PROJECT VISIT TO ARBAN UK FUNDED CLINIC JHEELPUR SLUM, DHAKA, 23 – 29 NOVEMBER 2012

REPORT ON FINDINGS BY TRUSTEES SAFFIA BULLOCK AND JO JENKINS AND CHARLOTTE WEBB

Purpose of visit

The purpose of Saffia and Jo's visit was to see first-hand how the clinic has been set up and to try and ascertain if it is being successful and having an impact on the lives of slum dwellers. Jo was to use her medical knowledge to gain a comprehensive understanding of the clinic. For Charlotte the purpose was to experience medical care in the developing world as she wishes to train as a doctor.

The Clinic – Set Up

There are 6 members of staff:

Two doctors (Dr Misty and Dr Jiasmin) who have a rota for who will take each clinic. It was easier for us to talk with Dr Misty as her English is better but both doctors appear competent. We were very impressed, particularly with Dr Misty, as how they care holistically for the patients. Dr Misty is very aware of the plight of these people and conducts her consultations very sensitively. She was giving practical advice such as to ensure water was boiled for the small children. However, it is important to note that simple advice becomes complicated when you have no money – one mother said she could not afford fuel to boil the water (cooking is mostly done in shared kitchen areas around the slum).

A caretaker – Rashid looks after the building. The clinic was very clean with everything in and orderly place. There is electricity and two ceiling fans but as yet no water connection – although there is a small sink with drainage pipe behind the doctor's desk. At present a bucket of water is used. For some clinics we observed Rashid stood on the door calling patients and keeping the crowds outside (probably not necessary when there are not foreigners visiting!)

An administrator – Ibrahim sits at a desk by the door and takes the consultation fee; issues the slip; records the number of patients and keeps the ledger where medication prescribed is signed for (sometimes with a thumb print as many slum dwellers are illiterate). He also liaises with the drug company reps who visited while we were there.

Two assistants - Sweety and Shireen. These girls are teenagers from the slum. They first worked as volunteers but since July have been paid. Shireen assists the doctors and Sweety assists Ibrahim. Both appear very competent in their roles, doing blood sugar tests, taking blood pressure. Their local community knowledge is also invaluable.

ARBAN Project Co-ordinator – Atique. It was Atique who showed us around and translated for us. He demonstrated a good knowledge of the project and commitment and enthusiasm. ARBAN is headed up by Dr Kamal who founded the NGO in 1984. Kamal is a humanitarian, deep thinking and ideological. He is committed to improving the lives of Bangladesh's poor. He is also well travelled and aware of how the West operates. ARBAN work with many other charities including Water Aid and UNICEF.

Volunteers – there is also a team of volunteers. Atique explained they help in the clinic as required and are also helping with the baseline studying being undertaking to ascertain the current number and health of slum dwellers. This is due to be completed in December 2012. The volunteers we met were very friendly and enthusiastic and seemed genuinely helpful. Atique explained that on the Friday before our visit he, Dr Misty and the volunteers had done a "clean up" in the main street of the slum.

Health Centre Management Committee – this has 17 members and is chaired by Rahima. Rahima is one of the older ladies and has lived in the slum for 29 years. She has gravitas and kudos and conducts herself with authority. They have monthly meetings at the clinic to review how it is running.

Training – in 2012 Dr Misty conducted basic first aid training for all clinic staff and members of the HCMC at the ARBAN Project Offices in Mirpur (five minutes from the slum).

Function of Clinic

The clinic is well run and organised.

There is one clinic every day but Friday, from 10am until 1pm or from 3 until 5pm. Patients arrive to be seen, pay 10 taka (TK) and a consultation slip is written out which includes the patient's age. It is interesting to observe that many patients have to think about how old they are and do not know exactly.

Because Shireen and Sweety live in the slum, they are able to assess ability to pay, so if someone can't afford the 10TK, they will be seen anyway, free of charge.

Ibrahim notes all patients seen in a ledger. Approximately 30 patients are seen each session. The registration slips are put on the doctor's desk, and she then sees everyone in order. Shireen calls patients in turn, they are marshalled very well by the helpers. (It is a bit like a health visitor's clinic).

Each patient has what we would call patient held notes. The Doctor makes notes about the consultation, and a carbon copy is made which is kept by the clinic. The patient then gets the main copy, which they are expected to bring back with them if they come back for a repeat visit (an example of patient held notes). Surprisingly, this system seems to work as most people coming do bring their previous notes. Many people have attended the clinic several times.

There is a curtain for privacy during consultations. Jo comments that Dr Misty has a very good rapport with the patients and generally makes a thorough examination of the patients. Jo had less time with Dr Jiasmin, but she seems to make some diagnoses based on what the patient says without necessarily examining them, which may lead to unnecessary treatment. However, not understanding what the patients are saying, it is important not to make too many judgements.

The doctors may refer patients to a "diagnostic centre", eg for ante-natal care. They request a discount on the patient held notes. This is often respected by the centres.

The registration slip is stapled to the notes which are taken to Ibrahim who issues the medication. Instructions are explained by the doctor and repeated by Sweety. For those patients who are illiterate, marks are highlighted on the boxes, or slits cut, to indicate how many times a day the medication must be taken. Patients sign or leave a thumb print for the medication. Pills are stored in a cupboard in the clinic. Vaccinations such as tetanus are kept in a fridge at Sweety's home.

Comments of Jo Jenkins, Paediatric nurse

I was initially surprised that many patients were attending the clinic with relatively minor ailments, for example a headache. However, because most people aren't educated well enough to have any understanding about their health, they don't understand what is wrong

with them. Along with the minor ailments, whilst we were there, the doctor saw many patients with long-term health problems, such as hypertension and hyperacidity which require chronic treatments. Also the clinic is able to pick up cases of malnutrition and more serious illnesses such as leprosy and TB.

The doctors treat all symptoms with their best guess, many of which don't really need treatment. Often they will advise the patient to go for a diagnostic test, such as an X-ray, but the patient won't go because they can't afford it. Also, because culturally there is an expectation that if you go to the doctor you will come away with a prescription, it would be difficult to change this. Everyone who attends the clinic leaves with at least one medication, most with 3 or 4. I am concerned that as we are paying for the drugs; we should try and encourage the doctors to be a bit more judicious in their prescribing. An example would be ensuring a patient would really benefit from prescribed antibiotics. For example, if a patient reports a sore throat, examine them to gauge extent of the problem and prescribe paracetamol for pain, but not antibiotics unless obviously unwell with significant pyrexia.

Also, many of the patients who have chronic problems are on long term medication, e.g. hypertensives. Funding long term medication could work out to be quite expensive.

We have been funding nutrition support for a few very needy people. We believe that this is only prescribed to those who are in real need. The food is given to the person actually in the clinic, and they must eat it there. It is proper food such as eggs and vegetables. We saw an extremely poorly looking malnourished baby in the clinic, who was 13 months, and only on formula/cow's milk, not breast milk. This baby was started on the nutrition program. If we are concerned about the funding of this, I think that we could limit it to a certain amount of people at any one time.

Finally, a real positive is that Dr Misty has been doing a monthly antenatal group where she talks to pregnant women about health during pregnancy. For example, going to the hospital, if possible, and signs and symptoms of pre-eclampsia. I would like us to be able to build on the clinic's ability to help pregnant women deliver live and healthy babies. We have discovered that most babies in the slum are delivered in the slum by '*Dais*', who are birth attendants with limited or no formal training. Most women can't afford to go to hospital and their husbands believe it is better for them to have the babies in the slum, probably because they don't want to pay the hospital fees. As a result of this, many women who we spoke to have lost one or more babies during delivery or shortly after birth. I don't think we have the ability to influence the culture of not going to hospital, but I think we can help by providing further training for the Dais. The Dais are women of standing in the community. Rahima, the chair of the HCMC, is a Dais and she told us that the training she had already received from ARBAN a few years ago had been helpful. I therefore think that she would be accepting of further training and could influence the other Dais. With further training, the Dais could be taught to recognise problems and educated to encourage hospital attendance where there is a problem.

Summary of observations by Jo Jenkins

I believe the clinic has had a very positive impact on the ability of slum dwellers to seek and receive primary health care. Health promotion is a part of the clinic's role and the doctors are able to do some health promotion at consultations. The women's health promotion groups will start in December. We can't do everything for everybody, but I believe improving antenatal care is another relatively cheap thing that we can help with. With the large amount of drugs being prescribed, I think we need to consider collecting some payment for them, especially as we are supporting some people who have long term drug needs, and we also need to liaise with Doctor Misty to encourage reduction of unnecessary prescribing.

Summary of observations by Saffia Bullock

I was very impressed by what I saw. I believe the clinic is functioning effectively and efficiently. I was impressed by the processes which seem to be well thought through and seemed to be working.

I was also very impressed and moved by the sense of community around the clinic. There is respect for the clinic and people are proud to work there. Sweety's dad told us he said to her "you serve, not for money but for the community". There is a sense of commitment and pride from the staff. The clinic is clean, well ordered and well set up.

Without data it can be difficult to assess impact but the impression is that the clinic is improving lives. Women are receiving ante-natal care that they wouldn't otherwise have. Monthly ante-natal sessions are run where advice is given as well as check-ups. I asked one patient if they would have gone to a doctor otherwise and he said yes, when he was able to raise the money. So people now have better access to healthcare and this could solve problems in the long term. For example a woman with leprosy was referred to the leprosy clinic at the early stages of the disease which will help her chances of cure and stop the likelihood of the disease spreading.

I do have concerns about the amount of medication being prescribed and how much this is costing each month, but believe that we can solve this problem through discussion with Dr Misty; encouraging a contribution and insisting with ARBAN that the initial budget is adhered to, which will in itself focus the doctors on what is being prescribed.

Reflections from Charlotte Webb, aged 16

I felt that the clinic was very useful. It provides free medicine for people who really need it and couldn't afford it otherwise. The system used for running it is very efficient and means that the clinic doesn't become chaotic or over-crowded. The building was clean and everyone obviously understood and respected the fact that it had to stay that way. Although the equipment wasn't the most advanced technology, it was used correctly and was helpful for diagnosing things. Both doctors understood the patients and were sensitive to their conditions.

I could see that the clinic also added to the slum's already strong sense of community. Everyone seemed very proud of it and as everyone who works there, excluding the doctors, lives in the slum they are able to make sure no-one is treated if they don't live there or is charged if they can't afford it.
Overall the clinic is very good and I believe it has made a huge difference to all the people who live in the slum.

Recommendations and actions

Controlling the cost of medication: As the monthly drug bill is set to exceed the budget we have asked Dr Misty, Kamal and Atique to discuss with the HCMC the idea of charging patients a small amount for drugs, e.g. a prescription charge of 5-10TK, which would still be much cheaper than if they bought it elsewhere. Certain rules probably could be applied; such as children under a certain age and pregnant women shouldn't pay for the drugs, or people who really can't pay. Alternatively, we charge a small charge per	Jo to contact Dr Misty to discuss concerns about the monthly medication bill. This will be a "soft" way to get Misty to think about the amount being prescribed. Matthew Bullock to prepare cost estimates and projections using figures provided during the visit. Await feedback from ARBAN regarding suggested 5TK contribution. Matthew Bullock to meet with Kamal and

medicine, which may encourage the doctor to only prescribe what is really necessary. Misty said she thought there would be some hesitation about this but we made it clear that a large medicine bill without contribution could mean that funding for the clinic was not sustainable.	Atique in January 2013 to discuss budget and projected costs.
Jo would like to encourage a GP from the UK with suitable and appropriate experience, and who has an interest, to visit the project on the pretext of helping Misty to rationalise drug prescriptions.	
Training for dais	Jo Jenkins to discuss with Dr Misty whether a placement in the hospital can be arranged.
We should continue to support the nutrition program if we can but limit the number of people receiving it at any one time.	
The Bangladeshi government is providing vaccination for babies and also the contraceptive pill for women, free of charge. HIV is an increasing problem in Bangladesh and therefore health promotion regarding this is important and leaflets could be provided in our clinic.	
With the microscopes we have provided, something we may be able to do in future is blood group testing for pregnant women, so that if they do need to go to hospital they know their blood group. Postpartum haemorrhage is common. I would like ARBAN Bangladesh to find out for us how much blood testing reagents would be and how much it would cost to train a technician. This could be one of the people who work in the clinic already, as they wouldn't be needed all the time. I think this may be beyond our means at present unless it can be incorporated into an agreed budget.	Follow up with ARBAN Bangladesh about cost of training.