

# Medical Report DHARA, Bangladesh 2018



By means of this medical report we would like to give you an impression of the activities during our third visit of the Medical Checks for Children team to the DHARA foundation in the Fernando Nobre Hospital in Noabeki, in February 2016.

By collecting all the data and information in our computer we have been able to demonstrate the results in the enclosed tables.

Thanks to enthusiasm of all our mission members, the MCC staff in the Netherlands and especially with the help from the local people we have been able to achieve these results for a lot of the children in the Noabeki region.

With kind regards,

Bert van Wijk  
Joep Avezaat  
mission leaders  
Medical Checks for Children

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## Introduction

In 2017 there was no mission to Noabeki possible because of safety problems due to political instability, but this year we could again organise a mission.

From February 21 to 27 we checked 807 children in co-operation with the local NGO DHARA. The checks were in the Fernando Nobre Mother and Child Care and General Hospital in Noabeki, Shyamnagor, Satkhira, Bangladesh

The MCC team was assisted by the DHARA Youth Support Group, namely fourteen students of English language studies who were working as translators, and employees of DHARA. They all were assisting in the carousel system, for example helping at the registration station, or with 'Weighing and Measuring', or at the station where blood was taken and hemoglobin levels recorded.

Like in 2016 parents who participate in the modest insurance system – for an annual payment of 50 Taka (58 euro cents) a patient is able to see the doctor free of charge four times per year - could bring their children to be checked by MCC. This made possible (when the continuing registration of this healthcare insurance is oke) that children can be readily identified enabling improved continuity and follow up of care, and also making it easier to contact these children for further health education, etc.

The success of this mission was due to the enormous dedication of the MCC team and DHARA team members, and especially Mrs. Lipika Das Gupta and her husband.

### MCC team

All team members are volunteers and responsible for their own costs for the journey and their stay at the Fernando Nobre Hospital.

A dentist and a dental assistant participated in the team this year. They gave treatment to a lot of children with dental problems.

Also a dietician was member of the team and she gave a lot information on food issues.

The MCC team was made up of the following team members :

- Joep Avezaat (doctor), team leader, responsible for all medical decisions
- Bert van Wijk (care manager), responsible for organizational decisions
- Aletta Lodel (social therapist)
- Anja Kalisvaart (nurse)
- Annette Pelgrim (midwife np)
- Bernardien Thunnissen (MD)
- Cisca Kok (GP)
- Esther Heijkoop (dietician)
- Femke Hagenmaier (orthopedic surgeon trainee)
- Josine v.d. Meijdenberg (child and youth psychiatrist)
- Margreet Luger (fracture clinic/plaster nurse & wound management)
- Marijke de Bont (MD np)
- Marjolein van Osch (dental assistant)
- Menno Oosterhuis (orthodontist)

### DHARA

The Bangla NGO Development of Health & Agriculture Rehabilitation Advancement(DHARA) is involved in several projects namely concerning health care, education for deprived children, women's emancipation and social support for the poor and needy. The building of the hospital named in the introduction was made possible by DHARA.

The founder and director of DHARA is Mrs. Lipika Das Gupta.

### MCC carousel

All children were checked in the so-called MCC carousel.

Within this model children are measured in height and weight, the level of haemoglobin (Hb) is measured via a finger prick and drop of blood. Other tests are possible, including measuring the percentage of oxygen in the blood, blood pressure measurement, and urine testing. After these tests the children are physically examined by one of the doctors. If necessary the child gets an antiworm tablet (albendazol) and other medication.

### Medication and treatment

The medication was ordered by DHARA on behalf of MCC who paid for the medication and most of which was available on commencement of checking

Each child received a toothbrush (with instruction how to use it) on leaving the location. The brushes were donated by firms that delivered dentist material.

### Region

Noabeki lies in the southwest of Bangladesh in the region Satkhira about four hours drive from the town of Jessore. It is a poor area regularly hit by cyclones and floods. Since the most recent cyclone, Aila, in 2009, arable farming has not been possible due to saline deposits in the ground.

Since 2012 rice crops have once again been able to grow, although some areas are annually flooded by salt water. There is just one harvest each year. Also in this area there are a number of fish and shrimp farms.

## Results

For detailed results we direct you to the tables enclosed.

### Amount of children:

Table 1.

In total we could check 807 children.

As in 2016 children came from different, sometimes remote, villages.

As can be seen in the tables: from 9 villages we checked more than 30 children. Those villages we specified in the tables.

### Age and gender of the children:

Table 1.

Younger children are more vulnerable than older children that is why we wanted to check as much younger children as possible.

22% of all the children checked was younger than 1 year and 48% was younger than 5 years.

We saw some more boys than girls (57% - vs. 43%).

### Caretaker

It is important that children are accompanied by one of the parents or a caretaker, because so we can get a better anamnesis and we can give information about the treatment etc.

We were very happy that all children (except 1!) were accompanied by an adult.

### School

93% of all boys at the age of 5 years or older are going to school and 84% of the girls does so.

### Checked las year?

Only 6% of the children we saw this year were checked in 2016 as well. So it was not possible to compare the results on a individual base.

### Anaemia

Table 2.

A frequent and main problem in developing countries is anaemia.

There are many reasons that are responsible for its cause. The most frequent cause is due to iron and vitamin deficiency through an unvaried diet, chronically infections such as worm infections, tuberculosis and other chronic infections.

23% of all children had anaemia, 2015: 28%, 2016: 39%. A significant improvement.

Seven children had serious anaemia, with a hemoglobin level under 5 mmol/l. These children were referred to a hospital or advised to have checked their blood after 3 months.

There was no difference in prevalence of anaemia between boys and girls (23 vs 22%)

In the different age groups the results were:

<= 1 year	31%
1 – 5 years	21%
5 – 10 years	20%
> 10 years	29% *

\* 5 children only

### Growth disorders

Table 3: weight/age

Table 4: weight/length

Table 5: length/age

Growth is an important parameter when assessing the health of a child. In the MCC carousel measuring height and weight takes an important place.

The height and weight need to be in line with the age of the child. The prevalence of growth disorders is an indicator of poverty, poor nutrition, poor living conditions, inadequate hygiene and chronic disease in the population. It is important to note that the exact age of the child is very often unknown to parent and child in this area.

The following criteria were used:

- Underweight: weight corresponding to age on or below the third percentile (P3) of a reference population. ( WHO growth curve, available for children under ten years of age) This is an indication of malnutrition or weight loss due to disease.
- Wasting: weight corresponding to height on or under P3of a reference population. (WHO growth curve is available for children up to 1.20 cm tall). This is an indication of acute malnutrition.
- Stunting: height corresponding to age on or under P3 of a reference population (WHO growth curve available for children up to 19 years of age). This indicates chronic malnutrition.

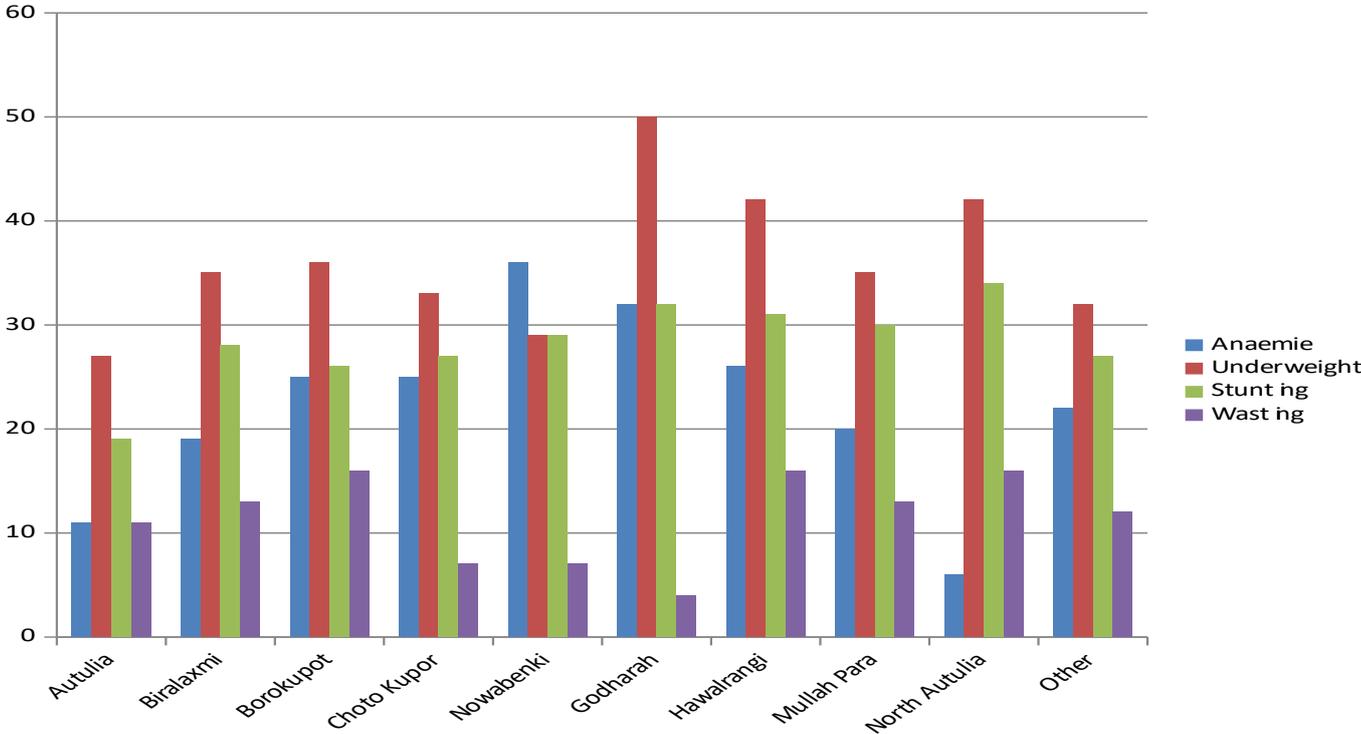
All children with growth retardation were given a multivitamin preparation for three months.

Underweight was indicated in 33% of the children. (2015: 22%, 2016: 28%)

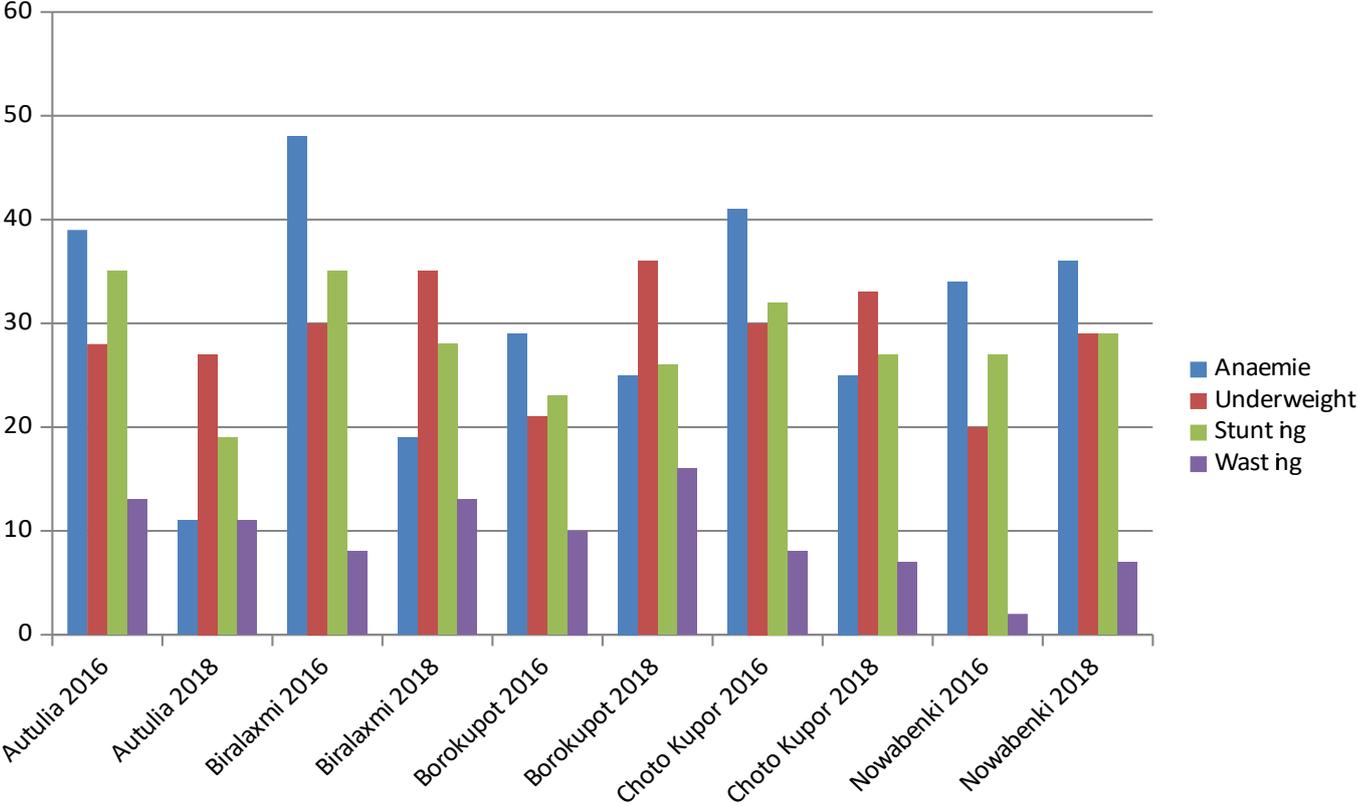
Stunting indicated in 27% of the children . (2015: 24%, 2016: 32%)

Wasting was present in 16% of the children. (2015: 15%, 2016: 12%).

**Figure A: anaemia, underweight, stunting and wasting per location**



**Figure B: anaemia, growing disorders per location in 2016 and 2018**



In almost every of these 5 villages we see a decrease in numbers of children with anaemia but the numbers of children with growing disorders is slightly increased or at least unchanged. We don't have an explanation for these results.

## **Worm infections**

Table 6.

Worm infections occur frequently throughout the world, mostly in developing countries. The prevalence of worm infections is related to poor hygiene conditions. (Faecal contamination of hands and food etc.) Very often these infections result in no complaints. When a child has many worms in his gut, this can lead to pain and discomfort and bloating of the abdomen. Malabsorption, where nutrients are not taken up in the gastrointestinal tract and chronic blood loss can lead to anaemia, malnutrition and growth disturbances.



The World Health Organisation (WHO) recommends that all children in these areas receive twice a year an anti-worm treatment (albendazol) as a preventative measure.

The government of Bangladesh is responsible for providing this medication. MCC gives an anti-worm tablet to every child that has not received one in the last 6 months; this tablet is taken by the child on the spot.

Children displaying symptoms of an active worm infection are given a course of Albendazol.

We diagnosed 133 times an active worminfection (16%).

52% of all children did not had antiworm prevention the last six month.(2015: 71%, 2016: 58% This is an improvement comparing last years, but still this percentage is to great and we can conclude that the worm prevention program does not reach enough children in this region.

## **Prevalence of diseases**

See table 7

### **Respiratory Tract/Airways**

10 children (1%) were diagnosed with a infection of the lower airways (pneumonia, bronchitis).These children received a course of antibiotics, with instructions given to their parents or caretakers.

3 children had asthma.

### **Heart Disorders**

Two children were diagnosed with a pathological murmur, indicating a heart defect.

They were referred to the hospital in Satkhira.

### **Gastro-intestinal complaints**

At least 8% of the children had complaints about obstipation (but probably the amount of children is greater because this diagnosis is not consistently recorded), mainly due to alimentary problems (see below), they and and their carers were given advice on this matter.

### **Ear- Nose- Throat**

Sixteen children (2%) had a acute ear infection (otitis media), eighteen (2%) a chronic ear infection and fifteen (2%) children had a infection of the external ear.

### **Dermatology**

About 4% of the children had eczema, 1% was diagnosed with mycotic infections of the skin and 1% with other skin infections.

Scabies was seen in case of fourteen children (2%), these children as well as their family were given anti scabies treatment and information about the infection and treatment

## **Eye**

Five children had strabismus

## **Urinary tract**

In eleven children (1%) we diagnosed a urinary tract infection for which a course of antibiotics were given.

## **Teeth**

During MCC missions we always see a lot of children with dental problems.

These problems are caused by:

1. inadequate dental hygiene: most children brush their teeth only one time a day (morning) and their brush technic is insufficient.
2. eating/drinking too much sugar and sweets.
3. bad construction of the teeth due to vitamin deficiency and malnutrition of the mother during pregnancy

In this mission 39% of all children had dental caries (310 children)

about 50% of this children had also dental pain.

A dentist and a dental assistant were part of the team this year. So we could give treatment to the affected children.

## **Neuromusculair**

This year we saw 16 children with severe, congenital-neurological problems.

Like we described in the medical report 2016 we always pay good attention to these children and their parents. We try to explain what the problem is and the limitation for possibilities for treatment.

## **Referrals**

Ten children (1 %, 2015: 0,8%) were referred to a specialist in a hospital, amongst them 2 children with heart valve problems.

One of these children was diagnosed already.

Most parents didn't had the money to pay the specialist and even they did not had the money to pay for the bus to Shatkhira, were the hospital is.

That is why we hired 2 minibuses for 6 children, accompanied by one of their parents, two of our teammembers, Mrs. Lipika, her husband and a translator.

All children were seen by a specialist (neurologist, paediatrician, cardiologist, surgeon. If necessary additional investigations were made the same evening: EEG, MRI brain, bloodtests etc.

Two children with epileptical convulsions were prescript medication.

MCC paid for transport, treatment, investigations and medication.

## **Health education**

From the two other missions we learned

- almost everybody knows that brushes teeth is necessary but it is practiced only once a day: in the morning
- rice is the staple food and is eaten 2-3 times a day
- most children eat at least once a week fish, some more frequently.
- meat is less available
- vegetables are plenty available for almost everyone but most children eat vegetables only once or twice a week
- when we asked why they don't eat more often vegetables people tell that this is not their habit and that the children don't want to eat more vegetables
- like in our country there are a lot of parenting problems concerning nutrition: children are reluctant to eat vegetables, they want sweet, does not eat fruit etc
- a lot of children don't drink much, probably this is one of the causes of obstipation

This year we could create an extra station in the MCC carousel because a dietician was part of the team.

Every child with anemia and/or growing disorder was referred to this station by the doctor.

Here information on food and parenting items was given in an interactive way both to individuals as to small groups of parents.

One of the team members was instructed by the dietician so she could help with this station.

In the attachments you will find a repo of the findings of our dietician.

Two team members planned to visit villages in the neighborhood to give health education, but due to logistical problems they could only make a few trips.





### **Translators**

This year we had a sufficient number of translators (14!), this facilitated our work very much.

Before the checks we gave them information about the goals en methods of MCC and we told them about our expectations of a good translator.

The MCC team we gave instruction about how to work with a translator and the do's and dont's.

During the week the teamleaders had evaluations with the translators.

We were very impressed and enthusiastic about their efforts and involvement.

### **Recommandations**

- the worm prevention: does the government run a program on this item, if yes; why so many children didn't have worm prevention the last six months? Can DHARA contribute to solve this problem? Maybe in cooperation with the schools?
- continue with health education in groups as well in individuals.
- give also health education for key figures as teachers etc.
- contact before the mission with the hospital in Satkhira to improve the referring of children and to overcome financial barriers for the parents.
- Intensive contact with Lipika Das Gupta about the goals of the next (last?) mission.

## Aknowledgements

We would like to take this opportunity to express our gratitude for all the cooperation and support we have been given and which made this mission possible.

On the first place, to Mrs Lipika Das Gupta, director of DHARA, her husband and her team, who were working very hard to make this MCC mission possible and whose hospitality was an enormous support for the MCC team.

Also we thank the translators, the Dhara Youth Support Group, who did their job tireless and with compassion for the children.

Furthermore we would like to thank the MCC workgroup "Missie Voorbereiding" and Iris van de Gevel for his analyses of the data.

Lastly we would like to thank our great team members for their enthusiastic dedication.

September 2018

Bert van Wijk  
Joep Avezaat  
mission leaders

## Attachment

Table 1: Summary of checked children per geographical location, age and gender

Age	Total		Autulia		Biralaxmi		Borokupot		Choto Kupor		Godharah	
	807		Total= 64		Total= 73		Total= 89		Total= 106		Total= 28	
	N	%	n	%	n	n	n	%	n	%	n	%
<=1 year	181	22%	11	17%	14	8	8	25%	22	21%	8	29%
>1 en <5 years	210	26%	17	27%	18	2	2	34%	24	23%	2	7%
<5 years	391	48%	28	44%	32	10	10	58%	46	43%	10	36%
>=5 en <=10 years	399	49%	36	56%	40	16	16	42%	59	56%	16	57%
>10 years	17	2%	0	0%	1	2	2	0%	1	1%	2	7%
<b>Gender</b>												
Boy	457	57%	33	52%	41	15	15	58%	61	58%	15	54%
Girl	349	43%	31	48%	32	13	13	42%	44	42%	13	46%

Age	Hawalrangi		Mullah Para		North Autulia		Nowabenki		Other	
	Total= 38		Total= 40		Total= 50		Total= 70		Total= 249	
	n	%	n	%	n	%	n	%	n	%
<=1 year	13	34%	6	15%	11	22%	23	33%	51	20%
>1 en <5 years	8	21%	10	25%	13	26%	14	20%	74	30%
<5 years	21	55%	16	40%	24	48%	37	53%	125	50%
>=5 en <=10 years	17	45%	22	55%	25	50%	31	44%	116	47%
>10 years	0	0%	2	5%	1	2%	2	3%	8	3%
<b>Gender</b>										
Boy	26	68%	23	58%	32	64%	34	49%	140	56%
Girl	12	32%	17	43%	18	36%	36	51%	109	44%

**Table 2: Prevalence of anaemia per geographical location by age and gender**

	Total		Autulia		Biralaxmi		Borokupot		Choto Kupor		Godharah	
	807		Total= 64		Total= 73		Total= 89		Total= 106		Total= 28	
	N	%	n	%	n	n	n	%	n	%	n	%
Anaemia	184	23%	10	16%	14	19%	22	25%	27	25%	9	32%
No anaemia	610	76%	52	81%	57	78%	66	74%	79	75%	19	68%
Unknown	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Hb <5,0 mmol	7	1%	1	2%	1	1%	1	1%	1	1%	1	4%
<b>Anaemia per age</b>												
<=1 year	56	31%	2	18%	4	29%	6	27%	8	36%	3	38%
>1 en <5 years	44	21%	3	18%	1	6%	10	33%	6	25%	0	0%
<5 years	100	26%	5	18%	5	16%	16	31%	14	30%	3	30%
>=5 en <=10 years	79	20%	5	14%	9	23%	6	16%	13	22%	5	31%
>10 years	5	29%	0	0%	0	0%	0	0%	0	0%	1	50%
<b>Anaemia per gender</b>												
Boy	107	23%	5	15%	8	20%	10	19%	19	31%	4	27%
Girl	77	22%	5	16%	6	19%	12	32%	8	18%	5	38%

	Hawalrangi		Mullah Para		North Autulia		Nowabenki		Other	
	Total= 38		Total= 40		Total= 50		Total= 70		Total= 249	
	n	%	n	%	n	%	n	%	n	%
Anaemia	10	26%	8	20%	3	6%	25	36%	56	22%
No anaemia	26	68%	32	80%	46	92%	45	64%	188	76%
Unknown	0	0%	0	0%	0	0%	0	0%	0	0%
Hb <5,0 mmol	0	0%	0	0%	0	0%	0	0%	2	1%
<b>Anaemia per age</b>										
<=1 year	4	31%	3	50%	1	9%	12	52%	13	25%
>1 en <5 years	3	38%	1	10%	0	0%	2	14%	18	24%
<5 years	7	33%	4	25%	1	4%	14	38%	31	25%
>=5 en <=10 years	3	18%	3	14%	2	8%	9	29%	24	21%
>10 years	0	0%	1	50%	0	0%	2	100%	1	13%
<b>Anaemia per gender</b>										
Boy	6	23%	5	22%	1	3%	12	35%	37	26%
Girl	4	33%	3	18%	2	11%	13	36%	19	17%

**Table 3: Prevalence of weight/age at or under P3 (underweight) per geographical location by age and gender**

	Total		Autulia		Biralaxmi		Borokupot		Choto Kupor		Godharah	
	807		Total= 64		Total= 73		Total= 89		Total= 106		Total= 28	
	N	%	n	%	n	n	n	%	n	%	n	%
Underweight	264	33%	17	27%	25	34%	32	36%	35	33%	5	18%
No underweight	542	67%	47	73%	47	64%	57	64%	71	67%	23	82%
Unknown	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
<b>Underweight children per age</b>												
<=1 year	55	30%	4	36%	4	29%	8	36%	3	14%	2	25%
>1 en <5 years	81	39%	6	35%	4	22%	15	50%	8	33%	0	0%
<5 years	136	35%	10	36%	8	25%	23	44%	11	24%	2	20%
>=5 en <=10 years	125	31%	7	19%	17	43%	9	24%	24	41%	2	13%
>10 years	3	18%	0	0%	0	0%	0	0%	0	0%	1	50%
<b>Underweight children per gender</b>												
Boy	142	31%	7	21%	11	27%	21	40%	18	30%	2	13%
Girl	122	35%	10	32%	14	44%	11	30%	17	39%	3	23%

	Hawalrangi		Mullah Para		North Autulia		Nowabenki		Other	
	Total= 38		Total= 40		Total= 50		Total= 70		Total= 249	
	n	%	n	%	n	%	n	%	n	%
Underweight	16	42%	14	35%	21	42%	20	29%	79	32%
No underweight	22	58%	26	65%	29	58%	50	71%	170	68%
Unknown	0	0%	0	0%	0	0%	0	0%	0	0%
<b>Underweight children per age</b>										
<=1 year	6	46%	1	17%	5	45%	7	30%	15	29%
>1 en <5 years	3	38%	5	50%	7	54%	4	29%	29	39%
<5 years	9	43%	6	38%	12	50%	11	30%	44	35%
>=5 en <=10 years	7	41%	7	32%	9	36%	9	29%	34	29%
>10 years	0	0%	1	50%	0	0%	0	0%	1	13%
<b>Underweight children per gender</b>										
Boy	11	42%	6	26%	12	38%	8	24%	46	33%
Girl	5	42%	8	47%	9	50%	12	33%	33	30%

**Table 4: Prevalence of length/age at or under P3 (stunting) per geographical location by age and gender**

	Total		Autulia		Biralaxmi		Borokupot		Choto Kupor		Godharah	
	807		Total= 64		Total= 73		Total= 89		Total= 106		Total= 28	
	N	%	n	%	n	n	n	%	n	%	n	%
Stunting	220	27%	12	19%	20	27%	23	26%	29	27%	9	32%
No stunting	586	73%	52	81%	52	71%	66	74%	77	73%	19	68%
Unknown	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
<b>Stunting children per age</b>												
<=1 year	46	25%	1	9%	4	29%	3	14%	4	18%	4	50%
>1 en <5 years	83	40%	6	35%	3	17%	14	47%	9	38%	1	50%
<5 years	129	33%	7	25%	7	22%	17	33%	13	28%	5	50%
>=5 en <=10 years	89	22%	5	14%	13	33%	6	16%	16	27%	4	25%
>10 years	2	12%	0	0%	0	0%	0	0%	0	0%	0	0%
<b>Stunting children per gender</b>												
Boy	129	28%	7	21%	9	22%	15	29%	17	28%	6	40%
Girl	91	26%	5	16%	11	34%	8	22%	12	27%	3	23%

	Hawalrangi		Mullah Para		North Autulia		Nowabenki		Other	
	Total= 38		Total= 40		Total= 50		Total= 70		Total= 249	
	n	%	n	%	n	%	n	%	n	%
Stunting	16	42%	14	35%	21	42%	20	29%	79	32%
No stunting	22	58%	26	65%	29	58%	50	71%	170	68%
Unknown	0	0%	0	0%	0	0%	0	0%	0	0%
<b>Stunting children per age</b>										
<=1 year	6	46%	1	17%	5	45%	7	30%	15	29%
>1 en <5 years	3	38%	5	50%	7	54%	4	29%	29	39%
<5 years	9	43%	6	38%	12	50%	11	30%	44	35%
>=5 en <=10 years	7	41%	7	32%	9	36%	9	29%	34	29%
>10 years	0	0%	1	50%	0	0%	0	0%	1	13%
<b>Stunting children per gender</b>										
Boy	11	42%	6	26%	12	38%	8	24%	46	33%
Girl	5	42%	8	47%	9	50%	12	33%	33	30%

**Table 5: Prevalence of weight/length at or under P3 (wasting) per geographical location by age and gender**

	Total		Autulia		Biralaxmi		Borokupot		Choto Kupor		Godharah	
	807		Total= 64		Total= 73		Total= 89		Total= 106		Total= 28	
	N	%	n	%	n	n	n	%	n	%	n	%
Wasting	100	16%	9	19%	12	24%	14	19%	8	11%	2	9%
No wasting	523	84%	38	81%	38	75%	61	81%	66	89%	20	91%
Unknown	183	23%	17	27%	22	30%	14	16%	32	30%	6	21%
<b>Wasting children per age</b>												
<=1 year	39	22%	3	27%	4	29%	4	19%	3	14%	2	25%
>1 en <5 years	26	13%	2	12%	1	6%	5	17%	2	8%	0	0%
<5 years	65	17%	5	18%	5	16%	9	18%	5	11%	2	20%
>=5 en <=10 years	35	15%	4	21%	7	37%	5	21%	3	11%	0	0%
>10 years	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
<b>Wasting children per gender</b>												
Boy	47	14%	2	9%	5	19%	7	16%	4	9%	1	9%
Girl	53	19%	7	28%	7	29%	7	23%	4	14%	1	9%

	Hawalrangi		Mullah Para		North Autulia		Nowabenki		Other	
	Total= 38		Total= 40		Total= 50		Total= 70		Total= 249	
	n	%	n	%	n	%	n	%	n	%
Wasting	6	21%	5	16%	8	19%	6	11%	30	15%
No wasting	23	79%	27	84%	34	81%	50	89%	166	85%
Unknown	9	24%	8	20%	8	16%	14	20%	53	21%
<b>Wasting children per age</b>										
<=1 year	4	33%	0	0%	3	27%	4	17%	12	24%
>1 en <5 years	0	0%	3	30%	2	15%	1	8%	10	14%
<5 years	4	20%	3	19%	5	21%	5	14%	22	18%
>=5 en <=10 years	2	22%	2	13%	3	17%	1	5%	8	11%
>10 years	0	0%	0	0%	0	0%	0	0%	0	0%
<b>Wasting children per gender</b>										
Boy	4	20%	2	13%	6	23%	4	14%	12	11%
Girl	2	22%	3	19%	2	13%	2	7%	18	20%

**Table 6: Prevalence preventive anti-worm treatment in the last half-year per geographical location by age and gender**

	Total		Autulia		Biralaxmi		Borokupot		Choto Kupor		Godharah	
	807		Total= 64		Total= 73		Total= 89		Total= 106		Total= 28	
	N	%	n	%	n	n	n	%	n	%	n	%
Anti-worm	390	48%	20	31%	44	60%	43	48%	62	58%	19	68%
No anti-worm	417	52%	44	69%	29	40%	46	52%	44	42%	9	32%
Unknown	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
<b>Anti-worm per age</b>												
<=1 year	27	15%	0	0%	3	21%	6	27%	5	23%	2	25%
>1 en <5 years	105	50%	7	41%	13	72%	17	57%	13	54%	2	100%
<5 years	132	34%	7	25%	16	50%	23	44%	18	39%	4	40%
>=5 en <=10 years	246	62%	13	36%	28	70%	20	54%	43	73%	13	81%
>10 years	12	71%	0	0%	0	0%	0	0%	1	100%	2	100%

	Hawalrangi		Mullah Para		North Autulia		Nowabenki		Other	
	Total= 38		Total= 40		Total= 50		Total= 70		Total= 249	
	n	%	n	%	n	%	n	%	n	%
Anti-worm	17	45%	14	35%	24	48%	33	47%	114	46%
No anti-worm	21	55%	26	65%	26	52%	37	53%	135	54%
Unknown	0	0%	0	0%	0	0%	0	0%	0	0%
<b>Anti-worm per age</b>										
<=1 year	3	23%	0	0%	1	9%	3	13%	4	8%
>1 en <5 years	3	38%	4	40%	6	46%	7	50%	33	45%
<5 years	6	29%	4	25%	7	29%	10	27%	37	30%
>=5 en <=10 years	11	65%	10	45%	16	64%	22	71%	70	60%
>10 years	0	0%	0	0%	1	100%	1	50%	7	88%

**Table 7 Disease prevalence among all children**

	Total	
	N	%
		<b>807</b>
syndrome n.o.s.	16	2%
pneumonia (clinical)	4	0%
bronchitis	6	1%
BHR/asthma	3	0%
diarrhoea without dehydration	4	0%
constipation	66	8%
active worm infection	133	16%
active lintworm	1	0%
otitis media acuta	16	2%
otitis media with effusion	18	2%
otitis externa	15	2%
tympenic perforation	1	0%
(adeno)tonsillitis	10	1%
candida stomatitis	1	0%
hearing impairment	4	0%
other	21	3%
caries n.o.s.	160	20%
pain n.o.s	4	0%
caries with pain	150	19%
wounds n.o.s.	1	0%
eczema n.o.s.	32	4%
dermatomycosis	8	1%
Impetigo/furunculosis	7	1%
scabies	14	2%
wounds infected,	2	0%
other (psoriasis etc)	12	1%
psychomotoric retardation	20	2%
hypertonia	2	0%
hypotonia	6	1%
epilepsy	13	2%
migraine/headache	1	0%
physiological murmur	1	0%
pathological murmur (suspected)	2	0%
refractory problem	1	0%
strabismus	5	1%
keratoconjunctivitis	1	0%
amblyopia	1	0%
thyroid dysfunction (suspected)	1	0%
epi/hypospadias	1	0%
inguinal hernia	1	0%
urinary infection	11	1%
hip dysplasia	1	0%
new fracture	1	0%
hernia(umbilical etc)	2	0%

**Table 8: Follow-up of all children per geographical location**

	Total		Autulia		Biralaxmi		Borokupot		Choto Kupor		Godharah	
	807		Total= 64		Total= 73		Total= 89		Total= 106		Total= 28	
	N	%	n	%	n	n	n	%	n	%	n	%
Dentist	337	42%	24	38%	36	49%	38	43%	50	47%	16	57%
Specialist in hospital	10	1%	0	0%	0	0%	1	1%	2	2%	0	0%
Revisit	10	1%	1	2%	1	1%	1	1%	0	0%	1	4%
X-thorax	1	0%	0	0%	0	0%	0	0%	1	1%	0	0%
Other...	279	35%	15	23%	33	45%	28	31%	39	37%	10	36%

	Hawalrangi		Mullah Para		North Autulia		Nowabenki		Other	
	Total= 38		Total= 40		Total= 50		Total= 70		Total= 249	
	n	%	n	%	n	%	n	%	n	%
Dentist	19	50%	14	35%	15	30%	30	43%	95	38%
Specialist in hospital	0	0%	1	3%	1	2%	0	0%	5	2%
Revisit	1	3%	1	3%	0	0%	0	0%	4	2%
X-thorax	0	0%	0	0%	0	0%	0	0%	0	0%
Other...	21	55%	8	20%	18	36%	26	37%	81	33%

**Table 9 Treatment among all children**

	<b>Total</b>	
	<b>807</b>	
	<b>N</b>	<b>%</b>
ferro	38	5%
mother iron	58	7%
multivitamins	343	43%
anti-worm	322	40%
acute worm	123	15%
anti-scabies	18	2%
amoxicillin	22	3%
augmentin	9	1%
co-trimoxazol	1	0%
AB urine infection	5	1%
eardrops	33	4%
mupirocine=Bactroban	7	1%
hydrocortisone cream	43	5%
dactacort cream	8	1%
fusidin cream	1	0%
sudo cream	1	0%
neutral cream	1	0%
eyedrops	3	0%

## Medication DHARA 2018

Medicatie	Eenheden	aanwezig	besteld voor missie	aantal ontvangen bij start missie	Aantal eind missie	Verbruikt	Geschat verbruik zonder compromise	Achtergelaten (voorraad op missielocatie)	exp. date	Samenstelling	opmerkingen
Iron bottles, Ferroglobin, 200 ml	200ml		50	50	11	<b>39</b>		<b>11</b>	12-19	200 mg ferrosulf/5 ml	
Iron tablets, 200 mg	tabl		10.000	10500	2610	<b>7860</b>		<b>2610</b>	04-20		
Multivitaminen syrup, Vitacod bottles	100 ml		1400	1588	282	<b>1306</b>		<b>282</b>	10-19		
multivitamin tabl, Envit			8000	10020	7320	<b>2700</b>		<b>2700</b>	08-19		
3/6=Albendazole 400mg	400mg		1000	1400	586	<b>814</b>		<b>350</b>	12-19		Rest: exp 11-18 → aan Dhara gegeven
5=Ivermectine 6 mg	tabl 6 mg		75+40	115	28	<b>87</b>		<b>28</b>	01-20		
10=Amoxicillin syrup, bottles 60 ml, 125 mg/5 ml, Moxilon	125mg/5ml		50	50	29	<b>21</b>		<b>29</b>	04-19		
10=Amoxicillin, tablet/capsules 250 mg, Moxacil	tabl 250mg		360+100	460	330	<b>130</b>		<b>330</b>	08-20		
10=Amoxicillin tablet 500mg, Moxin	500mg		100	100	9	<b>91</b>		<b>9</b>	01-20		
11=Augmentin syrup 125/31.25 mg Clamox	100 ml		15	15	8	<b>7</b>		<b>8</b>	<b>11-18</b>		
11=Augmentin tabl250/125 mg	250/125 mg		160	171	27	<b>144</b>		<b>27</b>	12-18		
12=Azithromycin syrop Tridosil	200mg/5ml		15	15	13	<b>2</b>		<b>13</b>	10-19		
20=Metronidazol tabl 200 mg nitrofurantoïne	200mg 50 mg		20 200	200 240	200 223	- <b>17</b>		<b>200</b> <b>223</b>	11-26 10-19		
32/76=eye/ear drops Cloramphenicol I-Guard			30	40	2	<b>38</b>		<b>2</b>	<b>07-19</b>		
50=mupirocine tube 10 gr Trego	crème		60	84	48	<b>36</b>		<b>48</b>	11-19		
51=hydrocortison crème 5 gr	15 gram		80	71	26	<b>45</b>		<b>26</b>	10-19		
52=econazol, tube 10 gram Econate	crème		50	50	33	<b>17</b>		<b>33</b>	12-19		
povidon jood oplossing			2	2	2	-		<b>2</b>	12-19		
Flammazine	crème		<b>5</b>	<b>5</b>	5	-		<b>5</b>	12-19		
Permetrine	creme		<b>30</b>	<b>30</b>	24	<b>6</b>		<b>24</b>	12-19		
Paracetamol	500 mg			<b>70</b>	36	<b>34</b>		<b>36</b>	07-20		Als tandarts meegaat
Toothbrush tasjes			<b>1.000</b>								

## **Speciale bijlage: het (originele) verslag van Esther Heijkoop (diëtiste) n.a.v. haar voorlichtende werkzaamheden op het gebied van (gezonde) voeding.**

Definitie Junkfood: gefrituurd eten wat op de markt gekocht wordt: zoet en hartig. De zoete varianten zijn veelal doordrenkt met suiker, de hartige hapjes zijn meestal uitjes, aardappel met pepers, pasteitjes gevuld met vlees. Deze variant kan ik niet per definitie als slecht bestempelen.

Ik weet niet hoeveel gesprekken ik per dag heb gedaan, heb ze niet geturft. Maar er was een tweedeling te maken in de thema's van mijn gesprekken en twee vaste thema's die bijna bij ieder gesprek ook aan de orde kwamen.

1. Het ging over de overgang van borstvoeding naar vaste voeding. Hoe doe je dat en hoe bouw je op. Wat heb je als moeder nodig aan informatie om dit goed te doen.
2. Weigeren van eten, niet eten of slechte eters.
3. Voedsel- en Persoonlijke hygiëne om zo de kans op wormen te verkleinen.
4. Genoeg drinken en Vezelarm eten.

### **Ad 1:**

De meeste moeders waren wel bekend met Hossepos, hoe ze aan deze kennis kwamen weet ik niet, dat werd niet goed beantwoord. Het was bekend hoe ze het moesten maken en dat je dat vanaf een maand of 6 aan je kind kon gaan geven.

Ik kreeg de indruk dat kennis over het opbouwen van voeding, eventueel eerst vloeibaar, dan gemalen en dan gewone consistentie niet bij alle moeders die ik sprak duidelijk aanwezig was.

Op mijn adviezen kreeg ik veelal te horen dat de kinderen het eten uitspugen en niet willen eten. Het leek dat ze de kinderen dan ook geen ander eten dan borstvoeding aanboden.

Veel kinderen van 2 tot(en met) 3 kregen nog nachtelijke borstvoeding. Soms ook nog meerdere keren overdag. Dit leek meer voort te komen uit zuigbehoefte van het kind dan uit trek. Maar het zat goed eten wel in de weg en ook een goede nachtrust voor de moeders.

De meeste moeders hadden geen goede moed en ondersteuning uit de omgeving om de kinderen van 2,5-3 jaar te laten stoppen met borstvoeding.

### **Ad 2:**

Dit leek meer aan opvoeding te liggen. Veelal kregen kinderen snoep of chips aangeboden als ze het eten weigerden. De kinderen gingen huilen/schreeuwen totdat ze snoep/chips kregen.

Bij sommige gesprekken kreeg ik het idee dat het kind de baas was/is in huis en de moeder zeker niet. Dat kan natuurlijk aan de cultuur liggen.

Op school werden de WHO biscuitjes uitgedeeld, naar ik begreep van een school die we bezochten, vlak voor het uitgaan van de school. De kinderen moeten deze biscuitjes op school opeten. Ze bevatten veel kcal en je zit er echt vol van. Als de kinderen dit vlak voor het middageten eten, dan is het begrijpelijk dat ze geen middageten/middagsnack willen. Ik kreeg bij de kinderen niet goed uitgevraagd hoeveel tijd er zat tussen de biscuitjes en het middag- of avondeten.

### **Ad 3:**

Het uitleggen over Voedsel- en Persoonlijke hygiëne ging goed en werd ook goed begrepen.

### **Ad 4:**

Bij navragen bleek het gros maar 500-750 ml per dag te drinken. Veel te weinig per kind. Er vanuit gaand dat de kinderen ook vezelarm eten (weinig groente en fruit per dag) verklaart dat veel van de doorverwezen obstipatie klachten en harde buiken.

De meeste kinderen drinken water en thee. Ik heb geen een kind gesproken dat frisdrank dronk.

### **Meest bijzonder ervaring:**

- Baby van 8 maanden die nog geen vaste voeding at, vond hij te vies, maar wel al heerlijk chocolade aan het eten was.
- Meisje van 9 maanden sabbelde al heerlijk aan een lolly ipv een gewoon eten.
- Een moeder van baby 7 maanden had een cakeje mee, ze had geen idee dat dat helemaal nog niet geschikt was voor haar baby. Het patroon van opbouwen voeding naast borstvoeding was haar totaal onbekend.
- Jongetje van 5-6 jaar die zijn moeder sloeg als hij niet kreeg wat hij wilde.
- Meisje wat dagelijks geld kreeg om zelf "Fastfood" op de markt te gaan kopen.
- Een jongetje van 7 liep zelf naar de markt en kocht daar snoep/chips op de pof. Vader ging 's avonds de schulden betalen.
- Veelal jonge moeders, tussen 16-20 jaar.
- Lieve vader van gehandicapt meisje (geheel binnen de curves van groeien en Hb)> Gezien handicap kon zij alleen vloeibaar en gemalen eten. Hij vertelde wat hij deed, hoe hij kookte. Dit deed hij perfect en met veel zorg.
- Een vader van meisje en jongen die ongeveer 3 gesprekken moest wachten voordat hij aan de beurt was. Bij ieder gesprek zag je hem aandachtig luisteren en de info opzuigen. Hij wilde echt info in zijn kinderen lichamelijk sterker en in gewicht wilde laten toenemen. Hij stelde ook heel gericht vragen.

### **Mijn adviezen voor Lipica.**

Opzetten van praatgroepen/consultatiebureau om moeders meer te helpen bij het opvoeden van kinderen. Een praatgroep van vrouwen waarbij problemen besproken worden en waarbij ze elkaar advies geven over het gedrag van de kinderen, maar waar ze elkaar ook advies kunnen geven over afbouwen borstvoeding, hoe bouw je goed op, wat geef je etc etc.

Misschien nog wel te geëmancipeerd voor dit gebied, maar dat vrouwen ondersteuning bij elkaar moeten zoeken lijkt me goed en een stap voorwaarts. Ze werken dan ook zelf aan verbetering van hun eigen positie.

Misschien kan Lipika hulp zoeken bij Unicef/Plan Nederland/VSO Nederland.