Dear shareholder / stakeholder

The 31st March 2017 is a historic day for all of us. It is the day we eventually open our doors to our systems go with all the registrations completed.

I know that it has been a long wait especially our initial investors that believed in us and have been very patient.

The success of Ahmed Al-Kadi Private Hospital is dependent on firstly you the shareholder who we hope will encourage your family, friends, colleagues to support your investment which will ensure a high occupancy, secondly on our wonderful handpicked staff with phenomenal experience who we expect will live up to our mission statement of Excellence in Healthcare and thirdly the support of a fantastic team of resident and supporting healthcare professionals.

From nothing to a reality of a world-class hospital which can compete with health facilities anywhere in the world.

Your confidence in our directors and management team is appreciated and we hope to reciprocate your faith in us by ensuring that your investment grows exponentially and your return on investment is double digits within twenty four months.

We already have plans for the next twelve months including the renovation of 24 Barnard Rd and 12 Elsie Rd.

The acquisition of 33 Barnard Rd and it’s demolition in the next two months will result in additional much sought after parking for both staff and visitors.

There are no shares available since we are now oversubscribed.

The new share price is R 14 per share meaning that those of you who bought shares at R10 now have a premium of R4 per share i.e. 40% increase.

We encourage you to hold onto your shares as a medium to long term investment.

The response from the medical fraternity who were hosted on the 10th February as well as the shareholders that have visited our facility has been fantastic.

We have been receiving a substantial number of calls of people wanting to be admitted to our facility.

As many of you are aware there has been an excellent write up in the Sunday Tribune 14 March as well as a double page advert on the 26 March 2017 resulting in Ahmed Al Kadi Private Hospital being the most talked about hospital in Durban and possibly the country.

There will be a double spread congratulatory feature opportunity on the 23rd April in the Sunday Tribune and if you want to participate, please call the Sunday Tribune Media Features Consultant: Lorraine Reddy 031 308 2833 lorraine.reddy@inl.co.za

FROM A DREAM TO REALITY
AHMED AL-KADI PRIVATE HOSPITAL,
EXCELLENCE IN HEALTHCARE.
PUTTING THE CARE BACK INTO HEALTHCARE.
Meet Our Team

Administration & Finance

Catering Department

Day, General & Medical Unit

Emergency Department

Infection Control & Night Management

Intensive Care Unit

Laundry Department

Marketing Department

Maternity Unit

MIMSYS Technologies

Neonatal Intensive Care Unit

Paediatric Unit

Pharmacy Department

Private Suite Department

Reception Department

Surgical Unit

Technical Department

Theatre Unit
The dream that became a vision with a mission to provide quality patient-focused healthcare to all communities has become a reality. Conveniently located off the N3 Highway at the corner of the King Cetshwayo Highway (M13) and Waterfall Road at the top end of Mayville making it accessible to patients and service providers. Ahmed Al-Kadi Private Hospital aims to provide world-class facilities and healthcare to all irrespective of ethnicity, gender, race or religion.

### Resident Specialists
- **Dermatologist**
  - Dr K Hooosen
- **Ear Nose & Throat Surgeons**
  - Dr J Naidoo
  - Dr M Smith
- **General Surgeons**
  - Dr I G Hooosen
  - Dr E Mansoor
  - Dr M A Noorhali
  - Dr U Singh
- **Neurologist**
  - Dr A Bhanjan
- **Neurosurgeon**
  - Dr S Lachman
- **Obstetricians & Gynaecologists**
  - Dr S Rahim
  - Dr S Suleman
  - Dr R Vatharajh
- **Ophthalmologists**
  - Dr S Aghdasi
  - Dr M J Motala
- **Orthopaedic Surgeons**
  - Dr R T Islam
  - Dr H Mahomed
  - Dr A Ramnarain
  - Dr Z Seedeat
- **Paediatricians**
  - Dr S Shetty
  - Dr M R Ghuman
  - Dr N Kader
  - Dr T Mitra
  - Dr A A Sayed
- **Physicians**
  - Dr K J Chinniah
  - Dr S Govender
  - Dr P Moodley
  - Dr A D Moosa
  - Dr J Muller
  - Dr S Naaidoo
  - Dr A Singh
- **Psychiatrist**
  - Dr J Ganie
- **Pulmonologist**
  - Dr S Suleman
- **Radiologist**
  - Dr S V Persal & Partners, Radiologist Inc
- **Urologist**
  - Dr A Bhartate
- **Vascular Surgeon**
  - Dr A M Kadia

### Admission Rights Specialists
- **Cardio Thoracic Surgeons**
  - Dr G Alexander
  - Dr K Naicker

### Part Time Specialist
- **Plastic Surgeon**
  - Dr S Ghooor

### Sessional Rooms - Specialists
- **Ear Nose & Throat Surgeon**
  - Dr Z B Khuzwayo

### Resident Allied Healthcare
- **Audiologists**
  - Ms N Patel
  - Ms P Suleman

### Allied Healthcare - Sessional Rooms
- **Cardiac Technologist**
  - Ms P Singh
- **Clinical Psychologists**
  - Mr F M Bassa
  - Ms B Dangor
- **Dietician**
  - Ms J Abraham
- **Orthodontist & Prosthodontist**
  - Mr F S Khamissa
- **Physiotherapist**
  - Ms N Omar
SABC An-NUR onsite episode filming featuring AAKPH

Staff of the Ahmed Al-Kadi Private Hospital Theatre team filming with SABC’s An-Nur team on 9 March. Great job!

An-NUR travels all around South Africa to capture the most interesting people and places. For their upcoming episode feature, Ahmed Al-Kadi Private Hospital was selected as part of the topic, centred around nursing, doctors and community service. We will let you know when our feature episode will be aired.
Ahmed Al-Kadi Private Hospital hosted the very first on site CME on the 15 March with the Durban IPA.

Ahmed Al-Kadi Private Hospital hosted and sponsored the CPD meeting of the Durban Independent Practitioners Association. A Skills Workshop was presented by our very own Resident General Surgeon Dr Ebrahim Mansoor which was attended by over 30 IPA members. The IPA members were also treated to a scrumptious dinner provided by our internal kitchen.
Corporate Social Responsibility
Broad Street Police Station

Staying Cool Under The Heat

The Technical Department of AAKPH sponsored their valuable time and resources to renovate the Broad Street Police Station with a new paint job and installation of air-conditioning units.
Our BIG AAKPH Family
Staff Aerial Pre-Opening Photo 30 March

WE ARE READY!

Welcome...
What is multidrug-resistant tuberculosis (MDR-TB) and how do we control it?

The bacteria that cause tuberculosis (TB) can develop resistance to the antimicrobial drugs used to cure the disease. Multidrug-resistant TB (MDR-TB) is TB that does not respond to at least isoniazid and rifampicin, the 2 most powerful anti-TB drugs.

The 2 reasons why multidrug resistance continues to emerge and spread are mismanagement of TB treatment and person-to-person transmission. Most people with TB are cured by a strictly followed, 6-month drug regimen that is provided to patients with support and supervision. Inappropriate or incorrect use of antimicrobial drugs, or use of ineffective formulations of drugs (such as use of single drugs, poor quality medicines or bad storage conditions), and premature treatment interruption can cause drug resistance, which can then be transmitted, especially in crowded settings such as prisons and hospitals.

In some countries, it is becoming increasingly difficult to treat MDR-TB. Treatment options are limited and expensive, recommended medicines are not always available, and patients experience many adverse effects from the drugs. In some cases even more severe drug-resistant TB may develop. Extensively drug-resistant TB, XDR-TB, is a form of multidrug-resistant TB with additional resistance to more anti-TB drugs that therefore responds to even fewer available medicines. It has been reported in 117 countries worldwide.

Drug resistance can be detected using special laboratory tests which test the bacteria for sensitivity to the drugs or detect resistance patterns. These tests can be molecular in type (such as Xpert MTB/RIF) or else culture-based. Molecular techniques can provide results within hours and have been successfully implemented even in low resource settings.

New WHO recommendations aim to speed up detection and improve treatment outcomes for MDR-TB through use of a novel rapid diagnostic test and a shorter, cheaper treatment regimen. At less than US$ 1 000 per patient, the new treatment regimen can be completed in 9–12 months. Not only is it less expensive than current regimens, but it is also expected to improve outcomes and potentially decrease deaths due to better adherence to treatment and reduced loss to follow-up.

Solutions to control drug-resistant TB are to:
- Cure the TB patient the first time around
- Provide access to diagnosis
- Ensure adequate infection control in facilities where patients are treated
- Ensure the appropriate use of recommended second-line drugs.
- In 2015, an estimated 480 000 people worldwide developed MDR-TB, and an additional 100 000 people with rifampicin-resistant TB were also newly eligible for MDR-TB treatment. India, China, and the Russian Federation accounted for 45% of the 580 000 cases. It is estimated that about 9.5% of these cases were XDR-TB.

Facts about TB
- Tuberculosis (TB) is second only to HIV/AIDS as the greatest killer worldwide due to a single infectious agent.
- In 2012, 8.6 million people fell ill with TB and 1.3 million died from TB.
- Over 95% of TB deaths occur in low- and middle-income countries, and it is among the top three causes of death for women aged 15 to 44.
- In 2012, an estimated 530 000 children became ill with TB and 74 000 HIV-negative children died of TB.
- TB is a leading killer of people living with HIV causing one fifth of all deaths.
- Multi-drug resistant TB (MDR-TB) is present in virtually all countries surveyed.
- The estimated number of people falling ill with tuberculosis each year is declining, although very slowly, which means that the world is on track to achieve the Millennium Development Goal to reverse the spread of TB by 2015.
- The TB death rate dropped 45% between 1990 and 2012.
- An estimated 22 million lives saved through use of DOTS and the Stop TB Strategy recommended by WHO.
- Tuberculosis (TB) is one of the top 10 causes of death worldwide.
- In 2015, 10.4 million people fell ill with TB and 1.8 million died from the disease (including 0.4 million among people with HIV). Over 95% of TB deaths occur in low- and middle-income countries.
- Six countries account for 60% of the total, with India leading the count, followed by Indonesia, China, Nigeria, Pakistan and South Africa.
- In 2015, an estimated 1 million children became ill with TB and 170 000 children died of TB (excluding children with HIV).
- TB is a leading killer of HIV-positive people: in 2015, 35% of HIV deaths were due to TB.
- Globally in 2015, an estimated 480 000 people developed multidrug-resistant TB (MDR-TB).
- TB incidence has fallen by an average of 1.5% per year since 2000. This needs to accelerate to a 4–5% annual decline to reach the 2020 milestones of the “End TB Strategy”.
- An estimated 49 million lives were saved through TB diagnosis and treatment between 2000 and 2015.
- Ending the TB epidemic by 2030 is among the health targets of the newly adopted Sustainable Development Goals.

http://www.who.int/mediacentre/factsheets/fs104/en/