KAILAKURI HEALTH CARE PROJECT

(Kailakuri & the Mati NGO)
Village Kailakuri, Madhupur Thana, Tangail District, Bangladesh

CHRISTMAS 2013: HOPE AMIDST SUFFERING

(Concern & Justice versus Disparity & Sustainability)

Dear Friends of Kailakuri

Thank you for your kindness. We wish you all the best of Christmas Greetings while sharing with you the problems and hopes of our people and situation.

Problems

Typhoons, floods and crop failures are natural disasters that strike unevenly resulting in both poverty and area disparity. Not only that but in the afflicted areas the powerful can stand up and recover whereas the poor and marginalised cannot.

But not all disasters are natural. A few years ago tumeric sold at a huge price. The following year everyone switched their cash crops to tumeric but the Indian market was lost because they had received adulterated tumeric from Bangladesh. Many became bankrupt (including Roton, one of our key staff members).

The high costs of education, medical care and lawyers' fees (and false court cases are common) push the poor into debt. Microfinance, which can make fortunes for the middle (and even lower middle) class along with the organisations that present it; can destroy the poor who are unable to repay their loans. And TV vigorously promotes unwise costly consumerism.

Politically instigated strikes, besides leading to breakdown of law and order, block transport, lead to decay of foodstuffs and raise market prices for the poor. Sadly the two leading political parties while rigidly opposed to each other on almost everything else are united in their commitment to total confrontation leading to violence (which tends to target minorities) and travel/transport blockades, disasterous for the poorest sections of the community.

BLOCKADE TO BURN PEOPLE?

In developing countries it is practically impossible for governments to undertake the whole multitude of activities and services necessary to meet the basic needs of the people. Hence the tendency for NGOs to proliferate, filling in the gaps. But they also need to find ways to develop and sustain service capacity, staff, office and administration

requirements, and they come unders pressure for sustainability from international aid organisations (freeing the donors from ongoing obligation). A lot of effort and efficiency is needed. Success however can lead to NGO affluence, even sometimes turning the NGO into a profit-making business hardly distinguishable from other profit-making businesses. Part of the cost may come from client payments. But even when payments are not taken from the poor, buildings, sophisticated administration and huge staff salaries cutting into service expenditure can in fact help sustain disparity.

If it is recognised that social inequality is of itself problem creating for the low income sector then it becomes apparent that despite various health and development activities it may be possible for NGOs to be not having very much effect on disparity issues. Then the bitter irony is revealed. Schemes which make organisations sustainable may be the very schemes which make solutions either unreachable or unsustainable.

A clear example of this is the medical college hospital. In order to be sustainable it must take high fees from its students. This means only the children of wealthy families (which compete economically with poor families) can afford medical education. In order to attract these students it must present a medical education that prepares for high paying employment in urban hospitals either in Bangladesh or overseas.

The Kailakuri Health Care Project (KHCP) is committed to health care for the poorest. It achieves this in three ways:

(1) Making costs very low (this requires prioritisation, simple low cost methods and low salaries). At Kailakuri salaries are low because the staff are local poor people caring for those in their own communities;

(2) Joining hands with other health organisations for cost sharing; and

(3) Finding external funding (this requires effective communication and information transfer).

However it is necessary to have medical supervision in order to satisfy government authorities. Doctors Jason and Merindy will not begin working at Kailakuri until July 2015 and because of language study will not be fulltime until July 2016. Even then they will be returning to America for six months every three years.

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Kailakuri needs Bangladeshi doctors as well. The difficulty is that the doctors produced by the medical colleges have been trained for and are eager to work in sophisticated urban situations employing costly technology and costly treatments

and have great difficulty with the hardships, frustrations and income levels pertaining to living with the poor. Even with high salaries it is almost unknown for doctors to continue on in remote rural areas. This is the problem that Kailakuri faces. We are still hunting for Bangladeshi doctors.

Solutions

1. I was recently asked to give a week's talks to medical students and others at the Gono Shashthya Kendra (GK). This is a very famous health organisation established by Dr Zafrullah Chowdhury (a wartime surgeon in 1971 at the end of the Liberation War) and has always been a champion of poverty issues, health for the poor and empowerment of women. The 2000 student medical college is headed by Prof. Laila who was a freedom fighter. She saw her father and other relatives shot before her eyes and for three days they were not allowed to touch the bodies left out in the rain. She is a woman of great courage and determination. The medical college is excellent but suffers from the same problem, how to get the graduates to go to the poor. I was invited to help with motivation.

They have two schemes which may well turn to our benefit:

i) Rotating interns are required to do three months in village centres. If we could have an arrangement of GK internee doctors rotating through KHCP this would enable the project to fulfil government regulations in the event of there are being no other regular ongoing doctor. And being internee doctors, it would be a requirement for their registration that they follow the standard treatments of the project and other rules necessary to keep costs low and services effective.

ii) GK has a small number of poor medical students whom they fund on the condition of a five-year bondage. If we could enter into partnership with GK and get five year rotating GK doctors then not only would that ensure our government acceptability but also they would be with us for long enough to fully identify, teach staff and strengthen and adjust programmes.

2. We have now become a part of the MATI NGO based in Mymensingh. This NGO is committed to the alleviation of poverty and determined to do it in a way that does not sacrifice the sustainability of people to the sustainability of structures and high salaries. Lenen Rahman is the executive director and a friend of the principal of the Mymensingh Community Based Medical College Hospital whose official aim is to prepare doctors to work in rural areas (a hard task for a private medical college!!). The principal wants to visit Kailakuri and check it out as a possible venue for rotating interns, another possible solution to our problem!

KHCP believes it has found the solution to health care for the poor, health care to overcome disparity. Do we have to allow disparity to block it?! Somehow we have to find doctors who will recognise the problems and share our commitment to solve them. And it is not only Kailakuri. 85% of Bangladesh's 160 million people are rural, 30% are poor and 20% extremely poor.

Gareth Morgan (a famous New Zealand philathropist and supporter of KHCP) has said KHCP is the model which should be rolled out across the country for the poor. Already we have restarted in the village of Thanarbaid and will go on to Dhorhati and Subokachona. Enthusiasm we have. Constraints are funding, management and medical supervision. The Swiss organisation World Child Future Foundation has agreed to fund our mother-child programme. (Thank you ever so much, Rita)

A famous Bangladeshi businessman Mintu (Abdullah al Mahmud, who introduced compressed natural gas technology to Bangladesh from New Zealand and who is an enthusiastic friend of KHCP) agrees that the model should be extended all over the place for the poor. But he says "Find me 100 suitable doctors!!"

The father of modern medicine, the famous Rudolf Virchow of 19th century Germany wrote "The purpose of medical education is not to prepare medical students for lucrative careers but to improve the health of the people!"

Kailakuri is dependent on communications and in the modern age this means English speaking computer "experts". The word expert here means people who will persist when Internet connections fail! (Kailakuri must be the worst place for Internet connection in Bangladesh which is itself not the best country in the world in this respect). I want to express our very sincere gratitude to Christine Steiner and Helena Boonstoppel from New Zealand who gave us great help despite extreme difficulties, and now to Nadine Vickers who has taken over the role with great enthusiasm.

And I must sincerely thank all our staff who work with such amazing devotion to help the poor. Christmas is the season of divine hope and joy. Surely they express this vividly. And we wish Christmas blessings on all our friends and on this world sad with its disparities. Please pray to Almighty God that we may find doctors and also a replacement for Nadine when her time comes to leave, and please pray for the kind of concern, justice and sustainability which God considers to be best.

Best wishes, Edric

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.

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