved--I would say that about 90 percent of our nurses are teaching English. Perhaps if they had some basic rules and instructions on how to teach English while they were here at the ATC it might be helpful. Because, this is one area of importance and does provide satisfaction and a feeling of accomplishment for the advisor.

I will give you an example. We had this one nurse who wanted some additional English teaching books because for some time she had been teaching English to a small group of nurses in the hospital. More and more of the nurses were interested in

learning and it had reached the point where she was having something like 15 or 20 nurses from the hospital attending these English classes. I said, "How do you conduct your classes? What do you do with them? How are you using the materials?" She said she had started using the class period to introduce medical terminology by asking the nurse to discuss a patient. She would ask about a particular patient and then they would use the English terms. She said that not only had this been a tool to increase their knowledge of English medical terminology, but it had also given her a rapport with the nurses when she went on the wards. When they went back and made the rounds and saw the patients, she could then follow-up in terms of patient care or make suggestions about the patients. It also helped her to get a foot in the door in terms of the relationship with the nurses and the nurses would then be more willing to take suggestions the American advisor might make about the care of their patients. I thought that this was tremendous. Here she was using all sorts of techniques; she was interweaving these two important aspects--patient care and the teaching of English. She was setting up a concept of ward conferences, which is very important, at least in our American nursing tradition of discussing patient condition and care and giving assistance. She certainly was improving her nurse and nurse-patient relationship as far as the overall situation was concerned.

Another example: one of the nurses in Da Nang hospital saw a need for some kind of a simple manual on orthopedic nursing. It was primarily instigated because there were students coming on the wards and the students had nothing in their educational program that gave them the specifics of care in orthopedic nursing. This nurse saw a need and developed a simple manual along with her head nurse and in conjunction with the instructor. It was developed first in English and then in Vietnamese. Now there is a manual that is used, not necessarily by the students, but by the nurses that are working on that ward. This idea has been adopted by each of the nurse advisors in that hospital. They are all preparing manuals now for basic care in terms of the specialty of their different areas. These kinds of application of initiative I think are very, very good.

Role of the Nurse Advisor and Vietnamese Values

I want to try to explain how I feel about the role of the American woman in Vietnam. I think that this is as important a role as the nurse advisory role because there are far less American women over there than American men. The picture that American women present, no matter what role they're in, whether they're nurses, secretaries, wives of contract people, whoever, this is the picture that the Vietnamese people are going to get of all the American women. I think this is important in terms of our national image.

Unfortunately Vietnamese get a distorted picture of American womanhood. First, they are seeing primarily all single women; second, they're not seeing unfortunately, the best physical specimens of our American womanhood. This is one thing that impressed me when I came back to Hawaii last week. Walking down the streets of town I couldn't help but think of how many lovely, pretty young girls we have. Every girl I passed on the street was young, healthy and looked neat and pretty. Vietnamese women are quite lovely, and unfortunately, by comparison, we have some rather unpretty American women over there. There are a number of overweight women and a number of girls who felt they couldn't make it back home and decided to come over--I'm not speaking just of nurses--to Vietnam to see if they could find themselves a husband. We undoubtedly have some women who are a little bit bitter and discouraged with what they have discovered in life along with a few people who are relatively happy and normal individuals. I believe that in selecting women to come to Vietnam I would prefer to see a little bit more thought given to the kind of impression that our people make.

Now I think that our nurses do a good job. I think that their role as emissaries of the American way of life has been very good because of the very nature of the situation that they're living in; they're living in the provinces and in many instances the American nurses working in the hospital may be the only American woman in that community. I think more in the provinces and in the smaller towns the nurses have an opportunity to become more closely acquainted with Vietnamese people than in Saigon, Da Nang or Can Tho, where we have the bigger, more metropolitan areas.

Where we have larger American communities the tendency is to associate with the American community rather than with the Vietnamese community. In the smaller towns they're more or less forced by the circumstances to contribute or to participate in the social life of the Vietnamese. I think this is good because in this way they can relate some of the thinking and feelings on a one-to-one basis. I've had very many of the nurses tell me that they feel that their most important contribution during their period of time in Vietnam has been their one-to-one relationships with people whom they have gotten to know in the towns and they feel that they have made lifelong friends with many of these people, even though they may never see each other again. I think this is important.

Now, in terms of the role of the nurse advisor and what their contribution to nursing in Vietnam will be--they can only contribute as much as the Vietnamese are willing to accept or as much as the Vietnamese want. Here again, this gets down to a very personal relationship. What are the motivations of the nurses they're working with, what kind of rapport have they established with the nurses in their hospital so that they can convince these people that the ideas, suggestions and thoughts that they might have will really be beneficial in the long-run?

I really and truly do not believe that we're going to make any drastic change in nursing in Vietnam. Certainly not in a year and a half period of time. Five, ten, fifteen or 25 years would be more reasonable to consider changes. We've already been there well over ten years. The nurses who come in today, after they go into a hospital and are there for two or three months, say the same things that the nurses ten years ago said they were going to change. They want to improve sterile techniques, they want to get a little bit of organization in their systems, they want to improve medication systems, they want to improve administration of medications, improve shot techniques. They want to make the nurses more aware of the patients as individuals and the needs of patients as individuals. These are the same things that the nurses ten years ago said they wanted to change. We haven't made a great deal of impact in these areas. I think the basic difference or basic problem is the conflict of cultural background and as it relates to nursing. American nurses, from the time that they first begin to think about going into nursing training or education, are motivated because they want to do something to help someone. They want to make somebody more comfortable, they want to make

them well, they want to do something for that person as an individual. Vietnamese do not always have this concept. The individual is not important as long as that individual is not a member of the immediate family. If it's a member of their immediate family, that's something entirely different--then they will get the care and attention needed. The Vietnamese as a people don't have this feeling of concern about other individuals and you see this in every aspect of their lives, all day long. They don't have a nationalistic feeling--this is one of our overall problems with Vietnam. How can we generate a feeling of nationalism among people who are only concerned for their immediate families?

Not only do they have this family allegiance, but they also have a big concern for lines of authority. I think this is one of the greatest means that we have within nursing to bring about change. There has been an attempt to gear recent changes in the nurse advisory program to recognize this means. The Vietnamese will not take instructions or orders from Americans because they're not in any line of authority over the Vietnamese. We're wasting our time and effort in hospitals where the medecin chef (the Director of the hospital) does not sincerely want to have the American nurse advisor improve nursing. You can put a dozen American nurses in a hospital and if the medecin chef doesn't support them, they're not going to get anywhere; they're not going to be able to accomplish a thing because he is the final authority in the hospital. For instance, unless the direction comes from the chief nurse and the medecin chef supports the chief nurse in his or her role and says, "You have the authority to reprimand, to instruct or to order the nurses under you," no staff nurse working on the floor or even the head nurse will give a direction. If you have a progressive, open-minded medecin chef who is vitally concerned with improving nursing care, understands and has some concept of Americanized ideas on nursing, then you can establish programs that will take hold. But, unless the Vietnamese are involved in the planning, it's not going to be a success either. They have to be involved in it--the chief nurse, the head nurses.

One of the things the program has been trying to work toward is establishing routine meetings for the head nurses with the chief nurse so they can discuss the programs and plans, etc. Now, with the change in emphasis that started about six months ago, what is being attempted is to provide more nurse advisors with supervisory and administrative experience so that they can

work with chief nurses rather than having a concentration of the American general duty nurses working in the hospitals. The idea is to assist the chief nurse so that he can better understand organizational structure. They have little concept of organizational nursing structure in their hospitals. They know the basic techniques, they know the difference between right and wrong in the way of doing procedures. They get these things in their training program and, technically, the Vietnamese nurses are extremely competent. They are probably much more skilled with their hands than the majority of the American nurses are. They know the difference between right and wrong, but they're going to take the easy way out. If there's no disciplinary structure that makes them do something, they're not going to do it.

I do feel that much of the frustration felt by the Vietnamese people is based upon the fact that this is a country at war. There are many things that enter into this. For instance, one very important factor right now is manpower. In Vietnam much of the nursing is done by men. Although there are more and more women now within the last five or ten years who have gone into nursing, the reservoir of trained competent nursing personnel is still male--and particularly since Tet, with the increased mobilization of men within the country, this is putting a very definite strain on health needs. They don't have enough prepared health workers in Vietnam to meet the health needs of the country. Even these limited supplies are being stressed much more because so many of the men are being taken out and put into military service and this further reduces the capabilities of the hospitals. I'm sure that there are many people who will have much more motivation when the country is at peace to put into practice some of the things. I think that there's a feeling of futility among the Vietnamese right now. They've been at war for a quarter of a century and I really get the feeling sometimes that they feel, "What's the use? Until there's peace why plan for the future? We can only take care of now. If we live through today and tomorrow, we're lucky, so we won't plan any further than that."

Going back again to the cultural aspect--time does not have the same importance in the Vietnamese mind that it has in the American mind. This is one of the sources of frustration for the American nurses. They come into a hospital with their background, their knowledge, their ability to analyze the

situation, to see a problem, and provide a solution. We have a drive, a need to go in and start doing it because we can't waste any time--every minute counts, every second is important --our puritanical background comes rising to the fore. The Vietnamese don't have this concept of time. Theirs is a much more relaxed attitude, "We will talk about it for a while and we will discuss it and we'll think about it. Maybe three weeks from now I'll give the idea back to you with a possible solution and it will take another couple of weeks to get the wheels rolling." Time doesn't mean the same thing to them as it means to us; so, I think that eventually when there gets to be more overall stability, then they will take some of the things they have seen the Americans put into practice and they will build on this to meet their needs.

I'm not the missionary sort and maybe because of this I shouldn't be in Vietnam, but, although I believe that our way of doing things is right and superior for us as Americans, I don't necessarily believe that this may be the only answer for the Vietnamese. They can come up with some pretty real arguments about why they do things in the manner in which they do. As an example, take beds in the hospitals. The traditional Vietnamese bed is a flat board with a mat on it. This is the way they're used to sleeping, this is what they have in their homes, this is what they've been raised on. So, we donate all sorts of lovely beds with springs, mattresses, sheets, pillows and pillowcases. Why? Vietnamese are not really benefited by these beds with mattresses because, in the first place, they're not used to sleeping on them; secondly, they do not have adequate laundry facilities to take care of the linen that is necessary to put on the beds if you're going to use mattresses; thirdly, the mattresses become cesspools of infection because they have no means of sterilizing mattresses or changing them from patient to patient. You get a patient on a mattress who has had, for instance, a draining osteo. When this patient goes home the next patient who occupies that bed may be an abdominal surgical patient. So, what have you got? You've got a dirty bed that you're putting a clean surgical patient on; whereas, if he just had his regular Vietnamese-type bed he would have brought his own mat with him and slept with his own bugs, after having been able to wash down the beds with insecticides or germicides of some sort. The Vietnamese have

come to kind of look at the bed with mattresses as sort of a status symbol. Now where are all the beds with mattresses? They're where the patients are the sickest or where paying patients stay because it is a status symbol to have a mattress on the bed.

Vietnamese Hospital Facilities and Staff

AID/PHD's primary role in Vietnam is working with the Ministry of Health and those hospitals that come under the jurisdiction of the Ministry of Health. This includes the province hospitals--each province capital has a provincial hospital--some national hospitals and some regional hospitals. Sometimes the regional hospital and province hospital are under the same physical hospital. The Da Nang Civil Hospital in Da Nang is a regional hospital. This means that they accept patients from the whole I Corps area. The provincial hospital for the province of Quang Nam is in Hoi An and they receive patients from the province. Regional hospitals will receive patients from various areas, but these are all Ministry of Health hospitals. There are a few national hospitals, primarily around the Saigon area--there's the mental hospital at Bien Hoa, there's a cancer hospital at Gia Dinh and I believe that Cho Ray in Cholon is also a national hospital. These all come under Curative Medicine and the Ministry of Health. Under the Directorate of Health or the Preventive Medicine section--which is separate from Curative Medicine--are the district dispensaries, the Maternity-Infirmiry Dispensaries, and the Maternity Dispensaries. An MID is a dispensary where they have both maternity patients and a few beds for other illnesses where patients can stay overnight; the MDs have beds for maternity patients at a district level, but just a dispensary--they have no facilities for taking patients overnight. The patients who are that sick are referred to the province hospital or some other place for medical care.

There are both paying and non-paying patients in the hospitals. The non-paying patients are always in a ward--usually anywhere from 25 to 50 to 120 beds per ward. The paying patients are usually in a single room or a two-bed room and the physical situation is usually a little bit better. They do have some privacy, they have a little bit more room for their families

to come to the hospital and stay right in there with them. It's sometimes a little bit cleaner than some of the other rooms. In terms of nursing care, I don't think there's any difference at all. Although I have asked this question many times myself, it's very difficult to get an explanation from the Vietnamese about what the difference is between a paying patient and a non-paying patient. It took me a long, long time to figure out who paid and who didn't because I couldn't see that much difference. Now I don't even think that there's any difference, but apparently the paying patients pay according to their ability to pay. Apparently this is decided by the person who does the screening for admission into the hospital, or maybe the patient decides if he wants to be a paying patient.

I think something that we have not paid enough attention to is the role of the chief nurse. The role of the chief nurse is a relatively new role in Vietnam. They've only had chief nurses for about three years now, I think. The chief nurses who were appointed were appointed primarily on the basis of seniority or maybe because they happened to know the medecin chef and not because they had any particular background in administrative or supervisory skills. They were put into a position of being told, "Now you're a chief nurse," but no real explanation as to how they were supposed to function.

Last year the Bureau of Nursing in the Ministry of Health put on a series of two-week seminars for chief nurses throughout the country. They were held in each region and all the chief nurses from the hospitals at that time were supposed to attend. Basically, what they were supposed to get in this two-week course were administration and supervision techniques, pretty basic kinds of things. How many of these principles they were able to absorb in a two-week period is rather doubtful. Unfortunately, there was not the kind of follow-through to provide assistance to these chief nurses that they should have had. They should have had adept advisors to work with them when they got back into the hospitals, and not all of them did. Some of them did--there has been some improvement in this. But again, this is only taking place in hospitals where the medecin chef is really behind this concept. The nursing branch has tried for almost eight months now to get the Bureau to set up another course. Since the last course was completed there have been a lot of changes in chief nurses, due to the draft, due to people transferring from one hospital to another, etc. So there really is a tremendous need for this course to be repeated for

chief nurses who have been appointed since they had the class in their region. We (nursing branch) can't get the Bureau to move, they won't do it. Just before I left, one of the last things I heard was that the Bureau was going to schedule a work shop for December. Well, this is well over a year from the time that the last chief nurses' seminar had been held. They should be held at least every six months or probably even more frequently than that.

They're not training health technicians any more, unfortunately. I understand this is one of the programs that we recommended be abolished. They were a cut above nurses actually and very good in their training. They were prepared somewhere between nurses and doctors because they had a three-year course, if I remember correctly. A portion of their training included diagnosing and treatment of simple conditions. They prescribe, they diagnose and in many, many instances the health technicians are the only medical personnel for a whole district or a whole village. I think this is one of the areas where we made a mistake in phasing out this program at the time we did.

There is no nurses' association per se within Vietnam. There is a group of nurses--I can't remember what that group's name is but it's something about nurses in private practice. I really don't know how strong this group is, but I don't think they're very strong and I don't know how long it's been organized. I know very little about it, actually. The only thing that I do know is that they approached the Bureau of Nursing and asked for some kind of a refresher course to be sponsored by the Bureau so that they could improve some of their techniques and practices. Nurses in private practice in Vietnam do not function as private duty nurses as we understand it, but rather function as independent practitioners.

I do believe there is a tremendous need for public health nursing in Vietnam. They don't have public health nurses or public health nursing as we know it. Most of the public health nursing is done by midwives and by the health technicians; there are very few nurses who are involved in public health nursing. There are, I think, five public health nurse advisors working on the province level and they're doing a tremendously fine job, in most instances, in coordinating the activities and are beginning to instill some concept of public health nursing.

Like every other aspect of medicine in Vietnam, their needs are so very basic and I think this is where I have a tendency to get rather overwhelmed at times. How can you teach public health nursing practices or how can you think in terms of home visitation, case finding, follow-up, all of this sort of thing, which really is rather sophisticated, when you haven't even got the basic sanitary things to work with? You have no water, you have no clean water, you have no sanitation systems for disposing of waste materials, sewage and garbage. People are still defecating and urinating on the streets because they haven't got privies. You can tell them they're not supposed to do that on the street, but until they are provided with a latrine, what can they do? How can you tell them that they must wash their food carefully and that they must wash their hands if they don't have running water available? From what I have seen, if these are available, they will be used. When you see families standing on the streets of Saigon at an open water fountain where the water is rushing out, washing their hair and giving the kids baths with soap and scrubbing themselves right on the public streets--you needn't worry about whether or not utilities will be utilized. Give them the things to work with and I think we'll see a lot of improvement.

Use and Misuse of Resources

We need to give the people simple things they can use right now. I can't understand how come we have been, for instance, in this country for well over ten years and there is not yet an adequate water system. Why? They've got water; we certainly have poured in enough money to have built a dozen water systems. Today, in Vietnam, I can think of four hospitals at least, and I'm sure there are 30 more, that do not have running water on the wards. They're lucky if they have water in the hospital. Now how can you tell people that they've got to take baths if there isn't any water? You know, to me, this is such a simple concept that I don't know why we haven't done it.

Electricity is another thing. We have provided all sorts of elaborate equipment--X-ray machines, washing machines, lab equipment--all sorts of things that take a large amount of electricity. Yet the hospitals are lucky if the generators are operating for eight hours out of 24. If generators are not

working, how are you going to run the X-ray equipment? When I first came in-country--fortunately I have not seen this as much recently, (maybe I haven't looked for it)--one of the things that appalled me was the number of autoclaves that I saw sitting in hospitals--outside or inside, depending--that were not operational and hadn't been operational for long periods of time because they didn't have people who knew how to maintain them and when they did break down, the parts were not available for repairing them. Some of the autoclaves that I did see were of French origin and they no longer had the parts. But I saw some American autoclaves and I saw a few that had been donated by various army units that were just sitting there not being used. Now, unless we also establish some kind of maintenance program--I know this is not an original thought--along with the giving of equipment, it's ridiculous to continue pouring in this kind of equipment if it's going to break down within a three-month period. I've seen X-ray machines that were not usable because they kept blowing out tubes due to fluctuation of the current. There's not a steady current, so tubes blow out and it's not easy to get the tubes up to remote places like Tam Ky, Quang Ngai and other areas.

USAID Nursing Program in Vietnam

Maybe I'd better talk briefly about the changing emphasis of the nursing program in Vietnam from the administrative standpoint. Some time ago, USAID became very much aware of the fact that there was a great deal of frustration, particularly among the USAID general duty nurses, because they were not being able to accomplish the things they had set out to do. It was very difficult to really put a finger on the reason for this frustration and also for the number of resignations that were occurring. Actually, this was one of the things that stimulated the nursing branch to look at the entire situation. The regional advisors were asked to make an honest evaluation of how they felt about the general duty nurse program in Vietnam. There were also, in addition to the regional advisors, several of the general duty nurses who were fairly astute in their observations and had been working in the situation themselves who also wrote their evaluations. The upshot of the evaluation was that it was very obvious that the original objectives were not being accomplished --mainly that of teaching by doing and augmenting the nursing needs. In the first place, you couldn't teach by doing because

if you would do it, it was very difficult to get the Vietnamese nurses to do it along with you. Secondly, it was questioned from time to time as to how serious the shortage of nurses actually was in Vietnam. You couldn't walk into a hospital in Vietnam without seeing Vietnamese nurses sitting around the desk and chatting or reading rather than taking care of the patients. All in all, it was felt quite strongly that there was a greater need for emphasis being put on the supervisory administrative role in nursing. This is the greatest need.

Another role that the American nurses play in Vietnam is giving support to the American doctors. This is an important role, although we all try hard to deny the fact that the American nurses are there to support the American doctors. When it was decided to cut back on the general duty nurse program, it was the doctors who put up the loudest noise--"How could you possibly do that?" There is a need in some instances to provide operational support to American teams. This would be to work directly with the doctors in a more direct role than as an advisor who would necessarily work with Vietnam nurses.

A third area where there is a need is for nurses with particular knowledge in different specialty areas of nursing, such as pediatric nursing, surgical nursing, physical rehabilitation. It was thought that a few people in these kinds of roles would be good.

The fourth role would be in hospitals that have schools of nursing--maybe to have general duty nurses assigned to some of the wards in these areas to help in the clinical aspect so the students would have a better clinical experience.

At the time, there were about 112 positions for general duty nurses. Considering all of these categories and a reasonable estimate of hospitals or the provinces where advisors could be placed, it was felt that a maximum of 45 positions were needed. A cut in positions from 112 to 45 was recommended. Under governmental process, to make a major cutback like this is really grinding against the wheels of progress, I guess. A full switchover has not yet happened because there are so many general duty nurses to whom commitments have been made prior to the cutback.

USAID will probably not get down to 45 positions until the end of December. Currently there are 66 nurses in-country and most of the cutback will take place by attrition. Then recruitment of replacements with the needed qualifications can begin. It will probably take a while to get geared into the new concepts. Again, I think sometimes we as Americans try to gear into something too quickly. This all sounds good but it is going to take a good year to really see if it's on the right track.