The Kailakuri Health Care Project

NEWSLETTER

The Sorrows of the Poor

(and their collaborators)

1. ONEKA, BIPASHA AND BIKASH:

Some of our long term friends and newsletter readers will remember the story of Roneda, Oneka and Bipasha a poor tribal Hindu family who lost everything in medical bills. Finally after surgery for perforated peptic ulcer but without recovery of health they come to us. We (Edric and team) sent Roneda to another hospital for repeat surgery and then cared for him in our nutrition unit where he returned to excellent health but the family had nowhere to go. Everything had been sold. So, we kept them here.

Roneda looked after the cows. Oneka made mats & did cooking and Bipasha went to the local school. Eventually they bought a tiny piece of land but alas Roneda had cancer of the stomach and finally died after six month of unrelenting jaundice (no doubt due to liver metastases). Oneka and Bipasha remained with us. Then the son turned up, Bikash. Bikash built a little house of mud with a tin roof for the family. Then appeared his wife with a son. Bikash was skilled at all sorts of things. Besides house building he was also an excellent barber. Oneka set up a saloon for him at the Kailakuri crossroads.

Again disaster struck. Bikash's behavior became increasingly antisocial. We discovered he was on marihuana and had him admitted at the APON drug rehabilitation center but he did not cooperate with therapy. One day when I visited it was obvious that he was suffering from delusions and hallucinations. He was schizophrenic. On one occasion he attacked his wife and slashed the next-door neighbour with a knife. He stole sacred things from the Hindu temple. He demands money and threatens his mother. He tore up all their clothes and bedding. We admitted him at Kailakuri but he repeatedly ran away. The situation was "out of hand" and we could not keep him on medication.

Finally (modern age) we e-mail consulted a New Zealand Bangladeshi psychiatrist, Dr. Shakhu, by whose arrangement he is now admitted at the National Institute of Mental Health in Dhaka. His attendant is one of our workers, Suruj, a Mandi Muslim. Bikash and Suruj were taken to Dhaka by our faithful Bormon worker Jugol. This morning I spoke with Suruj on my mobile phone. He said he and Bikash are both very happy at the hospital in Dhaka which is like a prison!! Bipasha is now aged 14 and in boarding high school in Madhupur supported by our New Zealand friend Christine whom all will remember from when she was for 18 months part of our group here looking after correspondence and finances and carried us through a difficult period.

A couple of weeks ago Oneka went to Madhupur to take money for Bipasha but unfortunately fell off the back of the motorbike (modern village taxi service, fast and cool but nobody bothers about crash helmets). So she was brought back to Kailakuri. She was not unconscious at the time of injury but became increasingly disorientated and so we were afraid of fractured temporal bone with torn middle meningeal artery and extradural hemorrhage. She also had blood and probably cerebrospinal fluid draining from her left ear.

We immediately sent her with Ujjol to the Mymensingh Medical College Hospital. As a woman attendant was needed and none of our staff wanted to go we drew lots and sent Hajera (Muslim). The CT scan cost us about Tk. 3,000. Add onto that travel, meal and medicine cost. She had a linear fracture in the mastoid region but no internal bleeding. A few days later we replaced Hajera with Hena (also Muslim, newlywed at the age of 40 and pregnant!). None of them liked the MMCH. They are all back here with us again. Oneka is back at work and just so happy that Bikash is happily settled in in "prison." None of us told Bipasha that we were afraid her mother might die.

2. DEBT STRUGGLES IN THE KAILAKURI AREA:

In recent weeks, our project manager Pijon and I (Nadine) surveyed 148 families "poor" or "extremely poor" families within our village programme area. Many of whom have benefited from the Kailakuri and Thanarbaid health programmes over the past 30 years. 127 (86%) of them have current loans from one or more of the microcredit NGOs working in the Madhupur area. 45 out of the 55 NGOs registered in the area offer loan services, at interest. Rates vary from 12 to 17% percent per year and are collected weekly or monthly. NGO workers can exert considerable pressure to get interest paid in time. Amounts vary considerately, some as little as 10,000 taka (equivalent to 2 months' day wages), others 60,000 taka or more.

One of our staff took a 40,000 loan for his business. Before getting the loan he had to make a deposit of 4,000 and will pay 12 monthly installments of 4000 in addition to his regular 100 taka savings payments (i.e. total repayment of 48,000 plus 5,200 taka savings). The monthly income in our area of poor a family with only one earner is about 6000 taka. If there are five family members (husband, wife and 3 little children or 2 children and one elderly person) living costs are about 5 to 6000 taka.

Availability of micro-credit is promoted as a huge advantage for the poor but it also has dangers. The loans are used for house repairs, children's education, medical bills or just ready cash so that they do not bring in the 12-17% interest required. Often loans are drawn to buy cows, goats or chickens, goods for business (e.g. cloth for tailoring) or to sell locally. But if there is a more immediate crisis then cash can be diverted and repayment not possible. Sometimes the cow may die or the business fails. Over 90% of our staff have loans and some are huge.

Poor and extremely poor beneficiaries (many illiterate) often get little preparatory training from the NGOs when they withdraw loans. There are also many informal loan exchange networkers like local money lenders (taking exorbitant interest rates) and neighbours and relatives. (Good news is that our new NGO Mati is beginning an interest free loan for income generation programme for 50 extremely poor families in our area.

3. DIABETES CARE FOR THE POOR:

Health services in Bangladesh are generally speaking beyond the means of the poor without taking loans or selling off essential home resources for them (e.g. Roneda's family). Even government hospitals are almost impossible. Patient numbers are overwhelming and costly investigations and medications have to be obtained outside the hospital. Services are usually far distant from the homes of the people. Finally attendants are needed whose meals have to be purchased outside.

A clear example of the dilemma of the poor is diabetes. We have about 1800 patient under supervision. Bad control means life threatening acute and chronic complications. About 800 are on insulin of whom about half are type 2 (needing insulin for diabetes control) and half type1 (needing insulin for survival). None of the

insulin patients (or indeed many of the others) could offered care and supervision without the Kailakuri diabetes programme. We always have 3 to 7 diabetes foot ulcer patients some with extensive gangrene.

4. HEALTH AND DOCTORS:

None of us is immune from occasional health problems. Even an ageing doctor has his/her share and when you are immersed with the poor in their conditions and problems inevitably to a considerable degree their lot becomes your own. Some readers of my (Edric's) age will have experienced prostate problems and maybe even gone into acute urinary retention (not to be wished upon anyone). Working in a hospital situation emergency care is immediately available and if the patient is disturbed and uncontrollable the quickest and most humane way to provide immediate relief is to get the staff to physically hold them down while being catheterized.

I had my surgery done at the Mymensingh Medical College Hospital by Prof. Fozlul Haque Siddiqui to whom I am constantly grateful. The prostate however remains and later on problems can recur. I rang the professor who advised keeping the catheter in for a few days, going onto medication and visiting him two weeks later. An indwelling catheter is not so thrilling (especially when you are working) but then neither is the drug tamsulosin.

Our American doctors Jason, Merindy and their newborns are on the way (see below).

Doctors are necessary but not easily available in the rural areas (where 85% of the people live). The famous Gonoshasthaya Kendra (well known for its commitment to the poor) offered us rotating internee doctors. Roton (health programme administrator) and I decided to do a round trip. We would go from Kailakuri to Gonoshasthaya and meet with Prof. Laila (head of the medical college) and Dr. Kader (head of the entire G.K complex of hospitals and projects) and then Roton would drop me off in Mymensingh and go on home. We left Kailakuri at 6:30 am and reached G.K at 12:30 (120 km). We had lunch with them and a very good meeting. They are offering to give us six monthly alternating internee doctors. We set out again at 2:30 and reached Taize House (paradise) at 7:30 pm (110 km). Roton left me there exhausted in the care of the brothers (Ujjol came next day to take me for my checkups in Mymensingh). Roton reached home at 11:00 pm (50 km). Many of our staffs deserve gold medals.

5. IDRIS ALI'S THROAT:

Idris Ali is aged 50 and fairly poor. He supports his family with three children by selling rice. He developed moist coughing bringing up blood a month ago. His house is practically next door to Roton's who sent him to us. He was referred to our TB department where the paramedic took sputum tests which were negative. Unfortunately he then sent him home without proper assistant (for which I gave him three weeks suspension. (He is now back at work on a day labour basis under close supervision). The family took him to a private hospital in Madhupur. Which did non priority investigations (including cardiac ultra-sonogram) and took 4000 taka. Roton, then sent him back to us. We sent him for laryngoscopy. (The cause had to be either cancer or TB). This was only available at a private hospital in Mymensingh and cost us 1000 taka. The left vocal card was paralysed. In our area the most likely cause would be either diphtheria (expected recovery) or nerve damage from cancer infiltration from the esophagus.

The next step was endoscopy. We were tube feeding him because he couldn't eat. However the relatives have taken him away to a traditional heater who has him on a fluid diet which he seems to be managing. We hope he will survive!

Summing up:

We are convinced that ways have got to be found to bring medical costs down and make care accessible to the poor. KHCP has developed ways to do this but the doctor is ageing. We are strengthening staff and structures, hunting for doctors and constantly hoping and praying that funding (almost entirely from private donors) will continue. Our two young American doctors Jason and Merindy are determined to come together with their newborn triplets (birth weights 1.2, 1.3 and 1.5 kg!!!) These two doctors are enthusiastic and committed to come with their three newborns. If only we could find just one Bangladeshi doctor with just one newborn baby enthusiastic to come and secure our project's survival!

We are planning to start an in country piggy (matir) bank programme to boost local income. If any of our in country Bangladeshi readers would be happy to hold a "matir" bank for us to help income, please let us know.

Best wishes and thanks to you all and especially to those who are keeping the Islamic fast,

Edric, Oneka, Bipasha, Hajera, Hena, Suruj, Ujjol, Nadine, Pijon, Roton and team.

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WEBSITES

http://sites.google.com/site/kailakurihealth AND www.kailakuri.com

Donations can be made by...

1) Posting a check to Ted Rose, Treasurer, Asia Connection Inc., (www.asiaconnectioninc.org)
600 Pennsylvania Ave. Unit 2, Los Gatos, CA 95030-5864, USA (NB new address)

   Please make the check out to Asia Connection Inc. and on a separate note state that it is for the Kailakuri Health Care Project, give your contact details for a receipt.

2) Paying online through our website via Paypal at http://sites.google.com/site/kailakurihealth

3) Making an online payment to our New Zealand Bank Account (ANZ, Whakatane, New Zealand):
Account Name: Kailakuri Health Care Project - Link Group; Account Number: 01 0486 0185024 00

For 2 & 3 please email Glenn Baker at treasurerkhcp@gmail.com with your donation and contact details for receipts, also details of any regular automatic payments set up.

4) Posting a cheque made out to "Kailakuri Health Care Project - Link Group" to
KHCP-NZ Link Group, 33 Waiewe St, Whakatane 3120, New Zealand

Thank-you so much for your support.

Our greatest need is gifts towards on-going running costs.