

Medical Report DHARA, Bangladesh 2016



By means of this medical report we would like to give you an impression of the activities during our second 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

From 17th February until 23rd February Medical Checks for Children (MCC) was invited for the second time to Noabeki, Shyamnagor, Satkhira, Bangladesh.

In collaboration with the local non-governmental organization (ngo) DHARA, MCC was able to see 740 children between the ages of 0 to 10 years and where able to treat them when necessary. These checks took place in the Fernando Nobre Mother and Child Health Care and General Hospital.

The MCC team was assisted by the DHARA Youth Support Group, namely eight 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.

Last year DHARA initiated a modest healthcare insurance scheme – 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. Parents who participate in this system, were also able to bring their children to be checked by MCC. The advantage of this system was to limit the amount of children presenting themselves to be checked by MCC, preventing the chaotic scenes in 2015. Another bonus is (when the continuing registration of this healthcare insurance is ok) 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. There was more opportunity to give individual attention to a child and his parents with the appropriate advice and information on a more personal level. This was also highly aided by the number and quality of the translators.

During this mission we have seen relatively large numbers of children with serious congenital disorders such as Down's syndrome and hydrocephalus. The parents of these children were often unaware of the nature of these conditions and the futures of their children, being told by local doctors that all would be well. We had long conversations with these parents explaining what we thought the probable outcomes would be, without destroying all their hopes. Despite their obvious sorrow on hearing our opinions they were also very grateful. These were intense moments for both doctors and our young translators alike. During feedback moments time and attention were given to the impact that this had on the team and individuals involved.

More children were referred to a specialist in a hospital this year than in 2015.

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 all their own costs for the journey and their stay at the Fernando Nobre Hospital.

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
- Addi Jansen (general practitioner (GP))
- Aletta Lodel (social therapist)
- Annette Pilgrim (midwife np)
- Cisca Kok (GP)
- Diana Wakker (emergency room nurse)
- Josine v.d. Meijdenberg (child and youth psychiatrist)
- Marijke Lutjenhuis (doctor)
- Sacha Jansen (GP).

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 carrousel

All children were checked in the so-called MCC carrousel. 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. Unfortunately no dentist accompanied the MCC-group, so children could not visit the dentist.

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 paid by donations of friends and family of the team members and money that remained from the 2015 mission. This financial resource was also used to meet the costs of further treatments and investigations of children who were referred but whose parents were unable to meet the costs themselves.

Health education

During the first mission in 2015 it was obvious that there was a general lack of knowledge with regard to a healthy diet, good mouth hygiene and parenting skills. Therefore this year two members of the team concentrated on giving health education to groups of parents and children. They were able to reach about eight hundred individuals, spread over eleven different locations in the countryside.

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 740 children.

This year the children came from more remote vilages than in 2015.

As can be seen in the tables: from 7 vilages we checked more than 30 children. Those vilages 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.

24% of all the children checked was younger than 1 year and 52% was younger than 5 years. We saw some more boys than girls (56% - vs. 44%).

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 almost all (99%) children 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.

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.

Figure 1. prevalence of anemia per age

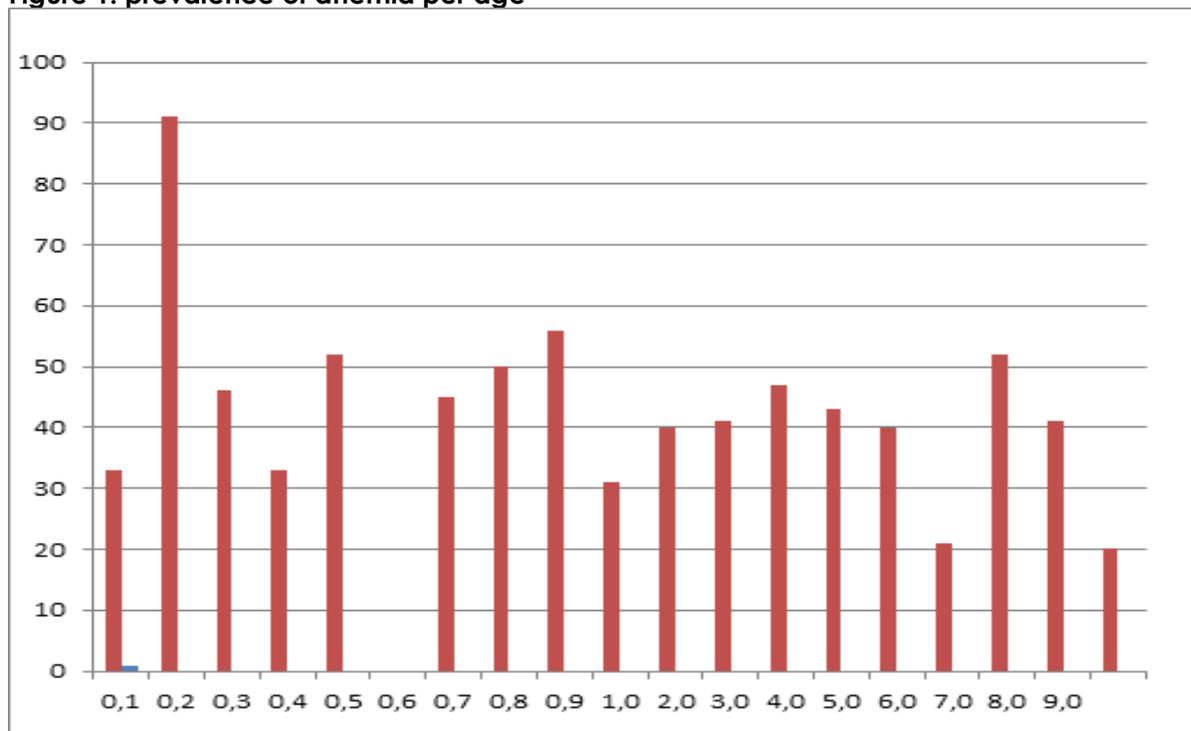
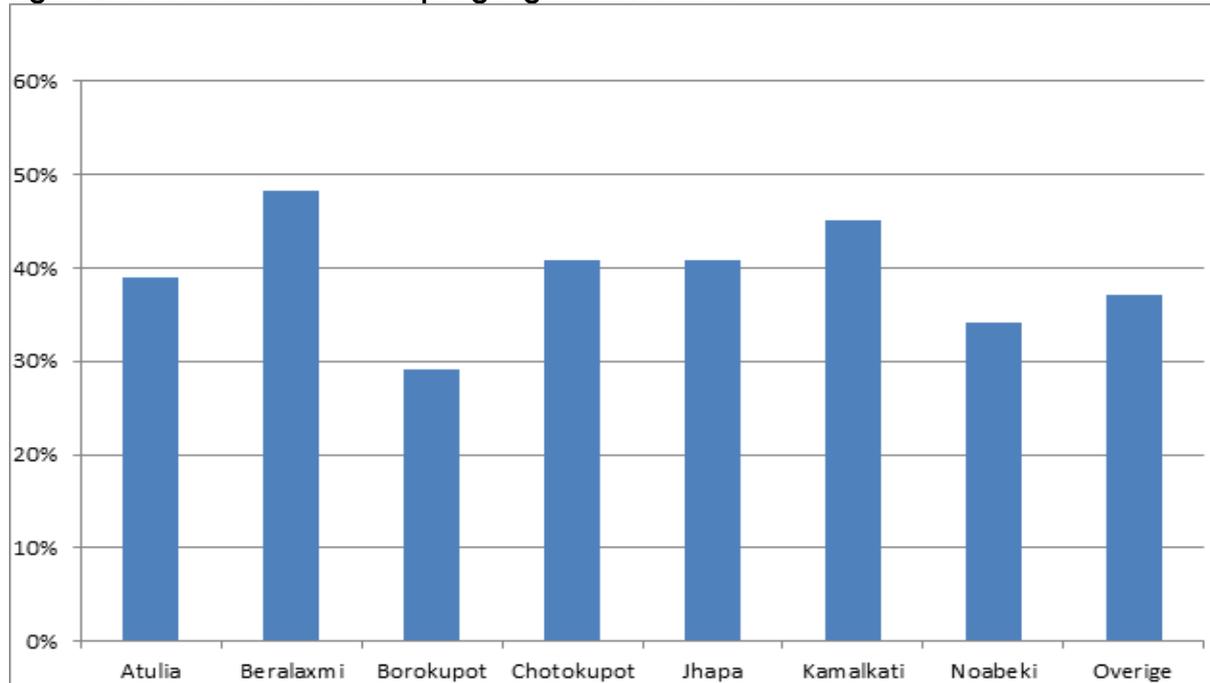


Figure 2. Prevalence of anemia per geographical location



In table 2 the children with anaemia are divided into location, age and sex.

This year 39% of all children had anemia. This was more than in 2015 when 28% of all children had anemia.

There was no difference in prevalence of anemia between boys and girls (40 vs 38%)

Under the age of 1 year 41% of the children had anaemia.

Children with anaemia, depending on whether this was accompanied by a growth disorder or vitamin deficiency, were given a three month supply of iron and/or a vitamin medication.

The mothers of breastfed children were given iron medication.

Nine children (3% of all anaemic 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 month of treatment.

One child had a Hb 4,4 mmol/l and was referred to a pediatrician. His first conclusion was that this anemia was probably due to thalassaemia but more analysis was needed.

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.

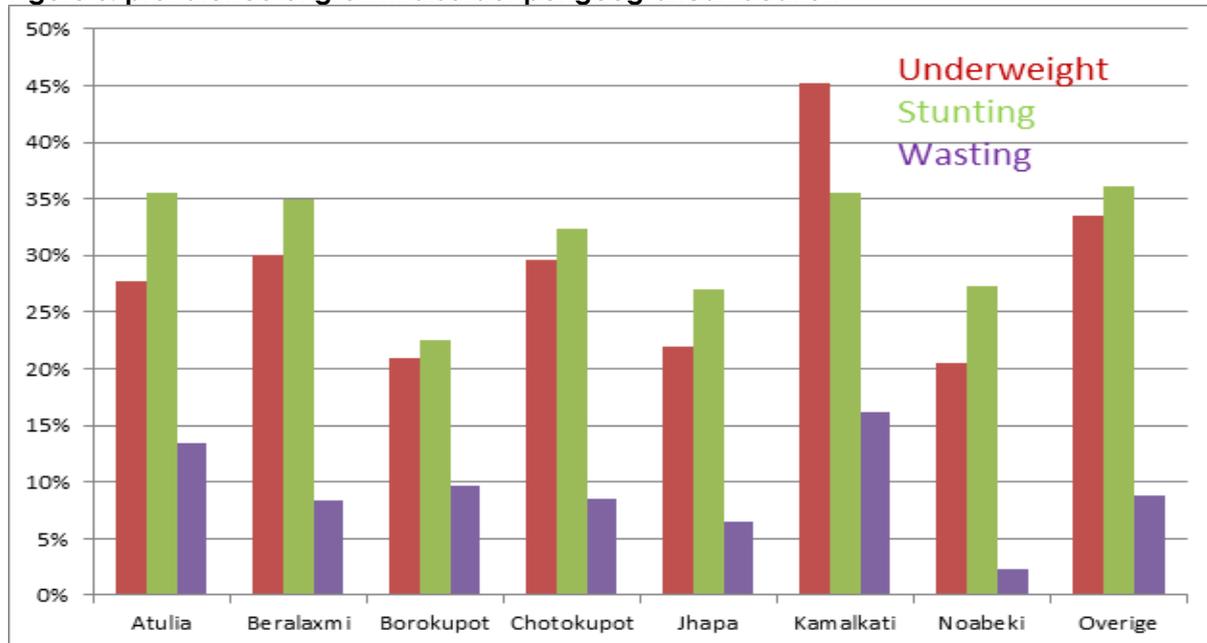
The following criteria were used:

- **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.



Figure 3. prevalence of growth disorder per geographical location



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

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

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

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 67 times an active worminfection (9%)

58% of all children did not had antiworm prevention the last six month. This is slight improvement comparing last year when 71% did not had a antiworm tablet, 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

table 7.

Respiratory Tract/Airways

12 children (2%) 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.

7 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 6% of the children had complaints about obstipation (but probably the amaount 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

Twenty two children (3%) had a acute ear infection (otitis media), thirteen (2%) a chronic ear infection and nine (1%) children had a infection of the external ear.

Dermatology

About 6% of the children had eczema, 2% was diagnosed with mycotic infections of the skin and 2% 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.

Eye

Two children had strabismus.

We saw very few eye problems. In principle the MCC carousel model does not have the facility to detect visual disturbances.

Urinary tract

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

One child 1 year old with a urinary tract infection and loosing weight was referred, the echo made in the hospital in Satkhira showed a bilateral hydro-ureteronefrosis. Further analysis and treatment will be carried out.

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 to much sugar and sweets.
3. bad construction of the teeth due to vitamin deficiency and malnutrition of the mother during pregnancy

In this mission 37% of all children had dental caries (273 children)

38% of this children had also dental pain.

Probably the number of children with caries is greater because of under registration.

Unfortunately we did not had a dentist in the team this year.

Neuromusculair

Numerically children with neurological problems are not a big problem, but amongst them there are always some with severe handicaps. Their parents often come to MCC hoping that we can cure their child where other doctors failed.

We gave these children extra time for a good anamnestical and fysical examination.

If we were convinced that there were no possibilities to cure this child, we considered it our duty to explane that to the parents to avoid vain and expensive consulting specialists without taking away all hope. Also we tried to give advice on care for their handicaped son or daugter.

Knowing that there are very few possibilities for these children in Bangladesh was for all team members and for the -young- translators an emotional burden.

Twelve children with psychomotoric retardation or a "syndrome" were seen (2%).

Some examples:

case 1.

Boy, 10 years old, obviously with Down's syndrome and Hb 2,2%. His mother asked why he could only say "mam and dad". The parents told that doctors had said that they should treat him with Calcium to cure him. The MCC doctor referred him urgently to the hospital by reason of the very severe anemia, but she explained also that the retardation will not be cured by treatment of the anemia. The doctor tried to explain the cause of the Down's syndrome and that is was not her fault. She stimulated the mother to continue with taking good care of her child. The mother was of course very sad after this conversation.

Duration of the consaltation: 45 minutes.

case 2.

Girl, 8 years old. She is not able to talk and walk and has epilepsy, she has medication for this. The mother had understood that the girl will be cured on the age of 15. The mother is collecting money to go to a doctor in India for better treatment. The child had a good-groomed appearance and was beautiful dressed.

The MCC doctor concluded, after physical examination, that the girl had probably a genetic defect and explained this to the mother. She praised her for taking so good care for this child and gave advices for movements of the joints etc. She also told that it was not the mothers fault tat the child was like this.

The mother was very sad and weeped a lot but was very gratefull for the attention and care.

Duration of the consultation: 30 minutes.

All cases exhibit some striking similarities:

- all children were taken care for with love, were properly nourished and dressed
- the parents knew almost nothing about the diagnosis and prognosis of their child. In Bangladesh doctors in common don't spend much time to their patients and, as in many other cultures, are not used to tell poor prognosis to their patients; they will always give hope on improvement even when improvement is not to be expected.
- after sharing our opinion on the condition of the child and expectations for the future all parents were very sad but also gratefull for the attention and they seemed to be relieved by understanding the condition of their child.

Referrals

Seventeen children (2 %, 2015: 0,8%) were referred to a specialist in a hospital.

From four children we received information about the first tests that were made in the hospital, these results are indicated in the figure below:

Figure 4: Children referred to specialist

Sex	Age (years)	Reason for reference	Result
boy	0,6	anemia: Hb 4,4 mmol/l	
boy	4	phimosis + miction problems	
boy	1	severe skin problems	
girl	8	convulsions	EEG: normal, futher analysis
boy	1	hypotonie, macrocephalia, tracheomalacie	hydrocephalus, futher analysis
boy	3	path. heartmurmer, Down's syndr	
boy	1	phimosis + miction problems	
girl	1	urinary tract infection and lose of weight	bilat hydroureteronefrose, infection
boy	0,08	fever, not drinking	
boy	5	convulsions, psychom. retardation	
boy	10	hemofilia?	
girl	10	struma, hypothyreoidia?	
boy	10	anemia: Hb 2,2 mmol/l, Down' syndr.	
boy	10	suspect hypothyreoidia	
girl	1	anemia Hb 4,4 mmol/l	prob. thalassaemia, futher analysis
boy	5	gnatoschizis	
girl	8	path. heartmurmur	

Health education

In **2015** we draw the following conclusions from the interviews with children and their caretakers:

- 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 (**2016**) we saw also children from more remote villages (the other side of the river). In these villages there is less availability of vegetables: the soil is not very suitable to grow vegetables and the market to buy them is on a greater distance.

Health education was given in two ways:

- individual: this year we had a sufficient amount of translators (8) so we could take a very good patient history of each child en could give customized education and advice.
- in groups: two members of the team concentrated on giving health education to groups of parents and children. They were able to reach about eight hundred individuals, spread over eleven different locations in the countryside. The main issues were: a healthy diet and how to learn my child to eat properly, oral hygiene and how to act when a child has fever. The audience was always very enthusiastic about this education and they were very eager to learn





Recommendations

- 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.

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 Emile Clous for his analyses of the data.

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

April 2016

Bert van Wijk
Joep Avezaat
mission leaders

Attachment

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

Age	Total		Atulia		Beralaxmi		Borokupot		Chotokupot		Jhapa		Kamalkati		Noabeki		Overige	
	740		Total= 141		Total= 60		Total= 62		Total= 71		Total= 137		Total= 31		Total= 44		Total= 194	
	N	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
<=1 year	175	24%	35	25%	17	28%	14	23%	20	28%	22	16%	3	10%	15	34%	49	25%
>1 en <5 years	208	28%	36	26%	21	35%	17	27%	27	38%	33	24%	15	48%	6	14%	53	27%
<5 years	383	52%	71	50%	38	63%	31	50%	47	66%	55	40%	18	58%	21	48%	102	53%
>=5 en <=10 years	356	48%	70	50%	22	37%	31	50%	24	34%	82	60%	13	42%	23	52%	91	47%
>10 years	1	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	1	1%
Gender																		
Boy	411	56%	63	45%	34	57%	43	69%	35	49%	79	58%	16	52%	28	64%	113	58%
Girl	327	44%	78	55%	26	43%	19	31%	36	51%	57	42%	15	48%	16	36%	80	41%

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

	Total		Atulia		Beralaxmi		Borokupot		Chotokupot		Jhapa		Kamalkati		Noabeki		Overige	
	740		Total= 141		Total= 60		Total= 62		Total= 71		Total= 137		Total= 31		Total= 44		Total= 194	
	N	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Anaemia	288	39%	55	39%	29	48%	18	29%	29	41%	56	41%	14	45%	15	34%	72	37%
No anaemia	451	61%	86	61%	31	52%	44	71%	42	59%	80	58%	17	55%	29	66%	122	63%
Unknown	1	0%	0	0%	0	0%	0	0%	0	0%	1	1%	0	0%	0	0%	0	0%
Hb <5,0 mmol	9	1%	3	2%	0	0%	0	0%	0	0%	2	1%	2	6%	0	0%	2	1%
Anaemia per age																		
<=1 year	72	41%	9	26%	8	47%	4	29%	9	45%	7	32%	1	33%	6	40%	28	57%
>1 en <5 years	79	38%	16	44%	11	52%	5	29%	9	33%	13	39%	7	47%	0	0%	18	34%
<5 years	151	39%	25	35%	19	50%	9	29%	18	38%	20	36%	8	44%	6	29%	46	45%
>=5 en <=10 years	137	38%	30	43%	10	45%	9	29%	11	46%	36	44%	6	46%	9	39%	26	29%
>10 years	0	0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0%
Anaemia per gender																		
Boy	165	40%	25	40%	15	44%	11	26%	17	49%	32	41%	8	50%	10	36%	47	42%
Girl	123	38%	30	38%	14	54%	7	37%	12	33%	24	42%	6	40%	5	31%	25	31%

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

	Total		Atulia		Beralaxmi		Borokupot		Chotokupot		Jhapa		Kamalkati		Noabeki		Overige	
	740		Total= 141		Total= 60		Total= 62		Total= 71		Total= 137		Total= 31		Total= 44		Total= 194	
	N	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Underweight	209	28%	39	28%	18	30%	13	21%	21	30%	30	22%	14	45%	9	20%	65	34%
No underweight	528	72%	102	72%	42	70%	49	79%	50	70%	105	78%	17	55%	35	80%	128	66%
Unknown	3	0%	0	0%	0	0%	0	0%	0	0%	2	1%	0	0%	0	0%	1	1%
Underweight children per age																		
<=1 year	33	19%	5	14%	2	12%	3	21%	3	15%	3	14%	1	33%	3	20%	13	27%
>1 en <5 years	81	39%	16	44%	10	48%	6	35%	10	37%	7	21%	8	53%	2	33%	22	42%
<5 years	114	30%	21	30%	12	32%	9	29%	13	28%	10	18%	9	50%	5	24%	35	35%
>=5 en <=10 years	95	27%	18	26%	6	27%	4	13%	8	33%	20	25%	5	38%	4	17%	30	33%
>10 years	0	0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0%
Underweight children per gender																		
Boy	116	28%	22	35%	7	21%	11	26%	9	26%	20	25%	7	44%	4	14%	36	32%
Girl	93	29%	17	22%	11	42%	2	11%	12	33%	10	18%	7	47%	5	31%	29	36%

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

	Total		Atulia		Beralaxmi		Borokupot		Chotokupot		Jhapa		Kamalkati		Noabeki		Overige	
	740		Total= 141		Total= 60		Total= 62		Total= 71		Total= 137		Total= 31		Total= 44		Total= 194	
	N	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Stunting	238	32%	50	35%	21	35%	14	23%	23	32%	37	27%	11	35%	12	28%	70	36%
No stunting	500	68%	91	65%	39	65%	47	77%	48	68%	100	73%	20	65%	31	72%	124	64%
Unknown	2	0%	0	0%	0	0%	1	2%	0	0%	0	0%	0	0%	1	2%	0	0%
Stunting children per age																		
<=1 year	71	41%	17	49%	7	41%	4	29%	7	35%	7	32%	1	33%	5	33%	23	47%
>1 en <5 years	91	44%	18	50%	9	43%	6	38%	11	41%	15	45%	6	40%	3	60%	23	43%
<5 years	162	43%	35	49%	16	42%	10	33%	18	38%	22	40%	7	39%	8	40%	46	45%
>=5 en <=10 years	76	21%	15	21%	5	23%	4	13%	5	21%	15	18%	4	31%	4	17%	24	26%
>10 years	0	0%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0%
Stunting children per gender																		
Boy	136	33%	22	35%	13	38%	12	28%	12	34%	21	27%	5	31%	5	18%	46	41%
Girl	102	31%	28	36%	8	31%	2	11%	11	31%	16	28%	6	40%	7	47%	24	30%

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

	Total		Atulia		Beralaxmi		Borokupot		Chotokupot		Jhapa		Kamalkati		Noabeki		Overige	
	740		Total= 141		Total= 60		Total= 62		Total= 71		Total= 137		Total= 31		Total= 44		Total= 194	
	N	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Wasting	68	12%	19	17%	5	10%	6	13%	6	9%	9	9%	5	21%	1	3%	17	11%
No wasting	509	88%	92	83%	46	90%	40	87%	59	91%	88	91%	18	75%	31	97%	135	89%
Unknown	162	22%	30	21%	9	15%	16	26%	6	8%	40	29%	7	23%	12	27%	42	22%
Wasting children per age																		
<=1 year	19	11%	5	14%	2	12%	1	7%	1	5%	1	5%	0	0%	1	7%	8	16%
>1 en <5 years	23	11%	6	17%	2	10%	2	13%	1	4%	4	12%	3	20%	0	0%	5	9%
<5 years	42	11%	11	15%	4	11%	3	10%	2	4%	5	9%	3	17%	1	5%	13	13%
>=5 en <=10 years	26	13%	8	20%	1	8%	3	19%	4	22%	4	10%	2	33%	0	0%	4	8%
>10 years	0	0	0	0	0	0	0	0	0	0	0	0			0		0	
Wasting children per gender																		
Boy	32	10%	9	17%	4	15%	3	9%	2	6%	5	9%	3	30%	1	5%	5	6%
Girl	36	14%	10	17%	1	4%	3	21%	4	12%	4	10%	2	14%	0	0%	12	19%

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

	Total		Atulia		Beralaxmi		Borokupot		Chotokupot		Jhapa		Kamalkati		Noabeki		Overige	
	740		Total= 141		Total= 60		Total= 62		Total= 71		Total= 137		Total= 31		Total= 44		Total= 194	
	N	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Anti-worm	312	42%	60	43%	26	43%	26	42%	32	45%	57	42%	15	48%	17	39%	79	41%
No anti-worm	427	58%	80	57%	34	57%	36	58%	39	55%	80	58%	16	52%	27	61%	115	59%
Anti-worm per age																		
<=1 year	18	10%	4	11%	1	6%	5	36%	2	10%	2	9%	0	0%	1	7%	3	6%
>1 en <5 years	96	46%	13	36%	12	57%	5	29%	16	59%	15	45%	5	33%	4	67%	26	49%
<5 years	114	30%	17	24%	13	34%	10	32%	18	38%	17	31%	5	28%	5	24%	29	28%
>=5 en <=10 years	197	55%	43	61%	13	59%	16	52%	14	58%	40	49%	10	77%	12	52%	49	54%
>10 years	1	100%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	100%

Table 7: Disease prevalence among all children

	Total 740	
syndrome n.o.s.	7	1%
pneumonia (clinical)	6	1%
bronchitis	6	1%
BHR/asthma	7	1%
dysentaria	6	1%
dehydration : acute diarrhoea	1	0%
diarrhoea without dehydration	2	0%
constipation	47	6%
active worm infection	67	9%
otitis media acuta	22	3%
otitis media with effusion	13	2%
otitis externa	9	1%
tympanic perforation	3	0%
(adeno)tonsillitis	3	0%
candida stomatitis	2	0%
sinusitis	2	0%
hearing impairment	1	0%
other	29	4%
cariës n.o.s.	167	23%
pain n.o.s	6	1%
fluorosis	1	0%
caries with pain	106	14%
wounds n.o.s.	1	0%
eczema n.o.s.	45	6%
dermatomycosis	12	2%
Impetigo/furunculosis	7	1%
lice	1	0%
scabies	14	2%
erysipelas / cellulites	6	1%
insect bite	1	0%
other (psoriasis etc)	9	1%
psychomotoric retardation	5	1%
hypertonia	2	0%
epilepsy	2	0%
migraine/headache	1	0%
leg kramps	0	0%
physiological murmur	3	0%
pathological murmur (suspected)	2	0%
strabismus	2	0%
keratoconjunctivitis	2	0%
thyroid dysfunction (suspected)	2	0%
epi/hypospadias	1	0%
urinary infection	8	1%
artralgia n.o.s.	4	1%
hernia(umbilical etc)	3	0%

Table 8: treatment

	Total	
	740	
	N	%
ferro	85	11%
mother iron	62	8%
multivitamins	319	43%
anti-worm	239	32%
acute worm	96	13%
anti-scabies	13	2%
niclosamide	1	0%
amoxicillin	33	4%
augmentin	4	1%
co-trimoxazol	1	0%
eardrops	9	1%
nystatine	2	0%
mupirocine=Bactroban	10	0%
hydrocortisone cream	49	7%
dactarin cream	12	2%
dactacort cream	1	0%
fusidin cream	4	1%
eyedrops	7	1%

Table 9: Medication

Medicatie	Eenheden	aanwezig	besteld voor missie	aantal ontvangen bij start missie	Aantal eind missie	Verbruikt	Geschat verbruik zonder compromise	Achtergelaten (voorraad op missielocatie)	Samenstelling
Iron bottles, Compiron, 200 ml	200ml		145	145					
Iron tablets, 200 mg	tabl	2900	10.000	10000	4000	6000		4000	ferrofumaraat 200 mg, foliumzuur 200 mugr
Multivitamines syrop, Vitagrow bottles	100 ml	1.031	0	1031	0	1031	1060	0	
multivitamin tabl, Envit		4.650	4000	8650	2550	6100		Ong 900	multivit + fe 50 mg
3/6=Albendazole 400mg	400mg	600	400	1000	340	660		340	
5=Ivermectine 3 mg	tabl 6 mg	0	40	40	0	40	60	0	
10=Amoxicillin syrop, bottles 60 ml, 125 mg/5 ml , Moxilon	125mg/5ml	25	15	40	8	32		8	
10=Amoxicillin, tablet/capsules 250 mg, Moxacil	tabl 250mg	89	300	389	308	81		308	
10=Amoxicillin tablet 500mg, Moxin	500mg	20	100	120	250	0		250	
11=Augmentin syrop 125/31.25 mg Clamox	100 ml	3	15	18	12	6		12	
11=Augmentin tabl250/125 mg	250/125 mg	18	160	178	196	0		120	
12=Azithromycin syrop Tridosil	200mg/5ml	15	0	15	15	0		0	
20=Metronidazol tabl 200 mg	200mg	20	0	20	20	0		20	
32/76=eye/ear drops Cloramphenicol I-Guard		18	20	38	20	18		20	
50=mupirocine tube 10 gr Trego	crème	38	60	98	88	10		58	
51=hydrocortison crème 5 gr	15 gram	0	60	60	6	54		6	
52=econazol, tube 10 gram Econate	crème	27	25	52	37	15		37	
povidon jood oplossing		2	0	2		0		?	
Flammazine	crème	0							