

KAILAKURI HEALTH CARE PROJECT

(Kailakuri & the Mati NGO)

Village Kailakuri, Madhupur Thana, Tangail District, Bangladesh



Christmas Good News for the Poor

December 2014: Health for the Poor by the Poor & the Kailakuri Health Care Project, Present and Future

I (Edric) often feel intensely embarrassed when people praise our work and praise me as if I invented it all and brought it into fruition. First I should say that inspiration and concepts came from home and education influences and basic ideology in the New Zealand I grew up in. Then I should say that these ideas were crystalised into mission conviction by the clear teaching of Jesus, the Lord (I am Christian) who demanded two things, that we love God and care for others, backed up by his giving up of everything to lift us out of the evil reality we are caught up in and to create a new society.

General and medical education, subsequent poor country experience and appropriate post-graduate study gave me tools with which to work and I got a huge impetus of drive and determination from exposure to impressive mentor-models and the radical social equality teaching of communism and to the war situation in Vietnam.

Our Kailakuri Health Care Project endeavour started from a small closed down dispensary of the Church of Bangladesh in the Mandi tribal village of Thanarbaid in the north central part of Bangladesh 2 miles south of Kailakuri in 1983. Right from the beginning it was a people project coming as much from the

wisdom and cooperation of the local people and Church and the community health concepts of the wider Christian community and from government programmes as from what I had to contribute. Then we have had several remarkable foreign staff for whose contributions I have often reaped the praise!



Now we have a vigorous highly motivated primary health care programme with 93 staff none of whom have national acknowledged medical qualifications, which touches about 27,000 people per year (in an almost unbroken continuum of a 160 million population). We consider about 55% of the people in our area to be poor and our aim is health for them done by them. Last year for a cost of USD 245 thousand (BDT 19 million,

NZD 300 thousand) we provided home mother-child care in 18 villages (1,400 under fours and 400 antenatals), gave health education messages to 25,000, saw 44,000 outpatient visits, cared for 1,800 diabetic patients, treated 84 TB patients and sent 97 patients elsewhere for surgery.

We have received widespread publicity and acclaim within Bangladesh but are generally criticised for being “unsustainable” and ultimately dependent on one person (myself)! That one person now has a serious progressive illness (pulmonary hypertension). What have we done to prevent collapse when that one-person withdraws/drops out?

The project has a strong motivated team of well-trained paramedics and we have updated our standard treatment book covering all the common diseases in 92 pages, which they have to follow. At present there is only one resident doctor (myself) but our Japanese lady doctor (Mariko) has made a return visit (and may make more). We have commenced an internee rotating doctor programme with the Gonoshashtaya Kendra Medical College Hospital (Bangladesh) and our two highly committed American doctors Jason and Merindy will arrive in April. Jason will come for a 3-week preliminary visit in January to learn the administration.

The KHCP management is strong and account keeping is good, transparent and government audited. The project has good relationships with government and the local communities. The majority of community care, patients and staff are Muslim but with significant minorities of Christian and Hindu, three ethnic-religious groups. Each day begins with joint prayer with the scriptures and involvement of the three groups.



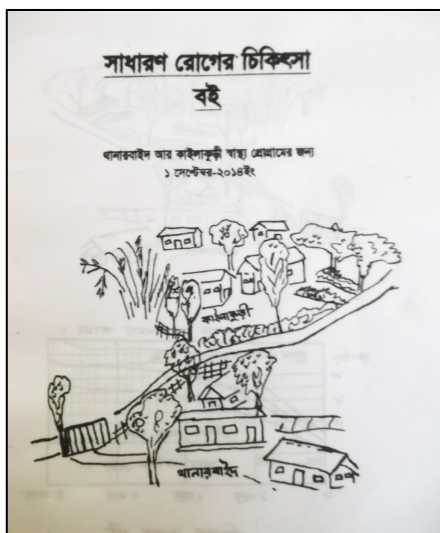
The project is part of a dynamic well-organized national NGO named Mati, which is committed to poverty alleviation and is influenced and supported from Germany. We however run our own project; make our own decisions and find our own funds. It has been particularly important to prepare a memorandum of understanding with Mati which defines the aims, methods and independence of both parties while at the same time enabling mutual support.

The Kailakuri Health Care Project however is owned by the diabetic patients! This is a historical reality following earlier efforts to make sure that these people all with a life-long disability could control their own project and destiny without the danger of being cut off or dropped. Now however we have the situation of the diabetes programme being about a 1/3 part of a vigorous general health project which should in no way be governed by patients of a single illness group.

So we have had to go back into the historical documents and work out a structure which would protect both the diabetes programme governed by the patients, their constitution and their committee and at the same time giving the general overall project to be controlled by the Project Committee which is a combination of staff and community

members. The ultimate authority for the diabetes programme is the Diabetic Patient Body and the ultimate authority for the overall project is the joint meeting of the Project Committee and Diabetes Committee together.

To make this possible required preparing an official history of the Kailakuri Diabetes Rehabilitation Project and KHCP, an official statement document of their relationship and a revision of the Diabetes Constitution. These have been done and passed by the two committees. They await however approval at the next Diabetes Patient Body meeting in 2016. Patients and community are intimately involved in decision-making. The medical coordinator is a member of each of the groups. In addition to these there are staff management groups. The daily running of the project is by the medical coordinator, department heads and management groups. All major decisions are made by the committees. Very major decisions and policy changes are discussed with Mati NGO and relevant support groups and organisations.



In preparation for the arrival of the new doctors together with the revision of the Treatment Book the paramedic leadership structure has been adjusted and

strengthened and a deputy medical coordinator appointed (Sujit Rangsa, senior paramedic) who will become acting medical coordinator in the event of an ongoing residential qualified doctor not being

available. All staff are highly committed to the aims and methods of the project. The paramedics are competent and able to run the project with a minimum of medical supervision and consultation.



Problem patients (especially surgical) are regularly referred to other hospitals. In addition to the direct relationship with government health services the KHCP is in communication with UNICEF which will be extensively involved in health work support in our district. We are seeking to strengthen relationships and cooperation.

The management, finance and fund monitoring structures of the project are strong but it will be essential to develop closer cooperation between management and medical-health activity without so drawing health care expertise away into administration as to erode health care supervision.

Basically the project is made financially possible by the combination of simplification and cost reduction, avoiding costly professional staff, cooperation with other medical/health organisations and receiving external donations. Almost the entire funding comes from private donors mainly in New

Zealand and America. The main supporters are Gareth Morgan (New Zealand), BIRDEM Hospital (Bangladesh), World Child Future Fund (Switzerland), Asia Connection Inc. and Quail Roost Foundation (USA) and the Mymensingh Bangladesh National Society for the Blind (BNSB) Hospital and Damien Foundation in Bangladesh (not to mention the Bangladeshi Social Islami Bank and the Dhaka British and American Women's Clubs). Even so the majority of funding comes from perhaps several hundred private donors. It is essential to maintain regular contact with these people and to send out regular newsletters (in English and Bengali).

Communications and funding have been the special responsibility of Nadine (Vickers) who after giving considerable support is now departing for New Zealand where she will commence development studies before returning to do development work in

Bangladesh. We are very grateful to her. She will speak to various groups in New Zealand on our behalf. We are anxiously busy seeking a replacement for her.



We are now embarking on a programme of distributing "piggy banks" in the wider Bangladesh community to increase local support. This method is accepted in Bangladesh and will build on the widespread publicity we have received.

The future sustainability of the project is in place but will not come about without strong commitment and generous support. Christmas season is the time of new hope for a new society and humankind. Please continue to support us - Edric Baker

KHCP – NZ Link Group NEWS

If any group would like a speaker, please get in touch with Peter Wilson, NZ Link Group Coordinator: kailakuri.nzlink@gmail.com

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WEBSITES

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

Donations can be made by...

I. Paying online through our website via Paypal at <http://sites.google.com/site/kailakurihealth>

II. 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

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.

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

For any changes to your contact details or if you would like to receive your newsletter by email
please contact Hilary Lynch at tui_eden@xtra.co.nz
Thank-you so much for your support