Kailakuri Health Care Project

(Kailakuri & the Institute of Integrated Rural Development, IIRD)

2012
ANNUAL REPORT
KAILAKURI HEALTH CARE PROJECT
(KHCP)
— Care for the Poor, Sustainability and the Future —

CONTENTS

1) Introduction:

i) Health Care Accessibility to the Poor

Despite remarkable achievements in the past two decades, both in economic development and in basic mother-child health indicators, 30% of the people of Bangladesh are still poor and 18% extremely poor with extreme difficulty accessing health care services and other basic needs.

The problems in health care accessibility are:

a) After basic expenditures on food and other necessities the poor have almost nothing left for health care.
b) Modern medical care is capital intensive and too expensive.
c) Qualified medical practitioners undergo long costly training and need high incomes in order to repay debts, establish themselves and achieve desired living standards. They cannot accept either low incomes or rural living conditions.
d) Investigations and medications prescribed are too numerous and too costly.
e) Bangladesh is a highly competitive society and paramedical workers are unlikely to retain commitment and motivation for the poor without strong programme organization and supervisory back-up.
f) Because the numbers of the poor are vast organisation is difficult and costs very great.
g) Health services for the poor cannot be financially self-sustaining.

Poverty comprises difficulty in accessing a whole range of basic needs which become part of the poverty-health complex, the root problem being inability to obtain sufficient work-income. Problems of distribution and social justice inter-relate. And poverty is probably the most important cause of ill-health.

Both government and NGO sectors have made enormous progress but continue to be frustrated by national corruption, poor governance and volatile politics leading to crippling strikes, violence and breakdown of law and order while political leaders expend their energy (and the trust of the electorate) on endeavours which appear to have little relevance to the urgent needs of the poor.

ii) The Kailakuri Health Care Project (KHCP)

After a long history of slowly working out methods, priorities and practicalities, teaching and development of staff and programmes, problem-solving and building up community trust, largely unknown outside its own area, the KHCP has now emerged into national publicity at a time when it is needing to develop funding security, strengthen itself for leadership change and extend its community coverage. The conviction and insistence of KHCP is that health care must be by the people, for the people: health for the poor by the poor.

iii) A Symposium on the Subject

On 2nd March 2013 the KHCP was able to present a high level medical symposium in the capital city on "Making Health Care Accessible to the Poor". Papers were presented by representatives from leading organisations in the field from both government and NGO sectors. The auditorium was full. Media and business sector representatives participated. Discussions were animated. (The Symposium was enabled by IIRD, ICDDR,B, PEAL and many others.)

There was a huge expression of concern for the problem. The Symposium will be followed up with regular newsletters in English and Bengali to sustain concern, and also to attract support for KHCP.

2) 2012 Kailakuri Health Care Statistics at a Glance:

		2012	% Increase	*2011*
1.	**The Village Mother-Child Health Programme (VHP):**			
	Number of Villages	17	0%	*17*
	Population	14,600	0%	*14,600*
	End of Year Under 4 Year Old Care	992	-3%	*1,025*
	Number of Women Given Antenatal Care	370	-1%	*372*
	Number of Staff Assisted Deliveries	51	42%	*36*
	(Women from outside the programme are coming for assisted deliveries.)			
2.	**No. of Persons Receiving Health Education:**	**23,000**	**10%**	***21,000***
3.	**Outpatient Visits:**			
	General	21,972	23%	*17,862*
	TB	1,848	2%	*1,814*
	Diabetes	18,240	36%	*13,408*
	Total	**42,060**	**27%**	***33,084***
4.	**Inpatient Admissions:**			
	General	987	25%	*789*
	Diabetes	315	1%	*311*
	Total	**1,302**	**18%**	***1,100***
5.	**End of Year Diabetes Patient Numbers:**	**1,434**	**21%**	***1,181***
6.	**No. of TB Patients Treated:**	**77**	**8%**	***71***
7.	**No. of Surgical Transfer Patients:**	**75**	**23%**	***61***
8.	**Total No. of Staff:** (equivalent number of full-time staff = 122)	**93**	**3%**	***90***
9.	**Total Expenditure:**			
	BDT (Taka)	171,00,000	21%	*141,00,000*
	USD (79.67)	$215,000	24%	*$173,000*
	NZD (65.86)	$260,000	17%	*$222,000*
	(Exchange Rate details – see page 5)			

3) Low-Cost Health Care at a Glance (including salaries)**:**

	BDT	USD	NZD
1. Antenatal care in the home for one mother/12 months health nutrition care in the home for one child:	1,360	17	21
2. Six Months multidrug treatment course for one TB patient (cost to KHCP):	3,117	39	47
3. One general outpatient visit (including medications):	105	1.30	1.60
4. Cost of keeping one inpatient admitted for one day (incl. medication, food for patient & attendant etc):	104	1.30	1.60
5. Cost of supervision and treatment of one diabetes patient for one year (cost to KHCP):	4,000	50	61
6. Staff pay for 91 staff for one year (including doctor):	72,96,000	91,578	110,780
7. Average pay, one staff member for one month:	4,800	60	73
8. Total project expenditure for one year:	171,00,000	214,635	259,642
9. Approximate cost per person touched (appr 25,000):	684	9	10
10. Fixed expenditure (total salary bill) per person touched:	292	3.70	4.40

Despite its constraints the Kailakuri Health Care Project provides a model of low cost health care for the poor.

4) Community Coverage and Benefit:

In the face of enormous community needs the slightness of KHCP's community coverage is sobering and clearly indicates the need for constant attention to cost-efficiency, management and medical supervision, extension of community coverage and advocacy for the poor. (Gender disparity, female percentage of beneficiaries, however, is striking in such a strongly male dominated society: Outpatients 69%, Inpatients 65%, Tablet Diabetes Patients 62%, Insulin Patients 51%, TB 48%, Under 4s 51%)

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 17 villages is very good but covers only 40% of the Shulakuri Union. Maternal complications come to the inpatient service. Many child admissions are prevented. Severe malnutrition is rare. Health education is being propogated through the village programme and all the project's services and has a wide and effective impact. KHCP is one of many organisatons motivating for and promoting the government's immunisation and family planning programmes (with a national growth rate of only 1.6% the latter is highly effective).

The Kailakuri TB Programme responsible for the Shulakuri Union, is very effective and coverage is very good. It is difficult to assess the community coverage of General Outpatient and Inpatient care. The Outpatient service lacks the capacity (staff and management) to accept the number of patients who present, although for long-term patients there is fairly good coverage of about 30% of the Shulakuri Union. Inpatient coverage is better, however, patient numbers prejudice patient assessment and duration of admission (because of needing to be discharged too quickly).

The Diabetes Programme is probably providing treatment and supervision for almost all poor Type One patients within 15 miles of its subcentres (ie from about 7% of the 10 million population in the three districts of Tangail, Jamalpur and Mymensingh). Tablet patients are less motivated for Kailakuri because the market cost 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 of other KHCP activities is at present a higher priority than increasing the coverage of Type Two diabetics.)

By improved management-administration and staff utilisation it should be possible to increase the extent of the MCH Village Programme and Outpatients services without great cost increase. The

request from the Church of Bangladesh to extend into its local area, using its land and buildings, open up the posssibility for this.

Extension of Inpatient coverage is more difficult in terms of costs, staff and supervision requirements.

5) Annual Accounts for the year 2012:

	BDT ('000s)	USD (79.67)	NZD (65.86)
Opening Balance	960	12,050	14,576
Income/Receipts			
Donations via Head Offie	155,98	195,783	236,836
Patient Fees	12,57	15,778	19,086
Staff Meals	1,26	1,582	1,913
Local Donations	4,48	5,623	6,802
Miscellaneous	70	879	1,063
Total Income/Rceipts	**174,99**	**219,645**	**265,700**
Total Opening Bal & Income/Receipts	**184,59**	**231,695**	**280,276**
Expenditure			
General, Diabetes and TB Programmes			
Salaries	64,15	80,520	97,404
Education Materials etc	6	75	91
Insulin & Diabetes Tablets	7,12	8,937	10,811
Other Medicines	18,35	23,033	27,862
Diabetes Equipment	3,32	4,167	5,041
Other Medical Equipment	69	866	1,048
Supplies & Equipment	46	577	698
Patient & Staff Meals	25,47	31,969	38,673
Gardens and Grounds	85	1,067	1,291
Firewood	2,48	3,113	3,766
Lamps and Kerosene	86	1,079	1,306
Bedding	51	640	774
Travel and Conveyance	6,06	7,606	9,201
Poor Patients	5,57	6,991	8,457
Surgical Transfers	10,52	13,204	15,973
Home Visits	75	941	1,139
Diabetes Meetings	58	728	881
Miscellaneous	46	577	698
Total	**148,26**	**186,090**	**225,114**
MCH Village Health Programme (excluding salaries)	**2,31**	**2,899**	**3,507**
Administration			
Salaries	8,80	11,046	13,362
Provident Fund	2,64	3,314	4,009
Stationery	1,02	1,280	1,549
Electricity	85	1,067	1,291
Phone and Emails	43	540	653
Furniture	24	301	364
Cycle Repairs	53	665	805
Building Repairs	2,19	2,749	3,325
Bank Fees	2	25	30
Total	**16,72**	**20,987**	**25,388**
Capital Expenditure			
New Cycles	9	113	137
New Buildings	2,47	3,100	3,750
Electrical Installations	42	527	638
Land Purchase	81	1,017	1,230
Total	**3,79**	**4,757**	**5,755**
Total Expenses	**171,08**	**214,733**	**259,764**
Closing Balance	**13,51**	**16,962**	**20,512**

Notes:

1. Expenditure Breakdown According to Programme

	BDT ('000s)	USD (79.67)	NZD (65.86)	% of Total
Diabetes Programme	52,52	65,922	79,745	31%
General Patients	48,74	61,177	74,005	28%
General Inpatients	*(25,78)*	*(32,358)*	*(39,144)*	*(15%)*
General Outpatients	*(22,96)*	*(28,819)*	*(34,862)*	*(13%)*
Total Inpatients,General & Diabetes	*(48,74)*	*(61,177)*	*(74,006)*	*(28%)*
Administration	16,72	20,987	25,387	10%
MCH Village Programme	16,01	20,095	24,309	9%
Surgical Transfers & Poor Patient Referrals	16,67	20,924	25,311	10%
Other	12,71	15,953	19,299	7%
Health Education	*(1,22)*	*(1,531)*	*(1,852)*	*(1%)*
Captial Expenses incl. repairs	6,51	8,171	9,885	4%
TB	1,20	1,506	1,822	1%
Total (excl. expenses in italics)	**171,08**	**214,735**	**259,763**	**100%**

(all costs include salaries where appropriate)

2. Exchange Rates at 31 December 2012 (mid-market rates from www.xe.com)
   USD 1 = 79.67BDT
   NZD 1 = 65.86BDT
   Euro 1 = 105.05BDT
   GBP 1 = 129.55BDT

3. Income, Receipts and Expenditures relate to the project not to the IIRD Central Office.

4. Differences from the official audit are due to:
   i. Different time period. (audit 15th Feb to 14th Feb)
   ii. Different format.
   iii. Inclusion of Rotating Fund etc

5. Total expenditure at 21% more than 2011 is due to inflation, increased number of surgical and other patient referrals and reducing the gross underpayment of staff. (The total expenditure increase is concealed in the USD and NZD figures due to changed exchange rates.)

6. Comment on Statistic and Cost Breakdown:
   The same process of simplification and prioritization which makes it possible to bring low cost services to the poor also has its effects on statistic collection and the breakdown of expenditure between various programmes. Expenditure breakdown according to programme (see No. 1 above) is rough.

6) 2012 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, whose solid support has moved us from a position of struggling to continue, to a position of being able to concentrate on programme and staff development, search for future medical leadership and a national doctor, and the search for in-country funding, all essential for long-term sustainability.

2. The Japanese Overseas Christian Medical Service for giving us Dr Mariko Inui whose friendship, support and medical wisdom is appreciated by all who work with her.
3. The West Hamilton Anglican Parish (St David's), Hamilton, New Zealand for giving us Christine Steiner, whose accountancy, management and communication skills have completely changed the project's prospects for the future.

4. New Zealand donors giving via the NZ Link Group, the NZ Anglican Mission Board and the NZCMS (including some very large private donations).
5. Asia Connection Incorporated (USA)
6. American donors (including some very large private donations) via Asia Connection, Father Bob McCahill and the Maryknoll Fathers.
7. The members of the NZ Link Group
8. The Quail Roost Foundation, USA
9. Howick Presbyterian Church, Auckland, New Zealand
10. Preston Russell Trust, Invercargill, New Zealand
11. A Japanese private donor
12. St Stephen's Anglican Church, Whangaparoa, New Zealand
13. Overseas Bangladeshis in America, Japan and the UK
14. General Surgical Association, Dunedin, New Zealand
15. St Paul's Union Church, Taupo
16. A British private donor
17. An Italian private donor
18. Other Churches in New Zealand
19. NZCMS, AAW and CWS for friendship, support and prayer back-up.
20. The NZ Bangladesh Association and especially Mr Ataur Rahman for enabling essential contacts in New Zealand and Bangladesh.

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

1. The Government of Bangladesh gives authorisation and gives support through the Damien Foundation and local support at sub-district level.
2. The Institute of Integrated Rural Development (IIRD), our parent NGO, manages government authorisation and liaison, the project manager's salary and other support.
3. BIRDEM Hospital (Diabetes Association of Bangladesh) provides low cost insulin to our poor diabetics and provides free insulin for young diabetics.

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

4. The Nova Nordisk and Lilly Company provide free and concession priced insulin through BIRDEM
5. Damien Foundation provide free investigations and medicines for TB patients and brings the Kailakuri TB service into the National TB Programme.
6. The Bangladesh National Society for the Blind, Eye Hospital in Mymensingh provides free or low cost eye surgery for cataract and other eye patients.
7. The Social Islami Bank of Bangladesh whose donation enabled the upgrade of our intensive care unit.
8. The British Women's Association of Dhaka whose donation provided a diabetes subcentre building on donated land at Mominpur.
9. The Dhaka American Women's Club whose donation provided a new special nutrition building.
10. Bangladeshi friends who have given monetary donations.
11. The Pirgacha Mission, the Maryknoll Fathers and Sisters, the Taize Brothers and the Marist Brothers and Sisters give various kinds of help including important advice when needed.
12. Prominent Bangladeshi friends in Dhaka and Madhupur give important advice, encouragement and promotional assistance especially Md Abdul Razzaque MP (Minister of Food), Md Yakub Ali (Shulakuri Union Chairman), Md Abdullah Al Mahmud (Mintu) and Md Risal Mahmud (PEAL – Pipeline Engineers and Associates Ltd) and Professor Syed Faisal Hasan (Dhaka University).
13. The Bangladesh media has given publicity to the project, important for development of an in-country funding base and finding a national doctor.
14. The Department of Food and Nutrition Security of ICDDR,B and many others for their support of our symposium on "Making Health Care Accessible to the Poor'

7) Financial Situation and Budget:

I. Income, Expenditure and Balances for 2011-12, 2012-13 and 2013-14 (projected):

	2011-12	2012-13	2013-14
	USD	USD	USD
Opening Balance	33,500	47,000	141,000
Income	197,500	308,000	150,000
Total	231,000	355,000	291,000
Expenditure	-184,000	-214,000	251,000
Balance	47,000	141,000	40,000
II. Income Breakdown (%):			
Opening Balance	15%	13%	49%
Patient Fees	4%	4%	4%
Other Local Income	2%	2%	3%
Foreign Donations	79%	81%	44%
III. Source of Foreign Donations:			
USA	38%	11%	25%
NZ	62%	85%	75%
Other	0%	4%	0%

Notes:

(1) Financial data shown relates official audit year February 15th to February 14th.
(2) The high income for 2012-2013 is due to a fundraising tour of New Zealand.
(3) Forward projection estimates are rough because of the uncertainties involved and assume ongoing support from major donor.
(4) Almost all income comes from private donations.
(5) The low contribution of patient fees indicates the need to raise fees in line with inflation (if possible).

8) Staff, Training and Health Education:

The essence of "Health for the Poor by the Poor" is that staff are trained in the project for the aims and work of the project.

The Kailakuri Health Care Project has 93 staff led by the Medical Officer in Charge and the Project Manager. Dr Mariko Inui is now completing her term. Two young highly committed American doctors, (Jason and Merindy Morgenson) are hoping to begin long term work with Kailakuri next year transforming the project prospects for sustainability.

I. The Health Action Team: 72 (77% of staff), headed by two doctors.

i) Paramedics and Health Educators: 34 (37% of staff)
ii) Health Assistants: 12 (13% of staff)
iii) Village Mother-Child Care Staff: 17 (18% of staff)
iv) Cooks: 7 (8% of staff)
v) Doctors: 2 (2% of staff)

51% of the team work with general patients, 28% with diabetes. 18% in Village Mother-Child Care and 3% with TB. They are supported by two medically qualified doctors.

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

i) Project Manager: 1 (1% of staff)
ii) Administration and Office Staff: 6 (6% of staff)
iii) Finance Staff: 3 (3% of staff)
iv) Garden, Compound, Buildings, Maintenance, Market, Cows etc:11 (12% of staff)

The project is labour intensive. All but two of the staff are paid by the Project. Dr Mariko Inui is paid by JOCS (Japan Overseas Christian Medical Service), Christine Steiner partly by Hamilton West Anglican Parish (New Zealand) and the Project Manager by head office IIRD (Institute for Integrated Rural Development). Staff pay comprises 36% of all project costs.

III. Staff Training:

All staff have been trained in the project, previously by the medical office in charge. It is now the senior paramedics who give on-going training to the rest of the staff. Seven senior paramedics have undertaken the six month (LMAF) paramedic training course in Mymensingh. TB paramedics are trained and supervised by Damien Foundation.

IV. 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 five health educators give constant teaching in inpatient and outpatient departments and in the diabetes sub-centres. Village staff give regular teaching in the villages. 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.

9) The Mother, Child Village Health Programme (VHP):

Health wise, mothers and children are the main casualties of poverty. Well organised services are highly cost-effective. Surveys tell us that half the children and a third of the women in Bangladesh still suffer from malnutrition. Maternal health and nutrition is threatened by under-age marriages. Food is contaminated and many food items are deliberately adulterated, mainly with formalin.

Kailakuri Statistics for 2012

Number of Villages: 17 (population about 14,600)
Staff: 17, Village Workers 11, Supervisors 6
Under 4yr old Child Care: 992 children (4% less than 2011) at years' end. The weight survey at the end of the year showed nutrition problems in 5% (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 needing admission do not readily come.
Immunizations: Staff continue to support the government's EPI programme.
Antenatal Care: 370 mothers were given ANC (1% less than 2011).
Delivery Care: 21% of ANC mothers had staff assisted deliveries, 51 deliveries (42% less than 2011), 47 in their homes and 4 at the health centre.
Family Planning: Staff continue to motivate for the government programme and 16 couples received oral contraceptives from the VHP.
Religio-Ethnic Breakdown:

	Bengali Muslim	Mandi Christian	Borman Hindu
Village Workers	45%	55%	0%
Supervisors	17%	50%	33%
Under 4yr old Children	63%	26%	11%
Antenatal Mothers	77%	15%	7%
VHP Assisted Deliveries	93%	7%	0%
Family Planning (tablets)	31%	56%	13%

The total cost of the VHP for 12 months was BDT 16,01,000 (USD20,095) (NZD24,309) about BDT 1,400 (USD18) (NZD21) per mother or child cared for. This is very cost effective and of enormous benefit to the community. It should be extended.

10) The Diabetes Primary Health Care Programme:

In a country where 30% of the people are poor and with rapidly increasing diabetes prevalence, KHCP has the only significant primary health care diabetes programme for the poor. It is essential for the masses of the people and the future of the country that its methods be studied, refined and copied. Its methods are very simple. All the work is done by paramedics under medical supervision, at the same time linking with the BIRDEM (Diabetes) Hospital. Results are as good as any with the poor in Bangladesh and costs much cheaper.

Kailakuri Statistics for 2012

End of Year Patient Analysis

Total Number: 1,434 (21% increase from 2011)
Treatment: Insulin 718 (50%), Tablets (glibenclamide) 689 (48%), Diet only 27 (2%)
Religio-Ethnic Breakdown: Muslim 1316 (93%), Christian 19 (1%), Hindu 72 (5%)
Gender: Male 618 (44%), Female 780 (56%)

Insulin Patients

Total Number Treated during 2012: 796 (9% increase from 2011)

Continuing from 2011		682
Started in 2012		114
Diet Only	17}	
Transferred Out	6}	
Defaulted	22}	78
Died	33}	
Continuing into 2013		718

End of Year Insulin Patient Analysis

Total Number of Patients 718
Regular Outpatient Attendance 93% (665)
Diabetes Control (Benedict): Good 71% Fair 26%
Distance of Home from the nearest Sub-Centre:
Within 15miles 97%, 0-5miles 30%, 6-10miles 23%, 11-15 miles 44%
[15miles = 24.1km, 10 miles = 16.1km, 5miles = 8km]
Functional Literacy: 61% (ie able to write name & read or write a very simple letter)
Age: Under 30yrs 54%, Under 21yrs 11%
Economic Status: Very Poor 52%, Extremely Poor 48% [based on home visit assessment]
Religio-Ethnic Breakdown: Muslim 93%, Christian 2%, Hindu 5%
Gender: Male 49%, Female 51%

Tablet (glibenclamide) Patients

Total Number Treated		877	(38% increase from 2011)
Continuing from 2011		499	
Started in 2012		378	
Diet Only	10}		
Transferred	11}		
Defaulted	115}	188	
Died	27}		
Changed to Insulin		25	
Continuing into 2013		664	

(11 less poor patients were transferred to BIRDEM district branches)

End of Year Tablet Patient Analysis

Total Number of Patients 689
Regular Attendance 78%
Diabetes Control (Benedict): Good 70% Fair 23%
Distance of Home from the nearest Sub-Centre:
Within 15miles 86%, 0-5miles 22%, 6-10miles 24%, 11-15miles 40%
[15miles = 24.1km, 10 miles = 16.1km, 5miles = 8km]
Functional Literacy 54%
Age: Under 30yrs 9%, Under 21yrs 0%
Economic Status: Very Poor 38%, Extremely Poor 49% [based on home visit assessment]
Religio-Ethnic Breakdown: Muslim 94%, Christian 1%, Hindu 5%
Gender: Male 38%, Female 62%

Diabetes Patients Admitted at Kailakuri

Total Number: 315 (1% decrease on 2011)
Duration of Admission: 33 days
Religio-Ethnic Breakdown: Muslim 93%, Christian 2%, Hindu 15%
Gender: Male 39%, Female 61%

Top Problems: inadequate understanding of diabetes, severe uncontrolled diabetes (incl. DKA & NKHS), wasting, ulcers/abscesses, urinary tract problems, peptic ulcer, diarrheal diseases, pregnancy/delivery, hypertension/stroke/heart failure, cataracts.

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

Number of Patients Sent: 75
Travel Cost BDT 147,133 (USD 1,847), (NZD 2,234)
Average Cost per Patient BDT 2,000 (USD 25), (NZD 30)
The high cost of sending patients to Dhaka is quickly recovered from the insulin price concession.

Cost of Diabetic Stock

	BDT ('000s taka)	USD	NZD
Insulin:	34,81	43,692	52,854
{Project Portion 16%	5,57	6,991	8,457
{BIRDEM Portion 84%	29,24	36,701	44,397
Glibenclamide Tablets	1,55	1,946	2,353
Diabetes Equipment	3,32	4,167	5,041
Total Cost	**39,68**	**49,805**	**60,248**
Cost to Project	10,44	13,104	15,851

Estimated Cost of the Diabetes Programme (to KHCP)

	BDT ('000s taka)	USD	NZD
Stock	10,44	13,104	15,852
Inpatient Care	17,65	22,154	26,799
Staff Salaries	15,25	19,141	23,155
Non-Diabetes Medicine etc	3,30	4,142	5,011
Cost of sending Patients to Dhaka	1,47	1,845	2,232
Meetings	58	728	881
TA & Home Visits	3,83	4,807	5,815
Total	**52,52**	**65,921**	**79,745**

The cost to the project was BDT 52,52,000 (USD65,921) (NZD79,744) about 31% of the KHCP expenditure for the year and about BDT 4,000 (USD50), (NZD61) per patient. If the BIRDEM subsidy of BDT 2,500 (USD31) (NZD38) is added it becomes BDT 6,500 (USD81), (NZD99) 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 rare. Chronic complications are late and difficult to change without great cost increases and serious disruption of life-style. Diabetes education is 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.

11) General Patient Care:

The KHCP general patient care programme, in fact, makes it into a small rural hospital handling serious and complicated patients, run by paramedics of low basic educational level, under medical supervision. This is revolutionary but essential because of the millions of poor and rural people for whom no other services are available without selling off essential resources. This is what needs to be studied, improved and replicated. And it needs commitment in order to do it.

Kailakuri Statistics for 2012:

I. Outpatients:

Total number of patient visits: 21,792 (23% more than 2011)
Religio-Ethnic Breakdown: Muslim 83%, Christian 12%, Hindu 5%
Gender: Male 31%, Female 69% and Children under 5yrs 7%
Distance of Home: 0-2 miles 37%, 2-5 miles 49%, over 5 miles 14%
[2miles = 3.2km, 5 miles = 8km]
Top Ten Problems: peptic ulcer, pain, anaemia, asthma, psychiatric/emotional problems, skin infections, hypertension (high blood pressure), epilepsy, allergy
Followed By: acute respiratory infections, injuries and burns, gynaelogical problems, worms, otitis media (middle ear infections), malnutrition/deficiencies

The Cost of Running the General Outpatient Department for 12 months was approximately BDT 22,96,000 (USD28,819) (NZD34,862) making the cost per visit BDT 105 (USD1.30) (NZD1.60) which includes salaries, medicines, stationery etc. This is low cost health care.

II. Inpatients:

The total number of admissions (general plus diabetes) was 1,302 (18% more than 2011).
General Patients was 987 (25% increase) and Diabetes was 311 (0% increase).
The average number of admitted patients (25 general plus 12 diabetes) was 32 and the average duration of stay for the general patients was 28 days.

General Patients

Religio-Ethnic Breakdown: Muslim (67%), Christian (23%), Hindu (10%)
Gender: Male (35%), Female (65%) and Children under 5yrs (20%)
Top Ten Problems: pregnancy/delivery/neo-natal problems, diarrheal diseases, malnutrition/wasting, acute respiratory infections (including pneumonia), injuries & burns, genito-urinary problems, surgical convalescence, peptic ulcer and complications, asthma, poisoning
Followed By: psychiatric problems, fractures/dislocations, skin sores and infections, TB
The Cost of Running the Inpatient Department (general plus diabetes) for 12 months was BDT 48,74,000 (USD 60,900) (NZD 73,800). With a total of 1,617 patients and average stay 29 days that is BDT 104 (USD1.30) (NZD1.60) per patient per day, which is extremely low cost.

Surgical Transfers (& Poor Patients Referrals):

The total expenditure for the year was BDT 16,09,000 (USD 20,196) (NZD 24,431). Surgical transfer cost was BDT 10,52,000 which for 75 patients averaged BDT 14,000 (USD 176), (NZD 213). This very costly item is nevertheless essential to the beneficiaries who would otherwise be deprived of necessary surgery.

12) The TB Programme:

This programme carried out 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 with the World's sixth largest TB problem is recognised as having developed a highly successful TB treatment programme. The national DOTS (Direct Observation Treatment, Short Term) programme is now able to concentrate on MDR (multiple drug resistance), child TB, sputum negative TB 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 which must be followed correctly (under observation) to prevent MDR which is currently 1.4% in new cases and 30% in previously treated cases.

Kailakuri Results:

I. Success Rate:

30 sputum positive patients started treatment between July 2011 and June 2012. Five were subsequently transferred to other centres. Of the remaining 25, 24 were cured, ie: 96% cure rate (amazing success rate).

II. Kailakuri Statistics for 2012:

Total Number Treated		77	(8% increase from 2011)
No. Continuing from 2011		19	(56% decrease from 2011)
Started in 2012		58	(23% increase from 2011)
Completed	38}		
Transferred	5}	48	
Defaulted	2}		
Died	2}		
Treatment Failed	1}		
Continuing into 2013		29	
(Preventative Treatment		1)	

III. Patient Analysis:

Category 1 (new sputum positives):	48	(62%)
Category 2 (retreatment):	1	(1%)
Category 3 (non-pulmonary)	28	(37%)

94% followed treatment regularly.
Distance from home: 100% were from within five miles and 32% within two miles
38% were under 30 years of age
Religio-Ethnic Breakdown: Muslim 68%, Christian 27%, Hindu 5%
Gender: Male 52%, Female 48%
16 (21%) were hospitalized, 9 at Kailakuri and 7 at Jalchatra
5% of patients also had diabetes

The total cost to KHCP of the TB Programme was BDT1,20,000 (USD1,506) (NZD1,822)

13) Conclusion: God, Action and the People:

Beginning each day in joint prayer gives witness to one caring creator God, the common source of strength for Muslims, Hindus and Christians. The joint participation of patients and attendants from the three communities provides powerful motivation for concern-action irrespective of group. The scriptures of each group are heard. (The effect is incarnational.)

Health care for the poor by the poor is the ethos and action of the Kailakuri Health Care Project, and in the present situation the main issues are:

1. On-going day by day health care actions
2. Evaluation of programmes for correction-adjustment, improvements of cost-efficiency and strengthening
3. Staff development
4. Leadership development
5. Improvement of management, administration and cost-efficiency in the entire project
6. Strengthening community involvement and cooperation with government and other organisations
7. Funding sustainability through donor communication and reports, new fund-raising, funding base development and publicity
8. Increasing the extent of population service coverage (rolling out the KHCP model)

With, at present, only one medical doctor for both health care action and administration leadership it is essential to prioritise. The three most immediate priorities are 1, 2 & 7 (above). The danger is that the pressures of 1 & 7 will displace attention from all the other concerns.

14) Last Minute Post-Script (and Commitment):

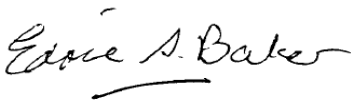
Over the last two or three months the level of political instability, protest, violence, breakdown of law and order, destruction of property, disruption to communications, life activity and commerce with loss of individual, corporate and national income (and deaths) has surpassed anything remembered since the liberation war in 1971. Minority groups have been targeted. Along with the political struggles for power is emerging the equally critical struggle between fundamentalism and liberalism; and garment workers seem to have become disposable!

At the same time the KHCP head office (IIRD) has been going through its own crisis. Now, in addition, government bureaucracy is delaying the release of KHCP funding. Lastly we have news that our two American doctors due next year are going to be delayed by health problems. We see one support after another on which we stake our security shaking and we realise how uncertain these things are. But there has to be commitment and self-giving based on the recognition that all people are sacred, important and of ultimate worth. Otherwise nothing will change. And it is the same for Bangladesh as a whole. Unless there are a significant number of people in high places determined to give themselves for the people (the rewards going to others, not themselves) then nothing will change. All of us must look into our lives, societies and religions for mentors and models to stir us (for christians the supreme mentor is Christ) and to the Transcendent for sustaining energy.

15) <u>Appreciation and Gratitude</u>:

With sincere gratitude we express our thanks to all who have supported and participated in our work in different ways. Most especially we express our thanks to Dr Mariko Inui from Japan who is now completing five years of work association with the project. Her years of gentle selfless service to the poor and the example of her careful meticulous clinical care have left their mark on the project and on all of us who have worked with her. We wish her peace and God's blessing as she returns to be with her family and to work for the people of Japan.

Thank-you for your help.



Edric S Baker
Medical Officer in Charge

(Note: Everything written in the 2011 Annual Report, available on the website, remains pertinent and read in conjunction with this report will fill out the picture.)

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WEBSITES

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