# Taking Doctors Where the Ultra Poor are:
## Assessment of the Panel Doctor Scheme of CFPR/TUP Programme

**Syed Masud Ahmed**
**Mohammad Awlad Hossain**

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**BRAC**
BRAC Centre, 75 Mohakhali, Dhaka 1212, Bangladesh
E-mail : research@brac.net Fax: 880-2-8823542, 8823614
Telephone : 9881265, 8824180-87 Website: www.bracresearch.org
*and*
**Aga Khan Foundation Canada**
360 Albert Street, Suite 1220
Ottawa, ON K1R 7X7, Canada
Telephone: 613.237.AKFC (2532), Fax: 613.567.AKFC (2532)
Website: www.akfc.ca

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## FOREWORD

Over a quarter of Bangladesh's people live in extreme poverty, not being able to meet even the barest of the basic needs. They spend most of their meagre, unreliable earnings on food and yet fail to fulfil the minimum calorie intake needed to stave off malnutrition. They are consequently in frequent poor health causing further drain on their meagre resources due to loss of income and health expenses. More often than not, the extreme poor are invisible even in their own communities, living on other peoples' land, having no one to speak up for them or assist them in ensuring their rights. Extreme poverty also has a clear gendered face – they are mostly women who are dispossessed widows, and abandoned.

The extreme poor are thus caught in a vicious trap and the story of denial and injustices tend to continue over generations for a large majority of them. Thus, a vast majority of the extreme poor in Bangladesh are chronically so. The constraints they face in escaping extreme poverty are interlocked in ways that are different from those who are moderately poor. This challenges us to rethink our existing development strategies and interventions for the extreme poor, and come up with better ones that work for them. This is the challenge that drove BRAC to initiate an experimental programme since 2002 called, 'Challenging the Frontiers of Poverty Reduction: Targeting the ultra poor programme.' The idea to address the constraints that they face in asset building, in improving their health, in educating their children, in getting their voices heard, in a comprehensive manner so that they too can aspire, plan, and inch their way out of poverty.

The extreme poor have not only been bypassed by most development programmes, but also by mainstream development research. We need to know much more about their lives, struggles, and lived experiences. We need to understand better why such extreme poverty persists for so many of them for so long, often over generations. Without such knowledge, we cannot stand by their side and help in their struggles to overcome their state.

I am pleased that BRAC's Research and Evaluation Division has taken up the challenge of beginning to address some of these development knowledge gaps through serious research and reflection. In order to share the findings from research on extreme poverty, the 'CFPR Working Paper Series' has been initiated. This is being funded by CIDA through the 'BRAC-Aga Khan Foundation Canada Learning Partnership for CFPR' project. I thank CIDA and AKFC for supporting the dissemination of our research on extreme poverty.

I hope this working paper series will benefit development academics, researchers, and practitioners in not only gaining more knowledge but also in inspiring actions against extreme poverty in Bangladesh and elsewhere.

**Fazle Hasan Abed**
Chairperson, BRAC

# Taking Doctors Where the Ultra Poor are: Assessment of the Panel Doctor Scheme of CFPR/TUP Programme

*Syed Masud Ahmed and Mohammad Awlad Hossain*

**ABSTRACT**

To facilitate access of ultra poor households to qualified allopathic care, especially for moderate-to-severe and chronic morbidities, the Challenging the Frontiers of Poverty Reduction/Targeting the Ultra Poor (CFPR/TUP) programme appointed a panel of doctors in its Area Offices. This study was carried out to assess the current status of this 'panel doctor' scheme, identify its problems and prospects from a participatory perspective, and suggest remedial measures for future improvement. Two *upazilas* from each of the 12 CFPR/TUP regions where the scheme is running for more than one year were included in the survey. Research activities included inventory of physical facilities, participant observation of the services provided, and exit interviews of the patients coming for treatment in these 24 sites. In addition, in-depth interviews with 12 panel doctors and six focus group discussions with groups of health workers and the community people were done. Findings reveal that the scheme was received favourably by the ultra poor and the beneficiaries were satisfied with the services of the panel doctors. However, some concerns were raised with respect to responsiveness of the scheme as also financial restrictions imposed such as capping the costs of medicines and lab tests. These issues need some rethinking in order to improve the ability of the scheme to mitigate the income-erosion consequences of ill-health for the ultra poor households and contribute to their efforts at sustainable livelihood.

## INTRODUCTION

Microcredit/microfinance programmes of the non-government organizations (NGO) are documented as an effective and powerful poverty alleviating instrument in Bangladesh (Husain 1998, Chowdhury and Bhuiya 2004). Health interventions are integrated in its core activities and the success of microcredit programme as a health intervention tool is reported elsewhere (Nanda 1999, Bhuiya and Chowdhury 2002, Pitt *et al.* 2003). However, it is now well recognised that this regular microcredit intervention is not enough to effectively reach the 'poorest of the poor' or the ultra poor who constitutes about 36% of the population and are excluded. (Husain 1998, Evans 1999, Halder and Mosley 2004, Rahman and Razzaque 2000). Reasons cited include both demand-side factors such as poor initial endowment of household, opportunity costs for attending meetings and income-earning activities, absence of adult males in the household, and supply-side factors such as screening out the potentially risky clients by the programmes.

This has encouraged BRAC, an indigenous NGO (http://www.brac.net), to test innovative approaches for addressing the problems of the extreme poor in recent years (Matin and Hulme 2003). Experiences gained from these activities were used to design a customized development programme for the 'ultra poor' called "Challenging the frontiers of poverty reduction/targeting ultra poor (CFPR/TUP)." Launched in 2002, the CFPR/TUP programme is based on income-generating asset grants, subsistence allowance, skill-training, social awareness development training and pro-poor advocacy, all delivered over a cycle of 18 months (BRAC 2001). Once the grant phase is over, it is expected that they will attain the foundation for sustainable livelihoods and participate and benefit from mainstream development programmes. The programme recognises the role of good healthcare in poverty-alleviation activities and designed specific health interventions to that end. Experiences have shown that the poor, especially the ultra poor, are often not able to take full advantage of the officially free services provided under existing essential healthcare (EHC) package (maternal health, family planning, communicable disease control, child health, and basic curative care) at primary facilities (BRAC 2001). Reasons identified include lack of access to information (on available services), lack of health awareness (unfelt need), lack of opportunity (exclusion from social and health institutions) and inability to pay (income poverty). The health component of the CFPR/TUP programme tailored specifically to overcome these barriers consisted of EHC services, counselling and consumer information on health and health services, free installation of latrines and tube wells, identity card for facilitated access to health facilities, and financial assistance (for diagnostics and hospitalization, if needed) through community mobilized fund (Hossain and Matin 2004). Thus, the health inputs served as a safety net against the income-erosion effect of illness.

To facilitate access of the ultra poor households to qualified allopathic care, especially for moderate-to-severe and chronic morbidities, the CFPR/TUP programme appointed a panel of doctors in its Area Offices (AOs). These Panel Doctors were appointed from among the available MBBS doctors in the area, one for each AO. They attend patients for one hour a day for five days a week and are paid a modest honourium (Taka 1,000 plus Tk 200 for transport per month)[1]. The panel doctors provide services to BRAC under a written agreement. The patients are usually selected and referred by BRAC's community health volunteers (*Shasthya Sebika,* SS) and community health workers (*Shasthya Kormi,* SK and Programme Organizer, PO). Ideally, facilities in the AOs consist of an adequately furnished and clean consultation room with curtained examination table and hand-washing facilities in an attached bath room or some nearby place. Basic medical equipments such as a stethoscope, a sphygmomanometer, thermo-meter, tongue depressor, torch and covered metal tray with surgical instruments for wound care are provided. No facilities for investigations are available, which if needed, have to be done from outside. Consultation is free and costs of prescribed medicine and any necessary investigations are paid by the CFPR/TUP programme, within certain limits.

An in-house review in January 2005 and a mid-term review by donors in March 2005 identified several problems with this panel doctors scheme:

[1] Effective 1st April 2006, this has been changed to two hours per day for four days a week. The honorium is now Taka 2000 per month only including conveyance.

- The panel doctors, recruited from public sector, were not disciplined in 'BRAC culture' and accountable to BRAC
- Diagnoses were mainly based on clinical findings, even if the illnesses were chronic in nature
- Supply driven demand and poly pharmacy

The mid-term review concluded that "BRAC panel doctor scheme appears to be falling short of the quality of care and efficiency of service delivery achievable at BRAC Health Centres (*Shushasthya)*." With this background, a comprehensive study is proposed to gain an in-depth understanding of the current status of the Panel Doctor Scheme and its problems and prospects.

**Objectives**

This study aims to study the current status of the panel doctors scheme including its problems and prospects in the CFPR/TUP areas. Specifically, the study will explore the following issues:

1. Current functional status of the panel doctor scheme (e.g., physical facilities, patient load, lab tests performed, illnesses treated, patient satisfaction, referrals.);
2. Motivation, incentives and perceptions of the participating panel doctors;
3. Perspectives of the CFPR/TUP programme personnel (SS, SK, PO);
4. Perspectives of the programme beneficiaries (patients, members of the CFPR/TUP households)

## MATERIALS AND METHODS

Two *upazilas* (including the sadar *upazila*) from each of the twelve CFPR/TUP regions where the scheme is running for more than one year were included in the survey. Survey of the functional status of the scheme with inventory of physical facilities, participant observation of the relevant activities in the AOs, and exit interviews of the patients coming for treatment were done in all these 24 sites. In addition, in-depth interviews were done with 12 panel doctors selected randomly (one from each CFPR/TUP region) to understand their motivation, incentives and overall impression about the scheme. Lastly, six FGDs were done with each group of the health workers and the community people (CFPR/TUP household members and other poor) of six randomly chosen regions to elicit perspectives of the programme people and the community.

## RESULTS

### Functional status of the panel doctor scheme

#### *Physical facilities*

An inventory of the physical facilities at sample AOs hosting the panel doctor scheme was made with respect to basic minimal amenities required for clinical examination of patient and diagnosis of diseases (Table 1). Around 20% of the AOs did not have separate consultation room and curtained examination table. Regarding instruments, simple appliances like torch and thermometer were not available everywhere.

**Table 1. Physical facilities at the AOs hosting panel doctor scheme (N=24)**

| Physical facilities at the AOs | No. | % |
|---|---|---|
| Have separate consultation room | 19 | 79.2 |
| Have curtained examination table | 19 | 79.2 |
| Have hand-washing facilities | 8 | 33.3 |
| Instruments (for clinical examination) | | |
| Stethoscope | 23 | 95.8 |
| Sphygmomanometer | 23 | 95.8 |
| Thermometer | 20 | 83.3 |
| Tongue depressor | 18 | 75.0 |
| Torch | 14 | 58.3 |
| Tray for wound care | 20 | 83.3 |
| N | 24 | 100 |

#### *Patient load*

The mean number of patients seen in each AO hosting the panel doctor scheme in the week preceding the date of survey was around 21, with a mode of 17 and a median number of 19 (Table 2). Majority of the patients were between 15-49 years of age. Body aches/pain, generalized weakness (with anaemia) and fever were the three most common reported illnesses for which they visited the panel doctors. In-depth interview of the panel doctors also revealed similar disease profile.

#### ***Diagnostic investigations*** (data not shown in table)

In all, only 19 lab tests were ordered in the 24 AOs in the week preceding the date of survey. In an in-depth interview, the doctors explained the reasons for so low use of diagnostic tests. According to them, the patients being extremely poor to afford the costs of the tests, they did not ask the patients to do investigations routinely. Rather they relied on their clinical judgment and experience and advised investigations when absolutely necessary. Qualitative data reveal that the doctors mainly asked for X-ray and routine blood tests. Sometimes they advised ultra sonogram for complicated pregnancy. Urine tests for pregnant women and ECG for the patient of heart disease were rarely ordered.

**Table 2. Patient load and morbidity profile in the preceding one week**

| | mean ± sd | median | mode |
|---|---|---|---|
| No. of patients treated in the preceding week | 20.9 ± 15.1 | 19.0 | 17.0 |

| Age profile of patients treated | No. | % |
|---|---|---|
| 0-5 years | 77 | 15.3 |
| 6-14 years | 51 | 10.1 |
| 15-49 years | 307 | 61.0 |
| 50-59 years | 45 | 8.9 |
| ≥60 years | 23 | 4.6 |
| N | 503 | 100.0 |

| Morbidity profile of patients* | | |
|---|---|---|
| Fever (uncomplicated) | 80 | 13.0 |
| Diarrhoeal diseases | 18 | 2.9 |
| Respiratory diseases | 34 | 5.5 |
| Body aches/joint pain | 121 | 19.7 |
| Worm infestation | 16 | 2.6 |
| Skin diseases | 21 | 3.4 |
| Pregnancy related illnesses | 7 | 1.1 |
| Reproductive diseases | 43 | 7.0 |
| Generalized weakness/anaemia | 103 | 16.8 |
| Others | 170 | 27.7 |
| N | 613 | 100.0 |

*multiple response

Most doctors mentioned that they referred patients to private pathology centres for lab tests as they thought that the private clinics were well equipped with modern facilities and could response in case of emergency and also, because the *Upazila* Health

Complex (UHC) did not have necessary facilities to do these tests. Few patients were advised to go to the district sadar hospital and BRAC health centre (*Shushasthya*) for investigations.

Most doctors opined that BRAC TUP programme provided the cost of lab tests for the ultra poor. Some doctors said that they didn't know who compensated the bill related to the cost of the tests. One doctor shared that BRAC did not provide the expenses of lab tests. He added that patients did the investigation on their own.

***Observation (findings from participant observation)***

Participant observation was made in 24 AOs with respect to the physical environment of consultation, patients visit to the AOs for treatment and doctor-patient interaction. Key issues are described below under thematic heads.

*Physical environment*

In some of the AOs, doctors were observed to share rooms with other programmes such as the social development (SD) programme, BRAC education programme (BEP) and BRAC health programme (BHP). In two areas, panel doctors were observed sharing TUP training room. Plausibly, the doctors were disrupted in discharging their services as the staff used to frequently enter into the room and a crowded atmosphere prevailed. In the Nilphamari *Sadar* AO, a weekly meeting of the TUP progrmme and doctors' consultation were going on at the same time. TUP supervisor was loudly briefing the staff at the meeting. As a result, conversation between the doctor and the patients was being interrupted and the doctor had to ask the same questions to the patients repeatedly. In another instance, the designated room was observed to be occupied by a programme person from the head office. The doctor was reluctant to enter into the room and waited until it was vacated. This delayed the beginning of the session

Most consultation rooms were found furnished with adequate equipments for clinical examination. In most cases (excepting five consultation rooms) there were examination tables while some of these were not curtained. Stair to climb the examination table was not found in most cases. Consequently some patients, especially pregnant women, were seen facing difficulties in getting on the table for physical examination. Most rooms were seen neat and clean while a few were found to be unhygienic e.g., two rooms were observed to store poultry feed from which bad smell was spreading. In one AO, a toilet close to the doctors' room was spreading foul smell and people were spitting here and there. In one place, a generator was set up near the doctors' room. In most cases, there was not any arrangement for washing hands for the doctors and in few cases, they were found to use washing facilities outside the consultation room. It is worth mentioning that under the circumstances doctors were found to examine the patients one after another without washing hands.

*Waiting to be seen…*

Patients usually started to arrive at the offices few hours before the scheduled time e.g., a patient in Gaibandha *Sadar* came to the office at 10 AM while the session was scheduled to start from 2 PM. Informal discussions with the patients reveal that they came earlier as they did not know the exact timing of the session. Some patients opined that doctors examined limited number of patients in each session. If they were late, their name might have been struck off from the list. Commonly, the patients were not greeted by the staff when they arrived at the offices. They were not asked anything by the staff in most instances.

Patients were found bored while they were waiting for a long time. In most cases, there was no formal sitting arrangement for the patients. Most offices did not have waiting room for patients. In two AOs, patients and attendants shared this room with people from other programmes. Mainly open places outside the room e.g., courtyard or office corridors were used for this purpose. One or two benches were found in some places while there was no sitting arrangement for the patients in most offices. Some patients were found waiting for the doctors sitting on the ground under a tree and sometimes open places under the sun. In almost all areas, the patients were in discomfort due to the hot weather. Some people were seen fanning themselves with 'health cards' they brought with them. They were also looking for drinking water but in most cases they did not find. Children were running here and there and some were crying loudly which disrupted the working environment.

While waiting for doctor's arrival, the patients were found gossiping about the reasons for delay. They did not know the exact arrival time of the doctors. They were worried if the doctor would come at all. Sometimes they became impatient and cursed the doctors:

> *"I can't understand why the doctor is delaying. I think he is dead (moira gese)",* said a female patient who was waiting for the doctor for more than an hour. Another

male patient reacted angrily: *"I will never come to this doctor."* An ultra poor patient also expressed her apprehension in this way, *"My two goats are in the field. If I am late, they may be lost."*

In some cases, the exhausted patients asked staff and health workers about the doctors' arrival. In most cases, they did not get an exact answer from them. Rather, the staff misbehaved with the patients. *"How can I say when the doctor will come? You and me are staying at the same place,"* responded a health PO. Also, it was seen that TUP staff were worried about the doctors' arrival. Some staff were communicating with the doctors over cellular phone and requesting them to come as soon as possible. In Kishoreganj *Sadar*, the patients had to wait for three hours before the doctor came. All the patients seemed to be hungry. Some patients were seen requesting the SKs and health POs to see them earlier. A TUP member requested a SK,

*"Apa (sister), call my name at the start. I have two children at home. They didn't still have breakfast. I will have to cook. They will have breakfast when I will go home".*

*The consultation began*

Fifty four per cent session did not start as per scheduled time due to delay in doctor's arrival. The maximum duration of delay in starting the sessions was two hours while the minimum was only 5 minutes. Before the session began, the SK/PO did the preliminaries such as arranging the room, equipments, etc. and also giving serial number to the patients. However, in some places, they were not well organized which hampered the smooth conduction of the sessions.

In almost all cases, the doctors started the consultation informally by asking the patients about their family and livelihood. This was followed by questions regarding the nature of the health problems. The observation data shows that almost all doctors seemed to be cordial and attentive during the consultation. Commonly, the doctors asked about the signs and symptoms of the current illnesses in all cases, but not the history of the illnesses.

The doctors performed some common physical examinations such as measuring blood pressure and chest examination by stethoscope. Other examinations (examination of abdomen, joints, mouth, eye, ear, etc.) were done based on the nature of the complaints. Weight of the pregnant women were recorded. In accident cases, patients were rigorously examined by the doctors. Most of the examinations were done in the room in the presence of others. Some were done on the examination table. In case of abdominal examination, almost all female patients were asked to lie down on the examination table, sometimes without the bed curtained-off to maintain privacy. Overall, the doctors did a careful examination of the patient and time was allocated depending on the seriousness of the illnesses. They were found to spend six to ten minutes for examining a patient with critical illnesses such as lower abdominal pain, chest pain, hypertension and accidents compared to around three to four minutes for less severe conditions.

*Ending the consultation*

Usually, the doctors did not discuss the condition or the treatment with the patients or the attendants at the end of the session. They simply told the patients, "Go outside and wait *(bahire giye opekkha koren)*." They also gave advice to the patients regarding life style changes e.g., giving up smoking and chewing tobacco. In case of pregnant women, doctors asked them to take vaccination and to take proper rest. They also asked them to come again for ante-natal check-up. They advised the patients to take medicine regularly. In a few cases, they advised the patients to go to hospitals if the illnesses were severe. In most cases, they saw all the patients who came to them during the sessions.

*Prescription*

In all cases, written prescriptions were given to the patients by the doctors. But they did not explain the prescriptions to the patients or how to take medicines. Usually, doctors did not give the prescription directly to the patients, rather they gave it to the attending health worker. In most cases, she did not tell anything about the prescription while the session was going on. They recorded some information from the prescriptions in a register and asked the patients to wait outside for medicine,

*"Wait outside the room with other patients. Your medicine will be provided from Bazar (pharmacy). We will go altogether there after seeing all the patients."*

*Medicine*

Medicines were usually provided to the patients from the medicine shops, usually located within 1 km of the AO in the local market. The patients had to wait until the consulting sessions were over to get the prescribed medicines which also increased the time spent in the AOs. It was observed that patients were huddled

together to the market by the health workers (SK/PO). The patients frequently went to the pharmacies from AOs on foot when the health workers went there by rickshaw or motorbike. Patients unable to bear the travel cost started for the shops on foot. Patients once more waited in cues for their turn to get the medicines outside the pharmacy. In few instances, the patients waited more than an hour.

In Nilphamari *Sadar*, patients were given medicine from both *Shushasthya* and the local medicine shops where it took one and a half hour. In some areas, prescriptions were photocopied by health workers before going to medicine shops where it took more time. In two areas, the health workers distributed prescribed medicine from AOs. In another area, the health PO brought the medicine from the shop and distributed these among the patients waiting at BDP office. In Thakurgaon *Sadar,* the session ended at 7 PM and patients were not given medicine on that day; they were asked to come on the next day to get the medicines. In Kurigram *Sadar,* health PO divided the patients into some groups. When 4 - 5 patients were examined they were brought to the shop and given medicine. In all cases, patients seemed to be bored while waiting for medicine at pharmacy,

> *"I have been here since morning. I have not yet got medicine. I have many tasks to do at home."*

They seemed to be dissatisfied with the limited number of medicines (within the financial limit) in most cases. A VGD member stated:

> *"We are all involved in BRAC. We are poor too. They only provide full medicine to them (ultra poor). I can't understand why will we not be given full medicine?"*

It was also seen that health workers explained the patients how to take medicine at pharmacies. They emphasized on taking regular medicine. They also advised the patients to take regular food and to drink adequate water.

*Exit interviews*

In all, 117 respondents were interviewed at 24 AOs hosting the panel doctor scheme (Table 3). Majority of the respondents were female adults. They visited the AOs mostly for weakness, body aches/pain, and respiratory illnesses. Only 6% came for diarrhea-related illnesses.

According to the respondents, privacy during clinical examination was maintained in only 56% of instances while the condition was explained by the doctor in 77% of instances. However, all respondents stated that they were satisfied with the services received. When probed for underlying reasons for satisfaction, 58% mentioned availability of medicine while only 14% mentioned about the behaviour of the physician. Around 90% of the respondents said that they would advice others to visit the panel doctors.

**Table 3. Exit interview of the respondents/proxy respondents about the visit**

| | No. | % |
|---|---|---|
| Type of patient | | |
| Adult male | 20 | 17.1 |
| Adult female | 63 | 53.8 |
| Male child | 14 | 12.0 |
| Female child | 14 | 12.0 |
| Elderly male | 4 | 3.4 |
| Elderly female | 2 | 1.7 |
| Reasons for visit (as per respondent's/proxy respondent's reporting) | | |
| Generalized weakness | 26 | 22.0 |
| Body aches/pain | 24 | 20.9 |
| Respiratory illnesses | 21 | 17.5 |
| Hyperacidity/indigestion | 16 | 13.6 |
| Skin diseases | 8 | 6.8 |
| Diarrhoea/dysentery | 7 | 6.2 |
| Others | 15 | 13.0 |
| Privacy maintained | 65 | 55.6 |
| Condition explained | 90 | 76.9 |
| Satisfied with services received | 117 | 100.0 |
| Reasons for satisfaction | | |
| Medicine(s) given | 68 | 57.9 |
| No user fees/visits | 22 | 18.6 |
| Behaviour of physician | 17 | 14.2 |
| Other | 10 | 9.3 |
| Will advice others to visit | 105 | 89.7 |
| N | 117 | 100.0 |

**Panel doctors: profile, motivation, incentives**

Majority of the panel doctors were medical graduates with around 37% having a post-graduate degree (Table 4). They had on average 14 years of professional experience. With one exception, all the panel doctors were regular employees of the government health services.

In-depth interviews revealed that most of them were involved in the Panel Doctor scheme for 7 to 10 months, and only a few were involved since the beginning. The data show that all the panel doctors in the study areas did not attend the patients on the same day of the week. It differed from region to region. Most of the doctors attended the patients four days a week

with a few doctors attending offices two to three days a week. Most of the doctors attended patients for one hour a day. Few attended patients for more than two hours or until the patients came.

**Table 4. Profile of the panel doctors (n=24)**

| | No | % |
|---|---|---|
| Professional qualification | | |
| MBBS | 15 | 62.5 |
| MBBS plus | 9 | 37.5 |
| Current designation | | |
| Medical Officer | 14 | 58.3 |
| UHandFPO | 4 | 16.7 |
| Lecturer | 1 | 4.2 |
| Resident Medical Officer | 4 | 16.7 |
| Assistant Surgeon | 1 | 4.2 |
| Health sector | | |
| Public | 23 | 95.8 |
| Private | 1 | 4.2 |
| Duration of experience (years) (mean ± sd) | 14.5 ± 9.5 | |

***Motivation, norms and values***

Most of the doctors interviewed said that they were fascinated to be engaged in the BRAC scheme when they came to know that the scheme would provide services to the poor and ultra poor people. They also said that some of them worked earlier in different NGOs such as BRAC, RDRS and as such were interested to work in the scheme. They said that they were comfortable in working within NGOs environment,

> *"I certainly feel comfortable with BRAC's norms and values. Because, both BRAC and we are doing the same kind of jobs. We are trying to develop health status of the people especially poor people. So, I am pleased to be involved with BRAC."*

A Few doctors said that they were involved in the programme as they were local residents and felt obliged to take part in activities for their communities. Staff of the CFPR/TUP programme including the supervisor and health PO were the main persons who motivated the doctors to engage in the scheme. Besides the Area Manager (AM), Regional Health Co-coordinator (RHC) or Regional Co-coordinator (RC) also motivated them. Few doctors were motivated by the previous panel doctors.

Almost all doctors said that they were comfortable in working with BRAC. They could cope up with BRAC's ethos. According to them, the local staff were helpful and cordial. They did respect them and recognized their work.

> *"All the staff of BRAC respect me. I am very much pleased with their cordial behavior. Moreover, I like an extrAOrdinary principle of BRAC that they do not dislike the poor. It has given me much inspiration to work for the poor."*

Some doctors said that they were present there only for a short time and as such didn't experience any discomfort there. One doctor said that he was a medical officer of *Shushasthya* and knew BRAC's norms and values quite well. Only one panel doctor expressed his shock at BRAC procedure to record attendance in register book. He added that since he was a government officer, he could not record attendance in two registers at the same time. He presented his case several times before the local staff but unfortunately, he added, they did not take any initiatives to solve this problem.

***Remuneration and non-monetary incentives***

The doctors in general expressed disappointment regarding the amount of remuneration provided by BRAC. They added that though the remuneration has been increased recently from Tk.1,200 to Tk. 2,000, it is still very poor. They expressed their mixed sentiments in these ways,

> *"If you want to recruit a good doctor in the scheme, you will have to provide him/her a good amount of money. Otherwise, you would not get good doctors. In fact, the amount of remuneration provided by BRAC is very poor I think we should be provided at least Tk. 4,000 per month."*

> *"In one sense, it is a little amount (Tk. 2,000 per month) for an MBBS doctor compared to their services being offered. On the other hand, we think that the programme has been introduced to help the poor people and that's why we commonly overlook the matter."*

They recommended further revision of the remuneration. They suggested an amount in the range of Tk. 3,000-5,000 per month. Most of the doctors were reluctant to receive any non-monetary incentives. Some doctors recommended that training courses could be offered among the doctors in county or overseas while few of them opposed the training course because according to them, they won't be available to attend this course.

***Physical environment***

In quite a few AOs, the environment of the consulting room was unacceptable. In some places, the panel doctors did not yet have separate rooms and as such, rooms occupied by different programme such as BEP, SD and TUP training rooms were being used as consultation room. Rehearsal of drama and refresher of BEP teachers were observed to take place close to the consultation room. The rooms were not well furnished, lacking adequate number of chairs, examination table, and hand washing facilities in the room. Lighting of the room was not sufficient. The doctors complained that the rooms were too small to accommodate necessary furniture. They also opined that the instruments provided by BRAC were not enough for them. They were lacking instruments like tray, torch, weight and height scale and it constrained proper examination of patients. Sometimes the rooms were crowded and the doctors could not pay proper attention during consultation due to noise. One doctor said that the room had been clumsy due to its use as storage for utilities like fridge, motorcycle, etc. The privacy of the patients could not be maintained, as the examination table was not surrounded by curtain. One doctor said that he did not examine the patients properly as there was no facility to wash hands after examination. These anomalies need to be sorted for improving the quality of care provided, the doctors opined. Their disappointments are summarized in the following words:

> *"There is no hand washing facility in the room. I have to go to kitchens' basin to wash my hands that is located at the back of four rooms from here. It is not possible to go to kitchen after examination of every patient."*

> *"The consultation room is not of a quality as I expected. I have been arranged in a room belonging to Social Development Programme. A staff is seen working in the room during my consultation with the patients. I think, thus privacy between doctor and patient is being interrupted."*

***Healthcare provision***

The panel doctors mentioned that they provided treatment to the patients from BRAC AOs. Some doctors said that they also attended patients (ultra poor) at the UHC, private chambers and their home beyond the scheduled hours in the BRAC AOs. The doctors said that they by no means refused these patients and tried to provide proper treatment wherever they attended.

> *"Sometimes 20-25 patients come to me for consultation at each session. At that time, I feel reluctant to attend the extra patients though none of them are refused at last. So, it is not possible to examine properly all the patients rather I have to be rush."*

Most of the doctors usually attended 7-10 patients while some of them also attended 15-20 patients a day. According to them, the number of patients they attended per day was reasonable and they did not consider it as a load. However, some doctors thought that the number of patients they attended at each session was a burden, given the time available.

Almost all doctors were of the opinion that the consultation was being overused as it was free of cost.

> *"I believe that consultation is being over used because of free treatment. Patients are not screened out in a right way by the health workers in the field. Those who complain about health problems are directly referred to us. Many patients come with common illnesses such as general weakness that could be treated by the health workers."*

The doctors also identified some reasons behind the over use of consultation. Many patients visited the doctors with minor ailments such as fever, common cold and flu. They did not seek help from SS or SKs. Initially, they came to panel doctors without informing their nearest health workers. Sometimes patients other than TUP members came to the doctors. They had to provide them treatment as BRAC staff were supportive of them. Also, some BRAC staff came to them with minor ailments as well as unnecessary examinations.

***Remedial measures suggested to overcome over use/misuse of consultation***

The doctors suggested that the SS/SK/POs should screen out patients based on type and severity of illnesses. Common diseases like fever, common cold and diarrhoea can be treated by the SS/SK in the field. Only complicated patients such as pregnancy related ailments, asthma, chronic dysentery, hypertension and the like should be referred to the panel doctors. The same patient should be treated only once time within 15 days, unless there is any emergency. They also recommended that a ticket system should be introduced in the scheme. Patients should be charged a small amount of money (e.g., Tk 5/-only) to visit the doctors which would check misuse/over use of consultation. They also suggested to fix the number of the patients

for a session (e.g. 10 patients per day) so that proper attention can be given to those in need.

***Use of medicines***

Almost all doctors expressed difficulties in prescribing medicine to the ultra poor patients. Different types of diseases require different medicines, but BRAC allows maximum Tk. 200 per patient per illness episode. As such, they usually did not prescribe antibiotics until it was absolutely necessary as it is quite impossible to get the full course within the stipulated amount. To quote:

> *"Generally I do not prescribe antibiotics to the patients. I prescribed them when necessary. I know that they can not buy these medicines as these are more expensive. For example, traxon is an antibiotic which cost about Tk.360 for completing the course. If I prescribe it, patients will manage it collecting money from neighbours on credit. Moreover, they will manage medicines by selling rice or fowl."*

> *"It is difficult to prescribe medicine within Tk. 200. I am asked to prescribe medicine within Tk. 200 instead of illness being severe. How could it be possible! Some days ago, I prescribed a patient medicine worth Tk. 230. BRAC provided her medicine of Tk. 200. She was asked to buy the remaining medicine. But she could not buy the remaining medicine."*

They usually prescribed inexpensive antibiotics in severe illnesses and also, to complete the course already started by previous healthcare provider. Similar strategy is also adopted for prescribing steroids and NSAIDS. According to them, they would wait for at least a week before they would prescribe NSAIDS to the patients, and would prescribe steroids in case of severe asthma only. They said that they tried to prescribe as few drugs as possible and generally refrained from prescribing unnecessary drugs. Regarding rational use of drugs, they opined that their strategy of 'using medicines when necessary' and 'not using unnecessary drugs' is consistent with the concept.

***Referral and follow-up***

Six patients were referred to health facilities purpose during this period.. Three of them were referred to nearby private clinic, two to the UHC and one to district hospital. Most of the panel doctors during in-depth interview said that they kept the number of referrals to minimum because, due to financial constraints, only a few can visit. Patients having hernia, tumor, severe diarrhoea, complicated pregnancy and children having ARI and severely morbid patients were promptly referred. As treatment was free of cost or inexpensive in UHC or district sadar hospital, patients were mostly referred there. Some doctors opined that patients were also advised to go to medical college hospitals for getting specialized treatment. It is worth mentioning that people who lived in the districts adjacent to medical college hospital (Rangpur, Barishal and Mymensingh) could mostly avail this opportunity. Two doctors who were former medical officer of *Shushasthya* said that patients were also referred to *Shushasthyas.* Few doctors said that they did not refer patients to any government health centres as the government hospital was situated far away and lack better facilities. They advised patients to go to private clinics or specialized doctors (e.g. eye specialist) for specialized treatment. Only one doctor said that he generally refer patients after doing proper investigations.

The panel doctors stated that it was easy for them to follow up the patients referred to the UHC as they were posted there, and also, other medical officers (MO) working there follow up the cases. Patients who were referred to the private clinic, private doctor and *Shushasthya* were never followed up by the panel doctors. Most of the doctors said that the patients referred to different hospitals or health centres were frequently followed up by BRAC staff.

Most of the doctors stated that BRAC didn't provide monetary support to all the patients referred to the hospitals in case of severity. BRAC responded to a limited number of patients. Nevertheless, some patients were fully supported by BRAC which were continuously followed up by BRAC field staff.

***Perceptions about the programme***

During in-depth interview the doctors in the expressed favourable opinion about the scheme and appreciated BRAC's effort in helping thousands of underprivileged people who hardly have had access to the qualified physicians. Also, if the scheme didn't provide them medicine free of cost they would have suffered a lot. As they put it:

> *"Panel doctor scheme is very effective for the poor and ultra poor people. In this scheme the patients are not only given free consultation but also they are given free*

*medicine. Besides, some pathological tests are supported by the scheme. Earlier they could not imagine about these opportunities."*

However, prescribing medicine within the limit of Tk. 200 only was frequently pointed out as a drawback of the scheme. The doctors had to face difficulties in selecting medicines within this limit. They could not prescribe full courses of the medicines and in most of the cases, the patients did not complete the course by buying medicine on their own. This resulted in revisit to the doctor with the same problems later. Doctors also expressed their dissatisfaction with the limited support for pathological tests. BRAC did not provide for all the tests advised by the doctors. As a result, some complicated diseases could not be diagnosed properly in time. Few doctors said that BRAC purchased medicines from selected pharmaceutical companies under an agreement. According to them, some companies do not produce quality medicines but they had to prescribe these medicines because of this agreement.

***Suggestions for improvement***

Doctors in general suggested improving the consultation room environment and provision of necessary equipments for clinical examination. Beside covering the total cost of the full course of medicine for the ultra poor (including those already graduated but not in a condition to buy medicines and IGVGD members) and more lab facilities, the doctors also recommended appointing doctors to the densely poor outreach areas to save time and money for the poor/ultra poor. They suggested to set up some satellite clinics staffed by trained health workers (e.g., medical assistants/SACMOs) to support the scheme. The doctors also opined that BRAC staff were not adequately aware about the existing government health facilities. So, they suggested to organize some workshops/seminars to acquaint them with these facilities of the government which would also improve the GO-NGO relationship.

To reduce rush and control use/misuse of the scheme, they urged for effective field level screening of the patients (by the SSs/SKs/POs) to be seen by the doctors. They thought the more the doctors are appointed from the government hospitals the more the patients can get facilities from these hospitals. They urged to take measures for providing medicine at the BRAC AOs as the patients have to suffer a lot to get medicine from shops mostly located far away. They also recommended that some common medicines (e.g. paracetamol, antacid) should be stored in the area office all the time. This would save time, money and unnecessary harassment of the patients. Interestingly, some doctors observed that BRAC staff other than the TUP staff are less sensitive to the plight of the ultra poor and according to them, they need proper motivation in this regard. Also, the BRAC TUP staff should try to provide correct message about the scheme including limitations to avoid misconception and heightened expectations. Finally, they stated that until and unless the patients get proper diet and rest, treatment alone is not going to cure them. To quote some of their feelings:

*"The ultra poor patients should be provided full treatment. Otherwise, they will not show interest to come to us for treatment. As a result, they will not get the benefits of the programme. I recommend BRAC supporting full medicine and all pathological tests for the poor people when necessary."*

*"Patients with common diseases such as fever, general weakness should be treated by the health workers. Also, they can advise them to eat vegetables and nutritious food. Only patients with severe and chronic diseases should be forwarded to them. All the patients can be examined properly if there are fewer patients at each session."*

*"I think some field staff do not provide right messages to the beneficiaries. They should be trained up properly to response the health needs of poor people."*

**Perspectives of the programme implementers**

(FGDs/informal group discussions with the *SS, SK* and PO):

***Rationale of the Panel Doctors Scheme***

FGDs with BRAC's community health volunteers (SSs) and community health workers (SKs and POs) revealed that they were quite knowledgeable about the rationale of appointing the panel doctors. According to them, BRAC initiated this programme after realizing that it was not possible to change the livelihood of the ultra poor without improving their health. As one PO said:

*"We are providing them goats and cows. If they are sick, they cannot rear these assets properly rather they will sell these assets and will meet up their health expenditure."*

They also pointed out the poor quality of health services in the public system and its indifference to the plight of the poor/ultra poor.

> *"We don't have good government hospitals in our country. Generally poor are not treated well there. Doctors are not found there in time. Patients have to wait for hours. Though they get free consultation, they do not get medicine free of charge."*

In this regard, they said that BRAC *Shushasthya* were established to provide healthcare services to all members of the community including the poor. In the *Shushasthyas*, the consultation and medicine was not free of charge though it was inexpensive. Consequently, the ultra poor hardly could achieve the opportunities offered by the *Shushasthyas*. They also observed that the staff of *Shushasthya* did not follow-up the patients. A group of POs summarized the limitations of *Shushasthyas* in this way:

> "*Patients should be followed-up extensively after consultation with the doctors. Patients are not followed up by Shushasthya's staff. However, patients are being monitored by us (PO) as well as SSs through household visits after consultation with the panel doctors."*

According to them, BRAC is trying to fill up this gap by appointing the panel doctors close to the community:

> *"Earlier the poor people could not visit MBBS doctors because of financial constraints. Now they are getting consultation and medicine free of cost from qualified doctors. If this scheme would not be initiated, lots of poor people would have died without treatment every year."*

***Referral of patients to panel doctors***

Type and severity of illnesses were the prime factors for referring the patients to the panel doctors. Informal group discussions with the SSs and SKs revealed that the patients were initially screened by them before referring to the doctors. During their routine household visits, if they found someone sick with the ten common illnesses they are trained to manage, counseling and treatment were provided at home for three days. If the patients were not cured in spite of three days treatment, they were then referred to the doctors. To quote one:

> "*For the ten common diseases such as fever, cold, gastric, worm infection, etc., we treat the patients for 3 days. If the patients are not cured within 3 days, we call it complicated (jatil) case. Then we advise them to visit panel doctors."*

Besides SS/SKs and the Health POs, other non-health staff are also involved in referring the patients to the panel doctors or UHCs. Only severely ill patients were referred directly to the doctors by-passing the BRAC network. A non-health PO stated about the referral system as follows:

> *"Sometimes we refer patients directly to the doctors. Patient suffering from severe diarrheoa, dysentery and jaundice are advised to go to the doctors without any delay."*

Sometimes, the field staff had to comply with requests from villagers to help patients other than TUP household members. A health PO expressed her experience as follows:

> *"Some people who are not in the list of ultra poor want to come to panel doctors to get free consultation. In those cases we make them understand that the scheme is only for the selected ultra poor and they are not allowed there. We hardly refer them to the doctors, ..... in such cases, we refer them to the doctors for free consultation but they are not provided any medicine free of charge. We also inform them that they have to buy medicine from another place at their own cost."*

According to them, with the expansion of programme, it is become increasingly difficult for one PO to supervise appropriate referrals. To quote:

> "*It is not possible for one PO to control the entire field. As a result some patients with minor ailments come to the doctors without informing him/her*."

***Doctor's attitudes and compliance with BRAC norms and values***

The field staff perceived that the doctors were, in general, happy to provide services to the ultra poor. They cited an example of a panel doctor:

*"Dr. X does not refuse any patient even they come to him at the end of the sessions, rather he sees them with patience."*

They added that the doctors were providing services not for volunteerism only but also to be acquainted with the local people that would provide them more patients at private chambers. However, a few of the doctors were dissatisfied with abiding by the rules and regulations of BRAC such as recording attendance. The health workers felt that as they were not BRAC staff, they need not follow these strictly. According to them, doctors were more-or-less satisfied with the revised remuneration with some exception.

***Medicines, lab tests, follow-ups…***

Informal discussions with the POs and health workers revealed that only ultra poor household members and members of VGD card holder households were provided medicine free of charge. It was observed that arrangement for covering the costs of the medicine differed from area to area. The health workers could not always restrict the cost of medicine to Tk. 200 only per person per episode, especially in severe cases such as accidents and pregnancy-related ailments. In those cases, approval for extra expenditure was needed from head office. Even for regular illnesses, the amount was not always sufficient to cover the cost of the full courses of medicine (e.g., antibiotics). A number of SS said that sometimes patients took medicine (e.g. paracetamol, antacid) from them on credit but quite a few could not repay:

*"Some patients come to us to buy medicines on credit. But they cannot pay the bill in time. So, we do not ask for the bill any more."*

Sometimes they managed the cost of medicines by selling milk, eggs, vegetable and live-stocks. Some patients managed money from the subsistence allowance they got from BRAC under the CFPR/TUP programme and some received help from the *Gram Daridra Bimochon Committee* (GDBC). In most cases they could not buy medicines and suffered a lot. In most areas, patients were given medicine from selected medicine shops in the locality while others were given both from BRAC offices and medicine shops.

The health workers stated that the lab tests were advised by panel doctors for severe cases only. Regarding costs of lab tests, practices varied from place to place. While some said that the full costs of the tests advised were covered, majority said that they provided 50% of the costs while the patients managed the other 50%. While doing this, the patients face the same difficulties as for medicine described above.

Almost all health workers said that they did follow-up the patients during their treatment. *"We do follow-up the patients. Few patients tend to discontinue taking medicine. We regularly visit them. We create pressure to take medicine. Sometimes we examine medicine covers to be sure"*, said a health worker. The severely ill patients were also monitored by regional level staff such as the Regional Health Co-coordinator (RHC) and Regional Co-coordinator (RC), besides BRAC AO staff.

***Recommendations for improvement***

These were mainly directed to the major limitation of the scheme with respect to capping the costs of medicine and/or lab tests which was a major barrier to fruitful treatment and cure of a particular illness. Sometimes the patient had to wait for a month to get the medicine because there is a rule that patients can't be given medicine more than once in a month for the same illness. They recommended that for meaningful impact on health, full coverage of the treatment should be given.

They recommended to cover the transport costs for those coming from far away because distance was an important constraint in accessing the services:

*"Some patients live 15 km away from BDP office. They need 50 taka to meet the travel cost. They have to face many difficulties to collect the money. So, some patients do not show interest to visit the doctor considering travel cost though they are suffering from diseases."*

Alternatively, some POs suggested about holding satellite clinics in the outposts so that services reach the targeted clientele at time without incurring extra costs. The POs and health workers recommended that there should be some static clinics like *Shushasthya* for the ultra poor in every area. This is more important because:

*"Diseases do not come considering the schedule of the doctors. People can be sick anytime but cannot visit the doctor because they are not available at offices everyday. I think we should arrange the doctor everyday."*

They said that the patients can be followed-up by the doctors at *Shushasthya* as well as by them.

> *"We visit government hospitals with the patients. But we are not given importance there rather they (staff) misbehave with us. If we have clinics we can follow up patients regularly"* said a SS.

A SS who had experience working with *Shushasthya said,*

> *"Pregnant women get better treatment from Shushasthya. We brought them even at night and got proper treatment. At present, many women are suffering after closing these Shushasthyas.*

They also emphasized on recruiting some paramedics in the programme who can provide treatment in case of doctors' absence. A mini-lab at AOs to do routine tests will be very helpful for the ultra poor patients who cannot go to private or government labs for distance or lack of money, they opined. To quote:

> *"Patients do not know where to go for the tests. On the other hand, private clinics charge more money to do investigations. If we have our own laboratories, the tests done can be inexpensive."*

Lengthy process of approval of treatment/lab costs beyond allotted amount (e.g., Tk. 200 only) was raised as one of the main barriers to serve those with severe illnesses/accidents:

> *"It takes more time to approve more than Tk. 200 for medicine and Tk. 700 for severe cases. Normally, it takes one month. Sometimes it takes more than one month. We have to pay the bill from our pocket. Later we reimburse the bill. If the approval is delayed, we cannot provide our family expenses. In that cases, frankly speaking, we try to overlook the problems and don't response to the patients.*

A TUP supervisor shared his experience as follows:

> *"The process is so bureaucratic like government sector. At first health PO initiates the bill and then it is forwarded to us (Supervisor). We pass it to RC and RC delivers it to SRM. Finally it is forwarded to PC. We get it from PC after more than one month."*

Some recommendations made to solve this problem include extension of the period of IOU by the POs which are drawn to cover the treatment costs of ultra poor, approval from the regional management, and maintaining an emergency fund at BRAC AOs for this purpose.

Recommendations were also made to increase staff strength so that more close interaction and follow-ups can be done to improve the health of the ultra poor. As one non-health PO put it:

> *"We can't improve their health condition only through the intervention of panel doctors rather we should increase community level awareness."*

Occasional failure to maintain the schedule of the sessions by the panel doctors due to seminars, workshops, etc. was another concern raised by them. Some doctors also do not abide by the scheduled list of drugs used by BRAC and do not heed to their feedback. To make them accountable to BRAC, they advised recruiting doctors as regular employee of BRAC to be posted in the AOs. Finally, they said that all staff of BRAC should be sensitized to the plights of the ultra poor and made aware of the programme so that combined efforts can be taken at field level for the betterment of health and well-being of the ultra poor.

**Perspectives of the programme beneficiaries**

(FGDs with CFPR/TUP household members/patients)

Informal group discussions with the CFPR/TUP household members/patients show that most of them were aware about the panel doctor scheme. According to them, they could not visit MBBS doctors earlier for their problems; they had to rely on the nearby village doctors, *Kabiraj* and the salespeople at the drug retail outlets for treatment. As a group of ultra poor household members observed:

> *"We are poor people. We can't easily go to doctor because of financial problem when we are sick. BRAC has given us opportunities to visit MBBS doctors. We get necessary medicines free of charge from BRAC after visiting the doctors."*

They believed that the 'Panel Doctor Scheme' was introduced only for poor people like them to provide health services free of cost. To quote a CFPR/TUP member:

*"Every TUP member has been provided with a health card by BRAC. Generally patients are given treatment four days a week. If we become sick out of this schedule, then we go to hospital (UHC). If we show our card, the doctors of this hospital treat us very well. Otherwise, they don't see us well,"*

However, there was confusion among the respondents about the frequency and timing of the consulting sessions of the panel doctors. Also, a few appeared to be totally unaware about the scheme. Respondents in a FGD in Thakurgaon said:

*"Honestly speaking, for the first time I came to know about doctor (panel doctor) from your discussion. Nobody said this like you."*

*"A week ago, my son had pneumonia. I brought him to government hospital (UHC). Doctor saw my son but didn't give any medicine. I bought the medicines from the pharmacy. I had to sell eggs to manage the money. If I knew about the scheme, I could have saved money."*

***Selection procedure***

The respondents informed that the patients or their relatives negotiated with the SS/SKs before being referred to the panel doctor. Usually, they are referred when three days treatment of common conditions by the SS/SKs fail to cure the illness. As a CFPR/TUP member put it,

"*I had pain in chest and stomach (pete batha). I went to shastho apa (SS) to seek health care, she gave me some medicines. She also told me that if I was not cured within some days, I would have visited the doctor (panel doctor). I took medicine for seven days, but I was not cured. Then I went to panel doctor.*"

Patients were also referred by the POs, if during their routine household visit they come across a severely ill case. In any case, patients having problems such as pregnancy- related ailments, severe diarrohea, etc. were directly referred to the panel doctors by both health workers and BRAC staff.

***Perceived barrier to access the panel doctors***

During discussion in the groups, some barriers were identified to access the panel doctor's services by the ultra poor households. These were: financial constraints (cost of transport and medicine), lack of information about the scheme, cancellation of doctors' schedule, familial problems, lack of awareness, and suspicion of allopathic medicine.

Financial constraints were identified as the most common reason for not visiting panel doctors. These included transport costs (sometimes substantial as they had to travel from far away) and cost of medicines (as the full costs of the prescribed medicine was not covered by the scheme). To quote a CFPR/TUP member,

*"Some days ago, I visited the doctor. But BRAC did not give me all the medicines. I was only given medicine of Tk. 200. The remaining medicines were bought from the pharmacy that worth Tk. 60. That's why I didn't go to the doctor again instead of my illness"*

Lack of detailed information on the scheme was another factor preventing them from accessing the services. In some areas, there were misconceptions about the programme:

*" I did not go to doctor because I knew that BRAC did not provide free medicine. They provide only consultation free of charge."*

Familial problems such as spare time and spare person to accompany the ill person was cited as another reason for not accessing panel doctor services:

*" I am not free of work at home. I have two grand children in my home. Besides, I have a cow and two goats. How can I go to doctor leaving them at home?"*

Few participants were reluctant to go to the doctor because in earlier visit, the doctor was absent during the scheduled session. In a few cases, distrust in allopathic medicine was the reason for not visiting the panel doctor:

*"Asthma is not cured by allopathic treatment. Only homeopathic treatment can cure asthma patients. So, I am taking homeopathic medicine and did not visit doctor (panel doctor)."*

***Medicines…medicines…***

There was mixed responses regarding provision of medicine in the panel doctor scheme. Some were happy

that they got at least some medicines free of cost while others complained that they had to manage money to buy medicine when the costs exceeded BRAC approved limit of Tk. 200/- only per patient per month. According to them, they had to manage this money by various means: selling eggs, fowl and vegetables, withdrew money from the capital of their small businesses, from savings and so on. A beggar observed:

> "*I had cold and fever. Doctor prescribed me medicine. But they (BRAC TUP staff) did not give me all the medicines. I bought more medicine of Tk. 40 that I collected by begging."*

Another participant stated her experience as follows:

> *"I visited a panel doctor some days ago. He gave me some medicines and asked me to buy the remaining medicines. Every day, I would save some rice (musti chal) before cooking. I managed medicine cost by selling that rice."*

As a consequence of this, they had to cut down other household expenditure such as skipping or reducing the quantity of meals, taking low quality meals, stopping children's education and buying clothes, etc. Participants also disclosed that they were hardly supported by the *Gram Daridra Bimochon Committee* (GDBC):

> *"We did not get any support from them (GDBC) as yet. They do not have time to think for us. They only think how they become richer…most of the members of GDBC are poor too. So, they cannot give us support financially."*

Some said that they only took what they were provided free of charge from BRAC. Consequently, according to them, they were not cured and suffered from illnesses for long time. Also, the 'graduated' CFPR/TUP household members did not get the medicines totally free of cost:

> *"Earlier they (BRAC) gave all medicines. Now they give only half of the medicines. They said that there was a reservation to give full medicine to us as we completed two years with TUP programme."*

Regarding lab investigations, some participants opined that as doctors knew their conditions, they generally tried to avoid these. However, doctors advised few pathological tests to the patients. Blood test was mainly offered by the doctors. Besides, ultrasonogram and some operations were also advised by the panel doctors. Ultrasonogram was advised in case of pregnant women while doctors asked to do operation in case of uterus prolapsed and hernia. In most cases, BRAC supported all the expenditure of the investigations.

***Responsiveness of the scheme***

Participants were in general satisfied with the services of the panel doctors. Good behaviour of the doctors and the remedy of illnesses were the two prime determinants of their satisfaction. One of the participants said:

> *"In government hospitals, doctors do not give us enough time for consultation. They rush to see us. But here Mohsarraf doctor gives more time to see us. He is gentle and cordial. We can talk to him without hesitation. I am pleased with the doctor's behaviuor."*

Some participants opined that doctors not only examined them but also advised them on healthy life styles. They advised to eat proper food and to take adequate rest. They believed that panel doctors prescribed good medicine and thus they were cured soon. They also believed that panel doctors were of good quality and could easily diagnose their illnesses:

> *"I had pain in stomach. Also, I had gastric for a long time. Recently, I visited BRAC's doctor (panel doctor). He examined me and gave me some medicines. I took them as he advised. Now I am quite well. I am pleased with him."*

The participants were mostly satisfied with the cordial and helping behaviour of the BRAC staff attending the panel doctors' consultation sessions. An elderly woman said,

> *"I feel comfortable to talk to the staff. Because they are gentle. They talked to us in smiling face."*

On the other hand, some participants said that few staff seemed to be bad tempered. They did not hear their problems attentively. They feared to ask them anything. If they asked them anything, they replied in a rude manner and loudly; sometimes, they scold them. A participant observed the behaviour of a TUP supervisor as follows:

*"One day after the consultation with the doctor, I asked sir (TUP supervisor) how could I get the medicine? But he did not reply in a gentle way. Rather, he replied in a rough way that we could not give you medicine for the months."*

Interestingly, the participants considered the waiting time at BRAC (sometimes extending over one hour) to be less compared to the public facilities:

*"We spend less time here (BRAC office) for panel doctor. We have to wait for hours for the doctors at government hospitals."*

Most of the patients said that privacy during consultations was maintained while others disagreed, especially in those areas where there was no exclusive consultation room for the panel doctor scheme.

***Suggestions for improvement***

The FGD participants (which included some previous patients as well) in general expressed favourable attitude towards the panel doctors scheme. They regarded it as a "good initiative" for the betterment of the poor people. A CFPR/TUP member summarized the benefit of the scheme as follows:

*"Earlier many poor people cannot do any job because of ill health. Now they are getting treatment from the doctor and remain well. Thus, they are earning money by doing different jobs."*

They suggested following measures to further improve the scheme:

- Continuation of the scheme to provide qualified health services to the poor/ultra poor.
- All the medicines prescribed should be provided, not restricting to Tk. 200/- only. As it becomes very difficult to buy the rest, the treatment remains incomplete and ultimately, they become sick further and continue to suffer, with implications on their earning capabilities.
- Giving full support for complicated illnesses and surgery such as tumor, appendicitis, hernia, and cataract.
- Holding satellite clinics by the doctors in far-off places/villages as it is very difficult for the villagers in remote areas to travel and seek treatment at the AOs. Alternatively, they suggested for providing transport cost to the ultra poor patients so that they can easily visit the doctors.
- Recruiting some women doctors in the scheme so that women can discuss reproductive health-related problems with them.
- BRAC staff should behave and be cordial and helpful.

## DISCUSSION

This study was carried out to assess the current status of the 'panel doctor' scheme, identify its problems and prospects from a participatory perspective, and suggest remedial measures for future improvement. Findings reveal that the scheme was received quite favourably by the ultra poor, and the beneficiaries were in general satisfied with the services of the panel doctors. However, some concerns were raised with respect to responsiveness of the scheme as also financial restrictions imposed such as capping the costs of medicines and lab tests. These issues need some rethinking in order to improve the ability of the scheme to mitigate the income-erosion consequences of ill-health (reduce 'health shock') for the ultra poor households and contribute to their efforts at sustainable livelihood.

### Responsiveness of the scheme

One of the important goals of the Health Systems is to enhance responsiveness to the expectations of population by client orientation of the services provided (including attention to health needs of the patients with appropriate physical amenities) and respect for persons served (dignity, confidentiality and autonomy) (WHO 2000). Apparently, the panel doctor scheme is yet to achieve this responsiveness. In quite a few areas, lack of required facilities was observed such as absence of an exclusive consulting room with adequate privacy and hand-washing facilities, functioning medical instruments, and efficient patient load management. These compromised the quality of care provided.

Gaps remain in implementing effective procedure at field for screening patients for panel doctor consultation. This increased patient load to be managed within the stipulated time. The patients were not always well informed about the timing of the session and the doctors also did not always maintain the schedule. The procedure adopted for delivering prescribed medicines to the patients was also time consuming. All these combined to prolong waiting time and patient dissatisfaction, and increased their opportunity cost. The importance of waiting time in determining patient satisfaction was also noted in other studies from Bangladesh (Cockcroft *et al.* 2004, Ahmed and Rana 2005). The disease condition and the treatment were not explained to the patients as also the procedure for medication. This interfered with the patient's right to information about treatment and medication. The opportunity cost of the patients visiting panel doctors also increased because they were not given all the prescribed medicines due to capping of costs or required diagnostic tests done for management of chronic illnesses.

### Panel doctors

The participating doctors were in general well motivated to work in a scheme which gave them an opportunity to serve the poor and the disadvantaged. They appreciated BRAC's effort in helping the underprivileged people who hardly have had access to the qualified physicians' care. They felt at ease working with BRAC with some limitations. They could hardly provide quality services due to large number of patients scheduled at each session and restrictions imposed on the amount of medicine that can be prescribed or the diagnostic investigations that can be ordered. Suggestions for improvement included improving consultation room environment, proper screening of patients for visit, removing cap on cost of medicines and diagnostic tests, and organize outreach services through satellite clinics to extend coverage and overcome geographical and financial barriers for poor people living in far-off places. Providing correct messages about the scheme including limitations is emphasized to avoid misconception and unfound expectations. They asked for more sensitiveness on the part of the other BRAC staff to the plight of the ultra poor and motivation so as to complement each other's work.

### BRAC health staff

BRAC health staff involved in the scheme (*SS/SK*/PO) were unanimous about the necessity and utility of the panel doctor scheme for the ultra poor. They insisted that patients were screened strictly on the basis of type and severity of illnesses. However, sometimes they had to entertain requests from influential persons of the village society which may be responsible for large patient load. In emergency situations, they had to manage the extra expenditure from their own pockets which was later reimbursed from head office following a time consuming process. Besides advocating full coverage of treatment costs, they suggested holding

satellite clinics at outposts to reduce cost implications for the ultra poor, and also greater coordination among different programmes of BRAC to serve them.

**Programme beneficiaries**

The members of the beneficiary households were mostly content with the services offered by the scheme with some reservations. They were, in general, happy with the behaviour of the doctors and the cordial and helping behaviour of the staff. However, some barriers in accessing the services of the scheme emerged from the FGDs: cost of transport and other out-of-pocket expenditures to supplement costs not covered by the scheme, lack of accurate information about the services offered and costs covered in the scheme, familial problems and lastly, suspicion of allopathic medicine. Factors influencing responsiveness such as waiting time and lack of privacy during physical examination was also mentioned by them. They also alluded to the coping mechanisms of households for additional expenditures to cover the remaining costs of the medicine/tests, and its poverty implications. Extending the purview of the scheme to cover chronic and complicated illnesses (e.g., tumor, hernia, cataract etc.), and appointment of female doctors were emphasized by the ultra poor household members.

## RECOMMENDATIONS

In the context of the above findings and discussion, the following recommendations for the programme can be summarized:

**Physical infrastructure, instruments etc.**

- Exclusive consulting room with adequate facility for privacy and hand-washing facility nearby; adequate, functional instruments should be kept ready before the session begins. Hygienic environment of the consulting room should be ensured.

**Patient load, consultation environment etc.**

- Strict adherence to stipulated guidelines for field screening of patients for panel doctor appointment; the maximum no. of patients should not exceed 12 per hour (assuming five minutes per patient on average)
- Sequencing the appointment of the scheduled patients over two hours so that all do not come at the same time; this should be coordinated by the responsible PO in charge.
- Proper waiting arrangements (designated place, sitting arrangements and provision of safe drinking water) and using the waiting time productively by holding health education forums (e.g., showing some health related videos);
- All preparations for consultation to be completed by the relevant PO before the session begins (e.g., instruments ready for use, patients posted for consultation, names entered in the register book beforehand etc. to save time)

**Panel doctors**

- Panel doctors should be involved in the planning, management and supervision of the scheme to increase belongingness and adapt to BRAC working culture; they should be motivated to attend the sessions on time. A monthly meeting with relevant BRAC staff can be held to evaluate the last months sessions (e.g., medicine, chronic illnesses, referrals, patient screening etc.) and remedial measures taken to prevent future occurrences. Revision of the present remuneration can be considered as it is a felt need of the panel doctors.
- Outreach services through satellite clinics may be organized at difficult- to- reach out-posts (e.g., once in a fortnight) to increase coverage of the scheme
- Referrals for chronic conditions (e.g., hypertension, diabetes, arthritis) should be organized and followed-up by panel doctors with assistance from BRAC health staff

**Responsiveness**

- To avoid frustration and over expectations from the schemes, target households should be clearly informed about the types of services and financial assistance offered in the scheme. Privacy and dignity should be maintained.
- Beside reduction of waiting time and providing information about exact timing of the consulting session, the illness condition and its management should be explained to the patient or the attendant in as plain language as possible (? culturally sensitive).
- To avoid patients waiting for long time to receive prescribed medicines, some antibiotics and analgesics may be stocked (in consultation with doctor) at the AO before the session begins. Alternatively, a representative from the medicine shop may be present on the spot to deliver the medicines every half an hour. The instructions to take medicine should be clearly spelled out to the patients.

**Financial assistance**

- Some serious re-thinking on the issue of financial assistance to provide medicine or cover the costs of lab tests is required. Measures need to be undertaken to cover the total costs of medicines or tests performed for reducing ‘health shock’ to the ultra poor households. Incomplete treatment or sub-optimal treatment causes more

problems than solutions and the supplementary expenditure to cover the remaining costs contribute to savings and asset depletion of the ultra poor households with implications for poverty status. Funds mobilized from the community (e.g., zakat and fitra money, donations from philanthropic organizations), free medicine from the pharmaceutical companies, free medical samples from the doctors etc. may be some of the ways worth exploring.

- The financial assistance should be extended for chronic conditions as well as to the 'graduated' ultra poor for at least one more year to reduce the impact of 'health shock' on the road to sustainable livelihood for the ultra poor households.

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