Kailakuri Health Care Project

"Health For the Poor, By the Poor" (in association with Mati/IPDS)

2017 ANNUAL REPORT

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We remember the late Dr Edric Baker, Libby Laing and Fr. Doug Venne with gratitude and affection

1. Introduction:

2017 saw a number of changes take place within the Kailakuri Health Care Project (KHCP). As explained in the previous Annual Report, KHCP made the decision to become an independent NGO in late 2016. After submitting an application to the Social Welfare Department and undergoing a National Security Intelligence (NSI) Investigation, "Dr Baker's Organisation for Well-Being" was awarded Bangladeshi NGO status in June 2017. This was just the first step in the process – we subsequently applied for NGO Bureau registration, which will allow us to bring in foreign funds and volunteers in our own name. We are currently awaiting further investigations by the NSI, Tangail District Commissioner's office and Police – Special Branch before this registration can be granted. The third step will be to apply for approval of an FD-6 budget for the KHCP project (under the umbrella of Dr Baker's Organisation). We hope to achieve this by November 2018.

We also changed partner NGOs in September 2017, after a long association with Mati NGO in Mymensingh. KHCP was approved as a project of the Indigenous Peoples Development Services (IPDS) NGO in November 2017 (for a one-year period) and this may be renewed if we do not achieve full registration by then. IPDS is committed to assisting Dr Baker's Organisation achieve full registration and they do not charge a percentage for their services. In anticipation of the new challenges faced by KHCP management in becoming an independent NGO, several staff within the management team have been given additional roles and responsibilities and there is a higher expectation on heads of department to oversee the work of their departments and maintain quality of patient care as well as keeping within their budgets. Several experienced paramedics have been appointed as paramedic supervisors, after a thorough assessment process, to reduce the workload on three supervisor paramedics carrying out this responsibility.

A third development in 2017 was a concerted attempt by the KHCP project to reduce the monthly operating budget by 20%, given that we were drawing on reserves to meet our general operating expenses. This has involved widespread consultation with every department at KHCP, as well as further discussions amongst the management team and Executive Committee - with the aim of producing concrete recommendations. The KHCP-NZ Link Group (our support NGO in New Zealand) assisted with this process.

We estimate that the changes introduced in late 2017 are likely to reduce annual costs by 10-15%:

(1) Introduce a retirement policy to comply with Bangladeshi Labour law and NGO Bureau regulations. Employees over the age of 60 have been given several months' notice and an extra payout of two months salary (as well as their Provident Fund and pro-rata festival bonus entitlements).
(2) Further reduce overtime costs by tightening up rosters and installing a water tank on the inpatient side of the clinic, to decrease the workload and increase efficiency of kitchen and garden staff. The outpatients department will close on 10 government holidays each year but retain a facility for emergency patients. This does not affect the diabetes sub-centres, which carry on unchanged.
(3) Set realistic targets for outpatient, inpatient and diabetes patient visits and a fixed budget for surgical transfers each month so that we can maintain reduced overall expenditure. The mother-child health care programme (for all mothers and 0-4 year old children in our 22 village areas) and the TB programme (funded by the Damien Foundation) have been unaffected by these changes.
(4) Review patient fees for outpatients, inpatients and surgical transfer patients. Outpatient fees were raised slightly (by 5 taka for each category) and the inpatient fees for one month (per patient/ attendee) were raised from 200 taka to 300 taka. KHCP is still committed to treating the poorest patients who cannot afford to receive treatment elsewhere. Every patient is treated on a case-by-case basis and fees are reduced or waived for patients who cannot pay the usual fee. Fees for our regular diabetic patients are unchanged, as these had been reviewed one or two years earlier.

This has been a testing time for KHCP staff, which is understandable. However, they have come to understand the financial and legal constraints faced by KHCP, and risen to the challenge remarkably. The management team, Executive Committee and staff have become more aware of the difficulties of the NGO environment and the need to adapt to changing circumstances, especially given Dr Baker's absence. We are incredibly grateful to KHCP's donors who have continued to support us faithfully over the past couple of years and made it possible for Drs Jason and Merindy Morgenson to have a smooth transition to KHCP once they complete language training in 2018 and gradually take over medical leadership of the project.

As of December 2017, the full-time staff of KHCP numbered 85 (with one staff member having passed away, three retirements and one resignation in 2017). We have retained a strong relationship with Gonoshastaya Kendra Medical College, who provide two internee doctors on a two-monthly rotating basis, and an 80% discount for surgical transfer patients. We have also employed a registered Bangladeshi doctor on a short-term basis until Drs Jason and Merindy Morgenson settle at the KHCP project. Three paramedic staff are undergoing formal paramedic training alongside their duties. Volunteer Nadine Vickers left Bangladesh in September 2017, but continues to provide administrative support from New Zealand, alongside other members of the KHCP-NZ Link Group team.

Kate Day continues on the task of writing Edric's biography. She recently finished a chapter about the beginnings of the Diabetes Programme, and she is currently writing about Edric's methods for teaching paramedics. It's fascinating stuff! Kate hopes to finish the first draft manuscript by mid-2018, then revise this into a publishable form. She welcomes your prayers for the best ways to capture this important story.

We hope you will enjoy reading this 2017 Report and receiving further updates in upcoming newsletters and Facebook posts throughout 2018. Follow us at www.kailakuri.com and www.facebook.com/kailakuri.

Members of staff are presented with a cup and plate set in December 2017, thanks to a generous gift by a New Zealand donor.

2. Statistics at a Glance

		2017	% Increase	2016
1.	**The Village Mother-Child Health Programme (VHP):**			
	Number of Villages	22	0%	22
	Population	18,442	0%	18,442
	End of Year Under 4 Year Old Care	1,590	11%	1,438
	Number of Women Given Antenatal Care	490	4%	470
	Number of Staff Assisted Deliveries	166	-8%	181
	(including female inpatients from outside the VHP area coming for assisted deliveries & CS referrals)			
2.	**No. of Persons Receiving Health Education:**	**circa 28,000**	**0%**	**28,000**
3.	**Outpatient Consultations:**			
	General	23,826	-6%	25,294
	TB	1,473	-18%	1,796
	Diabetes	20,301	-3%	20,916
	Total	45,600	**-6%**	48,346
4.	**Inpatient Admissions:**			
	General	1,144	1%	1,130
	Diabetes	587	28%	457
	Total	**1,731**	**9%**	**1,587**
5.	**End of Year Diabetes Patient Numbers:**	**1,819**	**1%**	**1,803**
6.	**No. of TB Patients Treated:**	**88**	**-16%**	**105**
7.	**No. of Surgical Transfer Patients:**	**171**	**-10%**	**190**
8.	**Total No. of Staff:**	**90**	**0%**	**90**
	(equivalent number of full-time staff =)	(120)	(-4%)	(125)
9.	**Total Expenditure:**			
	BDT	243,84,000	5%	231,65,000
	USD	293,783	0%	293,228
	NZD	427,789	3%	413,661
	Euro	246,303	-11%	275,774
	GBP	217,714	-7%	233,990

(Total expenditure went up slightly in 2017. The fluctations in total expenditure in USD, NZD, Euro and GBP reflect varying currency rates in November 2017 vs November 2016. For full exchange rate details see next page.)

Notes:

1. The population in our village areas seems to be on the rise (although official statistics have not been updated), with an 11% increase in 0-4 year olds being cared for by our VHP staff in 2017.
2. Staff assisted deliveries have decreased slightly overall as government-trained birth attendants and other NGOs are providing these services in other areas. However staff-assisted deliveries in our VHP area (101) have increased from 42 in 2016, because of a renewed emphasis by VHP staff.
3. We have just begun keeping records of inpatient diabetics who come in for short visits (for BIRDEM and Changing Diabetes in Children camps) so inpatient numbers have increased overall.
4. In 2017, 35% of our TB patients suffered from extra-pulmonary TB (compared to 43% in 2016)
5. St Vincent's was unable to restart annual three-month surgical camps in 2017 but we send many surgical patients to Gonoshashtaya Kendra, who provide a 80% discount on treatment costs.

3. Low Cost Health Care at a Glance:

Low Cost Health Care	BDT	USD	NZD	Euros
1. Annual antenatal care in the home for one mother/ health nutrition care in the home for one child	1,150	14	20	12
2. Six months multidrug treatment course for one TB patient (cost to KHCP)	2,240	27	39	23
3. One general outpatient visit (including salary and medications)	113	1	2	1
4. Cost of keeping one inpatient admitted for one day (incl. medication, food for patient & attendant)	455	5	8	5
5. Cost of supervision and treatment of one diabetes patient for one year (cost to KHCP)	3,890	47	68	39
6. Staff pay for 90 staff for one year	114,92,000	138,458	201,614	116,081
7. Average pay, one staff member for one month (including overtime)	10,215	123	179	103
8. Average pay, one functional full time staff member (120 functional full time staff, see note. 2)	7,660	92	134	77
9. Total project expenditure for one year	243,84,000	293,783	427,789	246,303
10. Approximate cost per person touched (approx. 28,000)	870	10	15	9
11. Fixed expenditure (total salary bill) per person touched	410	5	7	4

2017 Exchange Rates:

USD 1 =83 BDT (2016- 79) **NZD 1** = 57 BDT (56) **Euro 1** = 99 BDT (84) **GBP 1** = 112 BDT (99)

Exchange Rates at 30 November 2017 (mid-market rates from www.xe.com)

Notes:

1. Many of the 90 staff work overtime so that the functional fulltime staff number is 120. The annual individual salary increment was 6%, and our salary bill was 6.5% more than 2016.
2. The 6% salary increase for all staff took place in late 2016 but had a noticeable impact in 2017, which is why salary rates have increased in the above statistics (despite remaining stable in 2017).

The Madhupur Upazila Chairman, Sharuar Khan Abu, and Fulbagchala Union Chairman, Rejaul Korim Benu, are at the opening of the new diabetes inpatient building at KHCP, kindly funded and built by local government.

4. Preparation for the Future

Kailakuri achieved Social Welfare Department Registration in June 2017 and entered a one-year partnership with IPDS NGO in November. As highlighted in the introduction, we have several more steps to accomplish before operating as an independent NGO, and we hope to achieve this by November 2018. We expect Drs Jason and Merindy Morgenson to complete language training and settle at the project by late 2018, and we would welcome suitable volunteers who can commit at least three to six months to the project.

i. Medical Supervision and Leadership:

Kailakuri is primarily a paramedic-run project, with 30 paramedics and health educators, 17 village programme staff, 10 health assistants and 2 patient-transfer staff. We have two internee doctors from Gonoshashtaya Kendra to provide medical supervision and expect Drs Jason and Merindy Morgenson (and their four young children) to arrive in Bangladesh within a few months. The Morgensons plan to be based in Mymensingh for six months to learn Bengali before gradually taking over medical leadership of the project.

ii. Strengthening the Paramedics:

Separate staff training is carried out once a week for the paramedic team, village health workers and general staff and 12 staff have completed a six-month non-official training programme in Mymensingh. Two staff members are completing their one-year paramedic course and one other staff has started a three-year paramedic training course (with a full scholarship from Japanese Overseas Christian Medical Cooperative Service (JOCS). He will work fewer weekly shifts at the project for the duration of his studies.

iii. Communications and Support:

We have continued to produce quarterly English newsletters and Annual Reports with input from volunteers such as Nadine Vickers and Ratan Bormon from New Zealand. We have also launched a new website, www.kailakuri.com, courtesy of many hours of hard work by Sophie McGrath and Ben McLaughlin.

iv. Committee Structures:

The Executive Committee of Dr Baker's Organisation assumed decision-making responsibilities for KHCP in Sep 2017, and the Diabetes Committee continues to operate as a sub-committee for diabetic patients. They began their programme of bi-annual diabetes meetings in February 2018 (more about that next year).

Members of the staff management team and Executive Committee sit together for a meeting

5. Community Coverage and Benefit:

Kailakuri provides **mother-child health care** for all pregnant mothers and 0-4 year old children in 22 villages, which covers about 50% of the Shulakuri and Fulbagchala Unions (with a population of 40,000, it is only 12% of Madhupur Thana). Maternal complications come to the inpatient service. KHCP is one of many organizations promoting the government's immunization and family planning programmes.

Health education is propagated through the village programme and all the project's services and has a wide and effective impact. The Kailakuri **TB Programme** is responsible for the Shulakuri and Fulbagchala Union, and receives patients from parts of surrounding Unions (when they come for diabetes treatment).

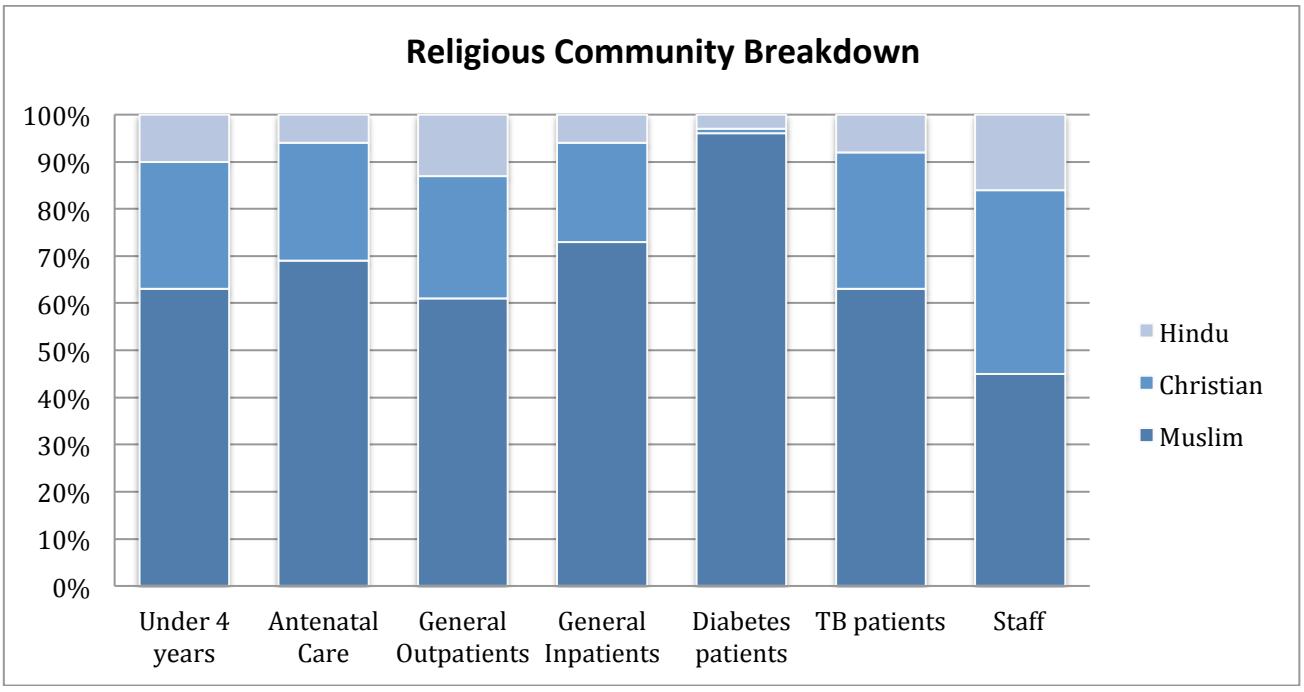
The **General Outpatients** service lacks the capacity to accept the number of patients who present on some days, although for long-term patients there is fairly good coverage of about 30% within an 8km radius of Kailakuri. **Inpatient** coverage is better, however, patient numbers prejudice patient assessment and duration of admission. Enlargement is difficult in terms of costs, staff and supervision requirements.

As per previous years, the general inpatient and outpatient statistics suggests we need to make outpatient attendance easier for working men. But this would require more paramedics, and greater project expenses. Amongst lung-TB patients, we receive a lower percentage of females (39%), probably due to their exclusion from public transport and crowded situations. But we receive many female patients with gland TB.

The **Diabetes Programme** is probably providing treatment and supervision for almost all poor Type One patients within 20 miles of its subcentres (ie from about 5% of the 11 million populationin the four districts of Tangail, Jamalpur, Mymensingh and Sherpur). 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.

Gender disparity (female percentage of beneficiaries) is striking in such a strongly male dominated society:

General Outpatients	General Inpatients	TB Patients	Tablet Diabetes Patients	Insulin Patients	Under 4yrs Children
67%	64%	39%	79%	69%	49%



6. Annual Accounts for 2017:

(1st December 2016 to 31st November 2017)

INCOME	BDT ('000s)	USD	NZD
Opening Balance	**68,08**	**82,036**	**119,456**
Income/Receipts			
Foreign Donations	158,00	190,361	277,193
Patient Fees	22,57	27,193	39,596
Staff Meals	86	1,036	1,509
Local Donations	369	4,446	6,474
Miscellaneous	98	1,181	1,719
Total Income/Receipts	**186,10**	**224,217**	**326,491**
Total Opening Balance & Income/Receipts	**254,19**	**306,253**	**445,947**
EXPENDITURE			
Salaries	101,87	122,735	178,719
Education Materials etc	44	530	772
Diabetes Medications	8,74	10,530	15,333
Other Medicines	23,06	27,783	40,456
Diabetes Equipment	5,19	6,253	9,105
Other Medical Equipment	1,02	1,229	1,789
Supplies & Equipment	51	614	895
Patient & Staff Meals	23,14	27,880	40,596
Gardens and Grounds	56	675	982
Firewood	3,16	3,807	5,544
Lamps and Kerosene	68	819	1,193
Bedding	37	446	649
Travel and Conveyance	905	10,904	15,877
Poor Patients	614	7,398	10,772
Surgical Transfers	16,95	20,422	29,737
Home Visits	1,51	1,819	2,649
Diabetes Meetings	0	0	0
Miscellaneous	83	1,000	1,456
MCH Village Health Programme (excluding salaries)	3,98	4,795	6,982
SUB TOTAL	**207,20**	**249,639**	**363,509**
Administration			
Salaries	**13,05**	15,723	22,895
Provident Fund	913	11,000	16,018
Stationery	140	1,687	2,456
Electricity	86	1,036	1,509
Phone and Emails	61	735	1,070
Furniture	18	217	316
Cycle Repairs	85	1,024	1,491
Building Repairs	37	446	649
Bank Fees	130	1,566	2,281
Audit Fees	66	795	1,158
Mati Central Office Service Charges	272	3,277	4,772
SUB TOTAL	**31,13**	**37,506**	**54,614**
Capital Expenditure			
New Cycles	0	0	
New Buildings	42	506	737
Electrical Installations	27	325	474
Land Purchase	0	0	
SUB TOTAL	**69**	**831**	**1,211**
Government Value-Added Tax (VAT)	482	5,807	8,456
TOTAL EXPENSES	**243,84**	**293,783**	**427,789**
CLOSING BALANCE (in Bangladesh)	**1,03**	12,470	18,158

Notes:

1. Expenditure Breakdown According to Programme

Programme	BDT ('000s)	USD	NZD	% of Total
Diabetes Programme	**70,72**	**85,205**	**124,070**	**29%**
Diabetes Inpatients	(21,95)	(26,446)	(38,509)	(9%)
General Patients	**75,59**	**91,072**	**132,614**	**31%**
General Inpatients	(48,77)	(58,759)	(85,561)	(20%)
General Outpatients	(26,83)	(32,325)	(47,070)	(11%)
Total Inpatients, General & Diabetes	(70,73)	(85,217)	(124,088)	(29%)
Administration	29,66	35,735	52,035	**12%**
MCH Village Programme	25,19	30,349	44,193	**10%**
Surgical Transfers & Poor Patient Referrals	23,22	27,976	40,737	**10%**
Other	6,02	7,253	10,561	**2%**
Health Education	4,81	5,795	8,439	**2%**
Capital Expenses incl. repairs	1,84	2,217	3,228	**1%**
TB	1,97	2,373	3,456	**1%**
Government VAT	4,82	5,807	8,456	**2%**
Total (excl. expenses in italics)	**243,84**	**293,783**	**427,789**	**100%**

(all costs include salaries where appropriate)

1. Exchange Rates at 30 November 2017 (mid-market rates from www.xe.com)

   USD 1 = 83 BDT (2016 =79 BDT) **Euro 1** = 99 BDT (2016 = 84 BDT)

   NZD 1 = 57 BDT (2016 = 56 BDT) **GBP 1** = 112 BDT (2016 = 99 BDT)

2. The total expenditure of BDT 243,84,000 (USD 293,783) has increased by 5% since 2016.

3. 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.

Japanese physiotherapist Ayako didi, from JOCS, provides regular training in rehabilitation to one of our paramedics, Shilpi. Ayako visits KHCP once a month to follow up on disabled patients, and Shilpi has been attending training in Mymensingh as well.

Shilpi will be attending a one-month residential training course in Savar in March 2018, with funding support from JOCS. She also has a child with disabilities, and understands the challenges faced by poor families in rural Bangladesh, who have few resources available to them. We are grateful to CRP who provide equipment and wheelchairs to many of our disabled patients.

7. Donor Supporter 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 has made it possible for us to continue working with the poor as they care for their own people.

2. **World Child Future Foundation** (Switzerland) for supporting our maternal and child health care activities from September 2013.
3. A very generous Japanese donor (**Dr Mariko Inui)** who supports our surgical transfer programme
4. The **Japanese Overseas Christian Medical Service** who sponsor paramedic training for staff
5. To New Zealand supporters and family of Nadine Vickers who carried through our English office and communications, especially **Invercargill Central Baptist Church** who financed her flights and visas.
6. **New Zealand donors** giving via the NZ Link Group, the NZ Anglican Mission Board and the NZCMS (including some giving very large private donations).
7. **Asia Connection Incorporated** (ACI) USA, who collect private donations on behalf of Kailakuri.
8. The **Quail Roost Foundation, (**QRF), USA, who continue to support us with an annual grant.
9. Members of the **NZ Link Group** who give extremely generously of their time and wisdom to support KHCP and visit the project from time-to-time.
10. **American donors** (including some giving very large private donations) giving via ACI, including generous support from Dr George Christian, a former colleague of Edric in Vietnam.
11. **Karl Klontz** for installing and maintaining solar set-up on the inpatient side of project
12. **Jason and Merindy Morgenson** and **Nicholas and Emily Tseffos** for enthusiastically fund-raising on our behalf in America.
13. **Howick Presbyterian Church**, Auckland, New Zealand
14. **Preston Russell Trust**, Invercargill, New Zealand, who contribute monthly financial support
15. Support from **Mukogawa Christ Church** and **Ashiyo San-Jo Church** in Japan
16. **Ms. Junko Yuasa**, a Japanese donor who visited the Kailakuri project in 2016.
17. **St. Stephen's Anglican Church**, Whangaparoa, New Zealand.
18. **St. Patrick's Catholic Church**, Lincoln, New Zealand.
19. The **Anglican Cathedral parish of Nelson**, New Zealand.
20. Homegroup at **St Martins church**, Spreydon, Christchurch
21. The **Rotary Club of Kapiti**
22. **Overseas Bangladeshis** in America, Japan, Hong Kong, Singapore, Australia and New Zealand.
23. **St Paul's Union Church**, Taupo, New Zealand.
24. **British and Italian private donors**.
25. Other **Churches in New Zealand**
26. **NZCMS, AAW, NZAMB, and CWS** for friendship, support and prayer back-up.
27. 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.
28. Many others (especially overseas Bangladeshis) who have given us great encouragement.
29. Everyone who has given via Pay Pal (through Kailakuri website link).

II. In-Country Support

1. The **Government of Bangladesh** gives authorisation and gives support through the Damien Foundation and local support at subdistrict level.
2. The IPDS NGO, our umbrella NGO, which has managed government authorisation and liaison and channeled our funding through their Bank account since November 2017
3. The **Mati NGO**, which acted as our partner NGO from September 2013 until August 2017.
4. **BIRDEM Hospital** (Diabetes Association of Bangladesh) which along with Novo Nordisk and Lilly Company provides low cost insulin to poor diabetes and free insulin for young diabetes.

Over the years **BIRDEM Hospital** has probably given more support to our work than any other group (their insulin subsidy equates to 13% of our annual running costs)

In-Country Support (continued)

5. **Damien Foundation** provides free investigations and medicines for TB patients and brings the KHCP TB programme into the National TB programme.
6. The **Bangladesh National Society for the Blind Dr K. Zaman Eye Hospital** in Mymensingh provides free or low cost surgery for cataract and care of other eye patients.
7. **Gonoshashtaya Kendra** for providing two-monthly rotating internee doctors since October 2014, as well as offering low-cost surgery and additional medical training for our paramedics
8. **GK Shondhani Club and Medicine Club f**or organisinga large number of blood donations
9. **Pacific Pharmaceuticals** gives a large donation of free drugs every month
10. **CRP,** which provides almost free care and surgery for our patients.
11. The **Sapporo Dental College and Hospital** in Dhaka for providing dental treatment camps
12. The **Taize brothers**, **Ayako** didid and **Naomi** didi from Mymensingh for their continued support
13. The **Dr Baker Blood Foundation**, founded by Arup Sorker, for donating blood for patients.
14. **Hemonto Henri Kubi** (Ministry of Public Administration) for advice and support
15. **Sharuar Hossain Khan Abu,** Madhupur Upazila Chairman, and **Rejaul Korim Benu,** Fulbagchala Union Chairman, for support and the buiding of diabetes inpatient accomodation.
16. Two women from the Mandi Christian community (**Mrs Kanchon Rozario** of Nalikhali and **Mrs Dirobala Nokrek o**f Mominpur) who made donations of land for diabetes sub centres.
17. **British Women's Association** have funded repairs to Dr Baker's house (used for meetings).
18. **Probash Bongo**, a Bangladeshi-Belgian group, who donated funds to fill up the huge hole beside the maternity building, so this space can be used more productively in the future.
19. **Notre Dame College** who provide accomodation to Dhaka patients almost free of charge.
20. The **Executive Committee** give generously of their time and wisdom for project management
21. **Dr. Samanta Lal Sen of the National Burns Unit** in Dhaka for giving us free patient care.
22. The **Apon Drug Rehabilitation Centre** in Dhaka which provides free care for our patients.
23. Prominent members of the business, 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. Shafiqul Islam (of the Statistics Ministry**) and **Md. Abdullah-Al-Mahmud (Mintu)** and **Md. Risal Mahmud** (Peal-Pipeline Engineers and Associates Ltd.).
24. **Donbari group** gave a generous donation towards the construction of an admin building
25. **Dr Zia** from Dhaka, **Opurbo Majumdar** (Singapore), **Md Jahid Islam**and **Shahid Khan** (a Bangladeshi living in Australia) have all given generously.
26. Other **Bangladeshi friends** who have given both monetary donations and wise advice.
27. **Md. Hanif Sonket** (of Ittadhy television programme), **The Daily Star** newspaper 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.
28. For all of those who have donated through the Matir 'piggy' banks distributed throughout Bangladesh (an those who have requested a bank for their shop, school, business etc).
29. **St Vincent Sick Centre** provides subsidised treatment to KHCP surgical transfer patients during surgical-medical camps twice each year, run by visiting Italian and Korean doctors.
30. The **Pirgacha Mission, The Holy Cross Fathers and Sisters, the Taize Brothers, Protibondi Community Centre, the Church of Bangladesh, the Xavarian Fathers** and the **Marist Sisters** give various kinds of help including important advice when needed.
31. **Caritas NGO**, Bangladesh, who provide follow-up midwifery training in Dhaka
32. **Blue Roses Foundation** who have donated medicine supplies
33. A number of Bangladesh **young people's voluntary service groups** who inspired by our TV publicity (thanks again Md. Hanif Sonket) have determined 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).
34. A number of **medical students** from various areas in Bangladesh who have visited Kailakuri, empathise with our model of health care for the poor, and wish to help in the future.
35. **Local religious leaders** who inspire us to work with the poor.
36. Representatives of **various TV channels, newspapers, magazines** and **Facebook groups** within and outside of Bangladesh who publicised Edric's work at Kailakuri and honoured his passing.

8. Financial Situation and Budget:

I. Income, Expenditure and Balances for 2017 (actual) and 2018 (projected):

	2017	2018
	USD	USD
Opening Balance	82,036	12,470
Income	224,217	251,000
Total	306,253	263,470
Expenditure	293,783	262,286
Balance	12,470	1,184
II. Income Breakdown (%):		
Opening Balance	27%	1%
Patient Fees	9%	9%
Other Local Income + Loan Received	2%	2%
Foreign Donations	62%	88%
III. Source of Foreign Donations:		
USA	11%	11%
NZ	69%	72%
Switzerland	12%	10%
Japan	8%	7%

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.

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 motivated local staff and committed leadership.

Kailakuri Health Care Project had 90 staff in January 2017 (NB: down to 85 staff by December 2017 with several retirements, one resignation and one staff member passing away). The leadership roles include Pijon Nongmin as Executive Director of 'Dr Baker's Organisation'/Project Director of KHCP, Sujit Rangsa as Acting Medical Coordinator, Roton Mia as Monitoring Officer, Harun Rashed as Finance Officer and Juli Simsung as Administrative Officer, as well as Heads of Departments for Outpatients, Inpatients, Diabetes, TB and Mother-Child-Health, who form part of the management team. New Zealand volunteer Nadine Vickers has fulfilled the English Communications/Funding role **(although we are looking for a replacement!)** and we expect Doctors Jason and Merindy Morgenson to take over the medical leadership.

I. The Health Action Team: 71 (77% of staff), headed by Acting Medical Coordinator Sujit Rangsa

i. Acting Medical Coordinator:	1
ii. Paramedics and Health Educators:	32
iii. Short term rotating Internee Doctors:	2
iv. Health Assistants:	10
v. Village Mother-Child Care Staff:	17
vi. Cooks:	7
vii. Patient Transfer staff	2

40% of the health action team work with general patients, 30% with diabetes, 24% in Village Mother-Child Care, 3% with TB and 3% with transfer of patients.

II. Support Staff: 21 (23% of staff)

ii. Project Director	1
iii. English Communications	1
iv. Administration and Office Staff:	6
v. Finance Staff:	3
vi. Garden, Compound, Market etc.:	10

III. Staff Gender and Religious Breakdown

Amongst the staff, 61% are male and 39% are female; Muslim 45%, Christian 40%, Hindu 15%. The project, of necessity, is labour intensive. Staff pay comprises 50% of all project costs.

IV. Staff Training:

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. Twelve senior paramedics have completed a six-month Local Medical Assistant and Family Planning (LMAF) training course 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 and diabetes training from BIRDEM Hospital (Diabetes Association of Bangladesh). Three paramedic staff are currently undergoing formal paramedic training, alongside their shifts at the project.

V. Health Education:

Health and nutrition education is essential and a priority in KHCP activities. It is probably the project's most cost effective intervention. The 4 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**. About 28,000 people received health education messages during 2017.

VI. Ongoing Medical Leadership/Supervision

As Edric has commented previously, 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. At this time it is managing well with its team of paramedics following the Standard Treatment Book and medical oversight provided by rotating doctors (interns) from GK and a registered doctor.

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.

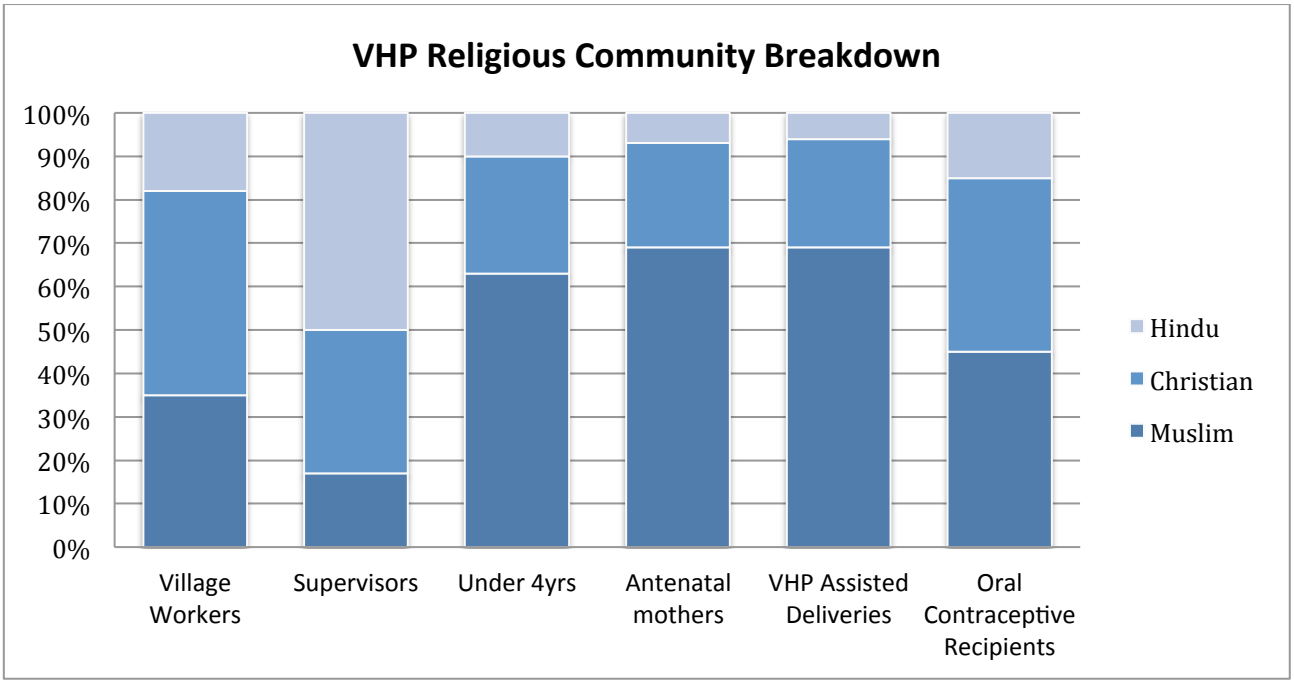
A group of visiting doctors and staff, accompanied by Dr Rakibur Islam Rakib (middle, in white shirt), a registered doctor who interned at KHCP, and continues to provide medical support to the project alongside post-grad studies.

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

Our village health staff visit the home of every pregnant mother and 0-4 year old child in our 22 village areas at least once a month. They offer health advice, promote immunisations and family planning, monitor weight gain amongst 0-4 years children and provide treatment for a number of common illnesses. In 2017 we appointed a supervisor of Bengali Muslim background, and a Christian village health worker was trained as a future supervisor. She will fulfill this new position soon. Two paramedics from the inpatient program were transferred to the VHP to replace three staff entering retirement, and a new HOD was appointed.

Kailakuri Statistics for 2017

Number of Villages: 22 (population about 18,442)
Staff: 17, Village Workers 11, Supervisors 6
Under 4yr old Child Care: 1,590 (10% more than 2016) at years' end. Weight chart survey at the end of the year showed nutrition problems in 4% (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: 490 mothers were given ANC (4% more than in 2016).
Delivery Care: 14% of ANC mothers had staff assisted deliveries, 101 deliveries (140% more than in 2016): 71 in their homes and 30 at the project health centre. Increase is due to a renewed emphasis by VHP staff.
Family Planning: Staff continue to motivate couples to use the government programme and 20 couples received oral contraceptives from the VHP.



The total cost of the VHP for 12 months was BDT 25,19,000 (USD 30,349) (NZD 44,193) (Euro 25,444) about BDT 1,150 (USD 14) (NZD 20) (Euro 12) per mother or child cared for.

Two of our VHP staff weighing a 0-4 year old child at the child's home in the village.

11.The Primary Health Care Diabetes Programme:

At KHCP all of the work is done by paramedics under medical supervision, while linking with BIRDEM (Diabetes) Hospital, which provides concession rate insulin, without which the KHCP programme would be unable to continue. Patients under the age of 26 are linked into the BIRDEM-Novo Nordisk "Changing Diabetes in Children" and "Life For a Child" programmes, which provide free insulin. The 116 young people involved follow the same KHCP methods as all the other KHCP diabetes patients monitoring their diabetes by Benedict urine test and adjusting their insulin doses accordingly, taught and supervised by paramedics and trainers the same as all other Kailakuri patients.

In 2017 one of the diabetes health assistants was kept on contract for six months beyond his retirement date and a garden worker has been given six months training so that he can step into this position.

Kailakuri Statistics for 2017
End of Year Patient Analysis
Total Number: 1,819 (1% increase from 2016)
Treatment: Insulin 877 (48%) Glibenclamide tablets 942 (52%),
Religio-Ethnic Breakdown: Muslim 1,754 (96%), Hindu 43 (2%) Christian 22 (2%)
Gender: Male 564 (31%), Female 1,255 (69%)
(Hindus and males are not coming in proportion to their expected numbers in the community)

Insulin Patients

Total number treated during 2017:		938 (4% increase from 2016)
Continuing from 2016		854
Started in 2017		+84
Transferred Out	-4	
Defaulted	-27 (3%)	-61
Died	-30 (3%)	
Continuing into 2018		877

End of Year Analysis	Insulin Patients	Tablet Patients
Total Number of Patients	877	942
Regular Attendance	98%	93%
Diabetes Control (Benedict):	Good 64% Fair 32%	Good 52% Fair 23%
Distance of Home from nearest Sub-Centre: [15miles = 24km, 10 miles = 16km, 5miles = 8km]	Within 15 miles 95%; 0-5miles 35%, 6-10miles 34%, 11-15 miles 26%	Within 15miles 82%, 0-5miles 25%, 6-10miles 29%, 11-15miles 28%
Functional Literacy: (able to write name & read or write a very simple letter).	71%	60%
Age:	Under 30yrs 16%, Under 21yrs 9%	Under 30yrs 1%, Under 21yrs 0%
Economic Status: [based on home visit assessment).	Very Poor 32%, Extremely Poor 67%	Very Poor 42%, Extremely Poor 57%
Religio-ethnic Status:	Muslim 96%, Christian 1%, Hindu 3%	Muslim 97%, Christian 1%, Hindu 2%
Gender breakdown:	Male 31%, Female 69%	Male 21%, Female 79%

Glibenclamide Tablet Patients

Total number treated in 2017:	1,105	(5% decrease from 2016)
Continuing from 2016	949	
Started in 2017	+156	
Changed to diet only	0	
Transferred	-18	
Defaulted	-105	-163
Died	-7	
Changed to Insulin	-33	
Continuing into 2018	942 (+1%)	

Diabetes Patients Admitted at Kailakuri

Total Number: 587 (28% increase from 2016)
Average Duration of Admission: 9 days
Religio-Ethnic Breakdown: Muslim 96%, Christian 2%, Hindu 2%
Gender: Male 29%, Female 71%
43% of the admitted patients were new to the project, admitted for diabetes teaching and for 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). Of these patients, 1 died from kidney failure, 2 from gangrene, 1 from heart failure, 1 from hypoglycemia, 1 from stroke and 1 from liver failure.

Top Ten Diabetes Inpatient Problems:

1. Wasting
2. Inadequate understanding of diabetes
3. Badly controlled diabetes (several with ketoacidosis)
4. Diabetic ulcers
5. Cataracts (including retinopathy)
6. Peptic ulcer
7. Other chronic complications of diabetes (neuropathy, nephropathy)
8. Hypertension
9. Pregnancy/delivery
10. Gynaecological problems

Followed by: ascaris, pneumonia, urinary tract infections, ketoacidosis, diabetes TB, diarrheal diseases, skin conditions, otitis media

New Insulin Patients sent for Concession Insulin Registration to BIRDEM Hospital, Dhaka

Number of patients sent: 84
Travel cost: BDT 3,69,325 (USD 835), (NZD 1,216)
Average cost per patient BDT 4,400 (USD 53), (NZD 77)

Cost of Diabetic Stock	BDT (000's taka)	USD	NZD
Insulin:	44,27	53,337	77,667
(Project Portion 17%)	(7,09)	8,542	12,439
(BIRDEM Portion 83%)	(37,18)	44,795	65,228
Glibenclamide Tablets	2,00	2,410	3,509
Diabetes Equipment	5,00	6,024	8,772
Total Cost	**51,27**	61,771	89,947
Cost to Project	14,09	16,976	24,719

Estimated Cost of the Diabetes Programme (to KHCP)	BDT (000's taka)	USD	NZD
Inpatient Care	14,09	16,976	24,719
Staff Salaries	21,96	26,458	38,526
Non-Diabetes Medicine etc.	22,26	26,819	39,053
Cost of sending Patients to Dhaka	7,41	8,928	13,000
Meetings	0	0	0
Other Travel & Home Visits	**51,27**	61,771	89,947
Cost to Project	1,45	1,747	2,544
Total	**70,72**	85,205	124,070

The cost to the project was **BDT 70,72,000** (USD 85,205) (NZD 124,070), about 29% of the KHCP expenditure for the year and about **BDT 3,890** (USD 47) (NZD 68) per patient. If the BIRDEM subsidy of **BDT 2,040** (USD 25) (NZD 36) is added it becomes **BDT 5,930** (USD 71) (NZD 104) per patient per year.

12.General Patient Care:

2017	Outpatients	Inpatients
Patient visits [2miles = 3.2km, 5 miles = 8km]	**23,826 (6% less than 2016)** Distance of Home: 0-2 miles 56% 3-5 miles 27% over 5 miles 17%	**1,731 admissions** (9% more than 2016) • 1,144 general patients (1% increase) • 587 diabetes patients (28% increase) **Average no of admitted patients**: 35 (22 general plus 13 diabetes) **Average duration of stay for general patients**: 8 days (9 days for diabetes patients) (overall average stay 9 days).
Religio-ethnic breakdown	Muslim 61%, Christian 26%, Hindu 13%	Muslim 73%, Christian 21%, Hindu (6%)
Gender	Male 33%, Female 67% Children under 5yrs 9%	Male (36%), Female (54%) Children under 5yrs (24%)
Top 10	**Outpatient Problems** (no of visits): 1. Peptic ulcer 2. Asthma 3. Hypertension 4. Gynecological problems 5. Epilepsy 6. Urinary tract infections 7. Abscesses, sores and ulcers 8. Pneumonia 9. Other skin diseases 10. Pregnancy	**General Inpatient Problems:** 1. Pregnancy/ delivery problems 2. Diarrheal diseases 3. Malnutrition/wasting 4. Peptic ulcer 5. Asthma/bronchitis 6. hypertension 7. Kidney problems 8. Pneumonia 9. Psychiatric problems 10. Abscesses, sores and ulcers
Followed by	kidney problems, psychiatric problems, arthritis/back pain, anaemia, otitis media, eye problems, worms, respiratory infections, bronchitis, other virus fevers, injuries and burns, nutrition problems	fractures, gynecological problems, arthritis, injuries burns and virus fever, urinary tract infection, anaemia, newborn babies and worms, poisoning patients, TB, epilepsy, jaundice
Cost of Running the Department	**Cost of Running the General Outpatient** (inc VHP) for 12 months was **BDT 2,683,000** *(*USD 32,325) (NZD 47,070), making cost per visit **BDT 113** (USD 1) (NZD 2) which includes salaries, medicines, stationery etc.	**Cost of Running the Inpatient Department** (general plus diabetes) for 12 months was **BDT 70,72,000** (USD 85,205) (NZD 124,070). With a total 17,31 patients and average stay of 9 days that is **BDT 455** (USD 5) (NZD 8) per patient per day.

III. Surgical Transfers and Poor Patient Referrals:
Surgical transfers comprise patients sent to other hospitals for surgery. 171 such patients were transferred, 10% less than in 2016. Poor patient referrals comprise patients sent to elsewhere for investigations or non-surgical treatment. The combined expenditure for the two groups was **BDT 2,322,000** (USD 27,976) (NZD 40,737), **1%** more than 2016.

13.The TB Programme:

This programme is 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 404 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).

I. Success Rate*:*
24 sputum positive patients started treatment between July 2016 and June 2017. Four were transferred to other centres (2 were 'default' patients) and all were cured of TB. One patient died. i.e. **96% cure rate**.

II. Kailakuri Statistics for 2017:

Total Number Treated		88 (16% decrease from 2016)
No. Continuing from 2016		19
Started in 2017	+69	(5% increase from 2016)
Completed	-35	
Transferred	-10	
Defaulted	-0	-49
Died	-0	
Treatment Failed	4	
Continuing into 2018	24	
(Preventative Treatment 19)		

III. Patient Analysis:

Category 1 (new sputum positives):	31	(35%)
Category 2 (retreatment):	7	(8%)
Category 3 (non-pulmonary)	31	(35%)
Preventative treatment	19	(22%)

100% followed treatment regularly.
Distance from home: 69% were from within five miles and 31% within two miles
48% were under 30 years of age
Religio-Ethnic Breakdown: Muslim 72%, Christian 17%, Hindu 11%
Gender: Male 60%, Female 40%
15 patients (17%) were hospitalized at Kailakuri
9% patients also had diabetes.

The **total cost** to KHCP of the TB Programme was **BDT 1,97,000** (USD 2,373) (NZD 3,456) which comes to **BDT 2,240** (USD 27) (NZD 39) per patient.

14.Conclusion and Appreciation

We hope you found these statistics and commentary informative, and gained a better perspective of how KHCP has fared in 2017. It has definitely been a challenging year, partly because of financial restraints and also due to other changes needed to adapt to the NGO environment. For the first time KHCP has introduced an official retirement policy, so we had to farewell three staff in 2017, with several more due to retire in 2018. It has been tough for staff to say goodbye to their colleagues, as well as having to fill gaps where we could not employ additional staff due to lack of funding. Staff have not received a pay-rise in the past 18 months, despite an increase in inflation and the cost of living in Bangladesh. They have also lost overtime payments. However, they remain dedicated to the cause of the Kailakuri project, to serve the sick and poor.

Installation of a water tank on the inpatient side has notably reduced the workload of garden staff, who were retrieving water from tube wells and carting it to the garden and toilets in buckets. Now there is a tap to wash dishes and a hose to water the extensive vegetable gardens. We hope to install another water tank on the outpatients' side in 2018 (if the budget allows), as this would create further efficiency gains.

Based on monthly statistics we seem to be achieving the new targets for outpatient, inpatient and diabetes patient visits introduced in October 2017 (slight reductions on 2016 levels), but it is still early days. There is an insatiable demand for inpatient services and surgical transfers, but we have to turn a number of patients away as we do not have the capability or funding to serve everyone. The paramedic staff find this quite troubling, as most patients are poor and the cost of treatment is so high elsewhere. However we continue to prioritise emergency cases, the extreme poor, and poor patients from within our working area. The new fee structure has been well received and we do reduce or waive fees for those who cannot afford them.

The paramedic roster is quite tight, and there's still a need for overtime to cover night shifts in the urgent care department, as well as covering staff on leave. Almost all other overtime has been eliminated. Management staff have expressed a desire to dedicate more time to health education for inpatients and diabetic patients in particular. This has proved difficult, as we only have 4 health educators and the number of patients at each of our five diabetes sub-centres is on the rise, which of course takes longer to process. It would require extra overtime for existing paramedics, or the appointment of more health educators.

We are focused on up-skilling our paramedics wherever possible. All staff attend weekly half-day training sessions and two paramedics were sent on a one-year paramedic training course in 2017. Another two staff will be given this opportunity in 2018. JOCS has generously provided sponsorships for other training, and organisations such as CARITAS offer follow-up courses to a number of paramedics each year. Our internee doctors and registered doctor work alongside the paramedics and regularly input at the training sessions.

In the midst of all these ups and downs, we remain thankful for the support of people around the globe and will do our utmost to be good stewards of these donations, so the poor may be blessed with good health.

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