Medical Elective Report– 'Amrit Dhoot' Award

'An Indian Summer'

During the summer of 2009, I embarked on my medical elective to the chaotic but wonderfully beautiful world of India. Before I departed on this adventure, I wrote down a set of clear aims and objectives that I wanted to achieve. From this experience I wanted to make sure that I understood what the meaning of practicing clinical medicine and surgery in a poorly resourced setting meant and what it was like to conduct public health work amongst the vast inequalities people face in developing countries. Additionally I wanted to immerse myself in the traditions and daily lives of villagers who constantly strive for their next meal.

I began the first half of my elective at Lady Willingdon Hospital (LWH), situated in Manali in the foothills of the Himalayas. LWH is a small, 45 bed hospital run as a Christian, charitable institution that manages to see 36,000 outpatients and 2000 inpatients annually. LWH charges a nominal fee to cover hospital costs but it never turns patients away.

My time spent at LWH varied from outpatient clinics, to ward rounds to scrubbing up in theatre. In addition to this I was able to conduct an observational study looking at the nutritional difficulties and barriers faced by pregnant women. From the study itself, I was able to make a few interesting observations including the nutritional status of children and babies. I am now more aware of the challenges facing women's health and the scarce nutritional resources in a developing country.

In addition to this, I was able to observe how the doctors were running the clinics. One obvious and clear observation was the lack of confidentiality. For example in the ante-natal clinic there would be five to six women at a time in the room. They were either being seen or waiting their turn to be seen. Does this prevent women from disclosing their full story? I asked about a dozen or random women and the vast majority seemed unnerved by this. "Why? We are paying for the service so it is not really a concern. Plus we are all pregnant so we have the same problems."

Even though a high volume of patients are villagers who come from poor backgrounds, the majority would spend a huge proportion of their income on getting good treatment for their illness. This was also reflected with ante-natal care, where the vast proportion of women would spend a huge part of their family income on getting sufficient nutrition and regular check-ups. However interestingly the highest expenditure cost for the people visiting the clinic was paying for transport in order to get to the hospital rather than the treatment itself.

The medical challenges faced by hospitals such as LWH are rife and are present in everyday life. There were a few cases which I will take away with me. The first memorable and moving case for me was a woman who gave birth to a baby who had passed away whilst she was in labour. The main reason behind this was her high blood pressure. She had been prescribed medication but was against taking them and she did not have regular ante-natal clinic check-ups due to high costs. To say the least, the patient was distraught with the outcome. Why would she not be? However what moved me more was the lack of counselling and support she received from the healthcare service after this, but more importantly from her family. The stark difference in healthcare facilities was evident with this episode.

The second case involved a young man, aged 23, who was brought in after falling from a second floor of a building. The patient had suffered from severe head injuries but at LWH we were unable to make the diagnosis of what side of the head the bleeding was occurring. The reason for this – there was no CT scanner. The nearest CT facility was two hours away by which time the patient would have bled to death. The next step was to therefore guess the side of the bleeding and as Murphy's Law always works out in situations like this, the side chosen was the wrong side. After drilling a burr hole on the right side, we had to close this and drill the left side. After four hours of operating, we finally drained the blood however after a day in recovery, the luck of the patient ran out and he passed away.

What does one take away from this experience? The fact that due to the poor resources available at the hospital, the patient could not be saved. Had he been in a slightly more developed town, he would have survived. What was even more hurtful

was explaining to the family what had happened – extreme shock and grief would be being kind to the scene.

With four weeks coming to an end, it was time to bid farewell to the wonderful doctors, nurses and support staff that help run the hospital. I hope to return soon and accompany the medical team to Ladakh and the Zanszkar Valley where the plan is to conduct medical camps and provide health check-ups to people who live in even more remote, challenging and harsh terrains.

The second half of my elective was spent working for an NGO called Hand in Hand (HiH). Here I was accepted onto the Global Leaders Internship Programme where I was given a project related to healthcare.

HiH's main purpose is to provide credit to poor families, especially women, who are then able to generate income by creating enterprises. This concept is widely known as microfinance. The importance of microfinance as a tool to eradicate and lift families out of poverty is vast. As mentioned earlier, microfinance institutions (MFIs) solely target women. The reason behind this is that women are more careful with the loans given to them. In addition they tend to create enterprises and from the income they generate they will theoretically look after their families. The repayment rate for these loans tends to be around 98%. In addition to this HiH conducts community health clinics, provides help for sanitation projects, and has 'village upliftment' programmes.

My work here was more related to improving access to healthcare and therefore had more of a public health perspective. The aim of my project was to develop a sustainable healthcare financing tool for the poor in a rural district in South India. This work revolved around the concept of micro health insurance; micro in this sense meaning being covered by an insurance scheme for a small monetary sum.

HiH had recently created a different type of healthcare financing tool where it would give loans to women who were pregnant. The reasoning behind this was that HiH wanted to encourage more women to deliver babies in a safe environment. The loan enabled the provision of antenatal care with antenatal and postnatal maternal education and enhanced maternal well being. Mothers therefore felt privileged and

proud and provided extra care for newborns. The loan is given two weeks before due date and can be given to an authorised individual if the mother cannot collect the money. Surprisingly the loan is very popular and women in general do not have problems in repaying the loan.

The concept of this loan is a crucial development in the improvement of maternal health and reducing child mortality. Pregnancy related mortality in developing countries is still considerably high. To achieve the Millennium Development Goal 5, which includes reducing maternal mortality and achieving universal access to reproductive health, innovative products like the one being implemented by HiH are a necessity. Medical expenditure in general is a tremendous burden for villagers with low incomes. From the success of the pregnancy loan scheme, HiH wanted to create further healthcare financing tools

My role involved carrying out fieldwork where I was responsible for interviewing members of the self help groups (SHGs). These consisted of 12-15 women who had received loans from HiH to set up enterprises, and from them I had to understand what their main source of debts was, what type of treatments they currently spent most of their money on and what their and their families health track record over the last 12 month was. Combined with this I had to find out whether they would be interested in a community based health insurance product and if so what they would want covered and how much they would be willing to pay for the scheme.

The scheme would involve the villagers pooling together limited resources in order to be covered for select treatments. The vast majority of treatments the villagers wanted covered were gynaecological treatment including cancers, contraceptive procedures, accidents, major surgical cases, eye surgery and minor health cases including colds and fevers. In terms of willingness to pay, many were limited to the idea of paying Rs 30-300 per month (GBP 0.40 to 4)

The experience at HiH was extremely satisfying even though very tough at times. Many did not understand what insurance was let alone health insurance so the task at times felt unachievable. In addition to this was the language barrier. Having a translator helped immensely however at times it was very frustrating trying to get the

same message across. However challenges were met, data was collected and useful conclusions were made.

The final leg of my adventure involved experiencing real India by travelling across the country. As the North and South cultures had been covered through my elective work, it was time to head to East India from where I would go across to West India. I managed to fit in Kolkata, Darjeeling, Delhi, and Rajasthan in the two and a half weeks I had left.

The elective period spent in India has undoubtedly been an eye opener. In terms of personal development, I have made networks and have memories which will last forever.

From my first placement at LWH, I am now able to understand and appreciate how healthcare is practiced in poorly resourced settings. This experience has been moving and allowed me to witness at first hand the inequalities that truly exist in the world. If only the vast majority of patients that attend hospitals like LWH were born or brought up in a slightly more affluent part of the world, they would have the latest medical resources at their disposal whenever they desired.

However at the same time, the elective has enabled me to realise the importance of giving back to society, to those who really do need help, to those who are less privileged, to those who only want happiness through good health and family life. For me it is now a personal challenge, a mission and a duty to remove these inequalities and provide access to healthcare to as many souls as possible. It is their right and we cannot deny such a right.

India is vast, virtually a continent within a country. With 1652 languages and dialects, a population of one billion plus and every state being different from another, the challenges are countless. The public health system within the country remains broken and providing quality healthcare to rural people remains a significant hurdle. We must address this problem and we must take responsibility to solve what we are able to do. We should act with probity and integrity. The future of developing countries and their

health does not depend on aid. It depends on innovative products, it depends on its people and it depends on its governments. The future lies in their hands.

On the flight back to London, I decided to ask a few travellers what they made of their experience in India and whether their adjectives would match upto mine. 'Vibrant, diverse, spicy, busy, hot, dusty, cold, exotic, aromatic, polluted and unique,' were some of the words they used. It is interesting to note how one country can have such a wide range of descriptive adjectives.

It would be appropriate to end by asking myself whether I achieved the aims I set out with and I feel the answer has to be yes. I have most certainly come back a changed individual, someone who wholly believes that we can help remove some of the inequalities that exist in the world. In addition to this, I have gained a lot more than imagined including the art of brewing a good tea, but of most surprise the realisation that I can actually use my camera and could potentially have a knack for photography.

I must end by thanking those who have made this journey possible. With the kind generosity of The South Asian Health Foundation, The Royal College of Obstetricians and Gynaecologists and Ethicon, The A H Bygott Undergraduate Scholarship from the University of London, The Lightfoot Travel Scholarship from King's College London and Gwen Rhys, my mentor and friend. These awards and funding also allowed me purchase supplies for LWH.

I have been able to make a difference in promoting access to healthcare to those who need it most; albeit a minuscule difference and I shall forever remain thankful. My plea is to encourage more medical students to apply for such awards. I feel privileged and honoured to be involved with taking part in projects for those who need it most, especially women, and I hope to continue for decades to come.

Thank you once again.

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