

ANNUAL REPORT FOR THE THANARBAID HEALTH CARE PROGRAMME

IN THE JUBILEE YEAR 2000

The Thanarbaid Health Care Programme (THCP) is a grassroots project of the Church of Bangladesh Social Development Programmes (COBSDP) and is deeply rooted in the local community. **The aim is health for all, especially the poor, by the poor.** Its value lies in its making health care of a reasonable quality available to the poor at low cost. The beneficiaries and staff are all local (except for the Medical Officer and the Village Program Coordinator). Patient fees cover 6% of total costs, the balance coming from foreign donations. Sustainability depends upon leadership, the committed staff group and community involvement, with planning, teaching and supervision, COBSDP support, and outside finding (poverty prevents the beneficiaries from financing their own programme). We believe the Plan of the Divine Compassion to be for the salvation of the poor and their full involvement in community change, so that all can share in the development process and the enjoyment of community life. As the poor come forth to be the driving force for change, so those with means come forth to join them for its empowerment and sustainability.

THE SITUATION OF THE COUNTRY

- enormous population density, urban and rural
- development that is dramatic but very uneven with markedly increasing disparity
- disharmony, disunity, and political instability
- extremely hierarchical male-dominated society
- oppression and extortion of the weak by the powerful
- order and control (such as exist) achieved by power and tradition (in a heritage of violence and of control by power)
- frustration, restlessness, and often violent anger
- little concern for the problems of others - - and yet widespread spontaneous caring in times of national emergency
- enormous need in rural areas for economic security, work availability, appropriate basic education, and low-cost health care
- a profusion of NGO activity of variable quality and sincerity
- planning at all levels frustrated by extreme unpredictability
- great need in community work for empathy, caring, patience, commitment, and common sense problem-solving
- deep religious and poetic sensitivity in a culture of religious and poetic sensitivity, but also of apathy, struggle, and violence
- desperately inadequate health care services
- motivation and empathy in government seriously frustrated and overwhelmed by demands, inefficiency, self-seeking and corruption
- enormous fertility of soil, population, and culture

Currents Converging on the THCP

- poverty, apathy, conservatism, and superstition
- injustice, oppression, manipulation, and extortion
- culture of struggle, liberation, independence, and disunity
- restlessness for economic and social improvement
- increasing awareness of urban lifestyle

- unmet health needs
- human concern and unconcern
- Christian faith, empathy, and motivation for caring and development
- scattered COBSDP social development programmes often frustrated by inefficiency and personal and sectarian interests
- Islamic faith and motivation for community brotherhood and improvement by organisation and action (and an enormous amount of energy channelled into visible religion)
- Hindu faith and a hunger for spirituality, prosperity, and inner peace
- suppression of women in the majority community
- tribal traditions and a longing for peace, security, joyful happiness, community, family, and prosperity (but with deep suspicion of the majority community)
- female dominance in the Garo (Mandi) tribal society
- basic hunger for justice, caring, and perhaps a vague sort of socialism
- justice and rights movements
- multiplicity of religions and development organizations
- generosity of foreign supporters
- pervading influence of a kind of thinking that concentrates on individual or group advancement without concern for the greater number of the poor or deprived or for marginalized minorities
- local politics
- sectarianism
- increasing education

THE THANARBAID PROGRAMME

The programme attempts a grassroots level community health care programme in a rural area with three local communities (Mandi tribal Christians, Bengali Muslims, and Borman tribal Hindus). The seventy-five staff members (apart from the foreign medical officer and community nurse) are all local and on-the-job trained. Almost all are under School Certification. They are divided between the Village Programme, the Clinic Base, and the TB Diabetes Centre (Kailakuri Subcentre). Extreme simplicity, low cost, and a close link with the people are aimed for in all parts of the programme.

Staff Statistics

Total Staff = 75

Village Programme: 20(27%) Thanarbaid Centre: 28 (37%) Kailakuri Sub-centre: 27 (36%)

Mandi: 47% Bengali Muslim: 41% Borman Hindu: 9% Foreign: 3%

Male:61 % Female: 39%

(The proportions are strikingly different within the Village Programme, in which 90% of workers are female, 50% are Mandi, and 30% are Muslim)

Staff Opinion Survey

(taken from 30 staff members of Thanarbaid Clinic and the Village Programme)

1. The five changes in the area in the past five years considered to be of greatest importance:
 - a. increased education;
 - b. increased use of clean drinking water and latrines;
 - c. dramatic extension of the government immigration programme;
 - d. decrease in poverty;
 - e. increased rural justice.
2. The THCP is still necessary.

3. There is no other health care programme that really cares for the poor.
4. Striving for sustainability of the programme is a higher priority at the present time than improving service quality.
5. The five most important changes in the THCP in the past twelve months:
 - a. regular meetings of a small, inner-staff group for programme problem-solving and decision-making;
 - b. semi-separation of the Village Programme under the supervision of the community nurse, Libby Laing;
 - c. establishment of the Community-Staff Executive Committee (for community involvement and decision-making) alongside the Church Supervisory Committee;
 - d. division of programme management under two managers for greater efficiency;
 - e. staff salary and wage increase.

THE VILLAGE PROGRAMME

The village staff of 20 members (90% female) work in their own communities and are engaged in mother and child health (MCH), health and nutrition teaching, and home health care in ten different villages. Workers are regularly supervised in the field and take part in discussion groups, training, and wont reviews at the Clinic Base. Overall coordination, supervision, and planning is by community MCH nurse, Libby Laing.

The Ten Most Important Diseases in the Villages

(opinion of 37 Thanarbaid Programme workers)

virus fevers & acute respiratory infections, neo-natal jaundice, delivery problems, diarrhoeal diseases, middle ear infection, infected sores, pregnancy problems, conjunctivitis, pneumonia, malnutrition, (followed by TB, peptic ulcer, injuries, and Kala Azar)

Child Nutrition (under 4 years statistics)

772 children were under supervision at the end of the year 2000 (Dec. 1999, 744 children) (Mandi/Borman 71 %, Muslim 29%).

Nutrition problems -(failure to gain weight over three months, drop of 0.8kg not yet regained or weight under the third centile) - 52 problems, 6.7%. (Dec. 1999, 83 problems, 11%)

Ante-natal Care Statistics

299 mothers were supervised during the year 2000 (Mandi 63%, Muslim 18%, and Borman 19%). Of 194 deliveries, 35% were staff-assisted.

Delivery Statistics

Staff assisted at 100 deliveries (Mandi 30%, Muslim 50%, and Borman 20%). 66% of these were normal (all these mothers had antenatal care and delivered at home). 34% were complicated deliveries: 58% were prolonged labour (15% of babies died), 18% were obstructed labour (all transferred on and 50% of babies died), and 21% were eclampsia (no mothers died but 86% of babies died).

There was one twin delivery and one of the twins died. There were no serious complications apart from the twin delivery amongst antenatal care-assisted deliveries.

Family Planning Statistics

1. *Natural Family Planning* (NFP). 19 couples were supervised (all Mandi).

21 % were discharged from the programme because they no longer needed supervision.

2. *Oral Contraceptives* (O/C): 147 couples were supervised (Mandi 20%, Muslim 61%, and Borman 19%).

12% left the programme: (5% in order to have a pregnancy, 3% because they got pregnant while using the method, and 4% for other reasons).

Failure Rate: 0% of the NFP participants got pregnant while on the method, but 3% of the O/C users did. Whatever the family planning method, failures will result if it is not used correctly.

THANARBAID CLINIC (excluding Kailakuri)

Outpatients

The total number of outpatient visits was 11,219 in the year 2000

Thanarbaid Clinic 90%, Dhorati Sub-centre Clinic 10%; (0-4 years 8%, over 4 years 92%)
(male 47%, female 53%).

The average number of visits per working day was about 40.

Probably about 40% of the patients came from outside the Village Programme area.

The 10 Most Common Outpatient Diseases

peptic ulcer, anaemia, intestinal worms, bronchitis and asthma, diarrhoeal diseases, arthritis, epilepsy, psychological problems, general pains, infected sores and abscesses

The clinic is a cluster of simple village buildings with a minimum of facilities and no laboratory X-ray back-up. Patients are seen at Thanarbaid Clinic Centre 5 ½ days each week and at the Dhorati Sub-centre Clinic 1 ½ days each week. Diagnosis and treatment are carried out by on-the-job trained under-matric paramedics. Problems are referred to the Doctor.

Inpatients

Admitted patients at Thanarbaid Clinic are cared for by four paramedics and two night-staff. They are housed in simple village buildings and sleep on the floor. Clinical history and examination are all important as there are no X-rays and next to no laboratory facilities. The Doctor assesses all patients, takes daily reports, determines most treatments, and checks problems.

Patients are very poor and pay only nominal fees. They are fed by the programme, along with an attending relative in the case of very sick patients. Many have nutrition problems.

Usually there are eighteen to twenty-five admitted patients. The total number during the year was 590 (Muslim 72%, Mandi 22%, and Borman 6%). Most come from outside the Village Programme area.

56% were male and 44% were female (0-5 years 14%). The male predominance was most marked among the Mandi (64%), who live in a strongly matriarchal society. This is probably due to the fact that their women are so well cared for by the Village Programme. The least marked male predominance (54%) was in the strongly male-dominated Muslim society, most of whom come from outside the Village Programme area.

The 10 Most Common Inpatient Diseases

injuries and burns, nutritional problems, urinary problems,¹ acute respiratory infections, surgery patients,² deliveries and miscarriages, Kala Azar, peptic ulcer, Berger's disease, (followed by psychological problems, bronchitis and asthma, poisoning, and fevers)

¹ mainly the repeated overnight admissions of a small number of urethral stricture dilatation patients

² before or after transfer

Surgical Transfer Patients

The increasing costs of surgery pose a major problem for the poor and also for the THCP. There is neither professional time nor facilities for surgery at Thanarbaid.

Surgical transfer patients amount to only 1 % of those touched by the programme,³ whereas their cost amounts to about 13% of costs. Frequently, staff members earning about TK 1,000 per month are asked to carry TK 6,000-8,000 as cost deposits for patients they are taking to the surgical hospital.

IMPORTANT ACTIONS and ADVANCES MADE by the THCP DURING 2000

- three-week external evaluation of programme running and doctor's role in sustainability by American Dr. Fran McCormack stimulated important developments and implementation of earlier plans
- establishment of the Community-Staff Executive Committee, bringing together community and staff representatives (with a female majority) in decision-making. (Two-committee arrangement sustains COBSDP oversight and involvement)
- Dhorati Sub-centre Community-Staff Executive Committee parallel to the one at Thanarbaid
- first two decisions of both Community-Staff committees: plan to improve sterile technique in village Muslim circumcisions and plan to eradicate stray village dogs (rabies menace)
- separation and upgrading of the Village Programme under the supervision of the community MCH nurse, Libby Laing
- management seminar conducted by IIRD gave new insights leading to improved management
- creation and regular meeting of inner-staff group for problem-solving and decision-making
- English-language Standard Treatment Book completed and in use (Bengali translation underway)
- separate programme managers for finances and for health activities
- increase in salaries and wages
- preparations for staff monitoring and evaluation
- regular local external auditing

THE ONGOING THANARBAID HEALTH CARE PROGRAMME

The Five Most Important Improvements Needed in the Year 2001

(in the opinion of the staff)

1. Further fund-raising
2. Bengali translation of the Standard Treatment Book (underway)
3. Communication improvement within the Programme
4. Training of more staff for specialized clinical procedures
5. Preparation of more outpatient paramedics

Main Problems Facing THCP (in the opinion of the MOIC)

- lack of an overall cohesive, concerned community in the area
- community's lack of initiative in solving its problems and a lack of any effective structure for doing so
- unconcern for the problems of others
- lack of unity among the poor

³ The total number of patients touched by THCP in the year 2000 (excluding Kailalcuri) was 13,213 (outpatients 85%, under fours 6%, inpatients 4%, antenatal care%, family planning 1%, deliveries 1%, and surgical transfers 1%). In the face of the total programme running cost of TK 2,5 16,000, the average cost per patient touched was TK 180.

- inability of the poor to sustain their own health programme
- lack of senior staff personnel who are competent, willing, and able to give themselves wholeheartedly to their work
- requirements for low-cost programme sustainability and proximity to the people cause great difficulty in finding suitable responsible senior staff who are skilled, motivated, and appropriately orientated
- educated tribal Christian staff do not easily understand and identify with the thinking of uneducated Muslims, and senior staff serve patients often much poorer than themselves (the majority of whom are Muslim), so that non-empathy frequently manifests
- preparation of committed, caring staff leadership
- medical officer having to divide time between the priorities of development, administration, sustainability, service quality improvement (greatly needed), and fund-raising
- need for stronger COBSDP Dhaka Head Office back-up

Areas of Increased Back-Up Support Needed From The COBSDP Office in Dhaka

1. Regular 3 monthly statement of accounts with clear explanations, especially of foreign donations and Head Office expenditure cuts.
2. Immediate referral to the project of relevant communications from supporting partners.
3. Swift replies to requests for advice, information, and help.
4. Programme support and coordination through listening and discussion;
5. Joint seminars and training projects within the COBSDP.
6. Clear advice on Head Office structure, staff roles, and changes.
7. Regular news on COBSDP activities in Head Office and other projects, especially health projects.
8. Organization of small sharing meetings of heads of local COBSDP projects to improve mutual understanding and friendship.

Service and Sustainability

The aim of the poor is to find security and fullness of life, which Governments and N.G.O.'s call development and sustainability. The T.H.C.P desire is that they should have health and that they should be the ones to provide it.

Their longing for security and a better life arises from their present state of deprivation. The possibilities of change are thwart with all the uncertainties of poverty and oppression. It is these same uncertainties which make advance planning and sustainability in development and health so extremely difficult. The T.H.C.P. runs up against these same difficulties. Being a Christian programme however, it adds the components of faith, intuition and trust in God to the usual development strategies of evaluation, analysis, planning, implementation and re-evaluation. We strive for the sustainability of our Programme but know it is always at risk.

The real object however is not the sustainability of a particular programme but rather a better life for the poor and better sharing of the good things of life especially health, and that these should be sustainable. The poor would certainly agree with this. They know what they want and they see that given support they can do it for themselves.

The health workers of the people (and the professional staff) join with the poor in a struggle for change. In the Jubilee Year 2000 we are especially aware of the empowerment of the Christ-faith. This and the strength of the faiths of our people (Islam, Hinduism and Christianity) and the basic goodness and common sense of the people are our hope for sustainability.

On behalf of the poor and the sick we are deeply grateful to Almighty God and to Christ our Lord, and to all who by their generous involvement have joined the people in their venture for health. We thank you all for your kindness.

Dr.Edric Baker, Medical Officer in Charge
Thanarbaid Health Care Programme - Bangladesh

STATEMENT OF ACCOUNTS FOR THCP FOR THE YEAR 2000
(excluding Kailakuri)
In Thousands of Taka

<u>Income</u>		<u>Expenditure</u>	
Opening balance	1,00	Staff Wages	8,00
Donations through COB		Provident Fund	66
Head Office	13,92	Medicines	6,80
Donations - other	12,62	Medical Equipment	24
Patient Fees	1,47	Supplies and Equipment	9
Miscellaneous	7	Stationary	26
Staff-Provident Funds	17	Miscellaneous	10
Loans	1,50	Patient Feeding	4,15
	-----	Gardening	3
	30,75	Firewood	12
		Electricity	24
		Lamps and Kerosene	8
		Bedding	7
		Furniture and Fixtures	2
		Building and Maintenance	23
		New Buildings	16
		Cycle Repairs	17
		New Cycles	8
		Travel and Conveyance	20
		Poor Patient Transfers	3,44
		Loans Refunded	4,83
		Bank Fees	2
		Closing Balance	76

			30,75

Actual Income: 28,25,000 Taka

Actual Expenditure: 25,16,000 Taka

SUMMARY STATEMENT OF THE COMBINED ACCOUNTS OF THE
THANARBAID AND KAILAKURI CENTRES
FOR THE YEAR 2000

<u>Income</u>		<u>Expenditure</u>	
Opening Balance	2,91	Actual Expenditure	35,44
Actual Income	34,39	Closing Balance	1,86
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	37,30		37,30

Of the actual income of Tk 34,39,000 93% came from donations, 6% from patient fees, and 1% from other sources.

Of the Tk 32,08,000 donations, 43% was channelled through the COBSDP Dhaka Office.

Of the actual expenses of Tk 35,44,000 71% was spent on THCP (Clinic and Village) and 29% on the Kailakuri TB-Diabetes Programme.

DONATIONS TO THE THANARBAID AND KAILAKURI PROGRAMMES
FOR THE YEAR 2000 (in taka)

CWS (New Zealand)	8,73,335
American Private Donor	5,38,000
USPG (United Kingdom)	2,66,350
UCN (Netherlands)	2,13,000
German Doctors	1,92,000
American Benedictine Sisters	53,800
Italian Lions' Club	53,800
American Private Donor	53,800
American Private Donor	42,824
American Private Donor	26,900
Italian Private Donor	26,900
Bolivian Private Donor	16,140

	23,56,849

*It is often difficult to give accurate figures. Some donations are not included because they are not yet in local banks or because we have not been able to trace the donors. Others may be included although they are not yet in local banks. CWS support comes from many donors (the largest being an American Private Donor and New Zealand Rotary Clubs) supplemented by Government. We do not have data on all donations through CWS unless donors notify us direct, and timing of transfer depends on accessing of VASS supplement. Our Statements of Accounts include donations in fact given in 1999.

Exchange Rate (to taka) British £1 = 76.1, German DM 1 = 24.0

Netherlands Dfl 1 = 21.3, New Zealand \$1 = 21, US \$1 = 53.8

*(rates vary)