Kailakuri Health Care Project

"Health for the Poor by the Poor" (a project of the Mati NGO)

2014 ANNUAL REPORT

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1. Introduction:

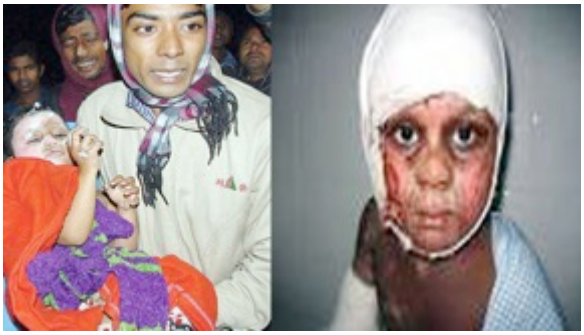
In 1971 when Bangladesh won its war of independence the country was devastated and had to be rebuilt from practically nothing. Then never before in history was so much foreign aid put into a country with so little to show for it. The political history was violent and traumatic with little regard for the wellbeing of the people. (When power seeking takes priority over the common good then it is the poor who suffer the most.....and die.) At every level misgovernance, injustice, corruption and extortion hampered national development, social wellbeing and health care (though with intermittent periods of political stability and advance).

Now industry and commerce however have boomed. With the huge population and low cost labour force, in-country garments and textile industries together with labour force export returning remittances back into the country, the base has been prepared for Bangladesh to become a middle-income country. National poverty is no longer necessary. The very strong NGO sector and the huge government emphasis on population control and women and children have combined to make life expectancy and mother-child-wellbeing statistic indicators much better than in India and perhaps most other countries in South Asia. It is now claimed that poverty is down to less than 30% (although the definition of poverty is obviously determined by those who are not poor). Enormous social problems have been created by wholesale migration to the cities leading to uncontrolled urban congestion and pollution (Dhaka has been said to be the world's least habitable city), divided and unsustainable families and soaring market prices. **Yet still about 80% of the population lives in rural areas. And Government has failed to provide widespread truly effective low cost health care safely nets for the poor** (except for family planning and immunization)

And now once again the country reels between secularity, religion and corruption, between democracy and its hijacking, recurrent strikes called by the opposition and backed by violence and terrorism, and the breakdown of industry and commerce, communication and social structures. Hard won health, development and economic gains are sacrificed while neither political grouping is willing to back off or compromise (and such comments are repeatedly expressed in reports and in the national press). In this situation hopes of ongoing national or social development, alleviation of poverty or health sector development become remote. Committed groups like the KHCP struggle on hoping to somehow hold what gains they have made until such time as political stability and good governance come about.

In the long prevailing context of inability of the poor to access necessary health care without selling off assets or taking loans the KHCP is committed to empowering them for improvement of their health (health for the poor by the poor). Different faith groups join hands for the common good and relief and uplift of the poor (on the creedal basis of one caring Creator God and a common humankind) and the Good News of the imminence of a more humane social order (God's Kingdom of caring) by means of grass roots mobilisation. The method is prioritization, low cost simplification, low cost staff, community immersion, caring, intensive health education, local control and ongoing training, supervision and evaluation.

{Note: According to government reports, poverty is now 25% (40 million in a population of 160 million) and extreme poverty, 11%}



2. Statistics at a Glance

		2014	% Increase	2013
1.	**The Village Mother-Child Health Programme (VHP):**			
	Number of Villages	19	6%	18
	Population	**17,679**	9%	16,220
	End of Year Under 4 Year Old Care	1245	13%	1,102
	Number of Women Given Antenatal Care	500	29%	388
	Number of Staff Assisted Deliveries	146	0%	146
	(including women coming from outside the programme for assisted deliveries & CS referrals)			
2.	**No. of Persons Receiving Health Education:**	**27,000**	**8%**	**25,000**
3.	**Outpatient Visits:**			
	General	24,480	15%	21,356
	VHP	547	-56%	1,239
	TB	1,987	7%	1,864
	Diabetes	20,172	3%	19,540
	Total	**47,239**	**7%**	**43,999**
4.	**Inpatient Admissions:**			
	General	1,170	16%	1,008
	Diabetes	513	18%	435
	Total	**1,683**	**17%**	**1,443**
5.	**End of Year Diabetes Patient Numbers:**	**1,681**	**-4%**	**1,755**
6.	**No. of TB Patients Treated:**	**78**	**-7%**	**84**
7.	**No. of Surgical Transfer Patients:**	**139**	**43%**	**97**
8.	**Total No. of Staff:**	**93**	**0%**	**93**
	(equivalent full-time staff number	129	4%	124)
9.	**Total Expenditure:**			
	BDT (Taka)	22,861,000	21%	18,962,000
	USD	296,900	21%	245,300
	NZD	381,000	28%	298,200
	Euro	235,680		
	GBP	187,385		

(Exchange Rate details – see page 8)

Notes;

1. Increase in service delivery is seen in i) U4 care and ANC (however the ?29% increase in ANC probably reflects a 2013 statistical error) made possible by WCFF funding and more efficient staff ulflisation, ii) OPs and IPs, and iii) numbers receiving health education.
2. Within Bangladesh, the fact that **this is an extremely low cost effective project** may be obscured because the project does not make patients pay for food, investigations and medications which they cannot afford. The project pays for them. Hence running costs look higher. Unfortunately, few organizations recognise that impoverished patients cannot afford to pay for these items.
3. The **total expenditure increase of 21%** is explained i) by increased service delivery, ii) appr. 10% inflation rate, iii) salary increases of about 10% (leading to salary expenditure bill increase of 22% --see p-6 below, note 2), iv) payment of VAT and 'service costs' to government).
4. The drop in VHP child OP visits is due to chanelling them through general OPs.
5. The increase in TB OP visits in spite of reduction in TB numbers is due to the large increase in general OP visits presenting more patients for screening without parallel increase in case detection .
6. Diabetes follow up visits have increased despite decrease in patients numbers because of increased patient awareness.

3. Low-Cost Health Care at a Glance :

	BDT	USD	NZD	Euros
1. Per year antenatal care in home for one mother/health nutrition care in home for one child:	950	12	16	10
2. Six months multidrug treatment course for one TB patient (cost to KHCP):	2,100	27	34	21
3. One general outpatient visit (including salaries and medications):	110	1.5	2.0	1.0
4. Cost of keeping one inpatient admitted for one day (incl. salaries, medications, food for patient & attendant etc):	285	4	5	3
5. Cost of supervision and treatment of one diabetes patient for one year (cost to KHCP):	4,000	50	70	40
6. Staff pay for 93 staff for one year (including doctor):	103,40,000	111,000	172,300	106,600
7. Average pay, one staff member for one month(including overtime):	8,900	120	145	90
8. Average pay, one functional full time staff member(129 functional full time staff, see note. 2):	6,400	85	110	66
9. Total project expenditure for one year:	2,28,61,000	296,900	381,000	236,000
10. Approximate cost per person touched (appr. 29,000):	800	10	15	10
11. Fixed expenditure (total salary bill per person touched):	360	5	6	4

Notes:

1. Despite its constraints the Kailakuri Health Care Project provides a model of **low cost health care for the poor**. (see also p3, note 2)
2. Many of the 93 staff work overtime so that the functional fulltime staff number is 129. The annual individual salary increment of 10% produced a 22% increase in the salary bill because of increased overtime plus sale of leave days back to the project.
3. The staff monthly pay (see 7. and 8 above) for most staff does not provide a living income. The only way most families can survive is by having additional income sources (e.g.: other members earning, livestock, agriculture, home food production or loans). Inflation and cost of living are rising. The only ways for the project to change the staff's hardship are 1. finding additional funding, 2. cutting back project activities and laying off staff or 3. making the patients pay much more and hence excluding the poorest!

4. Preparation for the Future:

KHCP faces its own challenges and imminent changes even apart from the current national crisis. With the sole ongoing medical officer (medical coordinator) facing major health problems, the well nigh impossibility of recruiting an ongoing national doctor and the present lack of an English speaker for email correspondence (when almost all support communications require this) then the project has had to make major structure and staff re-evaluations and preparations for its next stages.

i. Medical Supervision and Leadership:

It has become obvious that the present medical doctor is no longer able to give effective medical supervision and leadership to the project. While the project continues to be a very good primary health care intervention it is struggling with inadequate medical leadership and supervision. The internee doctors are of some help but their short stay of only two months makes the adjustment from sophisticated hospital to primary health care very difficult. If the project is going to run effectively full time ongoing committed residential medical leadership is necessary. Doctors Jason and Merindy Morgenson in the USA will come to Kailakuri and start work in October 2015 after 6 months' in

country language study. They have young triplets who will then be aged 14 months. The family will be supported by Interserve. Dr. Jason visited the project for 3 weeks in January this year to learn the administration and will be well equipped to take over the medical leadership provided the family and Interserve recognise that it will be a very full time commitment for him and they can make appropriate adjustments to enable this.

The project has had repeated media publicity and many people write in or visit, including medical students. So far however no doctor interested in ongoing work at Kailakuri has come to the project and all advice indicates that it is unreasonable to expect such in the prevailing Bangladesh social medical situation even if a competitive salary could be paid. (The fact of the huge gap between the rich and the poor, of doctors only coming from the upper classes, of the cost of medical education and the inconveniences of living in the rural areas do not augur well for health care for the rural poor).

ii. Strengthening the Paramedics:

The project's Standard Treatment Book has been updated and is required to be followed by all medical and paramedical staff. Teaching-training for all staff is ongoing conducted by the senior paramedics and carefully planned paramedic rotations enable a breadth of experience for future leadership. Nine have now completed a six months non official training programme in Mymensingh. The senior staff are very committed and determined to sustain the aims, methods and quality of the project. Salaries however remain inadequate with little prospect of improvement in the existing financial uncertainties (see p4; note-3)

iii. Communications and Support:

Ongoing support depends on regular and timely communication follow-through, reports and newsletters. These are by e-mail and in English requiring an English-speaking person up-to-date and identifying with the project situation, and probably resident in the project understanding and accepting its aims, methods, leadership and limitations. Christine Steiner and Nadine Vickers gave valuable and much appreciated support. However since the departure of Nadine Vickers there has been a gap, the task falling back on the medical coordinator and a new young staff member. We are seeking an English speaker who will be able to fit into this project and fill in the gap at least until Dr. Jason and Merindy arrive, preferably someone who has knowledge of the country and is already able to speak Bengali. It is not easy for new foreigners to adjust.

The project continues to seek in country funding. Along with ongoing publicity a piggy-bank programme has been started and also a Bengali newsletter. In the hope of improving project recognition and a closer alliance with government we have sought to develop a relationship with UNICEF. So far because of UNICEF difficulty in working with methods differing from those of government and large NGOs, UNICEF staff changes and the hazardous political situation little progress has been made.

iv. Project Structures:

In order to provide a strong base for continuity, adjustments, changes and challenges it has been necessary to clarify and modify the relations between the Diabetes Patient Body (owner of the Project) and the Diabetes and Project Committees. This required revision of the Diabetes Constitution and an official statement of the KDRP (diabetes programme)-KHCP relationship, thus confirming the power of the committees. A memorandum of understanding with Mati NGO (the project's umbrella NGO) has been prepared and signed providing Mati coordinating-office support while maintaining the Project's freedom for self-government and decision making. The project's leadership structures have been defined along with clarification of the relationship between the Diabetes Patient Body, the Committees, the Medical Coordinator and the Staff Management Groups and the NGO and the project's Support Groups.

v. Empowerment of the Committees:

The power of the Diabetes and the Project Committees has been cultivated for years. Both contain staff alongside community and patient representatives. They listen, think, debate and determine project decisions and self-governing. Dependency, interdependency and mutual participation give the medical coordinator and staff control over day to day running and decision making, the community-beneficiary committees control over major decision making and the NGO and the support groups inevitable influence over major policy and financial decisions.

5. Community Coverage and Benefit:

In the face of the national's enormous population and needs the slightness of KHCP's community coverage is sobering and clearly indicates the need for constant attention to community relevance, cost efficiency, management and medical supervision, extension of community coverage and advocacy for the poor. (KHCP only accepts responsibility for the poor.)

Gender disparity (female percentage of beneficiaries) is striking in such a strongly male dominated society: general outpatients 68%, general inpatients 57%, tablet diabetes patients 61%, insulin patients 56%, TB 36%, under 4s 50%). Most striking is the disparity seen in general out and inpatients, suggesting that there is a need to make outpatient attendance easier for working men. This however will have to await improved financial security and management capacity. The low female percentage in TB is probably due to their exclusion from an early age from public transport and crowded situations (markets, etc).

Religious community breakdown:
Under 4 year's childcare: Bengali Muslim 59%, Mandi Christian 31%, Bormon Hindu 10%
Antenatal care: Muslim 64%, Christian 25%, Hindu 11%
General outpatients: Muslim 84%, Christian 10%, Hindu 6%
General inpatients: Muslim 62%, Christian 19%, Hindu 19%
Diabetes patients: Muslim 97%, Christian 1%, Hindu 2%
TB patients: Muslim 55%, Christian 41%, Hindu 4%
Staff: Muslim 45%, Christian 40%, Hindu 15%
The majority community is Bengali Muslim.
In mixed religious-ethnic group community work, it is desirable to weight staffing towards minorities in order to avoid disempowerment.
The very low percentage of Christian and Hindu diabetics is probably due to the very large area from which patients are drawn, extending for beyond the immediate area of Christian and Hindu tribal concentration.

Shulakuri Union with a population of 35,000 is only 12% of the Madhupur Thana. The quality of the project's **mother-childcare** in its 19 villages is very good but covers only 50% of the Shulakuri Union. Maternal complications come to the inpatient service. Many child admissions are prevented. Severe childhood malnutrition is rare. **Health education** is propagated through the village programme and all the project's services and has a wide and effective impact. KHCP is one of many organizations motivating for and promoting the government's immunization and family planning programmes (with a national growth rate of only 1.6% the latter is highly effective).

By improved management-administration the MCH village programme has extended its area and population served supported by the Swiss World Child Future Foundation. The former Church of Bangladesh (COB) areas are now coverd along with two more Muslim areas to the North. **Outpatient service** has also increased slightly, from the COB Thanarbaid Clinic base.

The Kailakuri **TB Programme** responsible for the Shulakuri Union, is very effective and coverage is very good. It is difficult to assess the community coverage of general outpatient and inpatient care. **Outpatients** service lacks the capacity (staff, management and supervision) to accept the number of patients who present, although for long-term patients there is fairly good coverage of about 30% of the Shulakuri Union. **Inpatient** coverage is better, however, patient numbers prejudice patient assessment and duration of admission. Enlargement is difficult in terms of costs, staff and supervision requirements.
The **Diabetes Programme** is probably providing treatment and supervision for almost all poor Type One patients within 15 miles of its subcentres (ie from about 7% of the 10 million population in the three districts of Tangail, Jamalpur and Mymensingh). Tablet patients are less motivated for Kailakuri because the market price of medications is considerably less than the cost of travel to the subcentres. We are probably getting about 10% of poor Type Two's within 15 miles but almost all within five miles. (Upgrade and expansion of other KHCP activities is a higher priority than increasing the coverage of Type Two diabetics.)

6. Annual Accounts for 2014:

(1st December 2013 to 30th November 2014)

Income	BDT ('000s)	USD	NZD
Opening Balance	**31,11**	**40,403**	**51,850**
Income/Receipts			
Foreign Donations	199,12	258,597	331,867
Patient Fees	14,32	18,597	23,867
Staff Meals	1,24	1,610	2,067
Local Donations	7,25	9,416	12,083
Sale of cows	3,68	4,779	6,133
Miscellaneous	63	818	1,050
Total Income/Receipts	**2,26,24**	**293,818**	**377,067**
Total Opening Balance & Income/Receipts	**2,57,35**	**334,221**	**428,917**
Expenditure			
Programmes(General,Diabetes,TB,MCH-VHP, Health Education)			
Salaries	90,29	117,260	150,483
Education Materials etc	41	532	683
Diabetes Medications	8,86	11,506	14,767
Other Medicines	22,37	29,052	37,283
Diabetes Equipment	4,20	5,455	7,000
Other Medical Equipment	1,29	1,675	2,150
Supplies & Equipment	85	1,104	1,417
Patient & Staff Meals	26,26	34,104	43,767
Gardens and Grounds	86	1,117	1,433
Firewood	2,23	2,896	3,717
Lamps and Kerosene	91	1,182	1,517
Bedding	40	519	667
Travel and Conveyance	7,79	10,117	12,983
Poor Patients	7,81	10,143	13,017
Surgical Transfers	16,15	20,974	26,917
Home Visits	84	1,091	1,400
Diabetes Meetings	94	1,221	1,567
Miscellaneous	51	662	850
MCH Village Health Programme (excluding salaries)	1,85	2,403	3,083
Total	**194,82**	**253,013**	**324,700**
Administration			
Salaries	13,11	17,026	21,850
Provident Fund	5,60	7,273	9,333
Stationery	1,43	1,857	2,383
Electricity	1,22	1,584	2,033
Phone and Emails	63	818	1,050
Furniture	87	1,130	1,450
Cycle Repairs	64	831	1,067
Building Repairs	92	1,195	1,533
Bank Fees	36	468	600
Audit Fees	.....	.....	.....
Mati central office service charges	1,41	1,831	2,350
Total	**26,19**	**34,013**	**43,649**
Capital Expenditure			
New Cycles	.....	.....	.....
New Buildings	3,46	4,493	5,767
Electrical Installations	64	831	1,067
Land Purchase	.....	.....	.....
Total	**4,10**	**5,325**	**6,834**
Government VAT	**3,50**	**4,545**	**5,833**
Total Expenses	**2,28,61**	**296,896**	**381,016**
Closing Balance	**28,74**	**37,325**	**47,900**

Notes:

1. **Expenditure Breakdown According to Programme:**

	BDT ('000s)	USD	NZD	% of Total
Diabetes Programme	66,30	86,104	110,500	29
Diabetes inpatients	(2,013)	(26,143)	(33,550)	(9)
General Patients	7,382	95,870	123,033	30
General Inpatients	*(4,698)*	*(61,013)*	*(78,300)*	*(20)*
General Outpatients	*(2,684)*	*(34,857)*	*(44,733)*	*(12)*
Total Inpatients,General & Diabetes	*(6,711)*	*(87,156)*	*(111,850)*	*(29)*
MCH Village Programme (incl. salaries)	19,62	25,481	32,700	9
TB	1,61	2,091	2,683	1
Surgical Transfers & Poor Patient Referrals	23,96	31,117	39,933	10
Health Education	4,04	5,247	6,733	2
Other	11,93	15,493	19,884	5
Administration	23,41	30,403	39,017	10
Captial Expenses incl. repairs	5,66	7,351	9,433	2
Government VAT	3,50	4,545	5,833	2
Total (excl. expenses in italics)	**2,28,61**	**296,896**	**381,016**	

(all costs include salaries where appropriate)

2. **Exchange Rates** at 27 November 2014
   USD 1 = 77 BDT
   NZD 1 = 60 BDT
   Euro 1 = 97 BDT
   GBP 1 = 122 BDT
3. The total **expenditure** of BDT 2,28,36,000 (USD 296,896) is an increase of 21% on 2013 (see explanation p3 note 3
4. The **Morgan Foundation** donation of NZD 100,000 (BDT 64,00,000) is included within the listed donations totalling NZD 331,233 (BDT 19,874,000).
5. The **Swiss WCFF** gave its three year donation to the VHP in one sum at the outset so that its gift is not included in the 2014 donations.
6. The large amount of money having to be payed by the project to the **government** by way of **VAT** and in order circumvent bureacratic difficulties is disappointing when the project is doing so much to fulfil the government's health obligations to the poor.
7. **Sale of cows**: The cow programme was given by the Bangladesh Army, about six years ago. Because of lack of grass in the densily populated villages, food expenditure, inflation, reduced milk production and staff salaries the dairy programme was running at a serious loss.
8. **The closing Balance** (P.7) including the funding of the MHC village health programme, is BDT 48,51,000 (USD 63,000 , NZD 81,000 , Euro 50,000) all together. One year has completed. Two years remain. So the Closing Balance minus the amount committed to the MHC VHP for its third WCFF year is BDT 28,74,000-24,54,000 = 4,20,000 (USD 5,455 , NZD 7,000 , Euro 4,300). This is the **effective balance** for utilisation in the present year.
9. This **account** is so far unaudited and **unofficial**. Differences from the official audited account will due to: different time frame, inclusion of rotating fund and lack of official data from the banks and the central office.

7. Donor Support List:

I. Overseas Donors and Supporters

1. The Morgan Family Foundation (New Zealand)

> Our very special thanks go to Mr Gareth Morgan, a prominent New Zealand philanthropist and economist, and UNICEF ambassador, whose solid support makes it possible for us to continue working with the poor as they care for their own people, and to sustain and enlarge this essential work.

2. World Child Future Foundation (Switzerland) supporting our Mother-Child Village Health Programme.
3. The Japanese Overseas Christian Medical Service for giving us Dr Mariko Inui who despite retirement repeatedly comes back to help us and is appreciated by the poor and all who work with her.
4. Invercargill, Christchurch and Whakatane (New Zealand) supporters who gave us Nadine Vickers who carried through our English office and communications after the completion of Christine Steiner.
5. New Zealand donors giving via the NZ Link Group, the NZ Anglican Mission Board and the NZCMS (including some giving very large private donations)..
6. Asia Connection Incorporated (ACI) USA.
7. The Quail Roost Foundation, (QRF), USA.
8. The members of the NZ Link Group who give extremely generously of their time and wisdom to support the KHCP.
9. American donors (including some giving very large private donations)giving via ACI, QRF, Father Bob McCahill and the Maryknoll Fathers.
10. Jason and Merindy Morgenson and Nicholas and Emily Tseffos for enthusiastically fund-raising on our behalf in America.
11. Howick Presbyterian Church, Auckland, New Zealand
12. Preston Russell Trust, Invercargill, New Zealand
13. A very generous Japanese private donor.
14. St. Stephen's Anglican Church, Whangaparoa, New Zealand.
15. St. Patrick's Catholic Church, Lincoln, New Zealand.
16. The Anglican Cathedral parish of Nelson, New Zealand.
17. Overseas Bangladeshis in America, Japan, Hong Kong, Australia and New Zealand.
18. St Paul's Union Church, Taupo, New Zealand.
19. A British private donor.
20. An Italian private donor.
21. Other Churches in New Zealand
22. NZCMS, AAW, NZAMB, and CWS for friendship, support and prayer back-up.
23. The NZ Bangladesh Association and especially Mr Ataur Rahman and Dr. Mohammad Islam Sakku for friendship, advice and enabling essential contacts in New Zealand and Bangladesh.
24. Many others (especially personal friends and family and overseas Bangladeshis) who have given us great encouragement.

II. <u>In-Country Support</u>

1. The Government of Bangladesh gives authorisation and gives support through the Damien Foundation and local support at subdistrict level.
2. The Mati NGO, our umbrella NGO, which manages government authorisation and liaison and chanrels our funding through their Bank account.
3. BIRDEM Hospital (Diabetes Association of Bangladesh) which along with Novo Nordisk and Lilly Companies provides low cost insulin to our poor diabetes and free insulin for our young diabetes

Over the years **BIRDEM Hospital** has probably given more support to our work than any other group.

4. Damien Foundation provides free investigations and medicines for TB patients and brings the KHCP TB programme into the National TBprogramme.
5. The Bangladesh National Society for the Blind Eye Hospital in Mymensingh provides free or low cost surgery for cataract and other eye patients.
6. The Centre for the Rehabilitation for the Paralysed which provides almost free care and surgery for our patients.
7. The Apon drug rehabilitation centre which provides free care for our patients.
8. The National Psychiatric Unit in Dhaka for giving us free patient treatment.
9. Dr. Sen of the National Burns Unit in Dhaka for giving us free patient care.

10. The Sapporo Dental Collage and Hospital in Dhaka for providing almost free dental treatment camps at Kailakuri.
11. Two women from the Mandi Christian community (Mrs Kanchon Rozario of Nalikhali and Mrs Dirobala Nokrek of Mominpur)who made donations of land for diabetes sub centres.
12. The Social Islami Bank of Bangladesh has made donations for buildings and furnishings.
13. British Women's Assiociation and the Dhaka American Women's Club have given donations for buildings and furnishings.
14. Pacific Pharma Pharmaceuticals gives a large donation of free drugs to the project every month
15. A high government official in Dhaka has given a large private donation.
16. The project's committee mebmers give generously of their time and wisdom for the management of the project.
17. Prominent members of the buisiness, political and civil service community have given generously of their time and wisdom to help the project, especially Md. Abdur Razzak (M.P), Md. Yakub Ali (Shulakuri Union Chairman), Md. Safiqul Islam (of the Home Ministry) and Md. Abdullah-Al-Mahmud (Mintu) and Md. Risal Mahmud (Peal-Pipeline Engineers and Associates Ltd.).
18. Other Bangladeshi friends who have given both monetary donations and wise advice.
19. Md. Hanif Sonket (of Ittadhy television programme) and other members of the Bangladesh media community for enormous positive publicity support, essential for development of an in-country funding base and finding a national doctor.
20. The Pirgacha Mission, The Holy Cross Fathers and Sisters, the Taize Brothers, the Church of Bangladesh, the Xavarian Fathers and the Marist Sisters give various kinds of help including important advice when needed.
21. A number of Bangladesh young people's voluntary service groups who inspired by our TV publicity (thanks again Md. Hanif Sonket) have determind to help the poor in their own community or to find support for the Kailakuri project (most especially in Phulbagh, Modhupur, Phulbaria, Tangail, Dhaka, Hong Kong and Canada).
22. Local religious leaderess who inspire us to work with the poor.

8. Financial Situation and Budget:

I. Income, Expenditure and Balances for 2013-14 and 2014-15 (projected):

	2013-14	**2014-15**
	USD	USD
Opening Balance	40,400	37,300
Income	293,800	276,400
Total	**334,200**	**313,700**
Expenditure	-296,900	-318,200
Balance	**37,300**	**-4,500**

II. Income Breakdown (%):

Opening Balance	12%	12%
Patient Fees	6%	6%
Other Local Income	2%	0%
Local Donation	3%	5%
Foreign Donations	77%	77%

III. Source of Foreign Donations:

USA	23%	10%
NZ	77%	90%
Switzerland	0%	0%
Other	0%	0%

Notes:

(1) The income, expenditure and balances shown correspond to 1st December to 30th November financial years (as against NGO and audit 1st September to 31st August financial years)

(2) Opening balances refer to balances within Bangladesh..
(3) Inflation is expected to continue and exchange rates are expected to deteriorate.
(4) The American % of foreign donations is expected to drop.
(5) All this means that a special effort is needed to sustain New Zealand donations and a special effort to make sure that new donation possibilities are properly followed up from Kailakuri.

9. Staff, Training and Health Education:

The essence of "Health for the Poor by the Poor" is that ordinary local people are trained in the project for the aims and work of the project. It depends on the motivated good will of the local staff and on correctly orientated committed leadership.

The Kailakuri Health Care Project has 93 staff (calculated full time staff number 129, based on overtime consideration) led by the Medical Coordinator, (Project Director, Dr. Edric S. Baker), Deputy Medical Coordinator (Mr. Sujit Rangsa) and the Assistant Directors (Management, Programme Administration, Outpatients, Inpatients, Diabetes, Mother-Child-Health and Communications/Funding [currently vacant]). The arrival of Doctors Jason and Merindy Morgenson in October 2015 will open the way for ongoing sustainability.

I. <u>The Health Action Team</u>: 72 (77% of staff), headed at present by one senior doctor with accepted discontinuity up until the arrival of the two new senior doctors in October.

i. Ongoing Medical Doctor/Coordinator	½	(½ % of staff)
ii. Paramedics and Health Educators:	35	(38% of staff)
iii. Short term rotating Internee Doctors	2	(2% of staff)
iv. Health Assistants:	10	(11% of staff)
v. Village Mother-Child Care Staff:	18	(19% of staff)
vi. Cooks:	7	(8% of staff)
vii. Transfer patient staff	2	(2% of staff)

39% of the health action team work with general patients, 31% with diabetes. 25% in Village Mother-Child Care, 3% with TB and 2% with transfer patients.

II. <u>Support Staff</u>: 21 (23% of staff)

i. Medical Coordinator (Project Director)	½	(½ % of staff)
ii. Assistant Director, Management	1	(1% of staff)
iii. Administration and Office Staff:	6	(6% of staff)
iv. Finance Staff:	3	(3% of staff)
v. Garden, Compound, Buildings, Maintenance, Market, Cows etc:	10	(11% of staff)

III. <u>Staff Gender and Religious Breakdown</u>

Amongst the staff, 62% are male and 38% are female; Muslim 45%, Christian 40%, Hindu 15%. The project is labour intensive. All the staff but for Nadine Vickers (English office and communications) were paid by the Project. Staff pay comprises 45% of all project costs.

IV. <u>Staff Training</u>:
All staff have been trained in the project, previously by the medical coordinator. Now the senior paramedics give the on-going training to the rest of the staff. Nine senior paramedics have completed the six month paramedic training course (LMAF) in Mymensingh. Five have had short midwifery training from CARITAS in Dhaka. TB paramedics are trained and supervised by Damien Foundation. One paramedic has had eye training from the BNSB Eye Hospital in Mymensingh.

V. <u>Health Education</u>:
Health and nutrition education is essential and a priority in KHCP activities. It is probably the project's most cost effective intervention. The 4½ health educators give constant teaching in

inpatient and outpatient departments and in the diabetes sub-centres and teaching is ongoing by all the staff in the village mother-child and TB programmes. The very strong emphasis on teaching and awareness plus the fact that almost all staff are local **ensures the transmission of important health concepts and messages throughout the community and brings about community change**. Probably about 27,000 people received health education messages during 2014.

VI. Ongoing Medical Leadership/Supervision

For effective ongoing primary health care and medical work and enlargement of poor beneficiary service-population-area the project should have at least two full-time appropriately orientated committed medical doctors, not diverted into fundraising, communication, negotiation and other non-medical activities. (And it is usually not recognised that just as public health, pediatrics, obstetrics, infectious diseases, nutrition, gynaecology, orthopedics and psychiatry are medical specialties not easily interchanged, so also providing leadership for paramedic-provided primary health care is also a specialty, essential for the world's poor majority). In the absence of the two necessary ongoing doctors, the paramedics following the Standard Treatment Book are able to keep the project running, but the doctors are needed.

The entire project set-up and its work depend on the basic concepts of egalitarianism and the equal worth and rights of staff, patients and all people. All must be connected.

10. The Mother, Child Village Programme (VHP):

Health-wise, mothers and children, the elderly and the marginalised are the main casualties of poverty. Well organised MCH services are highly cost-effective. Probably one third to a half of the women and children in Bangladesh still suffer from malnutrition. Maternal health and nutrition are threatened by under-age marriages and there is a lack of satisfactory accessible primary mother-child health services. Most people in the villages now have safe water and sanitation and immunisation and family planning services are good. However food is often contaminated and many food items are deliberately adulterated.

The KHCP mother-child village programme is funded by the Swiss World Child Future Foundation.

Kailakuri Statistics for 2014

Number of Villages: 19 (population about 17,680)
Staff: 18, Village Workers 12, Supervisors 6
Under 4yr old Child Care: 1,245 (13% more than 2013)) at years' end. Weight chart survey at the end of the year showed nutrition problems in 3% (failure to gain weight over three consecutive months, a drop of 0.8kg not yet regained or below 3rd centile on weight chart). This very low figure shows the quality of care and teaching given. Unfortunately malnourished children needing admission do not readily come.
Immunizations: Staff continue to support the government's EPI programme.
Antenatal Care: 500 mothers were given ANC (?29% more than in 2013).
Delivery Care: 8% of ANC mothers had staff assisted deliveries, 30 deliveries (41% less than in 2013), 28 in their homes and 2 at the project health centre. The home delivery assistance decrease is due to increased assistance from government trained birth attendants.
Family Planning: Staff continue to motivate for the government programme and 27 couples received oral contraceptives from the VHP.

Religious-Ethnic Breakdown:	Bengali Muslim	Mandi Christian	Bormon Hindu
Village Workers	42%	50%	8%
Supervisors	17%	50%	33%
Under 4yr old Children	59%	31%	10%
Antenatal Mothers	64%	25%	11%
VHP Assisted Deliveries	73%	27%	---%
Oral Contraceptive Recipients	55%	30%	15%

(More Muslim staff should be taken on at new recruiting.)

The total cost of the VHP for 12 months was BDT 19,62,000 (USD 25,500) (NZD 32,700) (Euro 20,200) about BDT 950 (USD 12) (NZD 16) (Euro 10) per mother or child cared for. This is very cost effective and of enormous benefit to the community. It should continue to be extended. The need will always be present even though problems and service emphases may change. The effectiveness of the KHCP programme is clearly shown by the fact that the malnutrition rate is so slow, childhood deaths from diarrhea and pneumonia are rare and kwashiorkor almost unknown in our villages.

Note: Despite Bangladesh's amazing advance in mother-child wellbeing indicators (see P.2) the country has one of the world's worst records for abuse of teenage girls and teenage wives. (Hidden in Plain Sight, UNICEF, 2014)

11. The Primary Health Care Diabetes Programme

In a country where 30% of the people are poor and with rapidly increasing diabetes prevalence, (overall population prevalence appr. 5% in rural areas and 8% in urban areas) **KHCP has the only significant primary health care diabetes programme for the poor. It is essential for the masses of the people and the future of the country that its methods be studied, refined and copied**. Its methods are very simple. All the work is done by paramedics under medical supervision, at the same time linking with the BIRDEM (Diabetes) Hospital which provides concession rate insulin, without which the KHCP programme would be unable to continue. Results are as good as any with the poor in Bangladesh and costs much lower.

Patients under the age of 21 are linked into the BIRDEM-Novo Nordisk "Changing Diabetes in Children" programme which provides free insulin. The 103 children involved follow the same KHCP methods as all the other KHCP diabetes patients monitoring their diabetes by Benedict urine test (75% of all KHCP patients faithfully test their urine five times daily) and adjusting their insulin doses accordingly, taught and supervised by paramedics and trainers the same as all other Kailakuri patients. In addition they have three monthly HbA1c checks. No significant difference in diabetes control was found between these children and a parallel group of non-Kailakuri children (having home blood sugar monitoring and highly qualified staff supervision).The diabetes programme is run by a staff of 22 of whom 8 are paramedics, 5 health educators and 9 back-up staff.

Kailakuri Statistics for 2014
End of Year Patient Analysis
Total Number: 1,681 (4% decrease from 2013.
Treatment: Insulin 775 (46%), glibenclamide tablets 892 (53%), Diet alone 14 (1%)
Religio-Ethnic Breakdown: Muslim 1,615 (96%), Hindu 33 (2%) Christian 33 (2%)
Gender: Male 693 (41%), Female 988 (59%)
(Hindus and males are not coming in proportion to their expected numbers in the community)

Insulin Patients

Total number treated during 2014:		831 (4% increase from 2014)
Continuing from 2013		747
Started in 2014		+84
Transferred Out	-4	
Defaulted	-22 (3%)	-56
Died	-30 (4%)	
Continuing into 2015		775

End of Year Insulin Patient Analysis

Total Number of Patients 775
Regular Outpatient Attendance 99%
Diabetes Control (Benedict): Good 75% Fair 25%
Distance of Home from the nearest Sub-Centre:
Within 15miles 96%; 0-5miles 32%, 6-10miles 24%, 11-15 miles 40%
[15miles = 24km, 10 miles = 16km, 5miles = 8km]
Functional Literacy: 68% (i.e. able to write name & read or write a very simple letter).
Age: Under 30yrs 40%, Under 21yrs 13%
Economic Status: Very Poor 30%, Extremely Poor 64% [based on home visit assessment).
Religio-Ethnic Breakdown: Muslim 97%, Christian 1%, Hindu 2%
Gender: Male 44%, Female 56%

Glibenclamid Tablet Patients

Total number treated during 2014: 1,218 (29% increase from 2013)
Continuing from 2013 991
Started in 2014 +227
Changed to diet only -14
Transferred -20
Defaulted -200 } -326
Died -15
Changed to Insulin -41
Continuing into 2015 892 (-10%)

End of Year Tablet Patient Analysis

Total number of patients : 906
Regular attendance 83%
Diabetes Control (Benedict): Good 72% Fair 17%
Distance of home from the nearest sub centre:
Within 15miles 82%, 0-5miles 22%, 6-10miles 28%, 11-15miles 32%
[15miles = 24 km, 10 miles = 16 km, 5miles = 8km]
Functional literacy 58%
Age: Under 30yrs 11%, Under 21yrs 0%
Economic status: Very Poor 19%, Extremely Poor 77% [based on home visit assessment]
Religio-ethnic breakdown: Muslim 95%, Christian 2%, Hindu 3%
Gender: Male 39%, Female 61%

Diabetes Patients Admitted at Kailakuri

Total Number: 513 (18% increase on 2014)
Average Duration of Admission: 16 days
Religio-Ethnic Breakdown: Muslim 95%, Christian 2 %, Hindu 3 %
Gender: Male 42%, Female 58%
59% of the admitted patients were new to the project, admitted for diabetes teaching and because of wasting and other problems. All admitted patients and their attendants receive twice-daily diabetes and other education, most especially needed by new patients and other patients failing to control their diabetes.

The long average duration of admission is due to weighting by patients with advanced foot ulceration (with severe infection and necrosis) and a few patients with chronic osteomyelitis. There is no other satisfactory hospital to which these patients can be referred. There were 7 inpatient deaths (1% of admissions) 5 had uncontrolled diabetes & severe wasting (3 also had TB), and one probably died of heart attack.

Top Ten Inpatient Problems: wasting, inadequate understanding of diabetes, various oral problems, badly controlled diabetes (several with ketoacidosis), diabetic foot ulcers etc, other chronic complications of diabetes (neuropathy, nephropathy, retinopathy), cataracts, peptic ulcer, hypertension, urinary tract infections.
Followed by gynaecological problems, diarrheal diseases and pregnancy/delivery.

New Insulin Patients sent for Concession Insulin Registration to BIRDEM Hospital, Dhaka
Number of patients sent: 84
Travel cost: BDT 264,670 (USD 3,440), (NZD 4,400)
Average cost per patient BDT 3,150 (USD 40), (NZD 53)
From the project's view point the high cost of sending patients to Dhaka is quickly recovered from the insulin price concession. In terms however of diabetes funding utilisation it is hard to justify. Existing systems however do not easily allow this kind of rationalisation at the present time.

Cost of Diabetic Stock	BDT (000's taka)	USD	NZD
Insulin:	41,00	53,247	68,333
{Project Portion %}	17%		
{BIRDEM Portion %}	83%		
Glibenclamide Tablets	1,14	1,480	1,900
Diabetes Equipment	4,20	5,455	7,000
Total Cost	**46,34**	**60,182**	**77,233**
Cost to Project	12,29	*15,961*	*20,483*

Estimated Cost of the Diabetes Programme (to KHCP)

	BDT ('000s taka)	USD	NZD
Stock	12,29	16,000	20,500
Inpatient Care	20,13	26,100	33,600
Staff Salaries	19,74	25,600	32,900
Non-Diabetes Medicine etc	5,59	7,300	9,300
Cost of sending Patients to Dhaka	2,65	3,400	4,400
Meetings	94	1,200	1,600
Other Travel & Home Visits	4,96	6,400	8,300
Total	**66,30**	**86,100**	**110,500**

The cost to the project was BDT 66,30,00 (USD 86,100) (NZD 110,500), about 30% of the KHCP expenditure for the year and about BDT 3,900 (USD 50), (NZD 65) per patient. If the BIRDEM subsidy of BDT 2,000 (USD 26) (NZD 33) is added it becomes BDT 5,900 (USD 77), (NZD 98) per patient per year. Diabetes patients are rehabilitated and are able to live normal lives and the cost is extremely low. Serious acute diabetes complications are infrequent. Chronic complications are late and difficult to prevent without great cost increases and serious disruption of life-style. **Low cost service delivery and diabetes education are the key to diabetic health care.**

The causes of diabetes in Bangladesh still await clarification. (Almost none of our Type Two Patients are overweight at the time of first presentation.)This and the development of primary health care diabetes services for the poor are top national priorities. Services must be simple, low cost and easily accessible to the poor and the rural population.

12. General Patient Care:

The KHCP general patient care programme in fact makes it into a small rural hospital handling serious and complicated patients, run by poor paramedics of low basic educational level, under medical supervision. **This community safety-net is revolutionary but essential because of the millions of poor and rural people in Bangladesh for whom no other services are available without taking loans or selling off essential resources. This is what needs to be studied, improved and replicated**. To run such a project needs commitment and it needs back-up supervision by strongly committed medical doctors who believe that all people are important and that this is their duty to God and their country.

Kailakuri Statistics for 2014:

I. Outpatients:

Total number of patient visits:24,480 (15% more than 2013)
Religio-Ethnic Breakdown: Muslim 84%, Christian 10%, Hindu 6%
Gender: Male 32%, Female 68% and Children under 5yrs 7%
(Obviously an evening male clinic is needed).
Distance of Home: 0-2 miles 46%, 2-5 miles 33%, over 5 miles 21%
[2miles = 3.2km, 5 miles = 8km]

Top Ten Problems (by number of visits): asthma, peptic ulcer, skin infections and infestations, hypertension, epilepsy, psychiatric problems, kidney and urinary tract problems, arthritis/back pain, gynecological problems, anaemia.

Followed by: respiratory infections, worms, bronchitis, pregnancy problems, otitis media, eye problems, diarrheal diseases, other virus fevers, other skin problems and injuries and burns.

The Cost of Running the General Outpatient Department (general plus VHP) for 12 months was approximately BDT 2,684,000 (USD 34,900) (NZD 44,700), making cost per visit BDT 110 (USD 1.5) (NZD 2.0) which includes salaries, medicines, stationery etc. This is low cost health care.

II. Inpatients:

The total number of admissions (general plus diabetes) was 1,683 (17% more than 2013). General Patients were 1,170 (16% increase) and diabetes patients were 513 (18% increase).

The average number of admitted patients was 37 (25 general plus 12 diabetes) and the average duration of stay for the general patients was 13 days (as against 16 days for diabetes patients). (overall average stay 14 days)

General Patients
Religio-Ethnic Breakdown: Muslim (62%), Christian (19%), Hindu (19%)
Gender: Male (43%), Female (57%) Children under 5yrs (14%)

Top Ten Problems: peptic ulcer, asthma/bronchitis, pregnancy/delivery problems, diarrheal diseases, urinary tract infection, kidney problems, anaemia, malnutrition/wasting, newborn babies and worms.
Followed by: fractures, pneumonia, arthritis, gynecological problems, psychiatric problems, hypertension, abscesses, sores and ulcers, injuries and burns and virus fiver.

The Cost of Running the Inpatient Department (general plus diabetes) for 12 months was BDT 67,11,000 (USD 87,000) (NZD 111,900). With a total 1,683 patients and average stay of 14 days that is 290 BDT (USD 4) (NZD 5) per patient per day, which is extremely low cost (considering that the patients do not have to purchase food, investigations and medicines outside the hospital).

III. Surgical Transfers and Poor Patient Referrals:

Surgical transfers comprise patients sent to other hospitals for surgery.139 such patients were transferred, 43% more than in 2013. Poor patient referrals comprise patients sent to elsewhere for investigations or non-surgical treatment. The combined expenditure for the two groups was BDT 2,396,000 (USD 31,100) (NZD 39,900), 57% more than 2013.

13. The TB Programme:

This programme implemented by KHCP staff under the Damien Foundation is part of the government's national TB programme and a sub-centre of the Madhupur TB clinic. Bangladesh has the world's sixth largest TB problem. Prevalence is estimated to be 434 per 100,000 population. The national DOTS (Direct Observation Treatment, Short Term) programme is now able to concentrate on MDR (multiple drug resistance), child, sputum negative and extra-pulmonary TB. Disease prevention is by poverty alleviation, health education, treatment of infected cases and BCG (for prevention of life-threatening childhood cases). Treatment is six months (eight months for retreatment patients) which must be followed correctly (under observation) to prevent MDR which in Bangladesh is currently 1.4% in new

cases and 30% in previously treated cases. The National TB programme has a culture and sensitivity screening system for suspect MDR patients followed up by referral for specialised management

Kailakuri Results:

I. Success Rate:

36 sputum positive patients started treatment between July 2013 and June 2014. Four were subsequently transferred to other centres. Of the remaining 32 patients all were cured, i.e.: **100% cure rate**. **This is spectacularly successful**.

II. Kailakuri Statistics for 2014:

Total Number Treated		78	(8% increase from 2013)
No. Continuing from 2013		26	
Started in 2014	+52		(4% less than from 2013)
Completed	-43		
Transferred	-5		
Defaulted	0	-53	
Died	-5(6%)		
Treatment Failed		0	
Continuing into 2015		25	
(Preventative Treatment 1)			

III. Patient Analysis:

Category 1 (new sputum positives):	41	(53%)
Category 2 (retreatment):	2	(3%)
Category 3 (non-pulmonary)	34	(44%)

100.% followed treatment regularly.

Of the five patients who died, 4 may have died from advanced TB because of late start of treatment (one died of liver cancer)

Distance from home: 69% were from within five miles and 31% within two miles

38% were under 30 years of age

Religio-Ethnic Breakdown: Muslim 55%, Christian 41%, Hindu 4%

Gender: Male 64%, Female 36%

12 patients (15%) were hospitalized, 8 at Kailakuri and 4 at Jalchatra

There was 1 case of multiple resistance (1% of all cases) which was transferred to Damien Foundation Jalchatra Hospital.

6% patients also had diabetes.

The **total cost** to KHCP of the TB Programme was BDT 161,000 (USD 2,100) (NZD 2,680) which comes to BDT 2,100 (USD 27) (NZD 34) per patient.

Note: The WHO's 2014 report on its assessment of the National TB Programme was recently reviewed in the national press stating that it had fallen far behind on reaching its national millennium goals for 2015 because of lack of consistent leadership, inadequate monitoring, lack of proper patient supervision and misuse of funds.

14. Conclusion and Appreciation

The KHCP is preparing for new medical leadership and welcomes Doctors Jason and Merindy Morgenson. Up until their arrival there will be steps and gaps. However the project is grateful to Dr. Mariko Inui and the Gonoshasthya Kendra Medical Collage Hospital internee doctors for helping during this difficult time. The project must both sustain continuity and adjust to changes and new situations. Just as it is impossible irrespective of political and religious groupings to build a happy peaceful prosperous country without genuine commitment to the common good of all, likewise it is impossible to actuate effective health care for the poor without recognising that 1. they are poor and 2. they nevertheless have the same rights, dignity and human value as everyone else.

The question for the project is can it find both properly orientated committed medical leadership and also sustain its support and funding (requiring suitable persons for English and Bengali communications) without ceasing to be a low cost project immersed in and part of the community of the poor and controlled and implemented from within that community. The structures and the local staff are in place. Will the project be sustained? The real challenge is both national and international; is it possible for peoples to heal huge rifts of socio-economic and educational disparities, is it possible to unite for the common good of all, is it possible for people who have economic means and the necessary education and technical wherewithal to relinquish high income prospects to unite with the poor for the development and uplift of real community?

The importance of these questions has been widely recognised and solutions have been attempted in a variety of ways breaking down more-or-less into 1. political or social persuasion with varying degrees of compulsion or force and 2. religious or humanitarian motivation with varying degrees of inclusiveness. The history of Kailakuri is the latter with initial impetus coming from the Christian conviction of historical redemption requiring community immersion and social action----. Ongoing sensitivity-inclusiveness incarnates and multiplies. We and the entire poor community remain deeply grateful to Almighty God and all who have participated or assisted in this enterprise. We pray to God that it will continue with strength. **Every day as the day's programme begins with joint supplication by the poor (Muslims, Hindus and Christians---,staff, patients and attendants) to God, so the drive to join hands in carrying and connectivity spreads through the programmes and out into the community.**

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