Elective Grant Report

A very happy day spent exploring the mystical Taj Mahal

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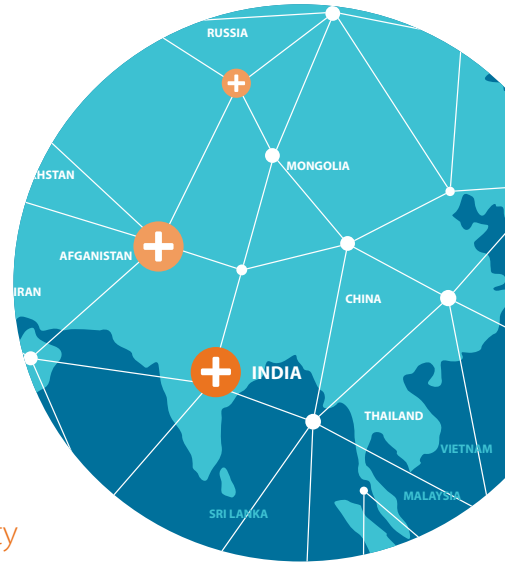

I completed my elective at Christian Medical College (CMC) in Vellore, India, with the support of the MIGA Elective Grants Program. CMC is composed of a medical school, a large tertiary hospital, and several smaller community health programs. My placement consisted of two weeks in the Obstetrics and Gynaecology department, and two weeks in the Community Health and Development (CHAD) program. Both departments provided unique and challenging opportunities to broaden my understanding of medicine within a developing country and a different cultural context. In many ways, I went into this elective with as few expectations as possible. Having travelled to India before, I was somewhat prepared for the complete saturation of senses I would experience; the sounds of car horns and friendly voices and barking dogs, the smells of hot samosas and steaming chai, the colours of intricate saris and ornate doors and bursting shopfronts, and the drenching humidity that was thankfully at its mildest in the early weeks of December. Despite these familiarities, the first few days of my trip still took some adjustment, as my sleep cycle reset and I let myself become slowly immersed in the pace and rhythm of life in Vellore.

CMC has a well-structured electives program, so the process of arrival, check-in and orientation all ran smoothly. We stayed on the hospital's 'Bagayam Campus', where both the medical school and all staff and student accommodation is situated. The campus was a true oasis. It is built like a small village, with dirt roads, lush tropical gardens, sporting facilities, a canteen and a well-stocked store. There is even a privately-owned swimming pool a few hundred metres down the road, which I retreated to every now and then for some leisurely laps. We were housed in Modale Hostel for International Students, so quickly befriended many other medical students from Australia, the USA, Sweden, Malaysia and Germany. Additionally, living amongst the local medical students, doctors and university staff was a true pleasure. Everyone was welcoming, and quick to make sure we felt at home. We formed a particularly special relationship with Latha, the woman who works as a kitchenhand in the canteen where we ate at least once a day. Despite the stark Tamil-English language barrier between us, our laughs and gestures broke down any communication difficulties, and she even invited a bunch of us to her own home for breakfast one morning.

The medicine at CMC was in many ways not dissimilar to the medicine I have experienced at home. CMC is a highly regarded hospital. Patients travel from all over India, and even from neighbouring Bangladesh and Sri Lanka, to receive exceptional healthcare. However, the structure of India's healthcare system is starkly different

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The international students out front of our accomodation, Modale Hostel

Hilary and I, tired but happy after a day in the mobile clinic with the CHAD Team

Grateful to my new friend for carrying me across the Jaisalmer Desert

Everyone is welcome at the CHAD mobile clinics!

to what we experience in Australia. Most resources and services come at a cost to the patient. There are some government-owned hospitals in the country, but most are privately owned, either by independent organisations or religious institutions. CMC is predominantly owned by the Christian church, and distributes its funding to best serve a broad demographic of patients. Those who are in a financial position to pay for their healthcare are asked to do so, while those with limited means can have their healthcare partially or completely subsidised by any residual funds. For most patients, this means contributing in at least some way to the costs of their own healthcare. This system unfortunately perpetuates structural inequality, and reminds us to be grateful for the healthcare that we often take for granted here in Australia.

The structure and facilities in the hospital are in many ways more limited than what we are used to in Australia. The labour ward is made up of two rooms, one for standard risk and one for high risk patients. The beds are separated by blue curtains, all of which flap madly under the breeze of a dozen fans that work 24/7 to keep the room at a bearable temperature. Having said that, I was sweating in my scrubs every day, and this was in the middle of winter! I have huge respect for how the patients and staff endure these conditions in the middle of summer, when it is 20 degrees warmer. Despite this comparably minimalist set-up, most of the necessary resources are available. However, their access is limited by the financial constraints of each patient. For example, in the main tertiary hospital, women admitted to the labour ward are given a list of the items that will be used during their delivery. They are then required to send a support person to the pharmacy to purchase these items, including saline, syringes, local anaesthetic, gauze and blankets for their baby. Alternatively, they are given an itemised bill for the resources used. The limitations of this system were most stark when observing the use of local anaesthetic for complicated deliveries, such as episiotomies. Unlike in Australia, the women were rarely involved in discussions about the types of pain relief available for them. They could theoretically request as much local anaesthetic as they wanted, but I found this happening very infrequently. It was often unclear if this was because of their financial constraints, or a cultural acceptance of pain, or a combination of both. When considering this disparity, I became increasingly aware of how fortunate we are to have a high level of health literacy and autonomy in Australia.

I was also lucky enough to experience a day on labour ward in the CHAD hospital, which is a smaller hospital that runs as part of the CHAD program. The hospital has a low-cost and resource-limited model, that is more accessible for patients on a very low income. Despite their minimal supplies, the doctors and midwives here were incredibly compassionate in coaching and supporting the women through every step of their delivery. I was repeatedly blown away by how strong, focused and determined the women were as they brought new babies into the world. They were endlessly grateful to the staff, and carried themselves with admirable poise as they embraced both the hardest and happiest parts of the experience.

Another perplexing example of different cultural expectations was the structure of the outpatient clinics. In many cases, two consults took place in one room at a time, on either side of the desk. Furthermore, multiple family members often crammed into the room to join the consultation, including children, sisters, mothers, fathers and husbands. The doctors were constantly ushering these extra bodies back out of the room, politely but firmly, however it was frequently a losing battle. As such, the consulting rooms often had up to 10 people in them at a time. The intimate details of the patient's gynaecological conundrum were therefore discussed in a setting that was far from confidential. I found this process to contrast starkly with the country's relatively conservative perception of the role of a woman, the sanctity of sex and the privacy of the reproductive system. Whilst often quite hectic, it was in many ways heartwarming to see how each patient was truly cared for by a community of people. The accompanying family were also often very helpful in providing bits and pieces of translation, as the patient and doctor may have spoken any combination of English, Tamil, Hindi, Bengali and a multitude of other less common languages. Despite challenging my perception of patient confidentiality, these consultations seemed to work in a way that was respectful and productive.

My experience on CHAD was much slower paced, and allowed time for more in-depth discussions with the patients and healthcare team. The CHAD program is built on foundations of education, public health, empowerment and equity of access. I sat in on subsidised clinics for patients in remission from leprosy, and jumped aboard a van that runs antenatal and chronic disease clinics in nearby villages. Additionally, we were lucky enough to spend a day in the remote Jawadhi Hills region, where a small team of staff coordinate several clinics. The diversity of these experiences gave me a strong appreciation for the breadth of services offered by CMC, in seeking to support people in multiple facets of life.

My weekends between placement were well spent exploring nearby towns and cities. Between the international students, it was always easy to rally up a crowd to explore Chennai, Bangalore or Tiruvannamalai (a nearby holy Hindu town). One student from Sydney, whose family is originally from Tamil Nadu, even invited us all to her wedding at the end of her placement! This was a very happy weekend of dressing to the nines, eating endless servings of food, and celebrating love and family. Another student from Melbourne had relatives living in Chennai, who generously welcomed us into their home for Christmas. We felt so embraced in a culture where hospitality, community and generosity are practiced in every way of life. After my placement, I had enough time to spend another 3 weeks travelling in north India. This was a great way to finish my trip, and I met many new friends with whom I enjoyed exploring the different food, culture and colours of the north.

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Hilary and I stopping for a rest along the Ganges

Breakfast of masala dosa and mango lassi, at the CMC Canteen

Hilary and I finished up at hospital with full and grateful hearts

I found this placement to be very significant in affirming my passion for primary care. India's healthcare providers must navigate a complex combination of poverty, limited resources, conflicting politics, multiple religions and vast landmasses. The way CMC is tackling this task, with primary care and health education at the heart of its ethos, is truly inspiring.

Furthermore, this experience has broadened my appreciation of the multiple considerations in providing healthcare to women. Effective women's health must encompass cultural understanding, social acceptance, education, affirmation and empowerment. CMC's model admirably attempts to incorporate all of these facets, whilst striving for high quality healthcare that is accessible to women of diverse backgrounds. I have left feeling more motivated and determined to work towards contributing to this field of medicine. Effective women's healthcare is a foundation upon which healthy families and healthy communities can thrive.

In keeping with my passion for primary care, I have gifted my $1,500 MIGA community grant to the Jawadhi Hills program run by the CHAD team. Specifically, this money will go towards a branch of the program that is seeking to educate and rehabilitate men who are battling with alcohol misuse. In the remote tribal regions of Tamil Nadu, access to education and healthcare for the family is largely dependent on the organisation and leadership of men. Due to recent surges in the availability of alcohol, in combination with minimal education surrounding its proper usage, alcoholism is becoming increasingly prevalent in these areas. It is predicted that 54% of men consume hazardous levels of alcohol, with introduction to alcohol beginning from as early as age 10. This is affecting the progress of other programs, such as education, primary healthcare and community empowerment. By funding the alcohol rehabilitation program, I hope to make a small contribution to the progression of a project that will impact not only the individual men enrolled, but also their families, communities and villages.

I am very grateful to MIGA for providing me with the funding to gift this grant, and for their financial support and encouragement of my elective experience. They have been immensely helpful in facilitating this adventure, and I highly encourage medical students to apply for this elective grant. Being able to contribute financially to the community you have visited is a particularly unique and rewarding part of this opportunity. I am now more excited than ever to finish my degree and commence working in a field that values not only healthcare, but social justice, equity and humanity.

Each year MIGA's Elective Grants Program offers 10 Grants of $3,000 to medical students undertaking electives in developing communities. Each Grant includes $1,500 to cover the student's personal elective costs and $1,500 to provide medicine or other aid to the local community. To be inspired by other past recipients and find out more about applying, visit our website.

MIGA's free Protection Package for medical students provides automatic cover for your elective and clinical placements. Insure with MIGA and undertake your elective with confidence – complete our simple online Application Form for immediate confirmation of your cover.

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