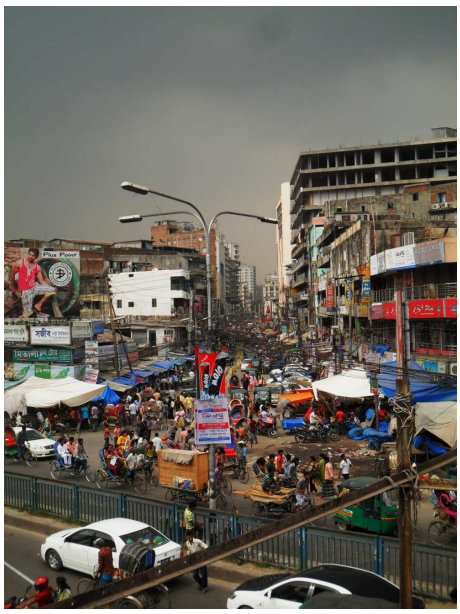

I'm still undecided as to how I can succinctly describe my experiences in Bangladesh. If I begin by describing Dhaka - hot, oppressive, busy, dangerous – it ends up sounding terribly negative, whereas in reality I had a wonderful trip. Bangladesh is not an easy country to visit, there is no hint of a tourist industry and foreign visitors are a few and far between, but those who do visit find themselves welcomed by an inquisitive but very hospitable country.

I spent the vast majority of my time in Dhaka (most recently voted the worlds least liveable city in a list of 140) working at the International Centre for Diarrhoeal Disease Research (ICDDR). The ICDDR is a giant in the sphere of public health but is otherwise largely unknown. Located in the centre of Dhaka, they run a busy charity hospital dedicated to treating diarrhoeal disease as well as housing laboratories and public health offices. The facilities are rudimentary yet they run an extremely impressive paperless system for all their medical notes. The doctors and nurses use basic palm top, touch screen devices to document patient problems, order prescriptions and to monitor patient test results. This has streamlined and accelerated the everyday running of the hospital: patients are registered and seen by someone within one minute of arrival at the hospital gates. As the system is electronic it allows constant performance monitoring, an essential tool in tracking the progress of cholera epidemics.

The wards at ICDDR hold hundreds of cholera cots, often with less than two feet between them, and are noisy, hot but surprisingly smell free and pretty clean. They have an emergency ward for acute cases, a long stay unit for more complex cases (young children, co-morbidities, malnutrition), a malnutrition rehabilitation unit and a small HIV ward. I was able to float freely between these wards but was supervised by an expert in malnutrition and child health, Dr Iqbal-Hussain. The medicine practised at ICDDR was superb, their management of patients is entirely evidence-based – much of which they have contributed to. Many of the patients I saw were brought in from Mirpur, one of Dhaka's biggest slums where cholera is endemic. The patients were often carried through the front doors cold, glazed and pulse-less. Within one minute they would have an intravenous line put in and fluids running through them. Within 30 minutes patients would seemingly come back from the dead and be sat upright, talking and able to drink oral fluids – it was amazing. I got some good experience with putting IV lines into these patients but I don't think the fluid balancing skills that I learned there will ever be applicable to my practise in the UK, we just don't see patients that dehydrated.

Prior to my arrival in Bangladesh I had intended to do a lot of travelling around the country but I soon realised that unfortunately this wasn't really a safe possibility. However, I did manage to escape the madness of Dhaka and experience more rural Bangladesh by travelling out to ICDDR's satellite hospital Matlab and with an NGO to some village projects.

The Matlab site was really very special: it was set in a lusciously green flood plain and, as it was monsoon season, many of the patients arrived by boat. It works as a cholera hospital but also as a maternal health centre with a labour ward and special care baby unit. There they have championed the use of 'Kangaroo Care' – using the warmth of the mother's chest rather than incubators for premature or low birth-weight infants. Their success rates are wonderfully high considering just how resource deprived they are.

I also managed to organise a trip out with BRAC – the world's largest NGO. To my shame, I had never even heard of BRAC before visiting Bangladesh. I visited a typical village where BRAC's programmes have been implemented and spoke to some 'graduates' of their microfinance scheme. BRAC's main focus in is on the empowerment of women and the success of the scheme is wonderful to see. What astounded me most was that the projects are run at a grass-roots level and supervised by volunteers from the community; local professionals willingly give up their time and resources to help these women and their families to lift themselves out of poverty and regain their independence and autonomy. The education of women is directly linked to improving malnutrition rates in children: 48% of children in Bangladesh can be classed as malnourished. Such generosity and altruism blew me away and appeared to be a common trait amongst the people of Bangladesh.

During my time there, I met some of Bangladesh's richest and some of its poorest people. The ex-pat community was strong in Dhaka with many social events and clubs that manage to source luxuries such as bacon and even G+Ts! I met several influential Bengali families through this community and was intrigued to hear their opinions as they had grown up in Dhaka but studied abroad. However, witnessing the extreme equality divide was something that never became easier. Bangladesh is the most densely populated country on earth and nearly 50% of its people live below the poverty line. One of the most distressing illustrations of the poverty that I witnessed was a small boy, no more than four years old, picking up out of date prescription medicines that had simply been dumped in a back street. He wasn't picking them up to sell, he was eating them.

Overall I will remember my trip to Bangladesh as a riot of colour and noise that challenged me every day. The ICDDR's passion for evidence based medicine and high quality, low cost health care for all left me inspired but also questioning just what we could do with our resources if they were better spent here in the UK.

For more information:
http://www.icddrb.org/
http://www.brac.net/