

ANNUAL REPORT FOR THE THANARBAID HEALTH CARE PROGRAM FOR THE YEAR 2001

Report of the Village Health Program
the Thanarbaid Clinic Program
and the Kailakuri TB and Diabetes Program of the Thanarbaid Health Care Centre

Introduction

Globalisation has opened doors around the world, removing barriers to the flow of knowledge, resources and technology - for those who are able to access them. Relevance and appropriacy in local situations however are less clear. Barriers moreover no longer easily stand before the plans of great power-holders, even though their interests may differ from those of the local majority. Local leaders then lose either the power or else the will to defend the interests of their people --- and the voice of the weak is lost.

Aims, efficiency, co-ordination and sustainability compete with feelings, needs, spontaneity and empathy.

Yet the poor are precious in the eyes of God. Their basic needs are their basic human rights, and small is beautiful.

Advances in medical science promote health actions that use up the resources of the poor. Medical professionals make a practice of prescribing expensive investigations and treatments, while their high service charges add to the burden. Media and advertising re-enforce the new trends, producing nations of poor whose demands conflict with their greater needs - most of which are simple and low cost.

The treasures of traditional society - simplicity, the value of the family and the individual, and the acceptance of what cannot be changed, are overwhelmed by galloping globalisation --- and the poor flee to the cities.

The Problem and the Programs

The Thanarbaid Health Care Centre (THCC) is the base for three very basic health programs:

- The Village Health Program (VHC) in 10 villages.
- The Thanarbaid Clinic Outpatient-Inpatient (OP-IP) Program.
- The Kailakuri TB and Diabetes Subcentre.

Bangladesh is one of the world's most fertile countries but perhaps the most densely populated, and one of the poorest. It is one of the most religious and also one of the most corrupt. Affluence is increasing and the rich becoming richer (and fighting for the spoil), while the numbers of the poor continue to increase. These inconsistencies call to be changed, for we do not believe that the poor are forgotten by God.

Illness is especially a problem of the poor. The basic problems of malnutrition, diarrhoeal diseases, worms, pneumonia, mother and child health, TB, peptic ulcer, anaemia, trauma and psychiatry persist, soon to be aggravated by the impending epidemic of AIDS (making TB and Kala Azar much worse), and the new epidemics of diabetes and arsenic contaminated drinking water. The poor will suffer the most. Their numbers are enormous. So health care must be simple and low cost, and the poor must do it themselves.

The aim of the Thanarbaid Health Care Program (T.H.C.P.) is health for all, especially the poor, by the poor. The THCC is necessary and wanted by the poor. More necessary however is the movement for health among the people as a whole. Despite their problems, the programs of the THCC provide models of services that are needed. They should be improved, and they should be noticed.

THE VILLAGE HEALTH PROGRAM ANNUAL REPORT

FOR YEAR 2001

For the Village Health Program, (V.H.P.) the year 2001 has been a year of expansion, consolidation and continued good progress. We set out to improve our standard of work, gradually expand the geographical area covered, and try to make the V.H.P. independent from the Thanarbaid Clinic, (T.C.) where possible. At the beginning of 2001 the V.H.P. was totally dependent on the T.C. for finances, administration, drugs and equipment supply and decision making.

By the end of 2001 the V.H.P. had its own management team made up of our six supervisors, who now make all the decisions relating to their program. It has its own drug and equipment supply, bank account, and financial system, but at present continues to be under the supervision of the T.C. financial staff. By mid 2002 we expect that this too will be fully independent.

Staff - Numbers remained stable at 20 throughout the year (3 -men, 17 women) (11 Mandi, 6 Bengali, 2 Borman). Only 11 staff members work full-time in the V.H.P. The rest work at least one day per week at T.C.

Geographical Expansion - With the purchase of 10 new ladies cycles early in the year, added to the three already in use, we were able to gradually expand the program area in three of the larger villages.

Program Activities.

Child Health and Nutrition (under 4 years of age) - In December 2001, 922 children were under supervision. (Dec.2000 - 772 children; Dec. 1999 - 744 children).

Nutrition Problems - (failure to gain weight over 3 months, drop of 0.8kg not yet regained, weight under 3rd centile). 46 problems-5%; (Dec.2000 - 52 problems, 6.7%; Dec.1999 - 83 problems, 11%)

Antenatal Care - 333 mothers were supervised during 2001. (2000 - 299 mothers).

Delivery Care - of 231 deliveries, 108 or 46% were staff assisted. (2000 - 194 deliveries, 100 or 58% were staff assisted).

Family Planning - 1) Natural Family Planning: 24 couples were supervised. (2000 - 19 couples). Discharged from program, no longer needing supervision - 6 couples; changed to other methods - 3 couples.

2) Oral Contraceptives- In October we decided to terminate the distribution of our oral contraceptive tablets because:

- a) with 287 women on our program and another 40 to 50 wanting to join, the cost had become too great. (Dec.2000 - 147 women).
- b) the Government health workers now distribute free oral contraceptives from the newly implemented "one stop health clinics" in our area.

We feel our role is now to continue motivating, teaching and supporting the government oral contraception program in the same way as we do with its immunisation program.

Failure Rate: 1 Natural Family Planning participant became pregnant while on this method. (2000 - 0), and 1 Oral Contraceptive participant became pregnant, (2000 - 4).

Latrine and Tube-well Project. - This has been made possible by a specific generous donation from the people of St. Paul's Union Church, Taupo, New Zealand. It got underway with the coming of the dry season in November. Because the need for tube-wells and latrines was much greater than anticipated, and because of the concern for future financial sustainability of the program, we decided this project would be limited to the finances available at the start. Rules were made to try to ensure only the most needy benefited.

By 31st December 2001, 8 tube-wells and 15 latrines had been installed. We hope to complete up to 50 tube-wells and 90 latrines before the rainy season begins.

Education and Training - Each worker continues to be accompanied by a supervisor at least one half day a week in the villages. Every Wednesday morning, the staff attend a work review meeting with their supervisor and also a half hour group teaching session relating to village work. In the afternoon they join with the T.C. staff for the formal weekly education session.

New staff are trained on the job by accompanying other workers in the villages.

In addition senior staff have attended a 3 day seminar with a 2 day follow-up on "Training the Trainers", provided by I.I.R.D; a 2 day seminar for all staff on antenatal care, provided by Sr. Margaret Ryan, SMSM; and a one day seminar on nutrition and the benefits of soya beans, including a cooking demonstration, provided by MCC.

At last the majority of staff are realizing how important the role of teaching is in their work, and the teaching aids supplied are now being used.

Finances - see over page.

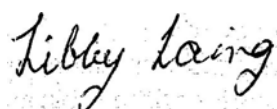
Ongoing and Future Needs of the Program

- A new Muslim worker, as soon as our newest worker is ready to work alone. This will allow another senior worker to start as supervisor. Further expansion of the work area will be curtailed until this occurs.
- Further encouragement and support of the management team, - only in place since mid-October.
- Assessment and upgrading of antenatal and delivery care, to improve the standard of care through out the wider community. This will be more readily achieved if our staff are utilized for teaching and assisting the traditional village birth attendants rather than carry out the deliveries themselves.
- To continue to develop good working relationships with Pargacha Mission health staff, local World Vision staff and government health workers and officials, school teachers and the wider community.
- Ongoing funding and attempts to limit expenditure.

Appreciations

I would like to record my appreciation and gratitude to -

- The local organisations that provided our free education and training days. (see above)
- U.S.P.G.(Great Britain) for their commitment to provide the majority of our funding for the next three years.
- Several private donors for their encouragement and support along with specific donations for our program.
- St Paul's Union Church Taupo, N.Z Association of Anglican Women, and N.Z. Christian World Service, for continued support, encouragement and financial assistance.
- Dr. Edric Baker and the T.C. staff for their assistance, encouragement and support.
- Last but not least, to the great team of village health workers for their enthusiasm, care and concern for each other and their village people; and for their total acceptance, constant patience, endurance and encouragement of me with my language difficulties. They are all very special people.



Libby Laing, Coordinator, Village Health Program, Thanarbaid Health Care Centre,.

The Village Health Program Accounts from 1st June to 31st December 2001

(In Taka)

<u>Income</u>		<u>Income</u>	<u>Expenditure</u>
Donation from THCC General Fund	1,51,316		
Provident Fund (Staff Contribution)	9,966		
Loan Receipts	1,22,000		
Latrines & Tube-wells	32,330		
Total	3,15,612	3,15,612	
 <u>Expenditure</u>			
Salaries	1,49,313		
Wages	52,929		
Medicines	54,770		
Equipment	7,428		
Stationary	6,649		
New Cycle	3,220		
Cycle Repairs	3,019		
Travelling & Conveyance	211		
Education Materials	1,348		
Latrines & Tube-wells	26,225		
Miscellaneous	1,751		
Total	3,06,863		3,06,863
Cash in Hand	644		
Latrine & Tube-well Acct. Balance	6,105		
Balance at Shonali Bank	2,000		
<u>Closing Balance</u>	8,749		8,749
		<u>3,15, 612</u>	<u>3,15,612</u>

Donations Received Specific for the Village Health Program for the Year 2001

U.S.P.G (in Taka)	4,00,640
N.Z. Association of Anglican Women	12,000
Anonymous N.Z. Donor (for cycles)	7,500
Subtotal	4,20,140
St. Paul's Union Church, Taupo (for latrines & tube-wells)	38,000
Private N.Z Donors (latrine & tube-wells)	30,000
Total	4,88,140

(Exchange Rate, US \$1=57 taka)

THE THANARBAID CLINIC PROGRAM

Thanarbaid Clinic is the base from which the T.H.C.P developed as a co-ordinated program of outpatient - inpatient services, village health care, and TB and diabetes activities. Always the aim was to be an alternative to the kind of capital intensive, professional-dependent and commercially orientated services that do not meet the needs of the poor. As it enlarged in size, for the sake of quality and sustainability the T.H.C.P. has had to divide into three. Still the base provides simple OP and IP services. Almost all the patients are poor and half or more come from the ten villages of the VHP. Improvements are needed.

Outpatient Statistics for 2001.

The total number of OP visits was 13,801. An increase of 23% on the year 2000. (Thanarbaid Clinic 86%, Dhoriti Clinic 14%) (0-4years 7%, over 4years - male 45%, female 48%)

The top ten problems were: peptic ulcer, anaemia, asthma, epilepsy, psychiatry, worms, hypertension, diarrhoeal diseases, arthritis and general pains.

Inpatient Statistics for 2001

The daily average IP number was 22.

The total number of admissions was 542, - 8% less than the year 2000. (male 56%, female 44%) (children aged 0-5 years 20%) (Muslim 57%, Mandi 32%, Hindu 11%)

The top ten diseases were: malnutrition, infections, Kala Azar, pregnancy and delivery problems, anaemia, diarrhoeal diseases, poisoning (attempted suicide), peptic ulcers, fractures and heart failure.

Staff Statistics

There were 30 staff at the year's end, including one doctor, three OP paramedics, five IP paramedics and four administration staff. (of the clinical staff - male 67%, female 33%;)
(Christian 78%, Muslim 11%, Hindu 11%)

Surgical Transfers

108 patients were transferred at a cost of Tk. 2,72,000, an average of Tk. 2,100 per patient. The commonest problems were: fibroids, cataracts, pyloric stenosis (complicating peptic ulcer), difficult deliveries and tumours.

The State of the Program

1. The Thanarbaid Clinic Program continues to be a major health resource for the poor although it has many problems and distant patients often have to be turned away because numbers are too great.
2. OP's and IP's continue to be cared for by locally trained paramedics and their assistants, with the Doctor determining standard treatments, taking reports and seeing problems. Simplicity keeps costs down. However empathy and carefulness need to be strengthened.
3. Poor patients needing surgery are taken to other institutions with all the difficulties of increasing hospital charges, apathy, investigation costs and expensive medications - most of which the Thanarbaid Program has to bear.
4. Regular staff training is conducted mostly by the Doctor based on the Standard Treatment Book.
5. Senior staff took part in two teacher training courses conducted by I.I.R.D. They give regular teaching to patients and share in staff training.

Further advance awaits the completion of the Standard Treatment Book translation into Bengali.

6. Staff do almost all clinical procedures. Two new OP paramedics have been prepared and their in-service training continues.
7. Regular clinical meetings are now held with IP and OP staff.
8. Except for sharing in the weekly staff training and in office facilities and some sharing of staff, the Village Program is now independent, although governed by the same Committees. Continuing close cooperation is necessary for clear awareness of health problems, for patient referrals and follow-ups, and for joint action in the event of epidemic or other problems.
9. Day by day administration, management of finances and ordinary decision making are in the hands of appropriate staff.
10. Important decisions are made by the staff Small Group (elected from the Clinic and Village Programs, together with the Doctor and the VHP co-ordinator).
11. The Community Executive Committee comprising selected community members, several staff members, Doctor and Sister, meets every three months.
12. Unfortunately the parallel Dhorati Committee has lapsed and meetings must be re-commenced.
13. The Church Supervisory Committee meets annually for review of the Program and for salary determination, and as necessary for disciplinary and other problems.
14. The special focus on shared decision making, meetings and administration improvement has been time consuming at the expense of clinical supervision, Treatment Book translation and fund-raising which are now urgent needs. The enlarging Kailakuri Diabetes Program also has problems urgently demanding attention.
15. Still the problem remains of only one Doctor divided between clinical, training, administration and fund-raising responsibilities for the two Clinics - although distribution of duties and the support of the VHP co-ordinator have helped greatly.
16. Mrs Libby Laing VHP co-ordinator will complete her term in the middle of 2002. Her enthusiasm, ideas, and hard work have benefited both Village and Clinic Programs.
17. Weakness of senior staff commitment persists.
18. Ongoing staff monitoring as a basis for more just salary and promotion has not come about. However modification has been made to the salary scale system so that determination may relate more to work performance, ability, and responsibility taking, rather than just years of service.
19. Salaries and wages have been increased but still not sufficiently (partly due to fund limitation).
20. Almost all the patients are poor and their fees provide only 8% of Clinic Program costs.
21. Local auditing continues but not very regularly.
22. Particularly with the increasing costs of the Diabetes Program further fund raising is urgent.
23. Kala Azar patient numbers have reduced, maybe due to Government DDT spraying. However when AIDS cuts away immune protection both TB and Kala Azar transmission will increase greatly.
24. Rabies persists. The area has a large jackal and dog population and bites are common. Government sheep-brain Anti-Rabies- Vaccine is no longer available and the alternative commercial Tissue Culture Vaccine is costly.
25. Stray dogs are the biggest danger for human rabies. A stray dog eradication campaign in which 83 dogs were killed in four days was widely supported by Muslim, Christian and Hindu communities, bringing them together in joint planning and in giving financial support.
26. The Muslim community has welcomed Clinic staff assisting traditional circumcisers for safer circumcisions (important with H.I.V. impending).
27. Clinic staff join in H.I.V.-AIDS seminars conducted by the Pirgacha Catholic Mission.
28. Both the stray dog and the circumcision program were decisions of community representatives and staff in the Community Executive Committee. Relationships are good.
29. International and national anxieties related to terrorism and the invasion of Afghanistan did nothing to disturb the excellent Christian Muslim Hindu relationships in our area.

30. Weakness of Head Office back-up and appreciation of local problems and needs brings an imbalance into the Program's Committees-Staff- Head Office relationship base.
31. A particular problem is difficulty in finance monitoring and planning due to lack of regular Head Office account statements (and also communication concerning efforts to recover Tk 4,00,000 interest owing to the Project by the Government Investment Bureau). Improvement in this area will benefit the Program and also relationships with Supporting Partners.
32. Just as in the global view we see the poor trapped and deprived by apathy and by the plans of power-holders, sadly we see the same at national level and sometimes even within the development programs of NGOs and the Church itself - even our own health program ---, and it calls for correction.
33. Complex though the situation is, yet we see large numbers of poor benefiting from the work of the THCC's programs and despite faults we see love and concern in action.

COMBINED STATEMENT OF ACCOUNTS FOR THE THANARBAID CLINIC & THE VILLAGE HEALTH PROGRAM¹ FOR THE YEAR 2001

(In Thousands of Taka)

<u>Income</u>		<u>Expenditure</u>	
Opening balance	76	Staff Pay	8,87
Donations	40,26	Medicines	8,11
Patient Fees	1,86	Medical Equipment	26
Miscellaneous	5	Supplies and Equipment	22
Staff Provident Fund	27	Stationary	36
Loans	<u>79</u>	Miscellaneous	13
	43,99	Patient Feeding	3,80
		Gardening	6
		Firewood	19
		Electricity	17
		Lamps and Kerosene	7
		Bedding	6
		Furniture and Fixtures	1
		Building Maintenance	15
		Teaching Materials	1
		Cycle and Repairs	58
		Provident Fund to Head Office	36
		Travel and Conveyance	24
		Poor Patient Assistance ²	3,72
		Banks Fees	4
		Loans to Kailakuri Subcentre	8,19
		Closing Balance	<u>8,39</u>
			43,99
Actual Income:	42,44	Actual Expenditure:	27,41

(US \$1 = Taka 54 approx.)

¹ V.H.P. accounts which separated June 2001 have been incorporated in this 12 month account.

² Includes surgical transfers and also local investigation costs.

COMBINED ACCOUNT OF THE THREE PROGRAMS FOR THE YEAR 2001

(Thanarbaid Clinic, Village Health Program, and Kailakuri Subcentre.)

(In Thousands of Taka)

<u>Income</u>		<u>Expenditure</u>	
Opening Balance	1,86	Thanarbaid Clinic Program	22,20 (approx.)
Patient Fees	2,86	Village Health Program	4,86 (approx.)
Donations	46,37	Kailakuri Program	14,97
Miscellaneous	8	Provident Fund to Head Office	36
Provident Fund		Closing Balance	<u>9,05</u>
(Staff contribution)	<u>27</u>		51,44
	51,44		
Actual Income:	49,58	Actual Expenditure:	42,39

(Donations comprise only those that reached the Project in 2001)

DONATIONS TO THE THANARBAID AND KAILAKURI PROGRAMS FOR THE YEAR 2001 (in thousands of taka)

(Donations to the Village Health Program are listed separately on page 4)

New Zealand Donors (C.W.S.)	6,48
VASS (New Zealand Government- C.W.S.)	12,97
Private American Donor	5,75
Uniting Churches of the Netherlands	2,15
U.S.P.G. (U.K.)	2,00
German Doctors for Developing Countries	1,96
British Donor	78
American Benedictine Sisters	56
American Donors	53
Scottish Donor	41
American Donor	40
Italian Donor	28
British Donor	28
Bolivian Donor	5
Total	34,60

(Listing is difficult due to staggering of dates of giving, arrival in country and arrival at the Project)

COMBINED BUDGET FOR THE THREE PROGRAMS FOR THE YEAR 2002

(Thanarbaid Clinic, Village Health Program & Kailakuri Subcentre)

(in thousands of taka)

<u>Income</u>		<u>Expenditure</u>	
Opening balance ³	9,00	Thanarbaid Clinic Program	25,00
Patient Fees	3,00	Village Health Program ⁴	5,00
Donations Expected ⁴	<u>38,0</u>	Kailakuri Program	18,00
		New Buildings for Kailakuri Program	1,00
		Closing Balance	<u>1,00</u>
	50,00		50,00
Actual Income	41,0	Actual Expenditure	49,00
	0		

Conclusion and Appreciation

The vocation of Christian health care is to concern for the poor and weak in the service of Christ their advocate, who refuses to let them be lost amidst greater concerns. When powerful interests or local diversion (or apathy) conflict with their needs, then the Church, the NGOs and health workers must also be advocates, and join hands with them in programs that effectively further their interests. We express our very sincere gratitude to all who have supported their work and ours.

Edric S. Baker

Dr. Edric S Baker. M.O.I.C. Thanarbaid Health Care Program.

³ Balance at Project and in local banks

⁴ Excludes latrines and tube-wells

ANNUAL REPORT FOR THE KAILAKURI SUBCENTRE OF THE THANARBAID HEALTH CARE PROGRAM FOR 2001

The Kailakuri Subcentre of the Thanarbaid Health Care Centre (T.H.C.C.) houses the Diabetes Program (informally linked to BIRDEM Hospital in Dhaka) and the TB Program (which is part of the National TB Program under the Damien Foundation. (D.F.) Both are paramedic based programs, determined to be accessible to the poor. The Diabetes Program is scheduled to become a separate NGO in the hands of the patients in 2005.

Kailakuri Subcentre Statistics 2001

Total No. of Registered Patients – 422 (27% increase)
Diabetes - 342 (44% increase)
TB. - 80 (16% decrease)

Total No. of Outpatient Visits – 5144 (5% increase)
Diabetes - 4055 (27% increase)
TB. - 1089 (36% decrease)
average no. of outpatient visits per month – 429 (Diabetes 338, TB. 91)
average no. of outpatient visits per day - 14 (Diabetes 11, TB. 3)

Total No. of Inpatient Admissions -304 (3% increase)
Diabetes - 277 (91%) (8% increase)
TB. - 12 (5 had diabetes as well)
Other - 20 (7%)

Total No. of Staff - 38 (41 %increase)
Diabetes Programme - 34 (89%)
TB. Programme – 4 (11%)
Muslim 71 %, Mandi 18%, Borman 11 %. Male 82%, Female 18%

THE KAILAKURI TB PROGRAM

This program is part of the National Program which is a WHO sponsored Government Program based on paramedics. Government has allocated different districts to different NGOs and the Kailakuri program comes under the Damien Foundation as a subcentre of the Damien Foundation Modhupur TB Clinic in Tangail District. The cooperation and support of the Damien foundation is excellent providing all the program requirements (apart from salaries and premises) and regular supervision through the visit of a senior paramedic. The medical-officer-in-charge (MOIC) has been given specific TB program training by the Damien Foundation and by Government.

TB. PROGRAM STATISTICS, 2001

<u>Total No. of Patients Treated</u>	80
Continued from 2000 -	33
Started in 2001 -	47
Completed - 40	} 55
Defaulted - 1	
Died - 3	
Transferred - 3	
Continuing into 2002 -	33
(All 3 deaths were probably due to TB.)	

Total Patient Analysis:

Category 1 - (new sputum positive) 68%, Category 2 - (retreatment) 10%,
 Category 3 - (sputum negative or non-pulmonary) 21

88% followed treatment regularly
 6% of TB. patients also had Diabetes
 4% of patients treated died
 1% of patients defaulted
 33% of patients live within 2 miles of the Clinic and 79% within 5 miles.
 58% were under age 30 (15% under age 15)
 Male 68%, Female 32% (a very large research program by the D.F. has shown that the male sex preponderance noted in all Bangladesh TB programs is in fact a prevalence preponderance not just a presentation preponderance)
 Muslim 64%, Mandi 29%, Borman 7%.

No. of Patients Admitted – 21

Kailakuri -12 (57%) (42% of these were diabetic)
 Jalchatra Damien Foundation TB.Hospital - 9 (43%)
Sputums Tested - 1202 (9% positive)

Outcome of TB. Treatment in Sputum Positive Patients (Category 1 and Category 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>	<u>5/3/99 - 4/3/00</u>	<u>5/3/00 - 4/3/01</u>
Total No Patients	43	44	36	52	48
Completed	78%	88%	86%	85%	85%
Defaulted	11%	7%	3 %	8%	4%
Died	11%	5%	11%	7%	10%
(sputum negative and transfer out patients are excluded)					

TB as the top cause of adult deaths in Bangladesh and expected to become an even greater problem when fuelled by AIDS immune deficiency is a top priority national health problem.

THE KAILAKURI DIABETES REHABILITATION PROGRAM

The Diabetes Crisis - National and Local

Repeated surveys conducted by the Diabetes Association of Bangladesh (D.A.B.) and BIRDEM Hospital (National Diabetes Hospital) have shown a rapidly increasing diabetes prevalence both urban and rural, rich and poor. It is predicted by the year 2025 one in ten of the adult population will be diabetic. (With a national population of 130,000,000 this means about 6 million diabetics). Patients come to Kailakuri Clinic from the four districts of Mymensingh, Jamalpur, Serpur and Tangail. From their population of 11 ½ million, approaching 600,000 diabetics may be expected. Apart from the Kailakuri Clinic so far none of these districts has a diabetes service easily accessible to the poor and able to keep diabetes controlled in the majority of patients.

A National Paramedic-based Diabetes Program

D.A.B. and BIRDEM Hospital have approached the diabetes problem by -

- 1) setting up a large modern hospital in the capital city with social assistance to poor patients,
- 2) supplying insulin to autonomous unsupervised branch centres at District level,
- 3) training Thana level Government doctors in diabetes care.

Unfortunately BIRDEM Hospital is overwhelmed with numbers and none of the methods is successful in achieving both easily accessible diabetes care for the poor and diabetes control in the majority of patients.

We strongly urge that consideration be given to a National Paramedic-based Diabetes Program at District and Thana level, paralleling the National Paramedic-based TB Program. Such a program we believe should be designed by D.A.B., BIRDEM and WHO and run by different organisations at District and Thana level (as is the National TB Program), but supervised by BIRDEM. In this context Kailakuri should be seen as a pilot project and given all necessary support.

Unique Features of the Kailakuri Paramedic Diabetes Program

The unique features of the Kailakuri program are:

simplicity, individualised patient care, low cost, on-job-trained local staff (mostly diabetes patients), and paramedic patient care under medical supervision. The service is economically accessible to the poor and good control is obtained in most patients. (Diabetes control is monitored by five times daily Benedict urine testing which is the optimal method with very large numbers of poor patients). Insulin is provided at a highly subsidised rate from BIRDEM Hospital. The cost of the Kailakuri program per diabetic patient supervised is approximately Tk 5,500 per year. (approx. US \$100)

Rapidly Increasing Patient Numbers

Year	No. of Diabetic Patients	% Increase
1995	33	
1996	47	42%
1997	66	40%
1998	123	86%
1999	160	28%
2000	213	37%
2001	330	55%
2002 (projected)	511	55%

In 1991 the numbers increased by 117 (55%) of whom half were Insulin and half Glibenclamide tablet patients although the % increase in tablet patients was far greater. (230% vs 30%) Most of the new patients were over 30 years of age (85%).

Patients from within 15 miles of the Clinic increased by 116%, whereas more distant patients numbers dropped by 25%, indicating that distant patient restriction will not affect the immediate problem. Restriction of non-Insulin patients however will.

Diabetes Statistics for the Year 2001

Total No of Patients Treated = 342

Continued from 2000 - 237, Started 2001 -105, Continuing into 2002 - 330,
There were 105 new patients, 0 transfers, 1 default, and 12 deaths
(12 deaths= 4% of patients. Under 40 years - 3, Over 40 years - 9)
(Causes: diabetic coma 1, kidney failure 6, stroke 4, chronic diarrhoea & hypotension 1,)

Analysis of 329 Patients at Years End

<u>Treatment:</u>	Injection Insulin	73%
	Tablets Glibenclamide	26%
	Diet alone	1%

Average No of Vials per month: (Insulin Patients) 2.7 vials.

Diabetes Control (Benidict test): good 66%, fair 18%, poor or bad 16%.

No of Patients with both Diabetes and TB: 5. (1% of diabetes and 6% of TB patients)

<u>Age:</u>	Under age 40 years	67%	Over age 40 years	33%
	(0-20 years 7%,	20-30 years 19%,	30-40 years 41%,)	

<u>Economic Status:</u>	Poor	78%	(Extremely poor	17%)
-------------------------	------	-----	-----------------	------

<u>Literacy:</u>	functionally illiterate	33%
------------------	-------------------------	-----

<u>Sex:</u>	male	58%	female	42%.
-------------	------	-----	--------	------

<u>Religio-Ethnic group:</u>	Bengali Muslim	95%	Hindu	4%	Garos Christian	1%
------------------------------	----------------	-----	-------	----	-----------------	----

Distance of Home from the Kailakuri Centre:

under 15 miles	79%,	over 15 miles	21%				
0-5 miles	12%,	5-10 miles	22%,	10-15 miles	45%,	over 15 miles	21 %,

Staff Numbers

Total staff = 34 (paramedics 7) (staff who are diabetic patients 62%)

Program Events and Present Situation

1. As stated above the rapidly increasing diabetes prevalence predicts about 600,000 patients in the adjacent four districts by the year 2025. Already numbers are putting pressure on staff, administration, finances, supervision, facilities and problem solving.
2. The M.O.I.C. attended a one week WHO sponsored training for Government medical officers at BIRDEM Hospital and gained a better understanding of the diabetic situation and actions

needed at village level. It also strengthened the Kailakuri Program's relationship with BIRDEM.

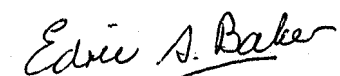
3. Several months later a BIRDEM group (including four doctors and one professor) visited Kailakuri. They recognised the centre's unique and important role and that a national paramedic based program on similar lines could be an answer to the country's problem. (The parting comment was "We have not seen a program like this before in Bangladesh. Very likely there is none in the whole of Asia.")
4. Further visits will be made from BIRDEM. It is essential to identify ways in which BIRDEM can give further support, and to continue focusing towards a national paramedic based diabetes program.
5. The Kailakuri Program runs according to the patients' determined Constitution scheduled for final revision at the end of 2002. Unfortunately staff still sometimes forget certain points. A series of Constitution seminars for different groups will be organised.
6. After the final revision a Constitution Celebration Day will be held to gain backing and solidarity.
7. Regular staff training continues.
8. Three new outpatient (O..P.) paramedics are in preparation.
9. Paramedics, administration staff and their assistants do all routine patient care, administration, Insulin requisition and management of finances and book-keeping under M.O.I.C. There are still serious weaknesses.
10. Regular O.P. review staff meetings are held and home visits made to those who fail to return. Registers are kept of chronic complications (eyes, kidneys, feet, hypertension).
11. A third O.P. centre has now been opened.
12. Bengali translation of the T.H.C.C. Standard treatment book is underway.
13. Teaching of patients and relatives by staff is ongoing. Senior staff have had teaching training from I.I.R.D.
14. Program decisions are made by a staff Small Group that meets regularly with M.O.I.C.
15. Salaries and wages have been increased.
16. Salaries are still too low, but funding is a problem.
17. Senior staff are not sufficiently committed and there are occasional problems of suspect dishonesty.
18. Senior staff positions are now all held double and efforts will be made to rotate to get the best placements.
19. Future leaders will need to be sort and prepared.
20. A new records system has been established with two specific staff also responsible for Insulin requisitioning.
21. Improved O.P. data recording facilitates stock monitoring and requisition.
22. A buffer reserve of Insulin is maintained.
23. Transport of Insulin from Dhaka in the Jalchatra Hospital vehicle makes armed robbery less likely.
24. The patients' Central Committee make major program decisions and expects them to be followed.
25. Local Committees all collapsed but with the appointment of a specific liaison worker they have now been revived.
26. A two day seminar will be held bringing together senior staff and all committee members. 27. The medical officer remains over stretched.
28. Increasing numbers require more buildings, delayed because of uncertainties due to neighbours making difficulties of access to the new program site. (and also funding anxieties).
29. A Peace Committee has been established to sort out problems arising with the host village of Kailakuri.
30. Rapidly increasing patient numbers require security of funding.

31. An annual and monthly budget will be carefully followed.
32. Local auditing must be done more regularly.
33. New middle age onset patients probably not needing Insulin will not be immediately registered. Often they fail to make necessary efforts. Before starting treatment they will be motivated for diet and urine testing and observed as outpatients.
34. All patients are required to pay means-based fees, but economic status is difficult to determine. A complete revision is underway and more affluent patients will be obliged to pay higher fees.
35. The Program is generously supported by foreign donors, however budgeting prediction is difficult.
- Request will be made of long-term supporters to make a commitment. New Zealand Rotary Clubs will be approached in this respect.
36. Regular contact must be maintained with New Zealand and Dhaka Rotary Clubs.
37. A speech given by the Doctor to the Dhaka Rotary Club was warmly received. A return visit to the Project will be urged.
38. Hope for matched Rotary grants supplemented by Rotary International so far have not materialised due to rule restrictions. A proposal for equipping the three subcentres may be acceptable.
39. New donors must be sort and proposals prepared.
40. An English-speaking fund-raiser is needed. A nurse or an accountant-administrator could both fulfil this role and also assist the Program through to independence. (A two year commitment would be needed from a Bengali-speaker, four years for a person needing to learn Bengali).
41. Several important requirements remain for the Program's passage to becoming an independent NGO.
- i) increased patient awareness and unity,
 - ii) strong wise committees,
 - iii) increased staff competence in clinical care and administration,
 - iv) good leadership,
 - v) a suitable fund raiser.

The Future

Malnutrition, infections and maternal child health will continue to be the country's main health problems, but aggravated by AIDS, TB, Kala Azar, widespread Diabetes and the Arsenic contamination of drinking water. Diabetes will come into the top bracket - presumably due to genetic predisposition plus changing life style. Peripheral level primary health action is essential. The Kailakuri paramedic run program should be studied and supported because there is no other way in which the individualised care necessary for diabetes control can be achieved.

We thank all those who by their support have shared in this program which belongs to the patients and focuses on the poor - whose voice goes unheard.



Dr. Edric Baker, M.O.I.C. Thanarbaid Health Care Program. Bangladesh.

(please see over the page for the Kailakuri Subcentre Statement of Accounts for the year 2001)

**STATEMENT OF ACCOUNTS FOR THE KAILAKURI SUBCENTRE
FOR THE YEAR 2001**

(in thousands of Taka)

<u>Income</u>		<u>Expenditure</u>	
Opening Balance	1,10	Staff Pay	5,66
Donations	6,11	Diabetes Medicines .	1,51
Patient Fees	1,00	Other Medicines,	1,21
Miscellaneous	3	Inpatient Feeding	3,13
Loans (to Thanarbaid Clinic)	8,19	Diabetes Equipment	32
	-----	Medical Equipment	6
	16,43	Supplies and Equipment	9
		Stationary	23
		Gardening	9
		Firewood	15
		Lamps and Kerosene	15
		Bedding	8
		Furniture and Fixtures	2
		New Buildings	61
		Building and Maintenance	15
		Cycle and Repairs	27
		Travel and Conveyance	1,00
		Poor Patient Assistance	12
		Loans Refunded	79
		Miscellaneous	12
		Closing Balance	67
			<hr style="width: 100%; border: 0.5px solid black;"/>
			16,43 Taka

Actual Income: 7,15,000 Taka

Actual Expenditure: 14,97, 000 Taka

(US \$1 = 54 Taka approximately)