

Hagam Area Visit November 2009 by Mike Guildford



Fig1 ORC at Yanglakot

Arriving in Nepal

I travelled to Nepal with a good friend and colleague, David Loveday, arriving on Sunday 8th November at Kathmandu Airport where we were met by Dr Gerda and Nisha, one of the PHASE Staff nurses. We were both a bit weary but the warm welcome together with a garland of bright orange flowers each helped to ease this. We headed over to the PHASE office, just a few minutes walk away from the airport, where we met Jiban together with some of the other PHASE employees and discussed various issues over coffee. I had been assigned to travel the next day to Hagam region and David to Fulpinkot. Nisha would spend the first half of the trip at Hagam and then travel over to Fulpinkot for the rest of the time. Later that evening we met up with Dr Deepa who had recently returned from Hagam and was able to give us some useful insight about what to expect. The following morning we caught the bus to Jalbire, approximately five hours from Kathmandu. From here Nisha and I walked for approximately 3 hours uphill to Yanglakot (altitude 1920m), one of the main villages in the Hagam area where the ORC and ANMs accommodation was located. It was dark by the time we reached the village but Pushpa, one of the two ANMs in this area, had trekked down to the village outskirts to greet us and lead us to their accommodation. On arriving at the house, I was greeted by Kalpana, the other ANM, who had only started working for PHASE a few weeks previously. She had prepared a meal of dhal bhat and mutton. I remembered Gerda's advice that by following a vegetarian diet she had avoided any gastroenteritis problems at all whilst in Nepal, so after having a small amount of meat to avoid offending the ANMs, politely asked if I could stick to a vegetarian diet.

The ANMs accommodation

The ANMs share a two storey rented house with another PHASE employee, Ganesh, just a stone's throw from the main clinic (ORC). The house had a good electrical supply, which only went down briefly on a few occasions during my time there. In addition there was an outside toilet and balcony with outstanding views over the valley. The nearest water supply was approximately 100m away at the village tap. Washing took place at the tap and we would collect water for the house as required. The girls cooked on an open fire using wood as their fuel source but as there was little ventilation, the house would quickly fill with smoke when cooking anything. My mobile phone signal (T Mobile) was actually better than in some parts of my practice area in Shropshire!.



Fig2 View of rented house from ORC



Fig3 Main room whilst cooking

Tuesday 10th November

I didn't sleep particularly well on my first night in the village, primarily because there was a local festival going on into the small hours but I think jet lag, a chest infection and just getting used to new surroundings all played a part. After breakfast of tea and biscuits Kalpana pointed me in the direction of the village tap so I could have a wash. This was an invigorating experience as it was still a bit chilly, the water was cold and I had a crowd of onlookers watching! Lunch of dhal bhat and tarkari was served around 9am. I remembered Andy mentioning at the meeting in Rotherham that he had found it difficult getting the ANMs to allow him to help out and I found much the same, particularly in the first few days. Eventually however I was trusted with collecting the water for the house. Washing up and cooking however were strictly off limits!

The clinic that day was at the ORC and the ANMs thought it would be quieter than usual due to the local festival. We saw 13 patients that day between 10am and 3pm as follows:

1. 28y female heavy periods rx norethisterone
2. 22y male URTI and previous history of glycosuria on routine test (asymptomatic).urine dipstick glucose ++ rx advised attend hospital for further investigation
3. 72y female foot injury rx cleaned and dressed
4. 17y female repeat depot injection
5. 32m URTI with mild malnutrition rx zinc, folic acid and albendazole
6. 20y male history tapeworm in stool rx niclosamide and bisacodyl

7. 7y female URTI rx paracetamol and advice
8. 71y female OA knee rx paracetamol and advice
9. 15m male conjunctivitis rx chloramphenicol
10. 4y male superficial wound left temple rx cleaned and dressed
11. 1y male URTI rx paracetamol and advice
12. 3y female URTI and dysuria urine nad perinea exam nad
13. 60y female URTI and ankle sprain

One of the ANMs would act as administrator, filling in the basic details of arriving patients in the register and filling out an OPD ticket whilst the other would consult. They seemed to share this workload equally. A few things immediately struck me as very different to practising in the UK. Firstly waiting patients would routinely walk into the consulting room during the middle of another person's consultation. This seemed to be accepted by the patients but the ANMs would make some attempt to extract the unwanted patient at some stage. Secondly, at times the ANMs would swap roles in the middle of a consultation with one completing the initial history then the other taking over. If it was quieter both ANMs would sometimes take a history together and this together with both Nisha's and my presence could make the consulting room a little crowded!

The ORC clinic appeared to be constructed from stone, wood and mud. The floor was made of compacted dried mud and this is repaired on a monthly basis by a local woman. As such it is not possible for this to be a sterile environment as we may strive for in the UK, but that aside, I felt the clinic was clean, drugs were kept in an ordered fashion within the main consulting room and dressing kits etc were also packed appropriately. The examination room was screened off from the main consulting room by a curtain ensuring a degree of privacy. There was plenty of natural light in both rooms within the ORC. However there was no electricity supply (not sure why, particularly, as the house just a few metres away is supplied?) and no water supply. The Height for Weight Chart was up but needed to be slightly repositioned to read correctly and there was a Snellen chart also in situ. There were both adult and infant scales available. Auroscope speculums were routinely disinfected. Clinical waste was burnt in a small pit behind the ORC on a daily basis. Basic equipment available included a stethoscope, sphygmomanometer, thermometer, urine dipstick (glucose and protein only), haemoglobin test strips, peak flow meter (only discovered after tutorial on asthma/COPD). In addition there were dressing kits, dental extraction kits and an emergency obstetric kit. The clinic was swept after surgery had finished and they would also sprinkle disinfectant randomly on the floor in the mornings (not sure that this provides any clinical benefit or what they have been advised to do in terms of cleaning?). Water for hand washing and cleaning was collected in a covered bucket from the tap each morning.



Fig4 Pushpa and local woman in the ORC

Later that afternoon we were invited by a local villager called Parilal to visit his home for tea. I believe he has been a keen supporter of PHASE's work in the village and both he and his family made me feel very welcome. After dinner of dhal bhat tarkari we sat down for a tutorial on asthma together with a run through various common eye conditions, using photos I had downloaded onto a PHASE laptop. Despite a long day they all seemed very keen to learn. I thought it was particularly helpful having Nisha present for this and subsequent tutorials as her command of English was that much better than the ANMs. She was able to act as an interpreter at times, particularly with some of the more difficult points to get across. They all took down notes and I used a sketch pad to write down new terms for them to copy or to draw diagrams e.g. Basic diagram of a normal bronchiole versus changes in the asthmatic patient.

Wednesday 11th November

After a similar early morning routine we headed to the SHP clinic at Bisinghar (altitude 1835m) , a small village approximately 30minutes walk away.



Fig5 SHP at Bisinghar

The clinic at Bisinghar takes place on alternate days. The facilities are certainly more basic here with no Height for Weight chart, no infant scales and, like the ORC, no electricity or water supply. The consultation room is reasonably well lit by natural light but relies on keeping both the door and window open for this, which then limits patient confidentiality. In addition the examination room has no natural light source other than

a door and even with this open it is barely adequate. With the door shut examination would not be possible without a torch (I have purchased a head torch for the ANMs which Dr James has hopefully delivered).

We saw 15 patients that day, many with similar complaints to those seen the previous day but a few cases are worth mentioning. The first was a 63 year old woman with chest pains, dyspnoea and a discharging wound on her left chest wall. She had had an operation on her chest wall in the past but was not sure what for and there were no notes available about this. Clinically she was breathless at rest with some mild recession, pus discharging from a small wound (?sinus) on her left lateral chest wall. She was dull to percuss and absent breath sounds over the left base. The ANMs struggled to produce a differential diagnosis but recognized that she was ill and required referral to hospital for further management. She was treated with co-amoxiclav, paracetamol and albendazole and advised to go to hospital.

Another case was a 3month old child with significant impetigo affecting the left pinna and surrounding cheek/scalp. After cleaning this the scabs were picked off which obviously caused the child considerable distress. The skin was then dressed and she was treated with oral antibiotics. I thought it would be useful to mention this case as removing scabs doesn't seem to be mentioned in the guidelines and also differs, certainly from our management of impetigo in the UK. Having said this, I discussed this case with David and he had seen a similar case which he then saw a few days later and this had healed beautifully.



Fig6 Impetigo 3month old female

After dinner that evening we had another tutorial on COPD and again looked at various clinical photos on the laptop.

Thursday 12th November

We saw 24 patients at the ORC one of which included an impressive dental extraction by Pushpa in an elderly woman who had been seen the previous day at Bisinhar. The rest of the patients seen had URTIs, worm infestations, minor skin infections, minor injuries, repeat depot injections and dyspeptic symptoms.

Later that afternoon we visited the Jaldevi Senior School which is supported by PHASE, where I had the opportunity to meet the teaching staff and the ANMs gave an impressive lecture to a group of students on HIV/AIDs. I learnt that some students

were walking to school from up to two and a half hours away on a daily basis six days per week!



Fig 7 Lecture on HIV/AIDs by Kalpana and Pushpa Jaldevi Secondary School

After dinner that day we started to go through the very helpful, 'clinical skills teaching' worksheet Gerda had provided. We had already touched on some of the subject matter but with the aid of a few sketches and photographs on the laptop we covered ear and eye examination including common differential diagnoses such as otitis media versus otitis externa. On a positive note I had witnessed both ANMs holding the otoscope appropriately and pulling the ear back to straight the canal when examining a child but they needed some support to get the parent to hold the child in a good position. They were also not routinely examining the throat in patients with URTI symptoms and so we talked about this and backed it up in subsequent clinics. Basic eye examination was covered but we didn't get an opportunity to use a fluorescein strip during my time there. We talked about using the Snellen chart and I got them to demonstrate its use to me at the next ORC clinic -we had to measure out the 6m distance which is at the door frame of the clinic entrance. We talked about cataract management and indeed saw a couple of cases during my time there but I had real difficulty trying to demonstrate a red reflex with the otoscope. We also covered chest and abdominal examination, heart murmurs and abnormal breath sounds at what they mean and congestive cardiac failure.

Friday 13th November

Clinic at Bisingkhar with only 3 patients so we did a quick revision through what we had learnt up to this point and I was impressed by how much they had taken in. One patient raised a few issues for me-he was an elderly man with a one year history of dysuria, urinary frequency and lower abdominal discomfort, possibly with some weight loss. He allowed the ANMs to examine his abdomen but refused a genital examination but would agree to me examining him without the ANMs or Nisha being present. There were no urine dipsticks available at Bisingkhar. I couldn't find anything in the guidelines about prostate examination and neither Nisha or the ANMs had ever done one before. I was a little concerned that I was stepping outside of my role of mentor to the ANMs but agreed to do a genital examination and found a several discharging wounds with thickening of the surrounding skin high up on the left scrotum. Examination was otherwise unremarkable. I cleaned his wounds and we treated him with ciprofloxacin and albendazole and asked him to come back a week later. The issues raised for me include:

- should the ANMs be taught how to examine the prostate (I told them briefly what a

normal and abnormal prostate should feel like)

- urine dipsticks should be available at all clinics

- what should we, as male mentors, do in this situation? I am aware that we are there to support rather than treat but otherwise this man wouldn't have been examined and treated appropriately (guidance appreciated!)

After clinic we were invited to a local villager's (Rajan) house for tea. Later that day we walked down to a village below Yanglakot where Pushpa and Kalpana gave a presentation to the community mainly on oral health but also smoking, drinking and using the toilet. By now I had learnt a few basic Nepali phrases and was able to (rather badly) introduce myself to the community. By that evening the girls were too tired for another tutorial so we got to watch a Nepali film instead.

Saturday 14th November

David arrived from Fulpinkot much earlier than I expected. I think we both found getting together part way through our period in the hills to be very useful. It was interesting to compare notes about what we had seen and how the ANMs were performing. Indeed it seemed that we had both had similar experiences to that point. After lunch David and I went for a walk and managed to find our way to the top of the 'Hagam hill' where the views across to both the Himalaya and the surrounding hills were spectacular. We managed to somehow persuade the ANMs and Nisha to allow us to cook dinner of fried rice. Despite heavy supervision the result was average at best and although they were polite enough to say it was very tasty, actions spoke louder than words, and they went on to cook another meal of dhal bhat immediately afterwards!

Sunday 15th November

A total of 28 patients were seen at the ORC, the majority of whom were unaccompanied schoolchildren with minor ailments such as URIs and minor injuries. However we did see an infected chalazion (a diagnosis the ANMs made!) and they used a peak flow meter for the first time on an older woman with a probable infective exacerbation of mild COPD. Throughout the clinic I tried to get across a number of learning points including patient confidentiality (keeping the door closed whilst consulting greatly aided this), using the peak flow meter, using the Snellen chart with a patient, and getting them to clean the thermometer appropriately between patients. We also covered basic spine and shoulder examination. As we had covered a lot of learning points this day and we had an early start the next morning to walk to Hagam village for the monthly clinic there, we decided not to have a tutorial that evening.



Fig8 Peak flow meter used by Pushpa at ORC

Monday 16th November

We set off around 7.30am that morning for the 3 hour walk to Hagam village accompanied by a young porter named Rajendra who carried a rucksack containing our medical supplies for the clinic. Along the way we passed a working water mill, waterfalls, swing bridges with endless beautiful views of the surrounding hills. We eventually arrived mid morning in the centre of Hagam. I was under the impression that the clinic would run in a SHP similar to Bisingkhar but this was still in the process of being built so the monthly clinic here took place within a covered porch area adjacent to the village shop, with a dark room behind this used for examining patients and this room opened directly onto an area where livestock were kept! Hence both confidentiality and a clean environment were lacking. We had a late breakfast and after setting up the portable dispensary and arranging some basic furniture the clinic began. By now a sizeable crowd had gathered in the square adjacent to the shop. The government health worker from Bisingkhar had travelled over and took care of the administrative duties whilst the ANMs split up and saw their own patients, with Kalpana performing repeat depot injections and seeing a few antenatal cases whilst Pushpa concentrated on the other patients. Antenatal and repeat depots were taken into the 'examination room' whilst Pushpa consulted out in the open. Occasionally she would need to use the examination room so these patients were slotted in between the depots and antenatals.



Fig9 The Hagam clinic



Fig 10 Hagam clinic examination room

In total they saw 49 patients over the course of about six hours. The majority of cases were similar to previous clinics (URTIs, worm infestation and gastroenteritis) but we saw a number of interesting cases including a cachectic 21 year old female with a

chronic cough, night sweats and clinically evidence of a pleural effusion who was referred to hospital with suspected pulmonary TB, a 14 month old female with probable pneumonia treated with oral antibiotics and follow up arranged for 2 days later at the Binsinghar clinic; a middle aged woman with a right sided neck mass that was increasing in size who was referred with ?thyroid cancer/TB;a 16 month old female with massive hydrocephalus who was referred to hospital in Kathmandu (the ANMs expressed doubts after clinic that she would be taken there due to cost and distances involved). Pushpa had seen this child at the previous months clinic and although she didn't know the diagnosis, had recognized that there was something seriously wrong and therefore advised the mother to take her to hospital but she failed to do this. As the light failed more patients arrived and we saw a middle aged woman with textbook hands changes of rheumatoid arthritis. The late arrivals (who did not appear to have any acute problems from what I could gather) were asked to attend the next Bisinghar clinic. A few local men seemed particularly vocal but Pushpa seemed to be able to deal with them. I wasn't sure what was being said at the time but she later said that they were unhappy that the Hagam clinic was only running on a monthly basis. She had told them this wasn't their decision and should raise this with the appropriate authorities. After tidying the clinic away we retired to the shopkeepers accommodation on the first floor where his elderly mother insisted that I sample the local brew of warmed buffalo ghee with millet alcohol after our dhal bhat tarkari. I reluctantly agreed to try a couple of mouthfuls which was absolutely disgusting, best described as lukewarm buttery vodka-yuk! She apparently drank several glasses of this daily. We were able to briefly discuss some of the interesting cases we had seen that day but shortly after dinner I retired to bed. I slept well initially but woke in the early hours to the scratching of a rat in the ceiling directly above me. Every now and again after a period of scratching, a small clump of mud would fall onto the polythene sheeting that was immediately beneath the ceiling. This didn't make for a particularly restful night but managed to get back to sleep sometime around 4am.

Tuesday 17th November

That morning we walked with the shopkeeper and his friend to the top of the local hill to take in the views of the Himalaya (I had asked about these over dinner the previous evening) and on the way down visited Hagam's Buddhist temple. After breakfast we left Hagam for another village some 30 minutes away where the ANMs talked to the local community about using toilets, smoking and alcohol use. From there we walked on for a further hour or so to the community of Hapra where each of the ANMs spoke to different classes at the local primary school about HIV/AIDs. After a late lunch at one of the villagers houses, we returned to the school with the aim of doing another community talk but as no one had turned up we decided to begin the walk back to Yanglakot . Kalpana had mentioned a few days previously that she had been diagnosed with osteoarthritis of the knee, although she had not had an x-ray and I'm not entirely sure who had made the diagnosis. However she had been having problems with her knee when walking between clinics and seemed to really struggle on this walk despite taking diclofenac and using a walking stick. Along the way Pushpa pointed out a spot where she had fallen down a waterfall a few months previously and also mentioned that they can be called as far away as Hapra for home deliveries. I was really taken aback by the thought of these young women walking up to four hours to attend a delivery, possibly at night, and then returning to run a clinic the next day! I also tried to ask about the cost of staying at the shopkeepers house but they were particularly evasive and didn't want me to pay (this had also been the case over me paying the 100 rupees per day Gerda had suggested towards food). Eventually with some reluctance Pushpa accepted some money towards the cost of our stay at the shop in Hagam. Pushpa also mentioned that she had been getting heel pain and the history sounded typical for plantar fasciitis. I advised her about analgesics, NSAIDs

and wearing supportive footwear. We were all tired as we arrived back in Yanglakot and so after having a wash and something to eat we all retired early that night.

Wednesday 18th November

My last full day in the area was spent at the Bisingkhar clinic where Kalpana saw the majority of patients whilst Pushpa took part in a meeting with the 9 local female health volunteers and government health worker. We saw around six or seven patients (I didn't record the exact number) and none with any particularly unusual pathology. I noticed that despite my advice about supportive footwear, Pushpa still walked to Bisingkhar in her flip flops! On returning home, after the 4pm snack we had a tutorial on some major learning points we had covered during my time with them.

Thursday 19th November

Woke early and was treated to a boiled egg for breakfast! After packing and saying our farewells I was presented with my second garland of flowers for the journey (and a further one in a plastic bag to give to Dr David when I saw him in Jalbire!). The walk back down was almost at fell running pace with a very sprightly porter leading the way- it took just over one hour back to Jalbire and from there on back to Kathmandu by bus.

THE ANMs

Pushpa



Pushpa has been with PHASE for approximately two years and at the time of writing this report had been in the Hagam region for six months, having previously worked in Humla for eighteen months. She is married to a college lecturer and originally hails from Dolakha in the Eastern region. She is studying towards a degree and one day hopes to become a college lecturer.

She was absolutely wonderful to work alongside and I felt she was a truly inspirational individual. She was always well presented, seemed to have a good rapport with the villagers wherever she went both during consultations and in other social settings, had a good sense of humour, never became flustered, seemed to very supportive towards

Kalpana, had a good knowledge of the PHASE guidelines but wouldn't hesitate to refer to them if she was unsure of a treatment or the correct dosage of a drug. In addition to this both ANMs could not have made me feel any more welcome. I felt truly humbled by their work ethic, and ability to provide such a comprehensive service in such difficult circumstances, for by Western standards, a meagre salary.

Kalpana



Kalpana has only been with PHASE for the past few weeks having worked for another NGO previously. Like Pushpa she also hails from the Eastern region of Nepal. It was difficult to assess Kalpana fairly as she was only a few weeks into the job when I arrived. Having said that she was a hard worker both in the clinic and at home, was very friendly and seemed keen to learn. She also seemed particularly assertive over maintaining patients privacy and would scold patients who walked in during somebody else's consultation!

Key areas we worked on

I have already mentioned above the various topics covered during my time with Pushpa and Kalpana but there were a few key basic areas that I particularly asked them to focus on as follows as these cropped up on a regular basis:

1. Try to maintain the confidentiality of the patient you are consulting with-don't tolerate others walking in during a consultation and try to minimize other staff, including porters or government health workers being in the room at the same time
2. When taking a history, try to explore the presenting symptoms (when presenting a history to me I was regularly told e.g....'cough for x days' without asking other relevant questions such as sputum amount and colour, haemoptysis, fever, sweats, weight loss, breathlessness, chest pain etc.) This seemed to improve during my time there

3. How to hold a child properly for ENT examination and always examine the throat as part of this
4. Examine the abdomen in a patient presenting with a change in bowel habit, abdominal pain (didn't seem to be happening consistently) and how to examine the abdomen appropriately
5. In young children consider pneumonia, OM and UTI in the differential diagnosis when they present with diarrhoea (NB this is listed in the guidelines under differential diagnosis of acute gastroenteritis but it doesn't seem to be listed under 'diarrhoea' in the ICMI guidelines)
6. Sterilize the thermometer between patients and also sterilize the skin appropriately before im injections
7. Look after their own health!!

A Few Queries/Suggestions

1. I wonder if the clinics could be provided with peak flow meters and spacer devices as their does seem to be a reasonable incidence of COPD. I'm not sure if there are appropriate peak flow charts for Asians?
2. Leading on from there a height chart for adults would be needed both to work out the predicted peak flow rate but would also be useful to document BMIs (though didn't see much evidence of obesity)
3. There are no height for weight charts or infant scales at either Bisingkhar or Hagam clinics
4. Although urine multistix are comparatively expensive these would provide much more clinical information (perhaps to be used only in certain cases)
5. The quality of the stethoscopes was basic and I wonder if posts could be provided with a Littmann or equivalent quality.
6. I am sure you have already considered this but some form of patient record which could be kept at the relevant clinic would seem to be the next logical step in building up a history for each individual patient.
7. In addition to this considering some form of repeat prescribing system could save the ANMs time (For example, I saw evidence of one lady with OA knee being given a small supply of paracetamol. She returned the following week and had her obs checked again and the register had to be completed when all she wanted was more paracetamol)
8. Impetigo scabs- to pick or not to pick?
9. Eclampsia guidelines- Pushpa thought that rectal diazepam had been removed from the treatment guidelines and instead a stat dose of Magnesium sulphate should be

given. As the guidelines I have still suggest rectal diazepam I thought I should raise this issue.

10. Occupational health issues -do they have anyone they can turn to for advice on medical problems that may affect their ability to work ? I remember reading that they should wear closed footwear at work but saw little evidence of this. Are they given any other advice about protecting themselves from injuries both in the workplace but perhaps more likely on the various paths between clinics? I was particularly concerned about the poor ventilation in the rented house causing this to become very smoky when cooking and possibly exposing the staff to the risk of COPD in later life. I would have thought an extractor hood type chimney would be relatively cheap and easy to install here

11. The laptop seemed invaluable to learning and I wonder what the cost would be of providing each area with one, then possibly expanding this to provide internet access?

Summary

I had a great time working alongside Pushpa, Kalpana and Nisha but feel I only scratched the surface of what could be achieved. Hopefully with a steady flow of doctors going out to continue the process, their clinical abilities should continue to expand further.

When can I go back?!