Selfless Elective Aid Bangladesh: August 2018

Introduction
This year I travelled as part of a group of 33 medical students, doctors and other humanitarians to Sylhet, Bangladesh. The product of 10 months of pre-departure preparation and organized through the charity Selfless, the objectives of the trip were multifold. We sought to establish connections with local hospitals, to experience healthcare delivery in this environment and finally to provide free health camps to remote rural regions and contribute to the setting up of a baby bundles antenatal visit and intervention scheme hoping to improve outcomes for the lowest income mothers of the city outskirts and their newborns.

Visiting local hospitals and healthcare providers

Providing a context to our own work, visiting the healthcare services available in Sylhet gave a sense of the tremendous challenges being faced with so little resources, as well as the interplay between the public and private sectors and NGO providers. A state-funded hospital, Osmani provided free beds, food, medicines, surgeries with ‘few charges’ although these including investigations. Seven ambulances operated for the hospital with small fees. It was nonetheless one of only 31 state hospitals for 64 districts, with 60% of Bengali healthcare provided by the private sector. There were 500 beds for 2,000-2,500 inpatients, 4,000-6,000 out patients. On one particular surgical ward there 83 for 48 beds and 3 nurses, with many being placed on mattresses on the floor. For someone who had never seen anything comparable, the sights were at times deeply distressing, although looking around at a 5 year old boy smiling after a genitourinary defect repair, a 1 month boy recovering after respiratory surgery, or a specialized 5 incubator neonatal unit provided by Muslim Aid, there was still undoubtedly life-changing care being provided to patients. Its busyness was also in sharp contrast to everywhere else that we visited, a demonstration of how much of the burden of healthcare it was
absorbing as the only free and to any extent comprehensive service in the region. At Upazilla Heath complex (equivalent to a district hospital but more like a clinic), 30 beds were available for a population in excess of 200,000 living in a 5km radius, the inpatient capacity essentially functioning as an intermediary point of care for those unable to reach Osmani, with a single ambulance available for transfers. There were hopes for the setting up of a minor surgery unit with local anaesthetic, with a capacity for performing emergency c-sections. Besides a 5BD registration fee all services were free, and included doctor consultations, immunization, community health worker visits, and a room for the education days/evenings. Finally venturing into the NGO-sector, we made a trip to the Lions Children’s Hospital and its neighbor the Jabalabad disability centre. Each had a capacity of 80 and 30 beds respectively, the first specializing in infectious diseases and the second providing long-term rehabilitation for patients as diverse as an elderly woman who had suffered a stroke, and 18 month old boy with cerebral palsy. Heavily subsidized, they were affordable to many but inevitably, not to all.

**Health camps**

Over the course of three days we delivered health camps to communities in Kulaura, Jaintapur and Jamalganj, providing healthcare access to over 4,000 patients. After an often long and bumpy journey on dirt track roads, we set up clinic in partner schools who kindly gave up their classrooms for the day, and were reliant on local volunteers to assist in triage, directing people and general crowd management. In the humid heat of 38 degrees, surrounded by people, working through the morning and afternoon, things were not without a level of stress. Compounding this was the nature of patient complaints, often desperate, the product of extreme poverty, or so easily preventable in the UK setting (a child with probable autism without any access to medical services, a woman with severe abdominal pain and post-caesarian complications, a young girl with rickets), an internal conflict between upholding key principles as a medic but respecting cultural context (Bengali doctors not requesting consent or not wishing to probe further into a patient’s symptoms or fully explain a diagnosis due to a belief in the general
ignorance of the population) and limited resources (prescription medications running out and often being unable to refer patients to other services in the knowledge that they would receive treatment due to their inability to pay). But for all the disheartening moments, there were also instances of shared joy or tangible impact: the smile of a mother as I picked up her child with cerebral palsy who had so often been shun by others, reassuring another mother as to the normality of frequent viral infections, or explaining to a man a medical diagnosis which he had lived with for years without ever being fully aware of the true meaning and implications of the label.

Antenatal community visits

The primary focus of our pre-departure preparation, we spent two days implementing the first part of a baby bundles intervention scheme designed to help improve maternal and infant mortality among the lowest income families in Sylhet city. Working alongside the community health workers whose role would be to continue the project far beyond the length of time we were able to stay and to provide follow-up, in pairs we visited around 30 mothers in their own homes. We began each visit by interviewing each mother in turn, sometimes in the company of their husbands, asking about both their current and, if relevant, previous experiences of pregnancy as well as their current socioeconomic circumstances and any challenges they faced, many of which were present in their very living conditions. It was profoundly saddening to meet a young mother of two children expecting her third and worried that they would become destitute at the loss of a second income in the face of high rent on no more than a mud house with a tin roof, unable to afford even the 25BD for BRAC-provided antenatal check-up. But as she and her husband spoke of a gift from God and having faith that somehow he would provide, we were aware of how much every birth was still a celebration of life. Walking from house to house we were also welcomed into the community, one which was no doubt a
source of support to everyone who lived there as well as a source of inspiration to us. Everywhere we were followed by a crowd of mothers and children, each of which asked about our lives just as we asked our theirs, who offered a chair for us to sit on or anything at all which they could provide, who spoke of both their hopes and fears for the future. At some point during the mid-afternoon, as some of the older children came home from school we were brought into a football match which served to put us to shame. Before leaving each house, we explained the intention of, and gave, each mother a small $Upahāra$ (gift), our baby bundle intervention. Contained within were a number of WHO-recommended items including iron and folate supplements for the mothers (to prevent maternal anaemia, puerperal sepsis, low birth weight, and preterm birth), maternity pads for after delivery (to prevent post-partum infection), chlorhexidine gel for the community health worker to apply to the umbilical cord (to prevent neonatal sepsis), and a mosquito net (to prevent cases of malaria). The development of a breast-feeding infographic was work to be continued upon our return to the UK.

Cultural experiences
Personally not having travelled any further east than Turkey, the trip was a huge cultural experience. Studying and attending placements around Whitechapel, it was also an incredible opportunity to travel to the homeland of so many of my patients, and to understand a little more of the country which still shaped their health and socioeconomic circumstances years later. Be it discovering my love of chili and the practice of eating rice and curry without utensils, adapting myself to the Bengali tardiness, turning a head from the chaos of the roads, the generosity and hospitality of those whom we visited or the vibrancy of their dress, I never failed to each day be overwhelmed by new details. Learning but a few Bengali phrases, I certainly developed my capacity for non-verbal communication as well as both appreciation and respect for the tremendous work of translators, whom I will no doubt be reliant upon on innumerable occasions throughout my career.

Conclusion
This trip has left with a wealth of experiences, memories, and basis for reflection. We all go into medicine with that basic intention of helping people, but to have made such a journey however short, as a student, is a privilege. It taught me just how much you can give, when even access to a healthcare professional is beyond the reach of many people, and it made me appreciate the extraordinary opportunity it is to be pursuing such a career. The exchanges I made with patients reached by the project are also more than relevant to my practice coming home. That interaction, that personal gratitude, strengthened my vocation and desire to always give my best, and helped me to make note of the value of the diverse cultures and experiences of the patients I meet. With an increased awareness of global health inequities, I shall continue my involvement in student-lead societies concerning themselves over these issues and hope that such work will one day form an integral part of my career as a doctor.