Kailakuri Health Care Project

"Health For the Poor By the Poor" (in association with the Mati NGO)

2015 Annual Report

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1. Introduction:

The most significant event for Kailakuri this year was the passing of Dr Edric Baker on 1 September 2015, founder and Medical Officer-in-Charge of the Kailakuri Health Care Project for many years. Edric had just celebrated his 74th birthday, but he had been suffering from a terminal illness for almost two years.

Edric was first diagnosed on 2 September 2014, after having an echocardiogram at Mymensingh Medical College Hospital. This confirmed the high blood pressure in his lungs. The test results were discussed by a conference of four doctors (including Professor of Cardiology at Mymensingh Medical College Hospital, Dr M. Saiful Bari, and several of his colleagues), who charged no fee for their services. They diagnosed Edric's illness as 'idiopathic pulmonary artery hypertension'. At first Edric refused to receive treatment, as he was reluctant to leave the Kailakuri project for extended periods of time, and did not want to accept medical treatment not available to the poor in Bangladesh. Eventually, Edric accepted the advice of Dr Momenuzzaman, Cardiology Consultant of United Hospital in Dhaka, and began taking medication to control the blood pressure in his lungs. All of his medication and treatment costs were covered by United Hospital, the medicine company and a close Bangladeshi friend of Edric. But Edric was adamant he would not be admitted as an inpatient in Dhaka, or receive any expensive interventions.

Within several months of his diagnosis, Edric started to have sporadic breathing attacks and he was no longer able to cycle or walk for long distances. But despite handing over a number of responsibilities to local staff, his mind remained sharp and he found it difficult to completely retire from project work. Edric was still making phone calls and emails and delegating various pieces of work until the day he died. He also refused to accept a wheelchair, preferring instead to be 'doubled' around on the back of his bicycle.

Quite aside from this, Edric would not accept an honorarium for the last few months before his death. Because of his lung condition, Edric was unable to fly home to visit his family in New Zealand, but he received loving care and attention from the dedicated paramedics at Kailakuri. Two of his sisters, Hilda and Hilary, as well as Hilary's husband Nelson, and nieces Heather and Rebecca, were able to visit him in 2015.

Although Edric was unmarried, he dedicated over 32 years of his life to treating poor patients in the Thanarbaid and Kailakuri Health Care Projects, and thought of the project staff as his sons and daughters.

Thousands of attendees at Edric's funeral

Edric being carried to his final resting place

Edric passed away quite suddenly around 1.45pm on a Tuesday afternoon, after falling ill a couple of days earlier. By that evening he was laid out on a table in the Kailakuri outpatients' waiting room. All through the night people came to pay their respects, to sing songs or pray, or to stand there silently. At 10am the next morning he was laid in his coffin and carried to the Kailakuri church. As the service progressed hundreds waited outside and then followed the casket back to his house. He was buried, as per his wishes, under the back verandah to his mud house. Edric was adamant that his grave not be decorated with any cement or brick structure, but rather with a flower garden and a clear space where people could gather to pray.

Edric's funeral service attracted thousands of well-wishers from all over Bangladesh. This included Dr Zafrullah Chowdhury and other colleagues from Gonoshashtaya Kendra (who have supplied us with two-monthly rotating internee doctors since October 2014), as well as Tangail's Deputy Commissioner (DC), Madhupur's Upozila Nirbohi Officer (UNO), Dr Shofikul Zaman (Porak) from Dr Z. Zaman BNSB in Mymensingh, A.MM. Farhad - Deputy Managing Director of Social Islami Bank, Upozila Chairman - Madhupur, Officer-in-Charge (OC)- Madhupur Thana, Shulakuri Chairman, the Taize Brothers from Mymensingh and thousands of local people who have received treatment from the Kailakuri project in the past. The Bangladesh government recognised Edric with a special salute, given by the DC, UNO and OC.

Edric's funeral service on 2 Sep 2015

Edric's grave, decorated for Christmas

Edric died leaving behind his mother, Betty Baker, aged 100, sisters Hilda and Hilary, brothers Les, John and Bruce and a number of relatives. His nephew Stuart (and wife Fiona) arrived at Kailakuri shortly after he passed away, in late September. A memorial service was also held in Whakatane, New Zealand. The church was beautifully decorated with flowers and a large framed picture of Edric, and speeches were given by his relatives, Steve Maina of the Anglican Church Missionary Society, Ataur Rahman (Honorary Consul for Bangladeshis living in New Zealand), Glenn Baker (treasurer of the KHCP-NZ Link Group) and many others.

Edric had a number of close friends in Bangladesh, as well as Vietnam, USA, New Zealand, Switzerland and other countries around the world. Some of these friendships, such as Dr George Christian, John Havican, Peter Wilson, Kerry Heubeck and Rita Lampart-Kimmel, were developed during the heady years of the Vietnam War and endured decades apart. But these are stories for another time. We hope to publish a biography about Dr Edric Baker's life in 2016 (with input from an experienced researcher and writer), to share about his philosophy and life's work with a larger audience.

Although Kailakuri was a little-known project in 1996, in a remote village of northern Bangladesh, by 2015 this model of 'health care for the poor by the poor' had received nation-wide recognition through various newspaper articles including the national Daily Star (English) and Protom Alo (Bangla) newspapers, as well as the Ittaydi TV programme and various national TV stations. Edric received Bangladeshi citizenship in August 2014 as a recognition of his immense services to Bangladesh, since he first arrived here in 1979.

Edric was also appreciated in his home country, New Zealand, having been awarded the "Officer of the New Zealand Order of Merit" in 1999. Through the advocacy of the Rotary Club of Kapiti, he was also granted the Paul Harris Award, the Rotary organisation's highest honour. Edric has been interviewed by TVOne's 'Close Up" programme (who sent a reporter to Kailakuri) as well as Shine TV's Nzone, and he was the subject of a NZ Listener article by philanthropist Gareth Morgan in 2012, who said that 'Baker is my hero. If I were religious, I would describe him as a 'modern-day saint'.

Before Edric passed away, he had the opportunity to think very carefully about the appropriate leadership structure for Kailakuri, and he appointed senior paramedic Sujit Rangsa as Acting Medical Coordinator until such time as American Drs Jason and Merindy Morgenson are ready to take over leadership of the project. Sujit is part of a three-person team, including Pijon Nongmin as Assistant Director, Management, and Roton

Mia as Assistant Director, Programmes. Edric also prepared the various Heads of Department (Inpatients, Outpatients, TB, Diabetes and the Village Health Programme) to take on greater responsibilities.
'Sister Doctor' Jenny Clarke, of the SMSM Sisters, accepted a voluntary position as Project Advisor to Kailakuri shortly after Edric's death. She had become a close friend to Edric during the 1980s and 90s, after he first visited her in Tuital, and she made repeat visits to Thanarbaid and later Kailakuri, acting as a sounding board for Edric amongst various project dilemmas. Sr Dr Jenny now lives in Dhaka, but travels to Kailakuri for a few days each month, as well as maintaining regular phone and email contact.

Kailakuri is operating well, with similar patient numbers and primary health care treatment given by a team of 50 local paramedics, as well as advice from Sr Dr Jenny and medical supervision by the two doctors from Gonoshashtaya Kendra. We look forward to the arrival of Drs Jason and Merindy Morgenson in 2016, who are committed to long-term medical service at Kailakuri, and are supported through Interserve USA. We have been actively searching for volunteer doctors and nurses to provide support in short-term roles, and of course experienced doctors within Bangladesh who may be interested in assisting us.

This has been a tough year for Kailakuri financially, with a low New Zealand – Bangladeshi exchange rate, and the question of whether major donors will continue to provide support in Edric's absence. We are immensely grateful for all of the emails, phone calls and practical support received in the months following Edric's death (from within Bangladesh and around the world). With your assistance, and the dedicated contributions of Kailakuri staff and volunteers, we are committed to providing low-cost, effective primary health care treatment and surgical transfers to thousands of local poor people in the years to come.

Edric Sargisson Baker

1. **Personal**:
   Born in Wellington, New Zealand, 12 August 1941
   Citizenship: New Zealand
   Acquired Bangladeshi Citizenship on 5th August 2014

2. **Education**:
   Primary and High School, Wellington, New Zealand
   Medical College, University of Otago, New Zealand: 1960-1965
   Passed MBBS, Otago Medical College, New Zealand: 1965

3. **Post-Graduate Qualifications**:
   i. Diploma in Tropical Medicine and Hygiene, University of Sydney, Australia: 1970
   ii. Diploma in Obstetrics, University of Auckland, New Zealand: 1971
   iii. Diploma in Tropical Paediatrics, University of Liverpool, United Kingdom: 1977

4. **Work Experience Prior to Bangladesh**:

1966-1968	: Rotating Internship, Wellington Hospital, New Zealand
1969	: Third Surgeon, New Zealand Surgical Team, South Vietnam
1970	: Obstetric Internship, National Women's Hospital, Auckland, New Zealand
1971	: Medical Registrar, Christchurch Hospital, New Zealand
1972-75	: Medical Officer, Min Qay Hospital, Kontum, South Vietnam
1976	: Paediatric Registrar, Goroka Base Hospital, Papua-New Guinea
1978	: Medical Officer, Katete Hospital, Zambia
1979	: Paediatric Medical Officer, Monze Hospital, Zambia

5. **Work Experience in Bangladesh**:

1979-80	: Medical Officer, Bollobpur Mission Hospital, Meherpur
1981	: Paediatric Medical Officer, Kumudini Hospital, Mirzapur
1983-2004	: Medical Officer in Charge, Thanarbaid Clinic (Church of Bangladesh), Madhupur Thana, Tangail
2004-2015	: Medical Officer in Charge, Kailakuri Health Care Project, Madhupur Thana, Tangail District

2. Statistics at a Glance

		2015	% Increase	2014
1.	**The Village Mother-Child Health Programme (VHP):**			
	Number of Villages	20	5%	19
	Population	18,442	4%	17,679
	End of Year Under 4 Year Old Care	1,308	5%	1,245
	Number of Women Given Antenatal Care	495	-1%	500
	Number of Staff Assisted Deliveries	178	22%	146
	(including women coming from outside the programme for assisted deliveries & CS referrals)			
2.	**No. of Persons Receiving Health Education:**	**27,000**	**0%**	**27,000**
3.	**Outpatient Visits:**			
	General	24,190	-1%	24,480
	VHP	280	-49%	547
	TB	1,936	-3%	1,987
	Diabetes	20,808	3%	20,172
	Total	**47,214**	**0%**	**47,239**
4.	**Inpatient Admissions:**			
	General	1,049	-10%	1,170
	Diabetes	475	-13%	547
	Total	**1,520**	**-10%**	**1,683**
5.	**End of Year Diabetes Patient Numbers:**	**1,724**	**2%**	**1,681**
6.	**No. of TB Patients Treated:**	**93**	**19%**	**78**
7.	**No. of Surgical Transfer Patients:**	**122**	**-12%**	**139**
8.	**Total No. of Staff:**	**93**	**-**	**93**
	(equivalent number of full-time staff =)	(129)		(129)
9.	**Total Expenditure:**			
	BDT	23,820,000	4%	22,861,000
	USD	$305,385	3%	$296,900
	NZD	$467,059	23%	$381,000
	Euro	290,488	23%	235,680
	GBP	203,590	9%	187,385

(Exchange Rate details – see next page)

Notes:

1. We included a new village, Gunarbaid, in the Village Health Programme during 2015
2. We had increased deliveries in the village areas since 2014 (+22) and at Kailakuri (+11). This has come about from closer relationships with village birth attendants (trained by various organisations), and they often call our village health workers before carrying out deliveries.
3. Within the national TB programme, people are becoming more aware of the symptoms of extra-pulmonary TB (outside of the lungs), and this is reflected locally with more patients seeking treament from KHCP. In 2015, 37% of our TB patients suffered from extra-pulmonary TB.
4. One of the reasons for fewer surgical transfer patients in 2015 was St Vincent's inability to hold annual three-month surgical camps, because of the unstable political situation in Bangladesh.
5. Despite a modest 4% increase in annual running costs, the total expenditure in NZD rose 23% in 2015, because of the low New Zealand-Bangladeshi exchange rate. This is problematic because the majority of Kailakuri donations came from New Zealand in 2015.

3. Low Cost Health Care at a Glance:

	BDT	USD	NZD	Euros
1.	Annual antenatal care in the home for one mother/ health nutrition care in the home for one child			
	1,040	13.3	20.4	12.7
2.	Six months multidrug treatment course for one TB patient (cost to KHCP)			
	1,900	24	37	23
3.	One general outpatient visit (including salary and medications)			
	120	1.5	2.4	1.5
4.	Cost of keeping one inpatient admitted for one day (incl. medication, food for patient & attendant)			
	380	4.9	7.5	4.6
5.	Cost of supervision and treatment of one diabetes patient for one year (cost to KHCP)			
	4,100	53	80	50
6.	Staff pay for 93 staff for one year (including doctor)			
	11,318,000	145,103	221,922	138,024
7.	Average pay, one staff member for one month (including overtime)			
	9,700	124	190	118
8.	Average pay, one functional full time staff member (129 functional full time staff – see note 1)			
	7,000	90	137	85
9.	Total project expenditure for one year			
	23,820,000	305,385	467,059	290,488
10.	Approximate cost per person touched (appr 27,000)			
	880	11	17	11
11.	Fixed expenditure (total salary bill) per person touched			
	420	5.4	8.2	5.1

2015 Exchange rates: USD 1 = BDT 78 (2014 - 77), **NZD 1 = BDT 51** (60) **Euro 1 = BDT 82** (97)

Notes:

1. Many of the 93 staff work overtime so that the functional fulltime staff number is 129. The annual individual salary increment was 19%, which produced a 9% increase in the overall salary bill.
2. 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. At this point, it is difficult to raise staff salaries because of Kailakuri's financial situation. But Edric has created a separate fund (the Staff Benefit Fund) to offer interest-free loans to staff, as a way of addressing problems of over-indebtedness (to microcredit organisations and moneylenders).

A staff skit on preeclampsia, with Suronjon (male) as the pregnant mother, and a doll as the newborn baby.

Edric and Roton supervising building work at Kailakuri

4. Preparation for the Future

KHCP's next challenge will be supporting Drs Jason and Merindy Morgenson (along with their family), as they adjust to life in Kailakuri, learn Bengali, and gradually take over medical leadership of the project. Kailakuri would also benefit from the services of an English Communications and Fundraising volunteer who is able to commit at least three to six months to the project, but preferably for two to three years.

i. Medical Supervision and Leadership:

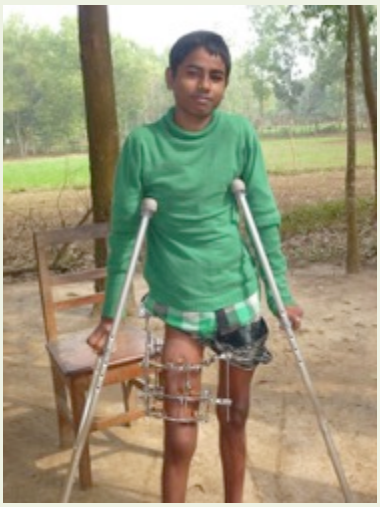
Kailakuri really appreciates the committed input of internee doctors from Gonoshashtaya Kendra, who despite coming from rich families, have adjusted well to Kailakuri, and are serving the poor. They have all accepted the Kailakuri philosophy and worked smoothly alongside the paramedic team. It is evident during each internee's farewell service that they have felt very deeply for Kailakuri and find it hard to say goodbye. Drs Jason and Merindy have welcomed another daughter, Isabella, in early February 2015. They are continuing to fundraise for their Bangladeshi expenses, and plan to arrive in Bangladeshi later in 2016. The paramedics at Kailakuri have really stepped up their responsibilities, especially those in various leadership positions. But we are still in a transition phase as we await the input of permanent resident doctors.

ii. Strengthening the Paramedics:

The project's Standard Treatment Book has been updated and copies were provided to all paramedic staff. Weekly staff training is carried out separately for the paramedic team, village health workers and general staff. Eleven staff have completed a six-month non-official training programme in Mymensingh (LMAF).

iii. Communications and Support:

We have continued to produce regular English and Bangla newsletters, with input from volunteers such as William Munford and Nadine Vickers from New Zealand. We welcome the services of a fluent English speaker committed to spending at least several months at Kailakuri, and willing to learn the Bangla language. In terms of Bangladesh in-country funding, Kailakuri has maintained its piggy-bank programme as well as seeking one-off grants from a number of local businesses and charitable organisations.



Patient Story: Khoka, aged 12

Three years ago, Khoka was studying in Class 4. But he fell down and broke his right femur when climbing a coconut tree.

Khoka's family could not afford medical treatment at the time, but took him to a private clinic in Jamalpur three months later. Khoka had an operation, and a steel rod was inserted in his leg. After three months the doctors gave him permission to do a little exercise. So he went out walking one day during the rainy season, with his crutches. But Khoka fell over and broke his leg again. This time he stayed at home for two years, in great difficulty. One day his aunty was admitted to Kailakuri, and he came to Kailakuri to see her. When Edric met him he insisted that Khoka be admitted as an inpatient. By this time he had developed a bone infection. While at Kailakuri, Khoka mentioned that his mother also had a broken leg.

She was also admitted to Kailakuri, and both patients were sent to Gonoshashtaya Kendra for surgery. But Khoka's mum died from her injuries before she could have an operation. Gonoshashtaya Kendra paid for Khoka's operation and all of his treatment costs. Then he spent seven months as an inpatient at Gonoshashtaya. Khoka's father has taken a second wife and does not provide for Khoka, but his grandfather takes care of him now. They are both very happy with Khoka's progress.

Having returned to Kailakuri a few weeks ago, Khoka will make another visit to Gonoshashtaya soon, to have the metal brace removed. He asks that we pray for him and wish the best for his future. Khoka comes from Donbari village, about 20 km from Kailakuri. He is looking forward to returning home, playing with all of his friends again, and enrolling in Class 5 at school.

iv. Project Structures:

This revised Diabetes Constitution is being presented to the Diabetes Patient Groups at the four subcentres during Kailakuri's bi-annual diabetes meetings (which would have been held in October 2015, but were delayed following Edric's death). Instead, they will be completed in February 2016. A memorandum of understanding with Mati NGO (the project's umbrella NGO) was signed in 2014, and the parties continue to abide by this.

v. Empowerment of the Committees:

The Diabetes and Project Committees continue to contribute to major decision-making within the project, and work closely with the Acting Medical Coordinator and Kailakuri management staff.

"Dr Bhai dedicated his life to serving the poor and neglected. Kailakuri is the best model for poor patients, who are treated with love, care and affection. The staff are committed and hard-working, and they have taken Dr Bhai's philosophy completely to heart. I pray that Kailakuri will continue forever and Dr Bhai will live on in our memories."

Dr Rakib (former internee at Kailakuri)
Gonoshashtaya Kendra Medical College and Hospital

Left: Dr Edric Baker with Dr Mariko Inui

Right: Dr Edric Baker with Md Roton Mia

5. Community Coverage and Benefit:

In the face of the nation's enormous population and its needs KHCP makes a small contribution but for the poor of the area, it is often the only possible health care. So for the target group of poor people, the community coverage is very high. Nonetheless we recognize that constant attention to community relevance, cost efficiency, management and medical supervision, extension of community coverage and advocacy for the poor will remain essential. Surveys show that 20% of people in this area are classified as extremely poor (not always able to eat) and a further 20% as poor (eat most days but not in a crisis).

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

General Outpatients 67%	General Inpatients 60%
Tablet Diabetes Patients 67%	Insulin Patients 56%
TB 45%	Under 4s 48%

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 (38%), probably due to their exclusion from public transport and crowded situations. But we receive many female patients with gland TB.

Religious community breakdown:

	Muslim (%)	Christian (%)	Hindu (%)
Under 4 years childcare	62	29	9
Antenatal care	67	22	11
General outpatients	86	10	4
General inpatients	66	25	9
Diabetes patients	97	2	1
TB patients	59	38	3
Staff:	45	40	15

The majority community is Bengali Muslim. In mixed religio-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 far 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-child care** in its 20 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 population growth rate of only 1.2%, the latter is highly effective) (World Bank database, 2016).

The Kailakuri **TB Programme** is responsible for the Shulakuri Union, and receives patients from parts of the surrounding Unions (i.e. when they come in for diabetes treatment). It is very effective and coverage is very good. It is difficult to assess the community coverage of general outpatient and inpatient care.

The **General Outpatients** service lacks the capacity (staff, management and supervision) 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.

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 population in 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. (Upgrade and expansion of other KHCP activities is a higher priority than increasing the coverage of Type Two diabetics.)

Chechua Diabetes Meeting

This meeting was held in mid-Jan 2016 (postponed from original date of Oct 2015), and we had a record voter turnout, 293 out of 322 registered voters from Diabetes Patient Body (who attend Chechua sub-centre for follow-up treatment). All were interested to hear about the project's future, especially how it is faring in Edric's absence.

The Kailakuri Health Care Project is especially vital for diabetes patients, as diabetes is a life-long condition. Without subsidised treatment from Kailakuri and free or subsidised insulin from BIRDEM Diabetes Hospital, these poor families would have really struggled to manage their conditions, leading to complications like foot ulcers, cataracts, kidney problems, wasting and often death.

6. Annual Accounts for 2015:

(1st December 2014 to 30th November 2015)

INCOME	BDT ('000s)	USD	NZD
Opening Balance	28,74	36,846	56,353
Income/Receipts			
Foreign Donations	23,247	298,038	455,824
Patient Fees	1,532	19,641	30,039
Staff Meals	123	1,577	2,412
Local Donations	770	9,872	15,098
Miscellaneous	43	551	843
Total Income/Receipts	**25,715**	**329,679**	**504,216**
Total Opening Balance & Income/Receipts	**28,589**	**366,525**	**560,569**
EXPENDITURE			
Programmes (General, Diabetes ,TB, MCH-VHP, Health Education)			
Salaries	9,878	126,641	193,686
Education Materials etc	44	564	863
Diabetes Medications	878	11,256	17,216
Other Medicines	2,150	27,564	42,157
Diabetes Equipment	466	5,974	9,137
Other Medical Equipment	111	1,423	2,176
Supplies & Equipment	75	962	1,471
Patient & Staff Meals	2,557	32,782	50,137
Gardens and Grounds	76	974	1,490
Firewood	531	6,808	10,412
Lamps and Kerosene	80	1,026	1,569
Bedding	49	628	961
Travel and Conveyance	851	10,910	16,686
Poor Patients	674	8,641	13,216
Surgical Transfers	1,542	19,769	30,235
Home Visits	84	1,077	1,647
Diabetes Meetings	1	13	20
Miscellaneous	38	487	745
MCH Village Health Programme (excluding salaries)	259	3,321	5,078
SUB TOTAL	**20,344**	**260,821**	**398,902**
Administration			
Salaries	1,440	18,462	28,235
Provident Fund	666	8,538	13,059
Stationery	168	2,154	3,294
Electricity	114	1,462	2,235
Phone and Emails	70	897	1,373
Furniture	107	1,372	2,098
Cycle Repairs	85	1,090	1,667
Building Repairs	191	2,449	3,745
Bank Fees	20	256	392
Audit Fees	56	718	1,098
Mati Central Office Service Charges	142	1,821	2,784
SUB TOTAL	3,059	39,218	59,980
Capital Expenditure			
New Cycles	**0**	**0**	**0**
New Buildings	14	179	275
Electrical Installations	55	705	1,078
Land Purchase	0	0	0
Total	69	885	1,353
Government Value-Added Tax (VAT)	348	4,462	6,824
TOTAL EXPENSES	**23,820**	**305,385**	**467,059**
CLOSING BALANCE	**4,769**	**61,140**	**93,510**

Notes:

1. Expenditure Breakdown According to Programme

	BDT ('000s)	USD	NZD	% of Total
Diabetes Programme	7,083	908,808	138,882	30
Diabetes Inpatients	*(2,172)*	*(27,846)*	*(42,588)*	*(9)*
General Patients	7,593	97,346	148,882	*32*
General Inpatients	*(4,764)*	*(61,077)*	*(93,412)*	*(20)*
General Outpatients	*(2,829)*	*(36,269)*	*(55,471)*	*(12)*
Total Inpatients, General & Diabetes	*(6,936)*	*(88923)*	*(136,000)*	*(29)*
Administration	2,206	28,282	43,255	9
MCH Village Programme	2,210	28,333	43,333	9
Surgical Transfers & Poor Patient Referrals	2,216	28,410	43,451	9
Other	1,205	15,449	23,627	5
Health Education	439	5,628	8,608	2
Capital Expenses incl. repairs	345	4,423	6,765	1
TB	175	2,244	3,431	1
Government VAT	348	4,462	6,824	2
Total (excl. expenses in italics)	**23,820**	**305,385**	**467,059**	**100**

(all costs include salaries where appropriate)

2. Exchange Rates at 30 November 2015 (mid-market rates from www.xe.com)
   USD 1 = 78 BDT (2014 = 77 BDT) Euro 1 = 82 BDT (2014 = 97 BDT)
   NZD 1 = 51 BDT (2014 = 60 BDT) GBP 1 = 117 BDT (2014 = 122 BDT)
3. The total expenditure of BDT 23,820,000 (USD 305,385) is an increase of 4% on 2014.
4. The Morgan Foundation donation of NZD 100,000 (BDT 5,100,000) is included within the listed donations totalling NZD 504,216 (BDT 25,715,000).
5. The **Swiss WCFF** gave its three year donation to the VHP in one sum at the outset so its gift is not included in the 2015 Annual Accounts breakdown (of foreign donations received in Bangladesh).
6. The large amount of money having to be paid 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. The **Closing Balance** including the funding of the MHC village health programme is BDT 4,769,000 (USD 61,140, NZD 93,510 , Euro 58,159). Two years have been completed, and funds for the third WCFF year are included in the Closing Balance. The Closing Balance for other programmes is the total minus the remaining amount committed to the MHC VHP i.e. BDT 4,769,000 -3,155,964 = 1,613,036 (USD 20,680, NZD 31,628, Euro 19,671). This is the effective balance for utilisation in the present year.
8. This **account** is so far unaudited and **unofficial**. Differences from the official audited account are due to: different time frame, inclusion of rotating fund and lack of official data from the banks.

Sujit, Onen, Bijoy, Leo, Pijon, Roton, Hakim & Edric

Some of Kailakuri team with Risal and Ataur Rahman

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 makes 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 Mother-Child Village Health Programme from September 2013.
3. The Japanese Overseas Christian Medical Service for funding Dr Mariko Inui (yet again!) when she made a special return visit to Kailakuri from May - August 2015, and assisted the project during the difficult time of Edric's illness. Dr Mariko Inui is appreciated by the poor and all who work with her.
4. To New Zealand supporters and family of William Munford and Nadine Vickers who carried through our English office and communications.
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, who also collect private donations on behalf of Kailakuri.
7. The Quail Roost Foundation (QRF), USA, who continue to support us with an annual grant.
8. The members of the NZ Link Group who give extremely generously of their time and wisdom to support the KHCP, and committed supporters who have set up regional support groups around New Zealand.
9. 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.
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, who have offered continued support and encouragement to Kailakuri since Edric passed away.
13. A very generous Japanese private donor, as well as Mukogawa Christ Church and Ashiyo San-Jo Church in Japan.
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. Homegroup at St Martins church, Spreydon, Christchurch.
18. The Rotary Club of Kapiti.
19. Overseas Bangladeshis in America, Japan, Hong Kong, Australia and New Zealand.
20. St Paul's Union Church, Taupo, New Zealand.
21. British and Italian private donors.
22. Other Churches in New Zealand.
23. NZCMS, AAW, NZAMB, and CWS for friendship, support and prayer back-up. A special thank you to Steve Maina, CMS, who gave a heartfelt speech at Edric's memorial service in Whakatane.
24. 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.
25. Many others (especially personal friends and family and overseas Bangladeshis) who have given us great encouragement.
26. 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 Mati NGO, our umbrella NGO, which manages government authorisation and liaison and channels our funding through their bank account.

3. 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)

4. Damien Foundation provides free investigations and medicines for TB patients and brings the KHCP TB programme into the National TB programme.
5. 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.
6. 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.
7. Pacific Pharma Pharmaceuticals gives a large donation of free drugs every month.
8. The Apon Drug Rehabilitation Centre in Dhaka which provides free care for our patients.
9. The Centre for the Rehabilitation for the Paralysed which provides almost free care and surgery for our patients.
10. Dr. Sen of the National Burns Unit in Dhaka for giving us free patient care.
11. The Sapporo Dental College and Hospital in Dhaka for providing almost free dental treatment camps at Kailakuri.
12. 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.
13. The Social Islami Bank of Bangladesh has made donations for buildings and furnishings.
14. British Women's Association and the Dhaka American Women's Club have given donations for buildings and furnishings.
15. A high government official in Dhaka has given a large private donation.
16. 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.
17. The project's committee members give generously of their time and wisdom for the management of the project.
18. 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.).
19. Opurbo Majumdar (Singapore), Md Jahid Islam who have given regular monthly donations, and Shahid Khan (a Bangladeshi living in Australia, who also gave generously).
20. Other Bangladeshi friends who have given both monetary donations and wise advice.
21. 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.
22. For all of those who have donated through the Matir 'piggy' banks distributed throughout Bangladesh (and those who have requested a bank for their shop, school, business etc).
23. 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.
24. 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.
25. Caritas NGO, Bangladesh, who provide follow-up midwifery training in Dhaka.
26. 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).
27. 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.
28. Local religious leaders who inspire us to work with the poor.
29. 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 2014-15 and 2015-16 (projected):

	2014-15	2015-16
	USD	USD
Opening Balance	36,850	61,144
Income	329,679	265,000
Total	366,529	326,144
Expenditure	305,385	340,000
Balance	61,144	-13,856
II. Income Breakdown (%):		
Opening Balance	12%	20%
Patient Fees	6%	5%
Other Local Income	4%	3%
Foreign Donations	78%	72%
III. Source of Foreign Donations:		
USA	2%	20%
NZ	88%	67%
Switzerland	10%	13%

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) Projected income for 2015-16 is somewhat lower than 2014-15 because of the low New Zealand exchange rate (which translates into less USD) and the loss of one of our donors.
(5) Calculations for 'Source of Foreign Donations', 2014-15, from Switzerland are based on WCFF's 2013 donation to Mother-Child Village Health Programme, made for the 2013-2016 financial years.
(6) The reason for the projected increase in USA donations in 2015-16 is not because of an increase in US donors, but is simply due to the timing of donations brought into 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.

Until September 2015, Kailakuri Health Care Project had 93 staff, 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, and Mother-Child-Health).

Following Edric's death, Mr Sujit Rangsa stepped up to become the Acting Medical Coordinator. The English Communications/Funding role was fulfilled by Edric for several months (with assistance from local staff), until New Zealand volunteer William Munford arrived in mid-August. Nadine Vickers has taken on this role again since William's departure in December 2015. We expect Doctors Jason and Merindy Morgenson to arrive later in 2016 and take over leadership of the project, paving the way for ongoing sustainability.

I. The Health Action Team: 74 (78% of staff), headed by Acting Medical Coordinator Sujit Rangsa until the arrival of the two new senior doctors later in 2016.

i. Acting Medical Coordinator	1	(1% of staff)
ii. Paramedics and Health Educators:	34	(36% 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. Patient Transfer staff	2	(2% of staff)

39% of the health action team work with general patients, 31% with diabetes, 24% in Village Mother-Child Care, 3% with TB and 3% with transfer of patients.

II. <u>Support Staff</u>: 21 (22% of staff)

ii. Assistant Director, Management	1	(1% of staff)
iii. English Communications	1	(1% of staff)
iv. Administration and Office Staff:	6	(6% of staff)
v. Finance Staff:	3	(3% of staff)
vi. 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. Staff pay comprises 48% 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. Eleven 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.

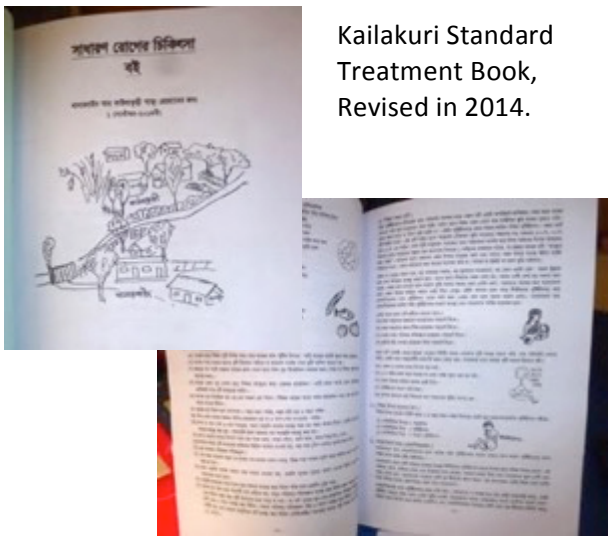
V. <u>Health Education</u>:

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**. About 27,000 people received health education messages during 2015.

VI. <u>Ongoing Medical Leadership/Supervision</u>

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 50 paramedics following the Standard Treatment Book and medical oversight provided by rotating doctors from Gonoshashtaya Kendra.

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.



Kailakuri Standard Treatment Book, Revised in 2014.

The Kailakuri Standard Treatment Book was updated in 2014. It became one of Edric's top priorities as he knew he had limited time and he wanted to prepare the project to operate in his absence. Copies of the book have been provided to all paramedics at Kailakuri, and also to the internee doctors who come from Gonoshashtaya Kendra.

This book is a reference manual for staff, assisting in diagnosis and treatment of a number of illnesses or injuries common to the local area. It is also used as the basis for weekly paramedic staff training, carried out by the senior paramedics at Kailakuri.

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

The Village Health staff at Kailakuri all agree that health-wise, mothers and children, the elderly and the marginalised are the main casualties of poverty. Despite becoming a lower middle-income country, the situation of the extreme poor has not improved much in Bangladesh. Food prices continue to rise, and the poor often miss out on nutritious food such as lentils, eggs, fish, meat and milk, instead subsisting on a diet of rice and few vegetables. Although Kailakuri village health staff encourage mothers to feed their under 4-children six times a day, these families are often on very low-incomes, and they cannot always provide this.

Staff provide advice and treatment for a number of common illnesses, such as measles, chicken pox and scabies, viruses, diarrhea, burns, abscess infections or bacterial infections. They encourage families to get timely vaccinations against various diseases, through the government-provided immunisation programme.

We have been working in the new village area of Gunarbaid for several months, and our staff have already noticed changes in how the local women relate to them. At first they did not accept the staffs' presence easily, and often asked for medication rather than health education. But slowly they are developing deeper relationships with Kailakuri staff, and opening up with their own questions. They were not familiar with children's weight charts, or aware of how to make saline at home (instead of buying packets). Gunarbaid women are also more confident to take their children to Kailakuri for diarrhea treatment when needed.

Village worker Bruno shared the story of a local girl, of low intelligence, who was married at 15 years of age. Her parents are uneducated and very poor. The girl is now five months pregnant, but quite malnourished. Bruno will encourage her to give birth at the Kailakuri project, as it is a high risk delivery.

The Swiss World Child Future Foundation funds the KHCP mother-child village programme.

Kailakuri Statistics for 2015

Number of Villages: 20 (population about 18,442)
Staff: 18, Village Workers 12, Supervisors 6
Under 4yr old Child Care: 1,308 (5% more than 2014) 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: 495 mothers were given ANC (1% less than in 2014).
Delivery Care: 12% of ANC mothers had staff assisted deliveries, 51 deliveries (70% more than in 2014), 44 in their homes and 7 at the project health centre.
Family Planning: Staff continue to motivate couples to use the government programme and 26 couples received oral contraceptives from the VHP.
Religio-Ethnic Breakdown:

	Bengali Muslim	Mandi Christian	Bormon Hindu
Village Workers	42%	50%	8%
Supervisors	17%	50%	33%
Under 4yr old Children	62%	29%	9%
Antenatal Mothers	67%	22%	11%
VHP Assisted Deliveries	69%	25%	6%
Oral Contraceptive Recipients	35%	50%	15%

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

The total cost of the VHP for 12 months was BDT 2,210,000 (USD 28,333) (NZD 43,333) (Euro 26,951) about BDT 1,040 (USD 13) (NZD 20) (Euro 13) per mother or child cared for. This is very cost effective and of enormous benefit to the community. It should continue to be extended.

11. The Primary Health Care Diabetes Programme:

In a country where 30% of the people are poor and with rapidly increasing diabetes, 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, while 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 106 children involved follow the same KHCP methods as all the other KHCP diabetes patients monitoring their diabetes by Benedict urine test (78% 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. 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 2015
End of Year Patient Analysis
Total Number: 1,724 (3% increase from 2014)
Treatment: Insulin 805 (46%), Glibenclamide tablets 913 (53%), Diet alone 6 (1%)
Religio-Ethnic Breakdown: Muslim 1,674 (97%), Hindu 24 (1%) Christian 26 (2%)
Gender: Male 556 (32%), Female 1,168 (68%)
(Hindus and males are not coming in proportion to their expected numbers in the community)

Insulin Patients

Total number treated during 2015:		850 (2% increase from 2014)
Continuing from 2014		775
Started in 2015		+75
Transferred Out	-4	
Defaulted	-18 (2%)	-45
Died	-23 (3%)	
Continuing into 2016		805

End of Year Insulin Patient Analysis
Total Number of Patients 805
Regular Outpatient Attendance 99%
Diabetes Control (Benedict): Good 78% Fair 22%
Distance of Home from the nearest Sub-Centre:
Within 15 miles 95%; 0-5miles 32%, 6-10miles 24%, 11-15 miles 39%
[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 38%, Under 21yrs 13%
Economic Status: Very Poor 24%, Extremely Poor 68% [based on home visit assessment).
Religio-Ethnic Breakdown: Muslim 97%, Christian 2%, Hindu 1%
Gender: Male 44%, Female 56%

Glibenclamide Tablet Patients

Total number treated in 2015:		1,118	(8% decrease from 2014)
Continuing from 2014		906	
Started in 2015		+212	
Changed to diet only	-6		
Transferred	-0		
Defaulted	-153	-199	
Died	-8		
Changed to Insulin	-32		
Continuing into 2016		919 (+1%)	

Sr Dr Jenny, Dr Mariko & Mironi Didi in meeting room

End of Year Tablet Patient Analysis

Total number of patients: 919
Regular attendance 94%
Diabetes Control (Benedict): Good 72% Fair 18%
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 9%, 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 24%, Female 76%

Diabetes Patients Admitted at Kailakuri

Total Number: 471 (8% decrease from 2014)
Average Duration of Admission: 15 days
Religio-Ethnic Breakdown: Muslim 96%, Christian 1%, Hindu 3%
Gender: Male 33%, Female 67%

54% 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 5 inpatient deaths (1% of admissions), of which 2 died of ketoacidosis, 1 died of a heart attack, 1 of heart failure, and 1 from acute kidney failure.

Top Ten Diabetes Inpatient Problems:

1. wasting
2. badly controlled diabetes (several with ketoacidosis)
3. inadequate understanding of diabetes
4. diabetic foot ulcers
5. urinary tract infections
6. cataracts (including retinopathy)
7. gynaecological problems
8. other chronic complications of diabetes (neuropathy, nephropathy)
9. hypertension
10. peptic ulcer

Followed by: pregnancy/delivery, diarrheal diseases, diabetes TB, psychiatric problems, skin conditions, fractures, otitis media

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

Number of patients sent: 75
Travel cost: BDT 263,320 (USD 3,376), (NZD 5,163)
Average cost per patient BDT 3,510 (USD 45), (NZD 69)

Cost of Diabetic Stock	BDT (000's taka)	USD	NZD
Insulin:	38,29	49,090	75,078
(Project Portion 19%)	(7,28)	(9,333)	(14,275)
(BIRDEM Portion 81%)	(31,01)	(39,756)	(60,804)
Glibenclamide Tablets	1,50	1,923	2,941
Diabetes Equipment	4,66	5,974	9,137
Total Cost	**44,45**	**56,987**	**87,157**
Cost to Project	13,44	17,231	26,353

Estimated Cost of the Diabetes Programme (to KHCP)

	BDT (000's taka)	USD	NZD
Stock	13,44	17,231	26,353
Inpatient Care	21,72	27,846	42,588
Staff Salaries	21,69	27,808	42,529
Non-Diabetes Medicine etc.	6,75	8,654	13,235
Cost of sending Patients to Dhaka	2,63	3,372	5,157
Meetings	1	13	20
Other Travel & Home Visits	4,59	5,885	9,000
Total	**70,83**	**90,808**	**138,882**

The cost to the project was BDT 70,83,000 (USD 90,808) (NZD 138,882), about 30% of the KHCP expenditure for the year and about BDT 4,100 (USD 53), (NZD 80) per patient. If the BIRDEM subsidy of BDT 1,850 (USD 24) (NZD 36) is added it becomes BDT 5,950 (USD 76), (NZD 117) 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. However many patients have adopted disciplined lifestyles, and been able to gradually lower their insulin dose (and transfer to tablets) over time.

Patient numbers keep growing, which has increased the pressure on paramedic services. We also follow-up patients who don't come for insulin, by contacting their relatives or visiting them at their homes. Educating uneducated patients about diabetes management is difficult, the staff need to explain very carefully and many times. **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 in its diabetes service. Our experience shows services must be simple, low cost and easily accessible to the poor and the rural population to be effective.

12.General Patient Care:

Outpatient services are operating at a similar level to 2014, but we still have fewer males visiting than females. This can be explained by several factors – men are often the main income-earners, and are reluctant to miss a day's labour by coming to Kailakuri. They often buy medication from local pharmacies first, and come to Kailakuri if their condition becomes more serious. However, females are also neglected in some households where husbands are reluctant to purchase medication for their wives (or take some of their wife's medication after it is prescribed!). An evening male clinic would enable more men, especially day-labourers, to receive care but Kailakuri currently lacks the funding and staff capacity to initiate this.

As our TB-in-charge commented, there is no lack of patients at Kailakuri! In March numbers can get up to 120 or 150, and the less urgent patients are asked to come back another day, as Kailakuri only has capacity to see about 110 patients a day. However there are often less patients in winter and the rainy season. If more paramedics could be assigned on outpatient services during the busy times of year more patients would be seen within the time, but this also depends on capacity issues.

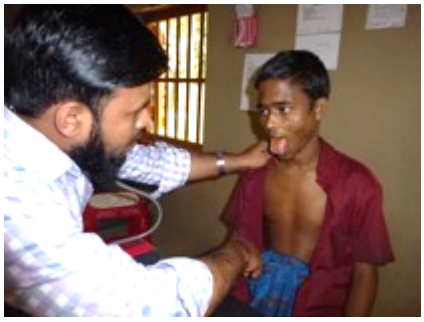
Kailakuri Statistics for 2015:

I. Outpatients:

Total number of patient visits: 23,694 (3% less than 2014)
Religio-Ethnic Breakdown: Muslim 86%, Christian 10%, Hindu 4%
Gender: Male 33%, Female 67% and Children under 5yrs 7%
(Obviously an evening male clinic is needed).
Distance of Home: 0-2 miles 44%, 2-5 miles 33%, over 5 miles 22% [2miles = 3.2km, 5 miles = 8km]

Top Ten Outpatient Problems (by number of visits):

1. peptic ulcer
2. asthma
3. hypertension
4. epilepsy
5. gynecological problems
6. psychiatric problems
7. abscesses, sores and ulcers
8. pregnancy
9. urinary tract infections
10. other skin diseases



Gonoshashtaya Kendra's Dr Rashed seeing an inpatient at Kailakuri

Followed by: kidney problems, arthritis/back pain, pneumonia, anaemia, otitis media, eye problems, worms, respiratory infections, bronchitis, other virus fevers, injuries and burns, nutrition problems

The Cost of Running the General Outpatient Department (general plus VHP) for 12 months was approximately BDT 2,829,000 (USD 36,269) (NZD 55,471), making cost per visit BDT 120 (USD 2) (NZD 2) which includes salaries, medicines, stationery etc. This is low cost health care.

II. Inpatients:

The total number of admissions (general plus diabetes) was 1,530 (10% less than 2014). General Patients were 1,049 (10% decrease) and diabetes patients were 471 (8% decrease).

The average number of admitted patients was 35 (22 general plus 13 diabetes) and the average duration of stay for the general patients was 9 days (as against 15 days for diabetes patients) (overall average stay 12 days).

General Patients

Religio-Ethnic Breakdown: Muslim (66%), Christian (25%), Hindu (9%)
Gender: Male (40%), Female (60%) Children under 5yrs (21%)

Top Ten General Inpatient Problems:

1. pregnancy/ delivery problems
2. diarrhoeal diseases
3. gynecological problems
4. malnutrition/wasting
5. abscesses, sores and ulcers
6. peptic ulcer
7. asthma/bronchitis
8. kidney problems
9. psychiatric problems
10. fractures

Dr Rajen from Gonoshashtaya Kendra, assessing patient's pulse

Followed by: pneumonia, hypertension, arthritis, injuries and burns and virus fever, urinary tract infection, anaemia, newborn babies and worms, poisoning patients, TB, epilepsy, jaundice

The Cost of Running the Inpatient Department (general plus diabetes) for 12 months was BDT 6,936,000 (USD 88,923) (NZD 136,000). With a total 1,520 patients and average stay of 12 days that is 380 BDT (USD 5) (NZD 7) 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. 122 such patients were transferred, 12% less than in 2014. Poor patient referrals comprise patients sent to elsewhere for investigations or non-surgical treatment. The combined expenditure for the two groups was BDT 2,216,000 (USD 28,410) (NZD 43,451), 8% less than 2014. St Vincent held fewer camps in 2015 (because of the country's political situation), but we were able to delay some of these operations for camps to be held during 2016.

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 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).

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 29% in previously treated cases (World Health Organisation, 2016). 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:

31 sputum positive patients started treatment between July 2014 and June 2015. Eight were subsequently transferred to other centres. Of the remaining 23 patients, 1 defaulted and 2 died i.e. **90% cure rate**. The two patients who died also had other illnesses (their causes of death being heart failure and stroke). The default patient took proper treatment to begin with, but within one month he felt healthy, and moved far away to another district. Despite dedicated attempts by staff, he declined to return for further treatment.

II. Kailakuri Statistics for 2015:

Total Number Treated		93 (19% increase from 2014)
No. Continuing from 2014		25
Started in 2015	+68	(31% increase from 2014)
Completed	-37	
Transferred	-12	
Defaulted	-3	-56
Died	-4(4%)	
Treatment Failed	3	
Continuing into 2016 (Preventative Treatment 1)	36	

Edric with Gareth & Joanne Morgan

III. Patient Analysis:

Category 1 (new sputum positives):	49	(53%)
Category 2 (retreatment):	3	(3%)
Category 3 (non-pulmonary)	41	(44%)

100% followed treatment regularly.

Of the four patients who died, one died from intra-cranial hemorrhage (stroke) at Mymensingh Medical Hospital, one from heart failure, two from severe malnutrition (one of whom had diabetes)
Distance from home: 73% were from within five miles and 27% within two miles
33% were under 30 years of age
Religio-Ethnic Breakdown: Muslim 59%, Christian 38%, Hindu 3%
Gender: Male 55%, Female 45%
22 patients (24%) were hospitalized, 21 at Kailakuri and 1 at Jalchatra
9% patients also had diabetes.

The **total cost** to KHCP of the TB Programme was BDT 175,000 (USD 2,244) (NZD 3,431) which comes to BDT 1,900 (USD 24) (NZD 37) per patient.

14.Conclusion and Appreciation

As in 2014, KHCP is preparing for new medical leadership i.e. when doctors Jason and Merindy Morgenson arrive in Bangladesh. During this transition time, we have benefited again from the volunteer services of Dr Mariko Inui, and we are grateful to the Gonoshashtya Kendra Medical College Hospital internee doctors for providing much-needed stability throughout Dr Baker's illness and after he passed away.

Ask many of the Kailakuri staff and they will tell you they learnt much from 'Dr Bhai' about how to really serve other people, and treat them as they would their own family. Early on, Edric used to require each new staff member to spend time either in the gardening or cooking departments, before they progressed to paramedic training or more senior roles. He also led by example, staying up through the night for difficult patients, and travelling long distances in the mud or rain to visit sick people in their homes. This commitment is well-embedded amongst the staff, and the internee doctors who come to work at Kailakuri often comment on the closeness between staff and patients, and the empathy shown towards them.

As Edric said in last year's annual report, it is essential to realise that the poor, despite their poverty, have the same rights, dignity and human value as everyone else**.** But before offering them help, we first have to listen to and understand their problems. When poor people are uneducated, they often lack confidence and feel hesitant to express their difficulties to others. They may seem confused or indecisive, as they do not understand the medical terminology, which treatment option is better, or how they can afford it.

Edric's central concerns for the Kailakuri project were that it retains appropriately committed medical leadership and sustains its support and financial backing, without losing its essence as a low-cost, primary health care project immersed in the local poor community, and led by people within that community. As programmes manager Roton Mia said in October, "When (Dr Bhai) was with us we learnt from him that it is important to be independent, to do what we thought was right and not wait for orders. We believe that our responsibilities have grown". Edric built up the project's capacity over many years so that it could become self-governing, with its own Committee and staff management team, paramedics, health workers and educators within various departments, administration and support staff and suitable medical oversight.

All the staff are deeply committed to continuing Dr. Bhai's legacy. At this time we ask that you continue to support us on this journey, and keep us in your prayers.

Yours sincerely,

Sujit Rangsa, Acting Medical Coordinator
Sr Dr Jenny Clarke, Project Advisor
Pijon Nongmin, Assistant Director, Management
Roton Mia, Assistant Director, Programmes
Nadine Vickers, English Communications

Edric with Ya Gabrielle, Pat Smith in Vietnam, 1974-75

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