

Kailakuri Programme Annual Report for 1999

Introduction

The Nature of the Kailakuri Programmes

The basic difference between the Thanarbaid and Kailakuri Programmes is that the Thanarbaid Programme is horizontal. It looks at a whole cross-section of health problems in the community of which it is part and tries to solve them within the community. The Kailakuri Programme on the other hand is vertical, cutting down on two specific diseases.

The TB Programme is part of an above-down action by the Government against a serious epidemic disease which is a major public health problem (explosive in the face of the impending HIV epidemic). Through the Damien Foundation the Kailakuri Clinic becomes a Subcentre of the Government Programme. Diabetes is not a priority public health problem but with the extremely high population density the numbers are great. The Diabetes Programme working with and under the BIRDEM Diabetes Hospital is directed to their needs.

The TB Programme's security lies with the security of the National TB Programme and with Damien Foundation (the world's largest international TB NGO).

The security of the Diabetes Programme lies with the BIRDEM Hospital and the Diabetes Association of Bangladesh with our success in empowering the patients to take it over as their own programme, the development of a clinically and managerially efficient staff core, and with the partnership of long-term support partners (especially Rotary Clubs of New Zealand and Bangladesh). It is hoped in due course that an overseas diabetic association or university link will be established.

The Aims of the TB Programme

The Kailakuri TB Programme aims are the same as those of the National TB Programme and the Damien Foundation TB Programme:

- 1) Treatment aims: to cure TB patients, prevent TB deaths, reduce disease transmission and prevent drug resistance.
- 2) Programme aims: to achieve 85% cure rate of patients treated, and to detect and treat 70% of sputum positive patients in the community.

The Aims of the Diabetes Programme

The aim of the Kailakuri Diabetes Rehabilitation Programme is to make it possible for poor diabetes patients to control their diabetes, to enjoy as far as possible normal health, and to return as far as possible to normal life.

Diabetes is a life-long disease.

The Diabetes Programme began within the Thanarbaid Health Care Programme, but it became obvious that it would be unreasonable to expect the Thanarbaid staff and committee and the Dhaka Head Office to take on all the problems of the diabetes patients and to sustain an ongoing commitment to their support. Hence, the Kailakuri Programme separated from the Thanarbaid Programme, and it is preparing for independence in the hands of the patients themselves.

The prime concern of treatment is to maintain diabetes control. This requires patient understanding and motivation, monitoring and supervision, and a regular supply of Insulin

(which is costly). The special characteristics of the Kailakuri Programme (patient care by highly motivated low educational level diabetic patients under medical supervision) make it particularly adept to achieve the first two requirements. However for the supply of Insulin, special investigations and management of certain complications it is dependent on the Dhaka based BIRDEM Hospital.

Problems of the Diabetes Programme

- 1) Special efforts needed to strengthen the diabetes patients' commitment as the "community base" for the Programme in its future independence.
- 2) The need to strengthen staff skill and efficiency in clinical care of patients and all aspects of management.
- 3) The need to locate and prepare suitable persons for Programme leadership.
- 4) Constantly increasing patient numbers.
- 5) The need to maintain and develop the partnership between the Kailakuri Programme and the BIRDEM Hospital to face changing circumstances.
- 6) The practical problems of transporting increasing numbers of patients to and from Dhaka to the BIRDEM Hospital (new patients for assessment and registration, and old patients for medical and social reassessment).
- 7) Increasing costs.
- 8) The increasing proportion of older patients.
- 9) The need to sustain and develop support partnerships.
- 10) The need to locate local professional support.

Approaching the Problems

The approach will be:

- 1) Move slowly.
- 2) At local level give priority to:
 - i) patient treatment, teaching and supervision
 - ii) staff formation
 - iii) strengthening administration
 - iv) problem solving by a Kailakuri inner-staff group
 - v) fostering a developing staff leadership
 - vi) ensuring that staff, committees and patients fully understand the proposed Constitution and the issues it faces, and then presenting it to the patients for their decision
- 3) At the wider level:
 - i) maintain and develop relationships with support partners (COBSDP, BIRDEM, Hospital, the Holy Cross Fathers, IIRD, New Zealand and Dhaka Rotary Clubs, One World Group, CWS, and NZAMB)
 - ii) seek local professional support and participation
 - iii) try to develop link-up with some overseas Diabetes Association or University

Long Term Security

The basic need is for either

- 1) The Diabetes Association of Bangladesh or an overseas Diabetic Association to take over on-going responsibility for the Programme,

- 2) or a national and/or overseas group of Rotary Clubs to take ongoing responsibility for the Programme,
- 3) or an overseas University to take ongoing responsibility for the Programme.

Activities of the Kailakuri Centre in 1999 (and the first part of 2000)

A. TB Activities

- ♦ Case detection and treatment Category determination
- ♦ Patient teaching and motivation
- ♦ Patient treatment
 - Categories 1 and 2: 8 months
 - Category 3: 12 months
- ♦ Supervision and monitoring
 - Direct observation of medicine taking by Programme Staff, other health workers, or responsible community persons
 - ✓ Category 1: first 2 months
 - ✓ Category 2: 8 months (whole course)
 - Sputum monitoring in Categories 1 and 2
- ♦ Home visits of patients not presenting for medications
- ♦ Record keeping

B. Diabetes Activities

- ♦ Case detection and taking to BIRDEM Hospital (Diabetes Hospital) in Dhaka (accommodation at Notre Dame College).
- ♦ Admission of new patients at Kailakuri for teaching and commencement of treatment
- ♦ Monthly outpatient supervision
- ♦ Monthly collection of Insulin stock from BIRDEM Hospital
- ♦ Taking old patients back to BIRDEM Hospital for once a year review
- ♦ Home visits to patients not returning or having special problems
- ♦ Admission of patients with special problems
- ♦ Record keeping

C. Staff Training

- ♦ Weekly staff teaching

D. Administration

- ♦ Specific duties: Medical Officer, Centre In-Charge, Diabetes In-Charge, TB In-Charge, Health Activity Manager, Finances-Building-Compound Manager, Outpatient Staff, Inpatient Staff, Cashier, Cooks, and Gardeners

E. Diabetes-Community-Base Formation

- ♦ Committees (now independent of Thanarbaid Management Committee)
 - Central Management Committee: all members are diabetic patients except for COBSDP representative and the medical officer in-charge
 - Three Local Committees
- ♦ Annual General Meeting
- ♦ Continuing work on Constitution Proposal

F. Preparation for Independence

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- ♦ Patient awareness and motivation
- ♦ Continuing staff formation
- ♦ Circulation of and discussion on Constitution Proposal
- ♦ Staff Seminar on Constitution Proposal
- ♦ IIRD support (especially: decision on year 2005 as date for independence, and Staff Seminar on Management)

Statistics, 1999

Kailakuri Centre Statistics					
♦	<u>Total No. of Registered Patients</u>			<u>270</u>	
	Percentages	Diabetes (157)		63%	
		TB (43)		37%	
	Percentage Increase from 1998	Diabetes (123-157)		28%	
		TB (43)		0%	
♦	<u>Total No. of Outpatient Visits</u>			<u>3,348</u>	
	Percentages	Diabetes		61%	
		TB		39%	
♦	<u>Total No. of Inpatient Admissions</u>			<u>257</u>	
	Percentages	Diabetes		93%	
		TB		7%	
	Inpatient Deaths	Diabetes		5	
		TB		0	
♦	<u>Total No. of Staff</u>			<u>18</u>	
	Percentages	Muslim	61%	Diabetes	83%
		Mandi	33%	TB	17%
		Borman	6%		
		Male	78%		
		Female	22%		

TB Programme Statistics

♦ <u>Total No. of Patients Treated</u>				<u>99</u>
- Continued from 1998				43
- Started in 1999			56	
✓ Completed	86%	48	} 56	
✓ Defaulted	5%	3		
✓ Died	5%	3		
✓ Transferred	4%	2		
- Continuing into 2000				43

(4% of patients had both TB and Diabetes)

♦ <u>Total Patient Analysis</u>			
Category	1		73%
	2		7%
	3		20%
Treatment	Regular		72%
	Irregular		28%
Distance of home from Clinic	0-2 miles		46%
	0-5 miles		85%
Age	0-15 years		18%
	16-30 years		45%
	31+ years		37%
Gender	Male		69%
	Female		31%
Religio-Ethnic Group	Muslim		58%
	Mandi		33%
	Hindu		9%

♦ <u>Sputum Testing</u>		
- Total No. of patients screened		309
✓ No. Diagnosed as TB		13 (4%)
- Total No. of sputums taken		1094
✓ Screening		87%
✓ Follow-up		13%

Outcome of TB Treatment in Sputum Positive Patients: Categories 1 & 2

12 month period during which treatment started

	<u>5/3/96-4/3/97</u>	<u>5/3/97-4/3/98</u>	<u>5/3/98-4/3/99</u>
Total No. of Patients	43	44	36
Completed Treatment	78%	88%	86%
Defaulted	11%	7%	3%
Died	11%	5%	11%

Note: Sputum negative (Category 3) and transfer-out patients excluded.
High death rate probably due to terminal condition at time of presentation.

Diabetes Programme Statistics

♦	<u>Total No. of Patients Supervised</u>		171
	- Continued from 1998		123
	- Started in 1999	48	
	✓ Defaulted ¹	2	} 14
	✓ Died ²	9	
	✓ Transferred	3	
	- Continuing into 2000		157
♦	<u>End of the Year Patient Analysis</u>		
	Total No. of patients		157
	On Insulin ³		92%
	Well controlled		84%
	Distance of home from Clinic	0-5 miles	14%
		0-10 miles	45%
		0-15 miles	83%
	Age	0-20 years	12%
		0-30 years	28%
	Gender	Male	60%
		Female	40%
	Religio-Ethnic Group	Muslim	97%
		Hindu	3%
	Literacy	Illiterate	66%
		Literate	34%
	Economic Status	Extremely Poor	60%
		Poor	93%

^{1,2} 8% of the total patient no. (171) defaulted or died, 8 of the 9 deaths were diabetes related
³ no. of Insulin vials / month = 326, average no. / patient = 2.1

Diabetes Patient Number Increase

<u>Year</u>	<u>Patient No.</u>	<u>% Increase</u>
1995	33	
1996	47	42%
1997	66	40%
1998	123	86%
1999	157	28%
June 2000	200	27% (6 months)

Proposed Diabetic Constitution

The Preparation of the Proposal

The first draft was prepared by the Medical Officer and the Diabetic Staff and presented for assessment and correction to the Central Committee and the three Local Committees. Then it was redrafted and presented again to the Central Committee. The Diabetic Staff have taken part in a Seminar on the Proposal and the issues involved. The next step will be a Seminar for all committee members to consider the issues.

A Special Patient Meeting is scheduled for later this year to make the final decision.

The Essence of the Constitution Proposal

The Proposal defines and secures the aim of the Programme, to enable poor diabetics to control their disease⁴. The Programme is for them and belongs to them, and no patient may be excluded because of poverty. (Rich patients may be treated but may not participate in decision making meetings or committees.)

The proposal defines how the poor diabetic patients will control the Programme—through the Constitution, their General and Special Meetings and their Central (Management) Committee. They determine the project director, the staff and their support organisations.

It describes the three-way partnership that develops between patients, staff and support organisations. It defines their roles, power and relationships. Ultimate decision-making belongs to the patients. Day-by-day running is in the hands of the staff and medical officer.

The Proposal secures female, juvenile and religious minority representation in decision making. In effect it makes the poor patients into members of a mutual support group and declares means-based fee-paying obligations.

Finally it states the criteria for determination of economic status—which is the basis for deciding who is poor and for fee determination.

⁴ See **The Aims of the Diabetes Programme** (in the **Introduction** section) for further elaboration on the aims of the Programme

**Statement of Accounts for the Kailakuri Centre for the 12 month period
1/1/99 to 31/12/99**

	<u>Income</u>		<u>Expenditure</u>
Opening Balance	73,366	Worker's Pay	2,32,898
Donations	6,46,5000	Insulin	89,207
Patient Fees	44,921	Other Medicines, Syringes, etc.	55,875
Miscellaneous Income	45	Inpatient Feeding	1,56,518
Loans	1,35,000	Firewood	12,542
Bank Interest	459	Supplies & Equipment	5,725
		Stationary	9,690
		Lamps	7,625
		Cycle Repairs	9,606
		Travel	47,298
		Building & Maintenance	21,893
		Furniture	1,750
		Bedding	520
		Land Purchase	15,050
		Garden	6,315
		Poor Patients	9,823
		Loans	21,000
		Miscellaneous Expenditure	5,197
		Bank Fees	970
		Closing Balance	1,90,788
	Tk 9,00,291		Tk 9,00,291
(Actual Income 6,91,925)		(Actual Expenditure 6,88,503)	

Tribute to Supporters and Partners

On behalf of our Diabetes and TB patients we express our sincere thanks to all who have supported the work of the Kailakuri Centre. First we express our thanks to the COBSDP under whose auspices the Centre is run. Then we thank the two major in-country support partners, BIRDEM Hospital (Diabetes) and Damien Foundation (TB) whose enormous support provides the life blood and guidelines of our patient care.

Then we thank the Holy Cross Fathers for their unending help, most especially in accommodating our patients at Notre Dame College in Dhaka, and the IIRD for its commitment and help in preparing for the ongoing security of the Programme in the hands of the patients themselves.

Our three principal overseas supporting partners are One World Group in Scotland, the Rotary Clubs of Kapiti (and other New Zealand Rotary Clubs) and Dhaka, and the New Zealand Christian World Service.

The long term friendship and generosity of the One World Group and the Kapiti Rotary Club are of very great inspiration to us.

Edric S. Baker

Edric S. Baker, MOIC