# Annual Report of the Thanarbaid Health Care Programme for 1999

The Ten Most Important Activities
of the Thanarbaid and Kailakuri Health Programmes
(in the view of the Staff involved)

AnteNatal Care
Under 4 Child Care
Immunisation Motivation
TB Treatment
Outpatient Treatment
Village Nutrition Motivation
Inpatient Care
Inpatient Nutrition
Delivery Assistance
Diabetes

followed by:

- Family Planning
- Book-keeping
- Latrine Motivation
- Virus Fever Treatment
- Village Teaching
- Diarrhea Treatment
- Provision of Low Cost or Free Treatment
- Provision of Essential Drugs

(drawn from an opinion survey of over 40 Programme staff)

## Introduction

### Aims and Difficulties

The aim of the Thanarbaid Health Care Programme (T.H.C.P.) is health for all, especially the poor, achieved by the poor. It is an attempt to make this possible in the special circumstances and needs of the area, and as such it is dedicated to the poor people of the area and to Almighty God Who is especially their God. Our desire is for a movement for health among the people.

In the struggle for health, practitioners, structures and institutions become necessary, but they get in the way when efforts to establish and perpetuate them overtake the priority of the people's movement and the people's health. Bangladesh teems with practitioners and institutions that have lost sight of the aims of health work. Many have even become obstacles to the health of the people.

What we should be doing is to nurture health action off a people's health movement or community base; but this becomes impossible when the community is so deeply and chronically divided. The only ways left to contrive a kind of community base are:

1) to take a minority group as "community base" and work off that, and—
2) to draw staff from different communities, "declaring" them representative, and then strive to unite them and train them up as health workers, and yet keep them faithful to the whole community of which they are not representative.

## The Essence of Health Care

In the face of such a quandary it becomes necessary to return to the basics. What in fact is health work and what are its aims? On what does it depend? And what are its priorities?

The principal aims are (in the service of God) to:

1) heal the sick and relieve suffering
2) prevent disease
3) eliminate unnecessary costs
4) make health care available for all, especially the poor, and—
5) build up a caring problem-solving society in which disease is less likely and sufferers are cared for.

The methods are:

1) awareness promotion, teaching and motivation for health
2) structures for health action, and—
3) promotion of community

Health workers are both part of the community and part of a team that is guided by consensus and by the teaching and direction of its leaders. Health work is a matter of relationships. No action is possible without concern for and identification with the people and recognition of their conditions—especially economic. The health workers are responsible to the people and to their God.

Priority goes to those in the society who are the weakest, diseases which are the commonest, and actions that bring greatest gain at lowest cost. (In poor communities the highest priority groups are small children and mothers, the highest priority problems usually nutrition and infections, and the highest priority families the poorest families).

Health care cannot discriminate between religious and ethnic groups.

Health care must be realistic as to what it can and cannot do.

The poor suffer the most from ill health and do not have the resources to change their situation. Health work must be directed towards them and they must do it. It must come from their initiative, or if they are so divided and disorganised that this is not possible, then it must immerse itself amongst them, draw them to unity and foster their initiative. Movements take priority over institutions.

| The Ten Most Important Health Problems in the Area | The Ten Most Important Background Social Problems |
|---|---|
| Virus Fevers<br>Diarrhoeal Diseases<br>Peptic Ulcer<br>Pneumonia<br>Anaemia<br>Pregnancy Problems<br>TB<br>Intestinal Worms<br>Delivery Problems<br>Kala Azar<br><br>(followed by: conjunctivitis, rabid bites, injuries, psychiatric problems, hypertension, otitis media and skin sores)<br><br>(Drawn from the opinion survey of Programme Staff.) | Poverty<br>Family disharmony<br>Social disharmony<br>Usury<br>Laziness<br>Foolish Spending<br>Malice<br>Dowries<br>Superstition<br>Carelessness<br><br>(followed by unavailability of work, lawlessness, lack of awareness, traditional healers, alcohol, ignorance, lack of family planning, injustice, marital infidelity and lack of child care)<br><br>(The prominence given to poverty and disharmony is striking.) |

## Thanarbaid Health Care Programme Problems

Over the years the T.H.C.P. has been an initiator and a part of a growing movement for health that has achieved enormous benefits for the people.[1] It has also had a considerable effect in bringing together separated religio-ethnic groups. Now it is faced with its own problems:

1) ever increasing work overload (due to continuing population increase, ever increasing gap between population numbers and available services, and the increasing recognition and demand for its services)
2) how to draw the people together from the three fragmented communities amongst which the health changes have taken place, make them into a people's community base—, and foster initiative from that base
3) how to cope with the problem of the constant demand for service from people coming from outside the local programme area
4) how to sustain basic service quality and at the same time develop administration
5) how to rationalise salaries in a society in which the professionally qualified demand rewards that put their services beyond the means of those who need them

[1] The health movement to which we refer has three characteristics: progressively spreading behaviour change producing improved health, concern for the health of others, and collective action for health. The first we see all around us. The second we also see. The third drags behind.

6) how to resolve the problems of its own internal disharmony, giving all its staff members equal footing, irrespective of whether or not they are members of its parent community (Church of Bangladesh)
7) how to achieve security of continuity, and at the same time remain faithful to its values and aim, and submit to the need for its own decrease and the people's health movement's increase

## Approaching the Problems

The approach will be:

1) Move slowly.
2) At local level give priority to:
   i) health teaching and health action
   ii) worker formation
   iii) strengthening administration
   iv) problem solving by an inner staff group
   v) fostering and developing staff leadership
   vi) developing and nurturing a Community Excecutive Committee
3) At the wider level:
   i) continue fund-raising and communication with support partners
   ii) continue and develop relationships with long-term partners and supporters (Church of Bangladesh Social Development Programmes (COBSDP), Christian World Service (CWS), U.S.P.G., Uniting Churches of the Netherlands, Rotary—New Zealand and Dhaka, German Doctors for Developing Countries, BIRDEM Hospital, Damien Foundation, the Holy Cross and Maryknoll Fathers and NZAMB)
   iii) seek national professional participation

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The Health, Poverty, Development Trialogue

In poor countries the most important determinant of ill health is poverty.

The costs of modern health care and the remuneration required by its practioners become so great that it ceases to be available to the poor who are the ones who need it most.

The role of health care is to address this problem. The Thanarbaid answer is that the poor must do it for themselves. (Two key questions arise: which health services are essential, and what proportion of the population is excluded because of poverty?)

This is the health issue.

The development issue is: The answer must be determined by the people and sustained by the people. The people must do it.

In Bangladesh however the people keep dividing, and they are controlled (economically) by powerful elite groups.

The T.H.C.P. is caught in this net and becomes a part of the net.

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# Activities of the T.H.C.P. in 1999 (and the first half of 2000)

## A. Actions for Health for All (especially the Poor)

1. Awareness Promotion, Teaching and Motivation
   i) Staff teaching
   ii) Village health teaching and motivation
   iii) Inpatient teaching
2. Actions for Health
   ii) Village: under-fours care, ante-natal care, health advice and teaching, delivery assistance, family planning, early disease treatment, patient home-visits, back-up of Government immunisation programme
   iii) Clinic Centre: outpatient care, inpatient care, nutritional resuscitation and rehabilitation
   iv) Kailakuri Centre: TB and Diabetes treatment and supervision
   v) Referrals: general surgery, eye surgery, Diabetes, X-ray, other
3. Actions for Community Promotion
   i) Basic health service for all
   ii) Patient and staff acceptance irrespective of religio-ethnic group
   iii) Ecumenical prayer
   iv) Constant striving for harmony

## B. Actions to Build Up Structure for Service Delivery and to Secure Continuity

1. Structure and Institution
   i) Institution: running Programme under C.O.B.S.D.P. with local Management Committee (two committees are on agenda—Church Supervisory Committee and Community Executive Committee)
   ii) Structure:
      – division into separate Thanarbaid and Kailakuri Programmes
      – Thanarbaid Programme division into Village, Outpatient, Inpatient and Administration
      – weekly programme rostas
      – programme management and running almost entirely in hands of local staff
      – staff supervision structure
      – consultatory decision making
      – regular external audit contract (now in action)
   iii) Fund-raising
2. Actions to Secure Continuity
   i) Ongoing staff training
   ii) Progressively putting more and more responsibility into hands on non-certificated local staff
   iii) Senior staff Management Seminar (conducted by I.I.R.D.)
   iv) External Evaluation looking at security of continuity

v) Responses to the challenges of the Evaluation:
- setting up of regularly meeting inner staff decision making group
- search for ways to reduce Programme overload
- search for ways to reduce Medical Officer overload
- separation of Village Programme under the supervision of registered nurse Mrs. Libby Laing
- appointment of two managers (finance-building-grounds manager and health actions manager)

vi) Complete administrative separation of the Kailakuri Centre (Diabetes and TB) and ongoing preparation for total independence in 2005

## Village Programme Statistics[2], 1999

**AnteNatal Care Statistics**

| | | |
|---|---|---|
| ♦ Total No. of mothers supervised (during year) | | 256 |
| | Mandi | 63% |
| | Muslim | 20% |
| | Borman | 17% |
| ♦ Total No. of mothers delivered (during year) | | 179 |
| Percentage delivered by Clinic Staff | | 33% |

**Under 4 Child Care Statistics**

| | | |
|---|---|---|
| ♦ Total No. of villages | | 10 |
| ♦ Total No. of children under supervision (year's end) | | 744 |
| | Mandi | 58% |
| | Muslim | 31% |
| | Borman | 11% |
| ♦ Total No. of workers involved | | 14 |
| ♦ Percentage of children with slight or more evidence of nutrition problem | | 12% |

[2] Note on ethnic and religious groups: Mandis are almost all Christian. Bengalis are almost all Muslim, but a few are Hindu. Bormans are almost all Hindu. Nearby Hindus are almost all Borman. Distant Hindus are mostly Bengali.

**Family Planning Statistics**

*I. Natural Family Planning*

| | | |
|---|---|---|
| • Total No. of couples supervised (during year) | | 19 |
| | Mandi | 93% |
| | Borman | 7% |
| • Total No. leaving programme (during year) | | 5 |
| Reasons: (% of all 19 couples) | | |
| no longer needing supervision | | 21% |
| pregnant while on method | | 5% |
| total | | 26% |

*II. Oral Contraceptives*

| | | |
|---|---|---|
| • Total No. of couples supervised (during year) | | 123 |
| | Muslim | 66% |
| | Mandi | 21% |
| | Borman | 13% |
| • Total No. of leaving programme (during year) | | 25 |
| Reasons: (% of all 123 couples) | | |
| changed method | | 4% |
| pregnant while on method | | 5% |
| planned pregnancy | | 4% |
| divorce | | 2% |
| side effects | | 6% |
| total | | 21% |

**Baby Delivery Statistics**

- Total No. assisted (almost all in homes) 67

| | |
|---|---|
| Mandi | 52% |
| Muslim | 32% |
| Borman | 16% |
| | |
| Had antenatal care | 88% |
| Complications[3] | 25% |
| Transferred to hospital | 6% |
| Maternal deaths (Eclampsia) | 1% |
| Baby deaths | 12% |

- Total No. Eclampsia Patients admitted 5

| | |
|---|---|
| Muslim | 100% |
| | |
| Had antenatal care (0) | 0% |
| Maternal deaths (1) | 20% |
| Baby deaths (3) | 60% |

[3] premature labour, eclampsia, obstructed labour, placenta praevia, post-partum haemorrhage

## Thanarbaid Programme Statistics, 1999

**Thanarbaid (and Dhorati) Centre Statistics**

- Total No. of Outpatient Visits (Thanarbaid and Dhorati) 15,179

| | | | | |
|---|---|---|---|---|
| Percentages | Thanarbaid | 81% | Muslim | 81% |
| | Dhorati | 19% | Mandi | 14% |
| | | | Hindu | 5% |
| | Female | 53% | | |
| | Male | 47% | | |
| | Age 0-5 | 8% | | |

- Total No. of Inpatient Admissions (Thanarbaid) ~797

| | | | | |
|---|---|---|---|---|
| Percentages | Male | 54% | Muslim | 61% |
| | Female | 46% | Mandi | 29% |
| | Age 0-4 | 21% | Hindu | 10% |

- Total No. of Staff (Thanarbaid and Dhorati) 48

| | | | | |
|---|---|---|---|---|
| Percentages | Clinic based | 69% | Mandi | 60% |
| | Village workers | 31% | Muslim | 23% |
| | | | Borman | 13% |
| | Male | 52% | Foreign | 4% |
| | Female | 48% | | |

**Thanarbaid (and Dhorati) Centre Statistics (continued)**

- Total No. of Staff (Thanarbaid and Kailakuri) 65

| Percentages | | | | |
|---|---|---|---|---|
| Thanarbaid | 74% | | Mandi | 52% |
| Kailakuri | 26% | | Muslim | 34% |
| | | | Borman | 11% |
| Male | 60% | | Foreign | 3% |
| Female | 40% | | | |

Top Ten Outpatient Diseases

Anaemia
Peptic Ulcer
Diarrhoeal Diseases and Malabsorption
Worms
Asthma
Skin and Wound Infections
Arthritis
Psychiatry
Tinea
Fevers (mainly virus)

(followed by: epilepsy, chronic conjunctivitis, obstetric and gynaecological problems, injuries and otitis media)

(drawn from an analysis of patients seen in February and July)

(Note: anaemia and peptic ulcer were far in advance of the other diseases)

Top Ten Inpatient Diseases

Injuries and Burns
Fevers
Malnutrition
Kala Azar
Diarrhoeal Diseases
Peptic Ulcer
Pregnancy and Delivery Problems
Respiratory Problems
Anaemia
Kidney Diseases

(followed by: heart failure, insecticide poisoning, arthritis, urinary problems, urethral dilatations, Berger's Disease)

## Rabies and Kala Azar

1. Rabies

Bangladesh has the world's second highest incidence of Rabies (following China). The Modhupur area problem is probably fuelled from the jackal population of the local forest. Rabies is rapidly fatal.

- Total number of patients given vaccine courses in 1999 following bites by suspect dogs or jackals = 50
- Total number of cases of rabies seen = 0

2. Kala Azar

The N.E. India leishmaniasis endemic focus was suppressed when DDT spraying for malaria mosquitoes knocked back also the Kala Azar sandflies. Now it has resurged. The disease is usually fatal. Treatment is costly and with dangers.

- Total number of patients treated for Kala Azar in 1999 = 45
- Total number of deaths = 0

**Poor Patient Surgical Transfers**

Government Hospital consumer cost-sharing policy makes surgical costs crippling for the poor and impossible for those who are extremely poor. Thanarbaid Clinic sends patients for surgery mainly to three hospitals, and bears most of the costs.

| Recorded number of patients transferred in 1999 | | 66 |
|---|---|---|
| Percentages | Poor | 97% |
| | Extremely Poor | 73% |
| | Male | 56% |
| | Female | 44% |
| Approximate Cost | | Tk 2,06,000 |

The Ten Most Important Health Activities Not Being Done

Anti-smoking campaign
Village Birth Attendant Training
Latrine Programme
Staff Examinations (following teaching)
Sufficient Village Health Teaching
Community Teaching on Sex Diseases
School Health Teaching
Health Dramas
Dog Eradication
Trachoma Programme

(followed by: malathiene impregnated mosquito nets to prevent Kala Azar, tubewell programme, health teaching by microphone, disabled rehabilitation programme, teaching on fever lowering, hypertension programme, deafness prevention programme)

The Ten Most Important Changes Needed in the Thanarbaid & Kailakuri Programmes

Reduction of Inpatient Numbers
More Village Health Teaching
Latrine Programme
Dog Eradication Programme
Help for those who are in fact poor
Village Birth Attendant Training
Increased Staff Discipline
Employ another MOIC
Cleanliness at Clinic Compound
Dining Room Bell

(followed by: anti-smoking campaign, more clinic badges, nurse training, health teaching in schools, deafness prevention, tubewell programme, further lowering of treatment costs, clinic pedal ambulance)

(drawn from the Staff Opinion Survey)

## Statement of Accounts for Thanarbaid H.C. Centre (excluding Kailakuri) for the 12 month period of 1/1/99 to 31/12/99

| **Income** | | | **Expenditure** | |
|---|---|---|---|---|
| Opening Balance | | 56,682 | Worker's Pay | 6,53,931 |
| Donations | | 18,74,583 | Medicinces | 4,84,858 |
| [Via Diocesan Office | 7,12,870] | | Inpatient Feeding | 3,82,403 |
| [Other | 11,61,713] | | Firewood | 15,964 |
| Patient Fees | | 1,25,761 | Supplies & Equipment | 8,249 |
| Provident Fund | | 14,265 | Medical Equipment | 5,781 |
| Miscellaneous Income | | 3,159 | Stationary | 22,805 |
| Loans | | 7,95,213 | Electricity | 9,402 |
| Bank Interest | | 3,203 | Lamps & Kerosene | 10,298 |
| | | | Cycle Repairs | 14,101 |
| | | | Travel | 11,101 |
| | | | Buildings & Maintenance | 7,765 |
| | | | Furniture | 6,402 |
| | | | Bedding | 4,914 |
| | | | Garden | 3,434 |
| | | | Poor Patient Transfers | 2,05,549 |
| | | | Loans | 9,12,663 |
| | | | Bank Fees | 1,912 |
| | | | Closing Balance | 4,098 |
| | | Tk 28,72,866 | | Tk 28,72,866 |
| (Actual Income 20,20,971) | | | (Actual Expenditure 19,56,105) | |

**Exchange Rates** (31/1/2000)

| | | |
|---|---|---|
| $1 USA | = | Tk 51 |
| $1 NZ | = | Tk 25 |
| £ 1 Stg. | = | Tk 83 |
| DM 1 | = | Tk 25.5 |

## Summary Statement of the Combined Accounts of the Thanarbaid and Kailakuri Centres for the period 1/1/99 to 31/12/99

(thousands of taka)

| **Income** | | | **Expenditure** | |
|---|---|---|---|---|
| Opening Balance | | 1,30 | Actual Expenditure | 25,48 |
| Actual Income | | 27,13 | Loan Balance | 4 |
| [Donations | 25,22] | | Closing Balance | 2,91 |
| [Patient Fees | 1,71] | | | |
| [Other | 20] | | | |
| | | Tk 28,43 | | Tk 28,43 |

## Donations to the Thanarbaid and Kailakuri Programmes 1999

(in thousands of taka)

| **Donor** | **Amount** |
|---|---|
| CWS (New Zealand) (incl. VASS) | 10,87 |
| Anonymous (plus 5,32 to CWS) | 40 |
| USPG (Britain) | 3,16 |
| German Doctors | 2,35 |
| Uniting Church of the Netherlands | 2,00 |
| Netherland private donor | 1,52 |
| British private donor | 77 |
| Benedictive Sisters (USA) | 50 |
| S. Andrew's Church Taupo (New Zealand) | 50 |
| British private donor | 41 |
| USA private donor | 36 |
| Italian private donor | 24 |
| One World Group Scotland (Britain) | 23 |
| USA private donor | 12 |
| USA private donor | 12 |
| Netherlands private donors | 8 |
| | Tk 23,63 |

(Note: Some donations in transit, especially from Rotary Clubs in New Zealand, have not been listed.)

Breakdown of the Staff Views on the Most Important Changes Needed

Actions to improve patient care.
Special problem or disease Programmes
Actions to improve staff and patient discipline.
Actions to improve the Village Programme.
Actions to improve financial security.
Actions to improve administration.
Village, community and school teaching activities.
Improvement of facilities at the Thanarbaid Clinic base.
Improvement of staff attitude and behaviour.
Actions to support the staff and improve their motivation.

(followed by: actions to cut back pressure on the clinic, and actions to improve staff teaching)

(drawn from the Staff Opinion Survey)

## Problem Solving Plan

**A. Programme and Community**

1. Two separate committees (Church Supervisory and Community Executive)

**B. Administration and Staff**

1. Programme separation (Village Programme, Thanarbaid Clinic Base, Kailakuri Diabetes & TB Programme)
2. Management allocation (separate finance and health activity managers)
3. Decision making and problem solving by inner staff group
4. Staff teaching and patient care based on Standard Treatment Book
5. Increased salaries and wages
6. Staff evaluation scheme
7. Refinement of salary scale system
8. Regular external audit

**C. Ongoing Security of Programme**

1. Staff preparation for total involvement in all aspects of the Programme and its decision making
2. Streamlining Administration
3. Community base development
4. Fund-raising and partnerships
5. Future leadership seeking and preparation

## Apology and Appreciation

Once again we give our very sincere thanks on behalf of our people to all those whose generous support makes it possible for the Thanarbaid Health Care Programme to continue. We beg them to accept our work even though we may fail to meet up to some of their expectations and to the enduring values of the God Who is both their God and the God of our people.

Concluding Reflection

Cowering before the insecurity of poverty and rapid social change, both society and the heart of man long for the security of some sort of Messianic Figure (maybe a village judge or a local community or religious leader, or perhaps a charismatic union chairman or political leader—whose character and qualities go beyond the ordinary). When Destiny provides one, the signs will be His identification with the people, His proclaiming and struggle for eternal values, His raising of the People's Movement and suffering its suffering, and His giving to it the security of His Presence and spiritual Charisma. (Such is the Christ of Christians.) The Thanarbaid Programme should give thought to this model as it seeks its role, its security and its future leadership.

The characteristics of the People's Health Movement will be faith, concern, caring and problem solving.

Finally as a Christian Programme we do well to remember the words of the Gallilean Oracle: "Blessed are the poor, who understand both the necessity and impermanence of structures and institutions. Uncluttered by their illusions, the security of the Spirit that moves the Movement of the People will be theirs."

Edric S. Baker, MOIC