**DD: Describe yourself in three words.**

BR: I think the words would probably be ‘curious’, about the world, about stuff, about anything. Then probably kindly say to myself a ‘whirlwind’, other people would say chaotic and always creates a little bit of havoc, sometimes good sometimes bad. And I guess the third, which has probably been the most important through life, has been just this incredible feeling of being justice driven, you know, feeling injustices, often far too keenly.

**DD: Hi everyone, welcome to the Global Health Lives Podcast, I'm Delan Devakumar and today I'm with Doctor Bhargavi Rao who is a malaria infectious disease expert at Médecins Sans Frontières and an associate professor at the London School of Hygiene and Tropical Medicine. Bhargavi is a clinical doctor and public health specialist in infectious diseases who's been plying her trade in the humanitarian world. Bhargavi, great to see you again.**

BR: Very nice to be with you, Delan.

**DD: I remember looking up to you as a young and naive public health registrar. When I started I had no idea what I would be doing, I didn't really know what public health was, and you were a year ahead of me and had all this wisdom that I saw your advice on things. And we'll come on to the many different things you've done in your life, and you've gained this broad knowledge in many aspects of infectious diseases, both clinical and public health, and applied that to the humanitarian context you work in. You talk about moving accidentally from one thing to another, but what is it that drives you forward? What has it been that's motivated you to make the choices that you have?**

BR: It's very kind of you to say that I gave you any sort of wisdom. But I do think a lot of my career has been accidental because I don't feel that I ever went into any of this with a plan. I picked up things that I found interesting along the way and, I think, always remain, and still do, open and interested to new things that have come along. And even today I find myself getting involved in new things all the time. I see it as fear of missing out or an inability to close a door, but really, it's just this natural curiosity and I think the other thing is, and this is definitely from my mum, is this real sense of having to do right and just doing something that brings some right. It's naive but it's certainly something that drives me.

**DD: So, you grew up in Walsall near Birmingham in the UK and had a stint of six years in Saudi Arabia before returning as a young adolescent. You were very smart, good at languages, and then realised you were good at maths and science, and your first interest was in journalism, but you were guided towards medicine, as many in South Asian families might recognise. Can you tell us how it happened?**

BR: Yes, I had a very itinerant childhood, really. My dad was a junior doctor and so we moved every six months, often sometimes more, and I didn't come from a particularly privileged background even though he was a doctor, he was very committed to being a surgeon but, perhaps, didn't have the career success that he probably should have had. My mum has this memory of him when he couldn't find work and going to a building site to try and make ends meet and when the foreman realised that he was actually a surgeon also at the local hospital he sort of told him to stop immediately, his hands were too precious. And then at one stage we moved to Saudi Arabia which was my first experience, really, of being abroad. I went to international school and it was incredible, it opened your eyes to the world, I got exposed to different cultures, and then we came back to the UK, as you say, found I could do a bit of science, and my parents were very clear that, actually, what I really needed to do, because I didn't need patronage if I was a doctor, I didn't need connections, I didn't need to have trailblazers ahead of me or people that would help me out. They had real confidence in the system of the NHS, which of course my dad was in, but had just such belief in the good of the NHS, the ability of people to come up within the NHS, and the idea of medicine as this very stable, important profession. My mother was, like, "Oh, you can write later." Of course I never have because medicine is so busy that it squeezes all that out of you, but one day, maybe.

**DD: It's interesting, there's this idea of the migrant journey across generations and it's usually the people who move - they work in business, they don't have opportunities, so they create opportunities. In the UK, the corner shop owners and people set up their own businesses, and I see this in my own family, my uncles started their own businesses, the next generation tend to be professionals. So that first generation make sure that they have proper jobs that are secure, that are stable, that are education driven, so doctors and lawyers and these types of professions, and then the third generation become artists.**

DD: [laughs]

**DD: They're the ones where there's this family stability and wealth and then they can explore and they can do other things and take risks, I suppose.**

DD: Absolutely. I never saw people on TV that looked like me back in the day, and it's just so different now, so much to be celebrated.

**DD: So, then you succeeded, and you went to Cambridge to study medicine, but it was really your BSc that ignited your interest. This was in disease, society and sexuality. Can you tell me what it was like going to Cambridge and then how your BSc influenced you?**

DD: Cambridge was pivotal, and I was so lucky, I realise, to have gone there. I arrived, sort of, a very middle class, very protected Indian girl and I just remember that first dinner where I had no idea what to do with the cutlery, I think I must have passed out after two glasses of wine in the soup, it was just- everything was new. I learnt to cut fruit with a knife and fork, still to this day I can eat a banana but picking it up and peeling it myself, these sort of life skills that who knows if you'll ever need. It was magical, I met people that I could only dream about meeting and had exposure to history and a diversity of backgrounds and subjects that I had never come across before. And then, as part of my final year at Cambridge where I could do a BSc before moving on to clinical school, I chose something that was called Anatomy B at the time, I don't know if it still is. All my friends were doing very serious subjects, so neurology-

**DD: Anatomy A.**

DD: Anatomy A, exactly [laughs], which was a serious subject, and then Anatomy B was disease, society and sexuality, and it was about exactly that, the impact of community, of media, of stigma, of sex, of all sorts on disease, of race, and for me this year was pivotal because it introduced me to things I had no idea about. I'd come from a household where we still don't watch sex on TV together and it's never talked about and suddenly we had these discussions, and as part of one of the projects I read this book, Randy Shilts, *And the Band Played On*. It was about the first identified cases of HIV and this idea of this patient zero, a pilot from San Francisco, and it blew my mind, and it started a lifelong love of infectious diseases, undoubtedly. But it also, I think, fed into lots of things that I had probably imbibed along the way about- by this stage I had started going to leprosy treatment centres in India when we went, it just brought into play a little bit, again, this justice drive. That there are vulnerable groups, that there is injustice in this society, and somehow it perpetuates disease and particularly infectious disease, I love story was born.

**DD: So, from there you worked as a clinician in infectious diseases in London working with the great and the good at the time. Can you tell me about your time in clinical medicine?**

DD: Yes, so I did my clinical studies at Oxford and then came down to London after that, and I think by this stage I knew that I wanted to do something infection related and I harangued people until I managed to get jobs at some really wonderful places and incredible infectious units to work at. Well three - the Hammersmith Hospital at the Hospital for Tropical Diseases, what was special is that I worked with people that had spent years in the field. It inspired me to realise that I could go out and work in the field, and that's what I needed to, I couldn't practice infectious diseases global medicine from London. And it was funny because it was on the floor of an A&E department where I met Carlton Evans who, at the time, was a registrar at the Hospital for Tropical Diseases, and he gave me, I guess, my first break. Which was he helped me set up a small research project and I went to Peru. Didn't speak Spanish, landed in Peru, had no idea where I was going. It'll make you laugh, of course, Delan, you also have a South Asian mum, my mum didn't know what to do with the idea that she was sending her daughter somewhere where she had no contacts. And, bless that woman, she through hook or by crook, found someone she knew that knew someone who had done a research project and had Peruvian friends.

And so, within a week of my arrival in Lima I had an invite to a Peruvian family who cooked for me and were amazing and were my family link there. But it was a real, again, an eye opener, it was a game changing experience for me, to live in the country, I lived in a very underprivileged area of Lima, I did some research around malnutrition and TB in the slum areas of Lima and in Iquitos and in the jungle areas, I mixed with other researches from Johns Hopkins and a group led by Robert Gilman who were really special because, again, I learnt a lot about what it meant to locally capacity build, his collaborations with Peruvian universities have been incredibly fruitful for Peruvians as well as for diseases that they've looked at, and it showed me the right way to do some of this work.

**DD: So, then you packed your bags again and did a Masters in public health in Harvard and then to a start-up NGO for three years in South Africa working on HIV treatment and management, and it sounded like a really exciting time, a time when there was a realisation that something could be done about HIV. Can you tell me what it was like working there in South Africa?**

DD: I ended up getting a job to be an HIV adviser to a start-up NGO that was linked between Harvard and PEPFAR which was then the President's Emergency Plan For AIDS Relief, and I landed in South Africa and on my very first day I got mugged at knife point, although, ironically, the guy pulled a knife and held it to my neck but then asked all the white people in the group for their money but didn't bother asking me for anything. Which is a recurring theme, again, in my time- was one of the real insights I had of my time in South Africa, what it also felt like, in inverted commas, an ex-pat. It was very easy for me to do the work, I felt much less threatened, I think, than other people in the groups, which was essentially to go daily into township areas and engage black, private GPs, often, and again, a relic of the apartheid system was, you know, these black doctors weren't necessarily working in the big, prestigious city hospitals, but they were in private general practice within the townships and so we thought that this was, perhaps, the most effective way of expanding the anti-retroviral treatment roll out to these areas where healthcare access was difficult, but we could both sponsor but use existing private GP capacity to help that treatment, and it was incredibly effective. The NGO grew massively during my short them there, I learnt a lot about medicine in South Africa because I've also practised at a local hospital, travelled the country going to townships and engaging people in responsibility for their own treatment. It was quite an interesting time to be in South Africa as well because it was also still the legacy of Manto Tshabalala who didn't believe in treatment of HIV. So, it was back in those days where it would be very anti-retroviral from a government perspective and so it was really interesting that this private sector rollout through NGOs were really an absolutely necessity in getting access to treatment.

**DD: And at times South Africa had the most HIV positive people in the world, is that right?**

BR: I think certainly at that time, and we would go to small villages and there would be a 50% prevalence of HIV of young people aged between, say, 18 and 40. And that was just this real worry that it was going to wipe out a generation if treatment wasn't made more available and, importantly, if stigma wasn't addressed. It was a time of great stigma and people weren't talking about it, partly because of the way that the government was handling the issue. We still see that now, of course, you know, I don't think stigma in certain groups of chronic diseases has gone away and we know that minorities are still persecuted for disease as well with very limited access to treatment.

**DD: So, then you returned to the UK, joined the public health training programme, started a PhD in infectious disease modelling at Imperial College, and this is the group that's now famous for its work on Covid-19.**

BR: All a little by accident, I just want to also point out.

BR: I came back in a very unplanned way, ended up on public health training in a slightly unplanned way, because of flight cancellations. I didn't get on to NID job, you know, I would have been happy with either, and a chance meeting on a train with my to be PhD supervisor. Just to give reassurance to anybody who thinks that people's careers are perfectly mapped out. It's about always being open to opportunities. But the PhD was about modelling malaria transmissions, a fantastic group at Imperial led by Azra Ghani, and I was the only clinician in the group and my particular interest was that they had developed this wonderful, really important, model of malaria transmission taking into account rainfall and seasonality and all of these sorts of things. But there was one step between the probability of being treated for malaria and the probability of not being treated, and that led, drove, some of the transmission model. And, essentially, my whole PhD was just blowing out that one small step into what it took to get treatment and factoring the various probabilities of that. So, what made the most difference? Was it distance to treatment and how that impacted your likelihood of seeking treatment or actually healthcare workers available to deliver that treatment, and if there was a capacity for referral onwards. So, it was a very medical healthcare delivery perspective on what was- and it gave me, I think, a real recognition of the importance- that models are brilliant, they're really useful and I'm a huge proponent of incorporating them in our work, but they need to be incorporated with some understanding of how healthcare is delivered and of medicine and of how people access and view care. And so we do need all of us to work together, in a sense, to continue that, and that's something that I hope to do in my work at the London School as well now.

**DD: And what kind of PhD was it? Were you talking to people, finding out these pathways, or was it mathematical, working with lots of difficult algorithms?**

BR: [laughs] It was a bit like *The Big Bang Theory,* you know, and I was the blond in the group. I was the only medic and everyone else was a mathematician or a physicist or incredibly clever and so it was mainly maths, it was true, and I had a really steep learning curve. I was also really lucky in that I was able to go do some field work in Tanzania through the Ifakara Health Institute and the ACT Consortium, at the time led by Catherine Goodman, and they were really incredibly generous with some of their survey data, so I went and did household and health facility surveys with them in Tanzania. It was a really lonely time, though, and I think that would be the other thing I would say and, again, pivotal for me, was I fell into a real depression when I was in my first year of doing a PhD, it was incredibly lonely, I had no idea what I was doing, and I just felt so out of my depth.

**DD: How did you cope in that time, that difficult time that you had?**

BR: I think in a variety of ways. There was a completely confidential service that was then available to doctors, it isn't unfortunately anymore, where you could go and seek counselling with a consultant psychiatrist, and it was really informative to go to those sessions and just talk through some of the things that I was going through. So, I think reaching out and getting help is really important. And I think the other thing, just having to let your guard down and accept that you aren't coping. I think swallowing pride, just accepting, and also giving yourself a break.

**DD: So then, after your PhD, you joined the humanitarian organisation MSF or Doctors Without Borders, and I've worked with them in the past as a paediatrician and in cholera outbreaks. So, in an ideal world we wouldn't have humanitarian organisations, but we don't live in that world. There are so many discussions about humanitarian work, about the benefits, about the problems, and it can be such a difficult environment to work in where people find it hard to cope and to do the right thing. My question to you, which I appreciate is a broad one, is what is the right thing for MSF or other organisations, and then where do you see the future of this field?**

BR: Thanks, Delan, and I think we probably first bonded or so at an MSF scientific day. So, I joined MSF straight after my PhD and I wanted to work for them for a bit to experience the humanitarian context of global health. And I know some people laugh at MSF for being somewhat of a religious cult, but I think when you start to work it is really an organisation like no other, and it's interesting when you talk about the right thing to do because I've very rarely worked anywhere, other NGOs, the NHS, where there is such an active examination of your actions. Of course, there are these principles that underlie MSF or other humanitarian organisations' work, you know, neutrality, transparency etc., but I think there's something very special about MSF.

Real focus also on temoignage, on bearing witness, but then the really difficult tension that is examined every day about how do you square being a civic organisations, we don't work through governments, with the responsibility that gives us to serve the communities that we're in. This very great awareness that we often speak on behalf of those communities, and that's not because we feel that our voice is somehow more important than them, I think a lot of the work is about facilitating stories and bearing witness statements coming out from the countries in which we work. But there is a constant tension there of examining what are we doing, the choices we're making, and the ethics about both what we're doing and the consequences of that. You know, people talk about what is the right next thing for humanitarianism to do, short term assistance and protection in emergency situations, or is it much more how to enable aid agencies to eventually get in, is it about supporting local communities to get the resources they need? And how do organisations like MSF that were set up, originally, to think about very acute emergencies and singular emergencies, now adapt to this complex, dirty, ugly, protracted, slow onset, slow burn, crises that we see where, often in global order has also really been diminished, undermined, and how do we make, in inverted commas, as you say, the right decisions, in those? What are the absolutes that we would do and wouldn't do? And, as I say, I kid you not, that is a real daily discussion at MSF.

**DD: I think they do emergencies well.**

BR: Yes.

**DD: In cholera camps I worked in you go and set up this big camp and treat thousands of patients and dramatically reduce mortality and then pack up.**

BR: I think we do emergencies well. And there's a lot of people who think that's what we should stay doing, right, short term assistance, emergency situations, in and out and that is your USP. And, of course, I think if I look at the portfolio of missions I support, more than 70% we've been there for at least 10 years if not longer. And so, then, is that just the nature of what emergencies look like now, of course, or is it that we're just not good at making that shift? How do you make those partnerships to make those shifts? You know, who is there to shift to?

**DD: Absolutely. And it was so difficult in Pakistan. Because the Ministry of Health they see this rich, foreign organisation running this thing, why would we come in and take that over?**

BR: I remember when I first joined and there was this discussion on whether MSF should stay in Myanmar and there were these active debates about we have 10,000 people on HIV, TB treatment there and we have a huge responsibility to those patients verses those saying, "What is happening in the Rakhine Province is unacceptable and by not speaking out there, by staying silent we are complicit and there we should get out. If we're not willing to speak out, we should get out." You know, I remember people tearing their shirts off in this frustration of these arguments, but that is the nature of the debate and that's how keenly I think every decision is felt.

**DD: Myanmar's interesting, so I was there in 2008, so probably a little before those discussions but I remember the ARV programmes. And I went in again, there was a cyclone, an emergency, alongside what was running, but it was always a big question within MSF, the treating thousands of people.**

BR: Should we ever get involved in those big, big programmes anymore? And I think- so, you know, when we talk about the rights and wrongs of humanitarianism, actually, thinking has also evolved, of course, right, and so would we now go in and commit ourselves to 100,000 people on long-term treatment? It makes you very unagile as a result. And other absolutes, well, there are choices that we make, of course, we chose to ensure that abortion care was offered in every single one of our projects. We lost money as a result and we lost support, but I think that was done very much through ensuring and asking our communities about their needs, about finding different ways to ask about those needs, and I think that's a really lovely thing about what I've learnt about developing programming in a different way through MSF, and that's role inclusion of social science, asking the questions in different ways. And you can do that when you are proximate to those communities, and I think that's the other, really, the thing that perhaps guides what MSF thinks is right or not, and that is their proximity to the communities they serve, they are on the ground, and so that, I think, enables the frameworks that we set ourselves around, what we think is right, what we ought to do in a situation, how do we ensure that news or witness statements get out, and how do we keep ourselves true?

**DD: Some of the other things you've talked about previously, this decolonising concept and how that applies to the humanitarian world – are these the kind of conversations you had within MSF and where do you think humanitarianism is going?**

BR: Sadly, I think, if anything, the year that we've had has shown us that inequalities of our world, the way in which the systems certainly disenfranchise and disempower communities and I think that, for me, nothing has been more evident that there is an ongoing need for humanitarian organisations. The question is also where is the space for them and where is that being squeezed? I think, if I may, I think there's six things that will shape, in a sense, what humanitarians do. One is, as we've seen this year, there is significant inequality and that inequality creates, perpetuates entrenched vulnerability. And we will have to really look athow do we get those pockets of populations- how do we deliver much more bespoke or inclusive assistance that addresses those specific vulnerabilities? How do we tailor what our offerings are? I've mentioned this a little bit before but also the international norms have just changed, and the landscape of humanitarian crises are different, they are long and they are protracted, they are complex, and they are often multiple. You know, we have Yemen, Syria, South Sudan, DRC, Khar, and the list goes on and on, Venezuela, none of these are short, they are all different, and this is a huge stretching on humanitarian organisations. And in the past, I think, individual crises have spurred things on, you know, the International Criminal Court after Rwanda and Bosnia, things like that. But what do we see coming out of Afghanistan and Libya, Syria, that is going to change our world? There has to be something, and even Covid, that changes our norms, our- I think there's something about the climate crisis, there has to be, about what this impact is on humanitarianism. And I think that there is something about the changing nature of what humanitarian work will look like. It will be urban, it will be internally displaced people but who don't- refugees are going to be- we're going to have climate refugees, we're going to have climate displacement. We know that with global warming we're going to see an increase in conflict as the resources people fight over become water, that the nature of crises differ, so it's going to be fires, extreme droughts and extreme malnutrition. And how do we, again, change our perceptions and norms around how we develop actions for that but also how financing works around those things, you know, it's sort of the way in which humanitarian organisations raise money is going to have to change in order to think about some of these crises.

You mentioned decolonisation and, of course, this is a huge issue at the moment. I think models such as MSF and other big, international NGOs are inherently colonial, I mean, I think we have to be honest with ourselves, they are. How do we think less about humanitarianism being getting aid in and more about how do we support local communities to get the resources they need and to protect themselves? How do we make sure that the solutions we offer are not just inclusive and participatory but actually very much locally driven? And I get that that is, of course, hard when often communities are brutalised or vulnerable. I think Covid has shown us infectious diseases, more prevalent, harder control, and can cause an absolute global shutdown. I don't think that was unimaginable, perhaps, to many of us. We know that they are based on these systems of water, of sanitation, of access to vaccines, all of these things that have been revealed to be real gaps in the way in which our global governance and our global financing is structured. And I think the last this is, perhaps, something we don't think enough about. Data is the new oil, right, and in humanitarian organisations we have a huge need for data in knowing what's happening, how do we improve our efficiency in targeting? But, you know, are we leaving communities behind with the intense focus on data and information but also, how do we stop weaponisation of that data? How do we protect the communities so that they are not targeted? Reporting on section and gender-based violence statistics basically enable people to track the community better in order to perpetuate further brutality.

**DD: Thank you, there's a huge amount there, and I think I'll need to listen to the episode myself and think about all of these points.**

 **And finally, before we wrap up today, I wanted to ask about a more personal matter. You recently lost your baby late in pregnancy and this is something that people don't tend to talk about or don't even know how to talk about sometimes. I know this must be difficult, but could you share a few words about it, please?**

BR: Well- how to talk about this, well, you know, I guess it's perhaps a side effect of the sort of global health lifestyle is that I met my partner quite late in life. And, you know, you get to that stage where you sort of assume you're not going to have children and you're fine with it, and we were very excited to find ourselves pregnant completely by chance. And it was glorious, something I didn't think was going to happen and I'd resigned myself to it not happening. And, of course, I was an old mother so I had a lot of scans, a lot of inputs, and unfortunately at our week 30 scan there was an abnormality noticed that hadn't been seen before, and within a couple of weeks it became very clear that this was not compatible with life and so we were offered a very late stage abortion. And so we took that option out of kindness, to be honest. Didn't feel right to, sort of, subject our baby to more pain or more difficulty on delivery. So had a stillbirth which was incredibly traumatic, gave me a lot of insight into some of the real stigma attached within our own maternity services. Talk for a long time about just, you know, the holes and the gaps and the way that so much of our maternity service is focused around the living baby and the joy of that moment and, actually, it's quite isolating to deliver a stillborn baby and how it's not prioritised because the baby's health is not at risk and, therefore, you as a patient are really not prioritised by the service. You know, obviously, my husband and I, it's a huge pain that never leaves you, you just sort of grow around it, it's like any sort of bereavement, of course, it never diminishes in its pain, it's just you almost grow bigger around it. It was quite nice, one of my colleagues has given me some feedback today, she was very nice and she sort of reversed it to me and talked about gaining empathy from past adversity and really building pain into building your resilience, but also how you then engage with empathy in other dimensions of your life. And I think that is something that both my husband and I have done, I carry that with me, I carry that sense of loss, that pain, that feeling of being disenfranchised as a patient in a way that if I can bring hearing or justice to situations in life, that is key. My husband gave her an amazing name which I think is really special, her name was Smriti which means, in Sanskrit, in essence, ‘that which is only heard but not written’, and it seemed the perfect name for her, she didn't get quite to be written but she's very much heard.

**DD: Thank you for speaking about that. It must be difficult. It's never very easy to talk about these things.**

BR: You know what it is? It's no one talks about it, and it's actually taken me a long time to also speak quite openly about it. I think there's a lot of shame, there's a lot of- I think there's a lot of, just, you don't want to upset people who are going to be mothers or people who are mothers. It's almost like don't bring the unhappiness out, in a way, that it's not seen as a real bereavement, so grieving becomes quite- grieving is certainly something you're encouraged to do very privately. And it was funny for me, I lost my father the year after, I think about 10 months after, and, of course, that's a very public grief. But it is very interesting to me just how differently I was able to grieve in those two losses and how readily I always was to talk about dad and his huge impact on my life, it seemed so much more acceptable, and I very rarely talk about Smriti, and that's not because I am unable to but because I often feel it is unacceptable to.

**DD: So, Bhargavi, thank you for joining me today. You've had a fascinating, wide-ranging career pushing the boundaries of infectious disease prevention and management in some of the most challenging places to work. Thank you.**

BR: Thank you.

**DD: Thank you to my guest Bhargavi Rao. This episode was produced by Paolo de Sosa and myself. The theme song is *Paper Stars* by Liam Aidan. This is a Global Health Lives podcast, thank you for listening.**