Health for the Poor (by the Poor) KHCP and sustainability.

May 2015

Sujit, Pijon, Roton, Onen, Bijoy, Hakim, Leo and Edric:
"**We are urgently needing an English office and communications assistant who will stay for one to two years**."

I. The Fourth World and the Indian Border: It is now known that all countries have a segment of their population which is chronically poor. This subgroup or subpopulation is often unrecognised or even forgotten but can almost be considered a separate national group with its own separate history and culture, own ways of thinking and behaving (unintelligible to others) and own specific difficulties. Often these people are marginalized and rejected. Life for them is hard and they can be very difficult to live or work with. One of their difficulties is getting health care which they can accept and make use of. But their most important need is to be recognised, accepted and included in society. Collectively globally they have been described as the Fourth World. The role of the Kailakuri Health Care Project (KHCP) is to accept them, be a part of them and ensure their health care.

Poor people have a history. Bangladesh's northern border with India has a history going back far beyond the Indian-Pakistan partition in 1947. The border is 160 miles long. The great forested hills of Indian Meghaloya with the world's highest rainfall give way to the flat alluvial plains of Bangladesh. This was tribal area (Garo, Kashi, Kooch and others) but with the huge Bengali population expansion it now has a mixed population. With national and international and ethnic conflicts there were times when tribal people fled across the border into India. Many remained but many returned to find their land illegally occupied.

Forests were cut down and forest land occupied for agriculture. Desperately poor Bengalis migrated into the area. There were floods and droughts. Each ethnic group has its separate history, community, religion and culture and often language, but together they share a common history and culture of poverty, neglect and oppression (not everybody is poor). Family is all-important. Border area livelihood is based on hunting and gathering, slash and burn, agriculture, small commerce and handicrafts. Main crops are rice, yam, cassava and various varieties of potato. Difficulties have been exploitation, land loss, border strife and crop destruction by wild pigs or herds of elephants. With deforestation in Indian the elephants come down from the hills in herds of 20,30 or 50. They do not appreciate being disturbed while eating and become vicious if attacked. They can kill by picking people up with their trunks and hurling them to the ground or by just trampling on them. If

threatened, they will destroy homes. The only way to frighten them off is with fire. They are a government-protected species.

The KHCP village of Kailakuri is about 50 miles from the border.

II. **The Importance of Family:** Torun Raksham is aged 26. His father Michael Nengminja was a builder and Torun used to help him. Michael's eyesight has deteriorated. So he can no longer do much work. For the last six months Torun has been suffering joints pains and has been unable to work at all. His father brought him to us a week ago.

The Garos are matriarchal and matrilineal. According to tribal marriage custom Michael was taken as husband to the home of his wife Rebekka Raksham. Even then it was a poor home. However over the past 20 years Rebekka has been mentally "short." She sits alone talking to herself, understands nothing, sometimes shouts, disputes or sings loudly or takes off her clothes and goes around naked (she has schizophrenia). The oldest son Bruno aged 27 works as a security guard in Dhaka but is unable to send money home for the family. Then comes Torun, then a brother named Bablu aged 18 who is severely handicapped following a febrile illness seven years ago. He is unable to either sit or walk. Then is Pria a 15 year old sister who was working in a beauty parlour in the great port city of Chittagong and is now married to a Bengali Christian and become part of his family. So she is not able to help either. The youngest is Dhiroba, a boy aged 13 who has probably got either acute rheumatic fever or acute juvenile rheumatoid arthritis.

Obviously this is a severely disabled Fourth World family. Close relatives are too poor to help. They live nearby to a Catholic mission and get some help from the priest there. There is also a small dispensary which is not able to do much. (Previously this was quite a good hospital run by a French religious nursing sister but she died of cancer and the hospital went into demise----. **We do not intend to allow this to happen to Kailakuri!**)The priest gave money for Torun to come to us and is going to send the mother and youngest son as well. (Latest news: Torun has run away and gone back home and the others are probably not going to come--a typical example of the understanding gap between the extremely poor and their potential helpers).

III. **Sujit Rangsa's Family:** Sujit is now aged 35. He grew up in an extremely poor Garo home five miles from the border. His father, now 60, was at one time a mission school teacher. He and his wife still work as land laborers when work is available about four or five days a week. Sujit was a good student but failed school certificate because debilitated by uncontrolled diabetes which he had been suffering for four years. Previously his treatment had been funded by World Vision. I was introduced to him when visiting the mission there in 2001 and brought him back to Kailakuri.

Cyril and Sujit

The next son Cyril is now 33. He left school before school certificate and worked in a restaurant in Dhaka for 12 years. He was brought to us with a huge kidney mass. We had him operated at the Dhaka Medical College Hospital where they drained off three litres of pus and found him to have TB. We completed his treatment from Kailakuri and then he returned to Dhaka. Three years ago he

met his wife there, also from the border area but working in a beauty parlour. They married and he now lives in her home. She is the inheriting daughter and they have a small piece of land.

The third son Monjit is 30. After four years at high school he got drawn into an undesirable group of youths involved in various kinds of antisocial behaviour and the family had difficulty getting him out but eventually succeeded, sending him to a different area where he worked in a rice mill. Now he has married a very poor Bengali Christian girl from another part of the country and brought her to his home. He supports her by catching eels. After Monjit comes Russel (27) who works in a garments factory in Dhaka and sends money for his parents. Then comes Rupia (25) who teaches in an NGO high school and is able to help her parents. Last is Surobi (17) who has entered a group of Catholic religious sisters, the Salesians, the same group that runs the dispensary in Torun's village.

IV. **KHCP Sustainability:** Sujit came to Kailakuri as an uncontrolled diabetic patient in 2001. He regained heath, learned to control his diabetes and became a good paramedic. At the same time he studied at Open College and passed school certificate and university entrance. He married and has two sons. The first, Rodro has cerebral palsy, is extremely handicapped, aged nine and still unable to sit and talk (but he can certainly 'talk' and control his parents with eyes!). Sujit and Shima are devoted to him. The second is Spring who is a boisterous hyperactive 4½year old.

Sujit became one of our best paramedics, highly committed to the KHCP and an excellent organiser. KHCP has a strong paramedic staff, short term rotating internee doctors and good management. The project is supervised by an elderly seriously ill medical doctor (myself) and is expecting two doctors, Jason and Merindy Morgenson from America. However they are having some problems and will probably have difficulty starting at Kailakuri before February next year. **We do not however intend to allow the Kailakuri essential health programme for the poor to go into demise!** The KHCP committee has appointed Sujit as Acting Medical Coordinator (project director) until Jason and Merindy come or we have another ongoing doctor who can take the role. Dr. Mariko Inui from Japan will be back in two weeks and will be with us for three months (very very many thanks to Mariko and JOCS!). **Our next most urgent need is for an English office and communications helper who will be able to stay for one to two years** (thus securing funding!).

(Edric Baker).

Our present leadership structure is:
Sujit Rangsa (Acting Medical Coordinator), Edric Baker (Medical Adviser),
Assistant Directors: Pijon (management), Roton (health programme), Hakim (Diabetes), Onen (inpatients), Bijoy (outpatients), Leo (village mother-child health), Edric (medical adviser and English office).

Back Row: Sujit, Onen, Bijoy, Leo.
Front Row: Pijon, Roton, Hakim, Edric.
(**Backdrop**: Beautiful Kailakuri).

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