Newsletter

Kailakuri Health Care Project

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

Village Kailakuri, Madhupur Thana, Tangail District, Bangladesh

APRIL 2013

Health care for the poor is never self-sustainable if the poor are truly poor.

(Edric Baker)

Can you help?

Will you walk with us for the next 12 months and then review?

Jita Mrong is 40, married with four daughters and one son. Her eldest daughter is married. Her husband, the only income earner in the family, works as a farmer.

Jita developed asthma symptoms in late 2009. She felt awfully tired all of the time and sometimes her breathing was so bad she felt like she was going to die. She was unable to carry out her usual cooking and household duties at home.

When Jita first visited the Kailakuri Health Care Project (KHCP) in October 2010, as an outpatient, she had a difficult cough, breathing problems and her whole body was in pain. A locally trained paramedic was able to diagnose her asthma and prescribe the appropriate treatment.

In addition to asthma, Jita also suffered from gastric and eyesight problems, which were also dealt with. Staff members taught her how to look after herself and how to take the medication properly. To begin with Jita came back every week for a check-up and to collect her medication. She now returns monthly at a cost of 25 taka/mth. (NZD0.38c/USD0.32c)

Jita can now manage her household duties easily and when her asthma flares up every now and then, the symptoms go away with medication.

Jita accessed medical care because of the low cost of treatment at KHCP. She felt that if the KHCP hospital had not been here she probably would have died. Jita and her family cannot afford treatment at other hospitals and rely on the Kailakuri Health Care Project.

In 2012 with a staff of *93* and at a cost of *171,00,000 taka (USD215,000 / NZD260,000)*, the Kailakuri Health Care Project served the local community. There were

42,060	Outpatient Visits,
23,000	received Health Education,
1,434	Diabetic Patients were regularly seen,
1,302	Inpatients received treatment,
992	Under 4 Year Old and
370	Pregnant Mothers were regularly seen in their homes through the Village Health Programme and
77	TB patients were treated (96% cure rate)

Over 31% of Bangladesh's population, around 48 million are in the category of 'poor' (those who have difficulty getting basic necessities such as food, housing, clothing and medical care). Health care is out of the reach of the many of these people. If part of the population is unable to access basic health care and health education they remain struggling, often with easily treatable common illnesses and diseases. And often when someone is unwell or there is an accident the family is forced to borrow money for medical costs plunging the family further into irretrievable poverty.

Funding groups prefer giving to organisations for start-up projects, for construction of buildings or provision of other capital assets rather than on-going running costs. For example a grant may be acquired for the first three years of a new project. What happens after that? Usually the funders expect the project will become self-sustainable. To achieve this

the project needs a regular income. It must then rely on those to whom it provides its service(s), to individual donors and the very few other organisations which will give for on-going running costs. If the project relies solely on those who need/use their service, it then finds it necessary to cut out the very sector of society that need help – the 'truly' poor.

Funding for on-going running costs is the most difficult to find.

Kailakuri Health Care Project (KHCP) provides health care for the 'truly' poor. Those who are not poor are turned away. Many families bring their sick here as they cannot afford to go elsewhere. Investigations and treatment are simple and diagnosis of the patients usually falls into the category of common illnesses and diseases.

Many of these problems are easily treatable with the skills of well-trained paramedics. KHCP's paramedics come from the local community. Many have low educational qualifications but are intelligent and highly motivated. Coming from the local community they are able to understand the ways of their community and not only dispense medication but effective advice which fits into the cultural settings of the patients.

Kailakuri Health Care Project has gained a positive reputation amongst other medical institutions in Bangladesh and acknowledges with gratitude the support it receives from BIRDEM Hospital(Diabetes Association of Bangladesh), Damien Foundation and the Government of Bangladesh (National DOTS TB programme), the Mymensingh BNSB Eye Hospital, Lilly Company (free syringes and concession priced insulin through BIRDEM Hospital), Madhupur Government Health Care Complex, the Medicins-Sans-Frontier/Government Mymensingh Kala Azar Programme, Taize Bros in Mymensingh, the Pirgacha Mission, and Notre Dame College, Dhaka.

If poorest of society are given the resources to lift themselves up then the whole of society must be better off. If a community is healthy, adults are able to work and children are able to attend school and learn, all having the opportunity to improve their circumstances and make a positive contribution toward the economic and social well-being of society. If a community is unhealthy the opposite happens. It stands to reason that the elimination of poverty benefits all.

Working at Kailakuri and building relationships with many who are truly poor, my impression is that those ready to be a drain on society are very few compared to those wanting to work and study hard to better their lives but are blocked through various circumstances.

So will you consider supporting us financially for a period of 12 months and then review to help us build up reserves?
Right now the balance in our account will only allow us to operate for another 5 months; it increases in small amounts each month but not enough to sustain us through a vital transition period.

We are working hard at building up in-country support but know that this will take some years. At the beginning of 2013 we held a Symposium "Making Health Care Accessible to the Poor" in Dhaka (see page 3). Through this and the building up of contacts within Bangladesh we hope to develop Bangladeshi support.

Next year Drs Jason and Merindy Morgenson will begin work at Kailakuri. They plan to stay long-term. This more than anything gives the Kailakuri Health Care Project long-term security and we humbly thank God for Jason and Merindy.

Discussions continue on the viability of using the KHCP as a model for future health care projects in Bangladesh and even other parts of the world. Dr Edric Baker has developed a health care system which could well provide millions of poor with one very important resource needed to improve their circumstances.

Please help the KHCP to continue to be part of the solution for health care for the poor.

Christine Steiner
KHCP English Administration/Funding Coordinator

P.S. Latest news from Jason and Merindy is that because of health issues their commencement may be delayed, however, we are hoping they will still start next year.

Donations can be made by...

1) Making payments to our New Zealand Bank Account (ANZ, Whakatane):
Account Name: Kailakuri Health Care Project - Link Group, Account Number: 01 0486 0185024 00

2) Paying online through our website via Paypal at http://sites.google.com/site/kailakurihealth
For 1 & 2 please email Glenn Baker at gabakerbcs@clear.net.nz with your donation and contact details for receipts, also details of regular automatic payments set up.

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

Thank-you so much for your support.

If you have not received a receipt for a donation made in 2012-13 year ending 31st March 2013, please contact our treasurer, Glenn Baker.

Anis Rahman, works in outpatients registration. is married and has lived in the Kailakuri village for 15 years. Anis has 1 son and 2 daughters aged 10 to 3 years.

Anis started work at KHCP after his stay in the the hospital as a diabetes patient. About 9 years ago, he began having fits every few days. To begin with the paramedic staff wondered if this was a symptom of his diabetes, however, after testing his blood sugar (which was normal) and discovering more about his fitting episodes, a senior paramedic was able to correctly diagnose his epilepsy.

While Anis still has occasional fits, his epilepsy and diabetes are both well managed with medication. Anis is one of a number of ex-patients who have been employed by the hospital. Having experienced the care the hospital provides these patients make excellent staff often working in the area of their own health issues.

SYMPOSIUM- 2nd March 2013

P.T.O

"MAKING HEALTH CARE ACCESSIBLE TOTHE POOR"

On 2nd March we were enabled to put on a high level scientific Symposium in Dhaka on the subject of Making Health Care Accessible to the Poor. The Symposium was presented by IIRD with the help of the Department of Nutrition of the ICDDR,B (International Centre for Diarrhoael Disease Research, Bangladesh). ICDDR,B gave their auditorium, and financial backing was obtained from PEAL (Pipeline Engineers and Associates Ltd), Eli Lilly and Co, Fresh, Md. Kabir Hossein, Square Hospital and the MGH group. Most of the organisational work was done by Prof Faisal Hasan (Dhaka University) and the Kailakuri staff. The Symposium brought together top performers from both government and NGO sectors, together with representatives from the media and the commercial sector. The auditorium was packed. The papers presented were excellent and gave wide coverage of the problems and a diversity of approaches. Discussions were very stimulating and the summing up speeches by Dr Zafrullah Chowdhury (our Chief Guest and founder of Gonoshashtya Kendra) and Prof Tahmeed Ahmed of ICDDR,B were superb.

Various presentations approached the problems in different ways but not one was able to present a method with a very high probability for widespread success. The problem is so vast. Several types of community services were illustrated with various categories of workers, one with externally funded low-priced services, and one was a health insurance with plan for group saving to enable medical cost payments.

The papers and discussions displayed wide-spread concern about the problems but considerable discontent and frustration about the possibility of a universal panacea.

But we are not going to give up!!

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WEBSITES

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