DECCAN HERALD, FRIDAY, AUGUST 8, 1997 B

30 kids hospitalised after consuming energy food

By Our Staff Reporter

BANGALORE, Aug 7

Over 30 children from the anganwadi kendra of Nettigere village in Bangalore South Taluk were admitted to Vani Vilas Hospital due to suspected food poisoning here today.

The children started vomitting and their tongues turned blackish soon after they consumed the energy food given to them at the kendra this afternoon. The anganwadi teachers and others immediately rushed them to the hospital.

The children were administered oral rehydration solution (ORS) immediately after their admission and the condition of the children is said to be stable.

Doctors suspect the food was fungus infected. A team of doctors comprising paediatricians were attending the children.

Resident Medical Officer Komala Shettar, who was monitoring the condition of the children, said chemical examination of the food was being conducted to ascertain the exact cause. About half of the children admitted have been kept under observation, she said.

Sunandamma of Bolare village, whose children Lakshmi (5) and Ratna (9) were hospitalised, said that it was the first time that such a thing had occurred. "My children started complaining of burning sensation in the stomach and later started vomitting," she said.

Rajeshwari, an anganwadi teacher, said that 34 children had consumed the food. Some of the children had shared the food with other children of the village, she said. "As soon as we saw the children vomitting, we suspected something fishy," she said. Two vans from the village were requisitioned to shift the children to the hospital, she added.

FORENSIC REPORT: Meanwhile, when contacted by Deccan Herald, Director, Department of Woman and Child Development Latha Krishna Rao said the forensic report on the energy food would be available by August 8. The director of the Forensic Laboratory had collected the samples of food and also visited Vani Vilas Hospital.

Ms Rao said the energy food given to the children as per the normal food pattern comprised a wheat-base fortified with soya, jaggery, gram and other essential minerals and vitamins. The food is kneaded into balls with warm water and given to the anganwadi beneficiaries under the Integrated Child Development Scheme (ICDS).

She said according to the anganwadi worker who prepared the food at the school, the energy food given to the children today was from the last few packets left from the stock. The food is supplied in one kg polythene packets.

Ms Rao said she had asked the assistant director of the department to direct the anganwadi supervisors not to give children any more energy food in the entire Bangalore (Urban) district till such time as the particular batch of energy food, from which today's packets were taken, could be determined.

She said today's food poisoning was an extremely serious matter as the food was being supplied to nearly 33 lakh beneficiaries in 40,000 anganwadis in the entire state under ICDS.

Bhiwandi food poison victims await relief

(101B 5&6/97

By Rekha Dixit

BHIWANDI: The Bhiwandi-Nizampur municipal council is in no position to honour its commitment to pay the generous compensation it announced for 113 powerloom labourers who were victims of a mysterious case of food poisoning last August, council's vice-president Khan Mukhtar Ahmed says.

Last year, the municipality announced a compensation of Rs 1.5 lakh to the families of each of the 88 workers who succumbed to the poison, as well as Rs 50,000 each to those who survived.

"That compensation was announced in the heat of the moment, when a morcha of angry labourers threatened to turn violent. The officials had to give a written statement to quell them," Mr Ahmed says. "However, we simply do not have such huge funds at our disposal. We cannot afford to fulfil the promise," he adds.

Incidentally, the Bhiwandi-Nizampur is one of the richest municipal bodies in the state. The revenue generated from octroi alone in 1995 was a whopping Rs 52.65 crores.

"Our budget allows for only a sum of Rs 25,000 per head. We are, however, planning to announce a compensation of Rs 15,000 each to the families of those who died. This announcement will be made on August 7, to mark the anniversary of the tragedy," says Mr Ahmed. When asked why the municipality will pay Rs 10,000 less than its "sanctioned budget", he explains, "It will not look proper if our compensation is higher than what the state and Central governments had announced."

The Central and state governments announced a sum of Rs 50,000 and Rs 25,000 respectively as compensation to the families of those who died. No monetary aid was declared for the survivors, though they continue to battle with the side effects of the poisoning even a year later.

However, this paltry compensation is not forthcoming either. The families of only 24 of those who died have reportedly received the money. Says Sakina Bano, whose son-in-law Sirtaj Ahmed died, "My daughter, who lives in Uttar Pradesh, has not received even a paisa so far. What compensation are you talking about?" Nisar Ahmed, who lost his brother Siraj adds bitterly, "The officials are only interested in pocketing the money. We gave all the requisite papers to local MLA Mohammed Ali Khan. But everytime we ask him about it, he says that some papers are missing."

The MLA's men, however, claim that they submitted all documents to Thane collector Ujjwal Uke. "Mr Uke is handling the matter. We have no idea about what is happening."

Mr Uke attributes the delay to the "meticulous" way in which the work is being carried out. "The victims were mainly migrant labourers who hailed from Uttar Pradesh, Bihar and Madhya Pradesh. Very often, in such cases, the actual relatives remain deprived of the compensation while others pocket the money," he says.

"In order to avoid such instances, we are contacting the collectors of each of the districts and obtaining the n[illegible] of the next of kin. Once we are su[illegible] the credentials, we send the mo[illegible] directly to the family."

Bitterness is palpable among friends and relatives of the survivors too. Mohammed Ishaq says, "My friend Rashid recovered. But he often sits down and starts rambling nonsense. He has seizures and cannot concentrate for long. He finally went away to his village. Why wasn't any money sanctioned for people like him?"

Anil Shinde

Mohammed Haroon, one of the survivors of last year's Bhiwandi food poisoning case, stands in the 'bhisi' where the labourers ate the fatal meal. The premises are being used as a storehouse as well as a dormitory at present.

Malaria, viral fever claim 11 in Cachar

FROM OUR CORRESPONDENT

Silchar, July 31: Eleven persons have died allegedly of malaria and viral fever in villages under the Udarbond block in Cachar district recently.

However, the state government's joint-director of health services claimed only two persons had died of malaria in the area.

A local organisation, the Mahakuma Upajati Parishad, in a press release, alleged that 11 persons, belonging to the Dimasa tribal family, had died of malaria and viral fever.

It claimed the diseases had broken out in a virulent form in the Chaltacherra, Ratanpur and Madhupur villages during the past week. The victims were aged between four months and 70 years.

With the advent of the monsoons every year, the rural habitation in the Barak Valley districts in south Assam fall prey to malaria. During last April, about 1,100 malaria-affected people were identified after blood samples were screened in the districts.

Reports of stray cases of death due to malaria during the past four months in the region were ignored by officials, who maintained the victims had died of other ailments.

The low-lying marshy tracts in the districts are dotted with cesspools of stagnant water, providing breeding grounds for anopheles mosquitoes, which are responsible for malaria, that has become a common malady here.

June was observed as "malaria month" to spread awareness about the disease among the local people.

According to the Cachar district officials, 15 malaria detection and eradication units have been set up to combat the disease in the district.

Dearth of adequate and trained manpower, however, has affected the functioning of the malaria units in Cachar and Hailakandi. The districts have only 157 personnel to fight malaria.

Revised TB project fails to break new ground

By Rupa Chinai
The Times of India News Service

MUMBAI: A pilot project for the implementation of the 'Revised National Tuberculosis Programme' in Mumbai reveals significantly poor outreach to patients. Based on a blueprint devised by international donor agencies and unquestioning policy-makers in Delhi, the programme offers no flexibility or scope for creative innovation, thus ultimately ensuring its failure.

Faced with implementing the programme at the grassroots, women community health volunteers (CHV) and medical doctors, despite their sincerity and hard work, are severely challenged. They are thwarted by the lack of training and the absence of coordination among senior bureaucrats.

The revised TB programme offers free drugs that assure a cure within six to eight months, provided the treatment course is strictly followed. The pilot project, implemented in three suburban wards of Mumbai since October 1993, has barely seen the detection of 4,000 TB cases to date. An estimated 25,000 TB cases exist in these three wards, covering a population of 15 lakhs. "More important than numbers reached is the number of people cured. We have achieved 74 per cent cure rate, as against the targeted 85 per cent," says a BMC official.

Discussions with health workers at the Ambedkar Road dispensary in Khar, within the pilot site, however reveals that the project has not been able to break new ground. A process of self selection determines its outreach to the 40 per cent who seek public sector services, creating a false image of successful treatment compliance and cure rates.

Alcoholics, diabetics and migrants are amongst the most difficult to deal with categories amongst TB patients, and are left out of the programme. The component of 'Directly Observed Treatment' in the programme thus expends an immense amount of manpower and money on those patients who are anyway keen to be cured, and are ready to come on their own to health centres, provided drugs are available and services are efficient. In the absence of adequate training and incentives, the health staff are not motivated to follow difficult cases.

Says Jayant Chavan, a doctor at the Ambedkar Road dispensary, "An alcoholic person defaults in taking his medicines. This is the worst thing affecting the pilot project. The slum areas have a high incidence of alcohol and TB. Although our CHV's are required to deliver the drugs three times a week to the patient's home and ensure their intake in her presence, the alcoholic is seldom pinned down. The CHV cannot go to the slum at odd hours of the evening or night. In such cases the programme should allow flexibility to educate and motivate a member of the alcoholic's family in supervising drug intake."

An estimated 50 per cent of TB patients are said to be seeking treatment from private medical practitioners. Studies have established that private sector doctors are prescribing at least 80 different drug regimens, one of the major factors leading to the 20 per cent multi-drug resistance amongst TB patients in Mumbai.

However, even within the pilot project site, there has been no attempt to draw support from these private doctors for the TB programme, or educate them about correct drug treatment. With the local general practitioner's timings usually more suitable to a patient, the BMC staff feel his efforts can be utilised in monitoring drug treatment, in coordination with them.

The therapy prescribed by the revised programme is fairly complex and doctors in the project site have undergone at least ten days of intensive training before mastering the nationally recommended treatment methods. In the absence of a strong training component to the TB programme, it is unlikely that the TB programme can be meaningfully expanded to the rest of the city by next year, as presently slated.

Apart from DOT, a key component of the revised TB programme is that patients are subjected to three sputum tests, taken at the start, during and at the end of their therapy, to ensure accurate detection and successful cure rates. The programme envisages setting up in a phased manner, 100 laboratories across Mumbai, existing or new, each covering a population of one lakh. A trained technician in each such lab will exclusively diagnose TB cases.

The rising number of HIV patients developing TB however, poses a new challenge to the programme. Diagnosis of TB in such patients is not usually possible with mere sputum tests. AIDS specialists say there is need for X-ray diagnosis, as well as recognition of clinical markers such as severe weight loss of over ten per cent of body weight, chronic fever and diarrhoea. While TB have a life threatening reaction to the drug Thiacitazone, Mumbai's health clinics are flooded with this drug. It's alternative, Ethambutol, is not available.

AIDS causing virus spreading in Vietnam

HANOI, Aug. 23 (DPA)

The virus that causes AIDS is spreading rapidly in Vietnam, where about 35,000 people are expected to become infected this year, according to official Vietnamese statistics.

That represents a 65 per cent increase over last year's infection rate and will mean about 100,000 Vietnamese will carry the deadly virus by the end of the year.

The estimates are based on voluntary, unlinked and anonymous bloodtesting around the country — known as sentinal surveillance — which is conducted vice a year.

Without a dramatic slow-down new infection, officials are now edicting Vietnam will have close 350,000 people with HIV, the us that causes AIDS, by 2000, cording to government statistics. At that time it is expected that ore than 20,000 people will have veloped full-blown AIDS and out 17,000 more will have eady died of the disease.

At the end of 1996, 2,612 had veloped full-blown AIDS and 89 had died.

Vietnam is in its early stages of epidemic. The situation is gh and it is going to get worse, Steven Kraus, a United ions-sponsored expert advising Government.

nternational experts praise the oi government's commitment onfront the problem but the ıtry is still far from turning the er on the rapid rise of new

a recent meeting of the nal AIDS committee, offi- admitted poor coordination lack of direction among con- d organisations a major m in the fight against HIV, ling to an official media ıt of the meeting.

committee, which is chaired puty Prime Minister Nguyen , called on the government ly double its expenditures anti-AIDS campaign from ent $ 5.5 million to $ 9 mil- ually.

national donors contribute s much as the government ng on the campaign.

ood news in Vietnam is is a strong political com- from the government at st levels but the challenge translate that into prac- saving steps that will al difference, says Kraus.

More needs to be done to promote the regular use of condoms, to offer effective treatment of sexually-transmitted diseases and to enhance information and educational campaigns, he said.

The government's campaign has succeeded in alerting most Vietnamese to the danger of AIDS but more carefully targeted messages are now needed to encourage safe sexual behaviour, he added.

Foreign non-governmental organisations are bringing their experience from other countries to Vietnam, where officialdom is reported, after some hesitance, to be increasingly receptive to the new approaches.

Save the children (UK) has pioneered the peer education approach in Vietnam to encourage safer sexual behaviour, first among high-risk groups like commercial sex workers, intravenous drug users and more recently to gay men and street kids.

The outreach work has gradually taken in more of the general public just as the virus breaks out from the high risk groups into the public at large.

But working in a sympathetic way with these groups has not always been easy because the government at the same time has launched an anti-social evils campaign aimed at suppressing drug use and prostitution. Homosexuality is still considered deviant.

But increasingly there is a pragmatic understanding of the need for clear knowledge about transmission (of the virus) and the means to prevent that transmission, said programme manager Mark Beukema in Ho Chi Minh city.

That same ambivalence complicates the government's approach to limiting the spread of AIDS among intravenous drug uses.

Until recently anyone caught with a needle or syringe was unceremoniously hauled off to grim rehabilitation centres, where traditional medicines did little to soften cold Turkey withdrawal.

As a result needle sharing is widespread, with assembly line-like injection from a common drug pot the norm in city shooting galleries.

More recently, the Vietnamese government has allowed two clean needle pilot projects to go ahead and the initial results have been encouraging, although it is unclear if more will follow.

Disease stalks flood-hit children

HT 8/8/97

HT Correspondent

NEW DELHI, Aug. 7

With the Yamuna crossing the danger mark, and flooding low-lying areas, thousands of slum-dwellers find themselves homeless today. With their homes waterlogged they have been forced to move to higher ground adjoining nearby arterial roads, including Vikas Marg and the Ring Road.

"My entire house has been washed away," said Shushant, who lived on the eastern bank of the Yamuna near the ITO bridge. "My family does not have a roof over its head now." He has a wife and three young children to provide for, but since he moved he has not been able to go for work.

Umesh is a little better off than Shushant because his house has not been flooded completely. "Everyday I pray that the water level does not go higher, otherwise I will have to move out as well," he says.

Though the house is just a few metres away from the stagnant water, Umesh does not want to move to one of the camps set up by the administration. "If I move out someone may steal whatever little I have in my *jhuggi*. Besides, who will guarantee that no one will encroach on my piece of land once people start coming back?" he asks.

Due to the close proximity to the stagnant water and the unhygienic conditions, several children have already fallen ill, said Badri Narain.

"Many children have been vomiting and have been running not afford to consult a doctor."

He says that till about a year ago there was a school near the slum cluster where local residents could get medicine and check-ups for free. "But ever since the school shut down, we have nowhere to take the sick to."

Slum dwellers were also angry with the administration and said that it had done little to help them. "We have received no help. I remember that about two years back, when there had been a similar flood, we had been given food packages and some monetary help," said Hari Lal, who has been living in these slums for the past 15 years. "However, this time we have been given no help."

"The only officials who have met us are policemen, but they come only to trouble us," said Sriniwas.

The policemen apparently do not let the displaced slum dwellers build any structure too close to the road. But because of their sheer numbers, many have no other choice.

Bridge opened for traffic: Meanwhile, as the Yamuna waters continued to recede for the second day going below the danger level mark of 204.83 metre, railway traffic was resumed on the Old Yamuna Bridge today.

Developing countries face shortage of doctors

WASHINGTON: Developing countries such as India continue to face a severe shortage of doctors while there is a glut of doctors in the developed world, latest figures show.

As per the latest estimates of the World Bank and the American Medical Association (AMA), India has only one doctor for every 2,459 persons in the country as compared to the U.S. which had one doctor for every 1,231 persons.

Ironically enough, these countries continue to be the largest exporters of doctors to the developed world, specially India which has at least 25,000 doctors of Indian origin presently practising in the U.S.

Among the least developed countries (LDCs), the doctor-patient ratio is the highest in Algeria with each physician attending to at least 1,231 people, the figures revealed.

Even Pakistan ranked higher than India in terms of the doctor-patient ratio with one doctor attending to every 1,923 persons.

Among other South Asian countries, Nepal has one doctor for 13,634 people and Sri Lanka one doctor for 6,843. At the bottom is Mali, which has one doctor for 18,376 people.

However, the figures, analysts say, may be skewed as they do not take into account indigenous systems of medicine which flourish in these countries.

Both western and indigenous systems co-exist in almost all South Asian nations and some of the indigenous medicines are found quite effective.

Life expectancy in Kerala and Sri Lanka, where traditional systems of medicine flourish, is very high, they point out demonstrating the efficacy of these systems. In fact, Sri Lanka has the longest life span in South Asia.

Among 20 countries in the world with fewest doctors in proportion to the population, 19 lie in African sub-Saharan region. (PTI)

New Delhi Friday September 26, 1997 ★ Air surcharge extra if applicable Late City Vol. 7 Issue 267 Pages 18 Rs. 2.0

Premier hospitals reject 'AIDS patient'

Staff Reporter
New Delhi

THREE PRESTIGIOUS hospitals in the Capital did not admit a "serious" patient on Wednesday as they allegedly took him to be an HIV case.

According to volunteers of Sahara, an NGO, the All India Institute of Medical Sciences (AIIMS), Ram Manohar Lohia (RML) and Deen Dayal Upadhyay (DDU) hospitals did not admit Prakash Chand (38).

The volunteers, who ferried the patient all over the city for nearly 17 hours (from 6.30 am to 11 pm), alleged that Prakash was not treated because doctors felt he was an HIV positive case.

Meville Felhore, who runs the NGO, alleged that the doctors' attitude was deplorable. "They will not admit an AIDS case and in case they do, the patient will be treated like an untouchable," he said. "At AIIMS, they will put a placard on his chest and bed: `HIV positive'."

Prakash, with a swollen leg, was picked up from the Nehru Stadium flyover. Sahara worker Cedric Fernandes, a reformed drug addict from Bombay, said: "He was in acute pain and we discovered that he was taking drugs intravenously. The needle had pierced his vein and the drug was injected in the tissue beyond it."

Prakash, being a drug addict, looked a perfect picture of an AIDS patient. "At AIIMS, the doctor in the casualty ward did not bother for a Doppler test. Then he just walked away as his shift ended. The new doctor asked us not to waste any more time at AIIMS," Melville said.

Cedric added: "The RML Casualty doctors said Prakash might be suffering from HIV, so they could not treat him. At the DDU Hospital, doctors claimed they did not have requisite facilities. Finally, we came back at 11 pm."

Meville said: "The doctor's attitude was totally pathetic, bordering on revulsion. A patient from Manipur, Lal Malsum, was refused admission in August by AIIMS, Safdarjung and DDU. AIIMS doctors referred him to Safdarjung, where the doctors begged us to take him away. At DDU, the same thing happened."

He added: "A boy, an advanced case, was bleeding from mouth, passing stools and urinating, but none cared for for him in any hospital." Malsum died on August 17 in AIIMS, admitted there with help from a friend in the World Health Organisation (WHO).

Sahara workers claimed that Malsum was kept in a dripping, isolated ward. "The hospital staff kept away from him. If they did enter his room, they maintained good distance," Elizabeth Felhore said.

Cedric said even doctors had misconceptions about HIV positive patients. "HIV is not half as infectious as TB or hepatitis. Hospitals will have to undergo a metamorphosis in attitude. Otherwise, people will start dropping dead of AIDS in Delhi within 10 years," Cedric added.

Malaria-hit Ghaziabad may succumb to dengue too

By Lalit Kumar
The Times of India News Service

GHAZIABAD: With Ghaziabad having witnessed hundreds of cases of malaria in August and pathologists predicting a further upswing in September, fears are being expressed that the area may find itself equally vulnerable to the dengue-causing aedes mosquito.

Meanwhile, the Ghaziabad municipal corporation has an elaborate plan to spray 25,000 houses with a long-acting agent that "kills mosquitoes soon after contact".

Although Ghaziabad chief medical officer Ram Babu claims "there is not much malaria in town", sources say 155 blood samples have in August tested "positive" for the malaria parasite at the district hospital alone. And a district hospital doctor remarks many cases are "masked because patients have already taken medication before coming to hospital."

At another local nursing home's pathology laboratory, a source says there were "about 70 malaria cases" confirmed there in August. "But the trend seems to be toward more cases this month (September)." At the district hospital, in the first five days of September, 18 blood samples have shown the malaria parasite to be present.

But hospitals catering to patients from more affluent areas have fewer cases of malaria to show. Pradeep Verma of Sarvodaya hospital says, "We have had hardly about 30 patients testing malaria parasite positive in August. But then, many educated patients take anti-malarial pills at the first sign of chills and rigour."

A prominent pathologist says more cases of malaria come from the lower-income localities. And there must easily be thousands of cases of malaria a month which are not detected under a microscope. "Very often, physicians prescribe chloroquin without waiting for a blood test."

But Dr Ram Babu, who is also in-charge of the 'malaria prevention unit' in Ghaziabad, says, "Malaria is under control here." He is unclear what steps the malaria unit is taking to prevent malaria or dengue.

On its part, the municipal corporation has plans to start an elaborate anti-mosquito operation from the last week of September. Mukhya nagar adhikari Hardev Singh says the corporation has already purchased cyfluedhrine worth Rs 11 lakh.

Mr Singh says the chemical will be sprayed inside 25,000 homes "and particularly in the slum areas". He says "the chemical forms a coating that kills mosquitoes and remains active for a number of months." He explained that "although malaria prevention is the malaria unit's job, the corporation is spending its own funds for tax-payers as a gesture of our commitment."

Earlier this year, the corporation had used the chemical delta-methrine on an "experimental basis". It has remained active for months. But Mr Hardev Singh pointed out, cyfluedhrine "has fewer side-effects".

Eight more down with dengue

Staff Reporter
New Delhi

EIGHT FRESH confirmed dengue cases were reported on Tuesday in different city hospitals.

Reports came in from the All India Institute of Medical Sciences (AIIMS), Ganga Ram Hospital and Cheeranjivi Nursing Home near Siri Fort. Whereas five patients were residents of Delhi, two were from Panipat and Ghaziabad.

Four of them were admitted in AIIMS, three in Ganga Ram hospital and one in Cheeranjivi Nursing Home, the Municipal Corporation of Delhi (MCD) officials said.

The hospitals where dengue patients were admitted told the MCD to take preventive measures.

MCD officials said the dengue patients from Delhi included a Vikas puri (West Delhi) resident, Gurvinder Singh, 22, and a Mausam Vihar (East Delhi) resident, Arsi Parvin. The two of them were admitted to AIIMS. Out of three Delhi residents, Laxmi Narayan Gupta, 75, from Rohini and Samadevi, 65, who stayed in LNJP Hospital campus, were admitted to Ganga Ram Hospital. The third, a South Delhi resident from Greater kailash Part I, Kripi Chopra, 21, was admitted to Cheeranjivi Nursing Home.

Whereas Kripi Chopra was admitted to a private nursing home, her blood test was done at Ganga Ram Hospital which confirmed dengue.

About another Delhi resident Sita Ram, 55, who was being treated in Ganga Ram hospital, the MCD officials said that "he had contracted the disease in Chamoli in Uttar Pradesh. Though Sita Ram was working in Ganga Ram hospital as a cook and stayed nearby, he had been on leave for a month. He fell ill on September 8 and came to Delhi on September 10."

Two outstation cases of dengue were admitted to AIIMS. Whereas one of them Sohan Lal, 22, was a Gaziabad resident and was admitted on September 11, another patient Ram Dhari, 28, was a resident of Panipat.

So far 17 confirmed cases of dengue were admitted to various city hospitals, out of which nine were residents of Delhi, MCD officials said.

Even as fresh cases of dengue were reported, the MCD officials on Tuesday morning detected Aedes mosquitoes breeding in A-1 and C-8 blocks of Keshavpuram, Nimbary colony near Ashok Vihar and Ganesh Nagar near Tri Nagar in North-West Delhi.

Last week, Municipal Corporation of Delhi (MCD) officials said 14,523 cases of Aedes breeding was reported in different parts of the city. During this period more than 1,00,000 coolers were checked.

With fresh cases of Aedes breeding coming to light, the MCD officials said: "We feel disheartened that we were not getting full co-operation from the public. Despite our repeated pleas, house to house distribution of handbills and advertisement in radio, television and newspapers some people do not seem to take it seriously. If people were conscious of this problem then Aedes breeding would have been much less." A Keshavpuram resident challenged the MCD officials to take action when the officials pointed out that there was Aedes breeding in his cooler and asked him to remove water from cooler. The MCD officials issued 'chalan' to him after removing water from the cooler.

Death is a recurring nightmare for these patients

By Manjari Mishra
The Times of India News Service

LUCKNOW: Revati (not her real name), a painfully shy, skin and bone mother of three from Ballia is not very articulate. She had a small lump in the breast, she explains in halting Bhojpuri, which grew worse with time. Finally she was taken to Kanpur where a surgeon operated upon it assuring a full and speedy recovery.

Revati is back in the hospital, a year later, this time the cancer ward in the KGMC, Lucknow and probably breathing her last.

So is Shyama, from Deoria, semi-literate and slightly more vocal who followed the doctors instructions to the T right from a hasty mastectomy to the "Bijali ki sikai." Still, "the wretched thing recurred" she sound clearly perplexed and needless to say worried.

Shakeela from Gonda preferred sweet pills to surgery and relied on the neighbourhood homoeopath till her family realised things were already out of hand. She is terminally ill with no chance of recovering and very much aware of her condition.

There are four more such women waiting for the 'final' exit from the ward. They may belong to different places and families or may have different case histories but one thing runs common, they all are the victims of either wrong diagnosis, wrong treatment or incomplete surgeries.

In the two former cases, the doctor on duty explained, the surgeons did not remove the malignant nodes in axila, and the third obviously fell prey to a unscrupulous homoeopath.

However, they are doomed to suffer a death sentence pronounced not by destiny but by doctors, who would go scotfree notwithstanding the big noise raised over the physician/surgeons accountability under the Consumer Protection Act. For the victims, words are Greek and Latin.

The startling fact corroborated by the oncology division (the only one in the state) of KGMC and the department of endocrine surgery SGPGI Lucknow is that nearly 60 per cent of the cases in breast cancer are fouled up irreparably before they reach experts.

The story is generally the same with a little variation. According to Dr Sanjeev Mishra the pool officer surgery KGMC, delay in disclosure to the family due to inhibition or indifference; delayed visit to the local doctor, or in the villages to those practising Ayurveda, unani or homoeopathy with or without degrees and finally the operation performed by the expert of the area who may not have a clue about the complication of a breast cancer or modified radical mastectomy.

There have been instances of quakes, 'jarrah' or unscrupulous surgeons removing lumps under local anaesthesia without bothering to send them for histopathological examination, safe in the knowledge that 80 per cent of growth may not be malignant. However, if it happens to be cancerous, it is the patient's misfortune.

Even the educated women prefer to go to their gynaecologists for any breast related problem. There have been instances where even these professionals have missed a small lesion due to a perfunctory examination or have failed to distinguish between a benign or malignant. This, says Dr I.D. Sharma, professor of oncology in KGMC, is an expert job best left to an expert.

The treatment of breast cancer is a multi-disciplinary process comprising a judicious mix of surgery chemotherapy radiotherapy and immunotherapy says Dr Arun Chaturvedi associate professor KGMC.

The state has only one oncology division and only about a dozen experts to deal with the cases. A dangerous situation indeed as the incidence of breast cancer in Uttar Pradesh has registered a rise of three to five per cent in the past few years.

Where drinking water comes mixed with sewage

In one of DDA's oldest colonies, ageing pipelines and residential boosters keep the poison flowing

KOTA NEELIMA
NEW DELHI, SEPT 19

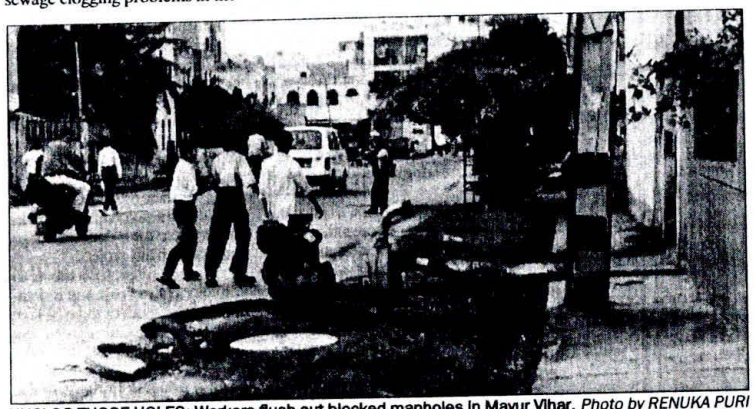
"HAVE tea, I don't think I should offer you water," says a housewife in Mayur Vihar Phase-I. "That is because the drinking water stinks of sewage. Even boiling it does not help."

This shocking fact, which is now an accepted part of living in one of the oldest colonies of the Delhi Development Authority (DDA), is due to leakage from drinking water lines which mix with the equally leaky sewage pipes and contaminate the supply.

"We moved into the house in 1977. And since then we have had this problem. Now even the promises of civic authorities that things will improve, does not convince us," says Jagdish Nanda, a resident of Pocket 2.

Predictably, that is what the Delhi Water Supply and Sewage Disposal officials had to say when the complaint was referred to them. "It is a matter of another two months," says a senior official of the area.

According to him, the solution lies in diverting the sewage load from the Chilla Chowk pump house which serves the entire neighbourhood and has limited capacity, leading to serious sewage clogging problems in the area. A proposal was floated for a new pump house at Kalyan Puri, but it did not take off because the project was caught in a technical wrangle with the Delhi Vidyut Board.



UNCLOG THOSE HOLES: Workers flush out blocked manholes in Mayur Vihar. *Photo by RENUKA PURI*

As the problem has now been solved, according to the officials, the new pump house is expected to begin functioning in the next two months.

"And when we divert the sewage, we shall also lay the new sewer lines. That should take care of the leakage which is leading to the contamination," says an official with the Sewage Disposal Undertaking.

The process of this dangerous contamination is very simple. The pipes laid for water supply and sewage have a life of 15 years on the outside.

Then they start corroding, leaking and degenerating underground. Most lines in Mayur Vihar were laid more than 20 years ago, the reason why they are in a bad state.

"When on such dilated pipes the residents fix boosters, they not only suck water but also other impurities from the neighbouring areas. In some cases, as they are in close proximity to sewage lines, they even suck sewage. That is the reason for the contamination," explains an official.

Another reason for the problem, according to the official, is because the residents have installed cheap service lines from the main line to their houses.

The residents, naturally, do not buy that. "Are the civic agencies trying to tell us that their contractors, after cornering their share of the moolah, do a better job than what we do for our own homes?" asks Ajay Mehta, another resident.

Authorities also reprimand residents for putting booster pumps on the lines.

"If a booster has to be set up, it must be done on a tank and not on the main supply line. But no one actually follows the rules here," he says.

Another major problem with the colony was that of bad maintenance of local parks.

Says Nanda: "After repeated requests, they are beginning to build a boundary to the parks. Before that, cattle from the neighbouring resettlement colonies used to come and graze here. There was no question of even going for a stroll in the parks, forget letting children play among the cattle."

While it has been about 20 years since the colony was set up, there is still no public transport service to the area.

Though the buses reach till Kotla behind the colony, no bus is headed exclusively for Pockets I and II forcing the residents to walk close to 2 km to catch a bus.

Dengue is back; two cases surface

Pioneer 11/9

Staff Reporter
New Delhi

DENGUE FEVER has staged a comeback in the Capital with two cases being reported in quick succession. This, despite a committed and a sustained awareness campaign by experts and civic bodies.

Anil Sethi (27), a resident of Dilshad Garden, was admitted to the St Stephen's hospital on September 4. The second patient, Vijay Kumar (17) of Tilak Nagar, was brought to AIIMS on September 8.

In both cases dengue has been confirmed. While the National Institute of Communicable Diseases (NICD) said Sethi was indeed a dengue patient, Dr Wali of the Department of Medicine, AIIMS, has said the same for Vijay Kumar.

However, Municipal Health Officer (MHO) Dr Devraj maintained that the disease had not emanated in the Capital, saying: "Sethi came from Jaipur on September 3 and was admitted to the hospital the very next day. He did not contract dengue in Delhi as he spends most of his time in Jaipur."

The MHO, however, pleaded ignorance about the AIIMS case. "We have not been officially informed by AIIMS. If it was a confirmed case, AIIMS should have informed the MCD. I have asked my officials to look into the matter. The MCD will get a report on Thursday."

Dr Devraj said the zonal MCD office had issued a challan to the Medical Suprintendent of St Stephen's and similar action would be taken against the Medical Suprintendent of AIIMS if the case is confirmed and the residential address of the patient falls under MCD jurisdiction.

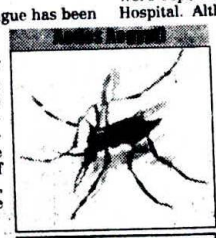
Incidentally, Delhi Health Minister Harsh Vardhan and Principal Secretary (Medical) Ramesh Chandra did not turn up at a dengue-awarness function organised on Dengue Day by the Delhi Health Services and the Delhi Medical Association.

Recently, three dengue cases were reported at Jaipur Golden Hospital. Although the patients were from Panipat, they created a scare in the Capital. While the Delhi administration and the civic authorities have been claiming that they have taken adequate steps to prevent dengue this year, they never ruled out the possibility of an outbreak nevertheless..

The Delhi Government has stepped up the dengue-prevention campaign by conducting door-to-door checks in all residential and commercial areas to eliminate sources congenial to the breeding of the dengue-causing Aedes Aegypti mosquito.

Last year the Capital reported over 400 dengue deaths and over 10,000 suspected cases.

The Aedes Egypti mosquito is also called the Tiger Mosquito because of the black and white zebra-like stripes on its body. The mosquito breeds only in fresh water and is largely found in coolers.



Keep coolers dry or face jail

NEW DELHI: Those who do not maintain their desert coolers can expect to find themselves in the "cooler", Union Health Minister Renuka Chaudhary said here on Wednesday.

As part of a drive to check the spread of dengue and other mosquito-borne diseases, imprisonment of up to six months has been prescribed for those owning coolers with stagnant water, capable of breeding the vector, she said.

After reviewing the dengue and malaria situation in the Capital, Ms Chaudhary said there was no cause for panic.

UNI

AIDS Scourge Strikes Developing World

By KALPANA JAIN

THE AIDS pendulum continues to swing between despair in the developing world and hope in the developed. New and expensive drugs promise a cure in the rich countries. But for about 30 developing countries, ominous signs are beginning to emerge as more children fall a prey to AIDS.

AIDS is particularly reversing the gains made in the health care of women and children in these countries. The National AIDS Control Organisation in India now considers infected children as a group large enough to be defined as a separate category. With only limited surveillance to go by, India already has four per cent of the world's AIDS cases below the age of 18.

Fate of Children

It means having to cope with a growing population of infected and dying children. Are we as a society ready to face it? With few resources, and even fewer organisations willing to take the emotional strain of handling an issue as complex as this, realistic answers may not be available. But solutions have to be found, especially keeping in mind the individual needs of countries.

Already, in developed economies, where the infection is now seen as curable, the debates are getting fewer. For developing nations, such as India, these issues are just about coming up: A large number of children will soon have infected parents — mothers who will not be able to provide care and fathers who may be thrown out of jobs or simply be unable to work.

What will be the fate of such children? As family incomes fall and medical expenses go up, these children may be forced to join the existing child labour force. Even if social support is available, schools may not be willing to take them in once the HIV-status of their parents is revealed to the community. And the subsequent trauma may wreck these children as they see their parents die a painful and horrible death.

Nowhere has this been more apparent than in sub-Saharan Africa which has had to face the brunt of the epidemic so far. For example, orphaned children suffered even if they had grandparents to look after them due to the crushing poverty that came on the family after losing breadwinners. Such children were removed from school and were compelled to earn a living.

Girls faced a worse future. They invariably suffered nutritionally. Some were subjected to sexual abuse. And a preference for extremely young girls either in marriage or in the flesh trade grew. Then there is the issue of those children who have been infected in the womb. Chiangmai town in Thailand witnessed an abandoning of such babies. Whether infected adults should be told to give up having children has been the subject of some debates.

In hospitals in developing countries, parents are beginning to come face to face with the reality of finding their children infected through blood. For thalassemic and haemophiliac patients, parents are finding they have to make a painful decision: tranfusions are essential for the survival of the children. But with each transfusion, the risk of getting infected with the AIDS virus goes up.

On most vital issues of public health, India's report card is already a disgrace. And AIDS comes with its special problems: In the rudimentary health care system at several places, hospital-acquired infection is a reality, clean syringes are rare and infection through blood is common.

There are enough examples already of young thalassemic and haemophiliac patients being denied admission to hospitals after they have acquired HIV as a result of receiving infected blood. There are examples of orphanages refusing to take HIV-positive children or children of such parents. There are also examples of HIV-positive mothers being thrown out with their children from their homes.

Support Systems

It is time then to take a look at current national policies in the context of child rights and set an agenda for tackling problems emerging out of HIV infection: For instance, critical issues whether HIV-infected mothers should be allowed to breastfeed their infants need to be discussed. Transmission of the infection through breastmilk is a reality and infants who have escaped getting HIV from their mothers during birth should be kept protected.The use of drugs in minimising the risk of transmission also needs to be examined.

It would be pointless to depend on the existing health care facilities for the care of such children. Social support systems need to be built and home care encouraged. But most of all, society itself has to be sensitised towards accepting these children. No support system will be able to work if HIV-positive face discrimination in their surroundings.

The Indian government has already been several steps behind the epidemic, when it should have been racing along: Planning begins only when the problem has taken root. And for AIDS, there is no time to lose in waiting further.

6/9 Pion

CITY

Fungus in sealed drug bottles

Vishwas Kumar
New Delhi

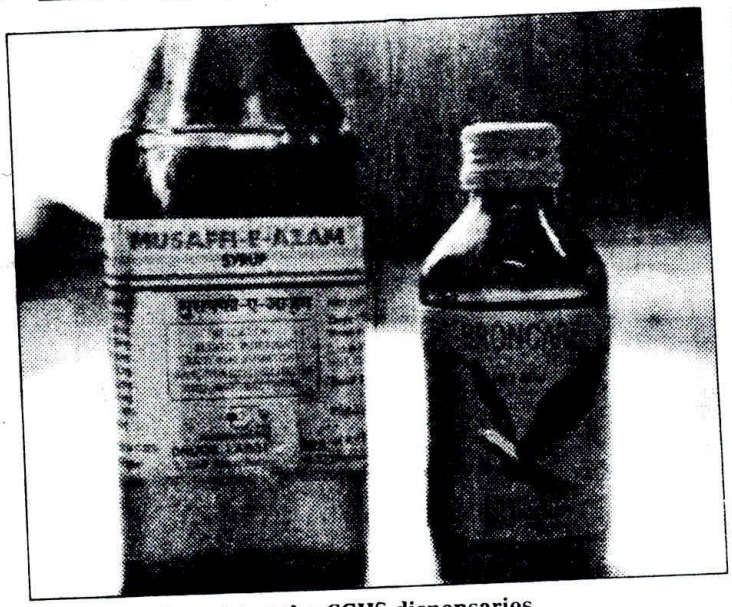
THE DISPENSARIES of the Central Government Health Scheme (CGHS), Unani wing, are stocked with contaminated drugs.

Two samples of contaminated drugs of a particular brand was brought to the office of The Pioneer by a patient. The patient had got the medicine from the CGHS Unani dispensaries at Sarojini Nagar behind the main post-office.

These two bottles, one of Broncare syrup and the other Musafil-i-azam, have a thick mass of fungus floating inside. The fungus can be clearly seen and was noticed by the patient when the sealed bottles were brought home from the dispensary.

Several patients have complained of contaminated drugs being given by the CGHS dispensaries. Despite earlier protests from medical officers, drugs belonging to a particular laboratory are being supplied again, putting the lives of patients in great danger.

"Today only we have received a complaint from the patients that Broncare syrup is contaminated with fungus and we have checked the stores and found contaminated bottles" said Dr Pasha, incharge of CGHS Unani dispensary in Sarojini Nagar, showing the sample of bottles with floating fungus inside it returned by the patients.



The bottles bought at the CGHS dispensaries

The Broncare syrup bottle, manufactured by Maxo Laboratories private limited at Najafgarh, Delhi is marked "for CGHS supply, not to be sold". The manufacturing date on the bottle is March, 1996.

Patients have alleged that earlier too contaminated supply of Broncare syrup were provided by the concerned dispensary. The bottles were withdrawn from the store for some time but have reappeared after a few months.

Dr Pasha said, "We had received similar complaints of contaminated Broncare medicines in January, 1997 and the entire stock of the medicine was sent back to the store. But again, the Unani drug store has started sending the drug."

He added, "I cannot say how drugs from the same laboratories are sent to the dispensaries despite similar complaints in January. We have asked the patients to give a written complaint so that I can take the matter to the higher authorities."

However, Dr Jawahar Lal, incharge of CGHS drug stores said, "Till date we haven't received any written complaint about the contaminated Unani medicines."

Sources said that the Maxo laboratories private limited earlier used to make Ayurvedic medicines. But they were blacklisted by CGHS Ayurvedic authorities on similar charges and started manufacturing drugs for CGHS Unani.

Poor sanitation blamed for spread of malaria in Goa

PANAJI: Poor sanitation, unscientific building and construction activity, water-logging and migrant labour are cited as the four major causes, in the official circles, for the spreading of malaria that has caused more than 40 deaths in Goa during the past few months.

The health authorities and several other government run hospitals, including the Goa Medical College Hospital, the apex institution are grappling with the problem to contain the disease. The multiplicity of agencies created by the state government without fixing responsibilities for scientific planning, development, drainage, sewerage have further aggravated the problem in Panaji, Mapusa, Vasco-da-Gama, Margao and several coastal belts.

The health department has now introduced a card system to ascertain the magnitude of the problem among the migrant construction labour who are listed permanent "positive" cases.

Open water tanks, scrap dealers, open drainage system and garbage heaps are said to be ideal breading grounds for malaria and other diseases. (UNI)

Incidence of mental illness on the rise

By Our Staff Reporter

CHENNAI, Sept. 9.

Incidence of mental illness appears to be on the rise going by the increasing number of out-patients seeking treatment at the out-patients department of the Institute of Mental Health, Kilpauk, says its director, Dr. V. S. P. Bashyam.

The institute was receiving about five times the number of patients it had received in the sixties, he said. While about 400 to 450 'repeat' cases visited the out-patient department for follow up treatment and to procure drugs, at least 40 to 50 new cases arrived at the institute, he said.

It was not possible to register all patients on the day they arrive as the process of interviewing patients took a long time. Hence, the institute was able to examine only about 25 patients on an average, on a "first come first served" basis. For the remaining, emergency line of treatment was rendered if required and they were directed to come the next day.

Growing awareness might be responsible to a certain extent for the increase in arrivals at the institute, Dr. Bashyam told presspersons here today. But, stress and depression-related disorders which have been increasing in the rapidly changing industrial society could also be responsible for the increasing incidence, he said.

In the face of growing demand for quality treatment, professionals in the field and concerned individuals have set up a trust, the INTERACTION (Institute of Mental Health Trust for Education, Research, Care and Rehabilitation of the Mentally Ill) trust. The trust president, Mr. T. T. Vasu said that the trust was in the process of building a half- way home, family therapy unit and a research and rehabilitation centre. The State Government had already given 25 grounds for construction of a two- storey building to house the projects. Work on the ground floor was almost complete and the trust was in the process of raising funds for the reminder of the project.

Dr. N. Mathrubootham, treasurer of the trust, said that the trust would also take up awareness campaigns and complement the district mental health programme.

So, Ms Chaudhury, y u're dead wr(ng

Dengue strikes the Capital again

EXPRESS NEWS SERVICE
NEW DELHI, SEPT 10

DENGUE has struck the Capital again. The first confirmed case of this dreaded viral disease was today reported from the All India Institute of Medical Sciences (AIIMS), while the conclusive diagnosis on another patient admitted with similar symptoms is still awaited.

Ironically, the report came at a time when the Union Minister of State for Health, Renuka Chaudhury, was busy claiming at a press conference that not a single confirmed case of dengue fever had so far originated from the Capital.

Seventeen-year-old Vijay Kumar, an electrician from Mahavir Nagar in Tilak Nagar, was admitted at the premier institute on Monday with high fever and other clinical symptoms of dengue. According to the doctors attending to him, the patient also vomited blood, which strengthened the suspicion of his suffering from dengue haemorrhagic fever.

"His blood sample was subsequently sent for the serological testing, which confirmed the presence of antibodies against the dengue virus," said Jyoti Prakash Wali, head of the Department of Medicine at AIIMS, under whose care the patients are being treated.

The other 30-year-old patient is also presenting the symptoms of the dengue haemorrhagic fever (DHF), though Wali today claimed the diagnosis had not yet been confirmed.

The above cases come close on the heels of four other confirmed cases of dengue fever — three of whom were reported from Jaipur Golden Hospital at Rohini and the fourth from St. Stephen's Hospital. Though the Rohini patients hailed from Panipat in Haryana and had arrived here for treatment, the one at St Stephen's, the authorities had argued, had recently come from Rajasthan and, therefore, could not be labelled as Delhi's patient.

But yet another case of suspected dengue reported from North Delhi's Tirath Ram Shah Hospital has further disproved the frequent Government claims that the vector control measures and dengue prevention campaigns were bearing fruit and there was no chance of the disease striking again.

With memories of last year's dengue epidemic, which claimed around 375 lives and affected at least 10,000 others, still fresh in people's minds, the fresh spate of cases is likely to create panic and fear about the viral ailment among the public. Wali, however, assured that the above might just be sporadic cases.

Though there are four strains of dengue virus, which is spread by the *Aedes Agypti* mosquitoes from the healthy or affected human hosts to other healthy persons, Dengue-II is the most dreaded of them all since it was found to have caused the maximum casualties last year.

According to Wali, the treatment of dengue patients is generally symptomatic, that is to control the fever and replenish body fluids in case of shock and blood in case of haemorrhage. While the dengue shock syndrome is characterised by reduced blood pressure, increased heart and pulse rate and reduced urine output, dengue haemorrhagic fever accompanies internal or external bleeding.

Earlier, Union Minister of State for Health Renuka Chaudhary announced at the press conference that "stringent action, including imprisonment" were on the anvil for Delhi residents who did not keep their homes and surroundings clean and free from stagnant water.

Such strict action had been successfully implemented in dengue and malaria prone countries like Malaysia and Singapore and there was no reason why it could not be equally effective in India, Health Ministry officials said.

"One man's carelessness could be the cause for another's dengue or malaria", the Minister stated, adding that a little bit of caution on the part of the public could sharply reduce incidents of disease.

Following a review of the dengue and malaria situation in Delhi, Haryana, Uttar Pradesh and Rajasthan yesterday, an 'Action Plan' for vector-borne disease prevention has been mooted.

The first confirmed case was reported from AIIMS, while the conclusive diagnosis on another patient admitted with similar symptoms is still awaited

The neighbouring states have been directed to report all cases of dengue which are referred to Delhi hospitals for treatment. The measure is to pinpoint areas of dengue density and enable the health services to crackdown with prevention efforts.

Denying reports of a shortage of blood platelets in the blood banks, the Minister said transfusion of blood platelets was required only in the severest of dengue cases. She said doctors had been sensitised on this issue and urged not to create a scare by ordering people to fetch platelets at the first signs of the disease.

The Health Ministry also plans to go ahead with its programme of resorting to "fogging" different parts of the Capital with anti-mosquito chemical sprays despite objections from some quarters that it could increase the resistance of mosquitoes to such pesticides and adversely affect the health of residents.

Govt steps come a cropper

■ ELABORATE vector control measures and crores of rupees spent on creating awareness about the prevention of dengue seem to have come a cropper, with the Capital renewing its date with dengue this year.

All along, the Union and State governments and the local civic bodies have strongly maintained that the disease was as good as eradicated as their efforts were bearing fruits. The fresh cases of dengue seem to prove otherwise.

Dr Pradeep Seth, head of the microbiology department at AIIMS, however, feels that the disease has already become endemic and its recurrence can not be totally avoided, since the desiccated eggs of aedes lying dormant for the entire season could be one of the reservoirs.

"The Government can initiate steps to control the breeding of *Aedes Agypti* mosquitoes. But it cannot enter each and every household and physically remove the breeding sources," he argues, adding that the mosquitoes bred in clean water and bit during the daytime. The surveillance, he feels, needs to be strengthened so that the situation doesn't go out of hands.

The facilities for a free serological test are available, besides the NICD, at AIIMS, Maulana Azad Medical College and GTB Hospital, while private laboratories charge upto Rs 750 for each test. And the plasma separators are also available at the hospitals, though the doctors maintain that platelets are not necessary in 90 per cent of the cases.

Community involvement crucial to the success of health plans

By Rupa Chinai
The Times of India News Service

MUMBAI: The recent international conference on parasitic diseases in Hyderabad has highlighted several technologies that are proving to be useful in malaria control, but Asian and African experience shows that many programmes fall flat in the absence of health education efforts and involvement of the community.

The vital role of sociologists, anthropologists and public health experts in communicating public messages, is increasingly recognised in the successful implementation of programmes.

Up to 80 per cent of the world's malaria burden is borne by Africa, with children suffering the worst impact of morbidity and mortality. According to W. Kilama, director-general of Tanzania's National Institute of Medical Research, rural Africans have lived with malaria for so long that they have come to accept recurring fever as a part of their lives.

For many in the community, controlling malaria is not a priority. Everyone however, is bothered by the mosquito nuisance which disturbs their sleep. Thus, while promoting the use of bed nets impregnated with pyrethroid insecticide, the government's public message talks of sound sleep without buzzing mosquitoes, rather than emphasising malaria.

Impregnated bed nets have brought protection ranging from 17 to 65 per cent in countries like Kenya, Ghana and Gambia, says World Health Organisation representative J. Cattani.

Successful use of tools is vitally connected to strategies of "social marketing" aimed at the community's acceptance of a technology, and building upon their understanding of how it can be relevant. "Technocrats can come up with technologies but you need sociocrats to push that technology," says Professor Kilama.

A pilot project to control malaria in a low endemic, rural area of the Philippines evoked a similar initial response because malaria control was low in priority, says Allen Saul of the Queensland Institute of Medical Research, (Australia), which supports the project. The community had greater concern about acute respiratory infections, diarrhoea, trauma accidents, heart, cancer and other problems. They had difficulty in understanding the concept of transmission, connecting the malarial parasite to the mosquito and man.

The programme however received widespread response when villagers found that their fevers were being quickly treated and they were cured. They realised that the programme was sustainable and they no longer had to put up with malaria. They became receptive to house spraying, use of bed nets and protection of water sources. Decline in malaria incidence has attracted an economic boom to this area. Surrounding communities are now taking their own initiative without waiting for intervention from the health department.

"When people get better immediately, there is tremendous reinforcement for the programme. Patients and volunteer field workers feel better about it. The sooner you treat a person, the sooner you break the cycle of transmission," says Mr. Saul.

Thailand is investing heavily in research on how people can be made to understand prevention and treatment of disease. University research is helping the government to know why programmes fail, says Pratap Singhasivanon, from the department of tropical medicine, Mahidol University, Bangkok.

Liver fluke, for instance, is a widespread problem in rural Thailand, because of the traditional practise of eating raw fish. How to persuade villagers to give up this habit has been a severe challenge, and answers have not come from policy makers sitting in air conditioned rooms.

Researchers have held focus group discussions with affected villagers, trying to understand why they continue this tradition, what they know about the risk and how they view the cure. "The health education system is coming from them," says Professor Singhasivanon.

The focus groups discussions revealed subtle nuances in the knowledge of the villagers. They knew that eating raw fish could cause illness, and they knew that drugs provide 100 per cent cure rates. The public health messages thus began to emphasise that no drug provides a total cure, especially when there is a delay in treatment. If the worms increase, there are greater chances of getting hepatitis and of developing liver cancer. Very young people are dying from this problem.

"Despite this effort, only 50 per cent are affected enough to give up eating raw fish. The most important programme now is educating children in the schools. Children are beginning to educate their parents. We have also had some measure of success in HIV/AIDS prevention, which has now peaked in Thailand, and reached a point of stabilisation. Our prevention efforts have focussed on strategies such as peer education and involving monks who command respect amongst a people who are very religious," says Professor Singhasivanon.

The Hyderabad conference saw the presence of several groups interested in international networking in development of research, sharing of information and material support. 'Rotary against malaria,' for instance, is an initiative emerging from Rotary Clubs in Australia and the Pacific, who are seeking to give material support to community education efforts through local Rotary Clubs. The Malaria Foundation, based in the U.S., is working to support development of research and dissemination of information on malaria with developing countries.

SmithKline Enters Genetic Diagnostics

Joint Venture With Incyte Bolsters a Promising but Troubled Industry

By Stephen D. Moore
Special to The Wall Street Journal

The promising area of genetic diagnostics has in recent years suffered from sluggish growth and overcapacity, sparking the withdrawal or drastic retrenchment from the industry by companies such as **Eastman Kodak** Co., **Hoechst** AG and **Sanofi** SA.

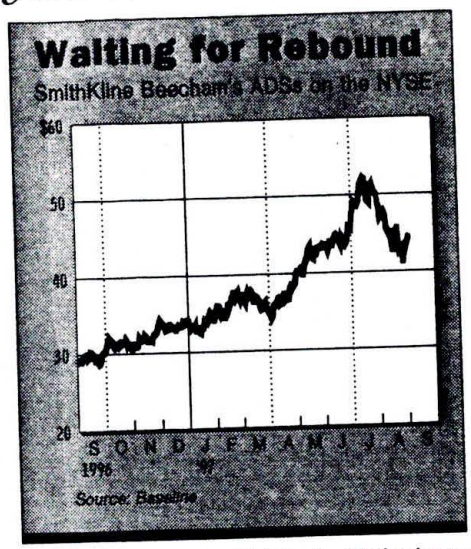
But several big drug companies, such as **Roche Holding** Ltd. and **Abbott Laboratories**, have gambled on the promise, betting on a technology-driven revival of the esoteric industry. This week, **SmithKline Beecham** PLC tossed in its chips.

SmithKline said it is forging a joint venture, dubbed Diadexus, with U.S. biotech star **Incyte Pharmaceuticals** Inc. The venture will inherit access to two of the world's biggest private libraries of genetic data – plus other technologies contributed by each parent in exchange for a 50% stake. That dowry includes marketing rights to five diagnostic tests, in the areas of cancer and bone disease, developed by SmithKline and now at advanced stages of clinical validation.

During the venture's first few years, its tests will be made available to physicians primarily through SmithKline's clinical laboratories division. SmithKline's unit, a leading lab network in the U.S., has struggled with anaemic sales in recent years and clearly needs a transfusion of the kind of patented, high-margin tests Diadexus has been set up to deliver.

Legal woes also have hammered SmithKline in recent years – and continued last month when the clinical labs division was sued by 37 major health insurers, which are accusing the company of violating federal racketeering laws in the U.S. and overcharging them by hundreds of millions of dollars since 1989. The suit came six months after SmithKline agreed to pay $325 million to settle similar charges of overbilling involving Medicare and other government health-insurance programmes in the U.S.

However, along with formidable scientific hurdles, Diadexus faces tricky management challenges as a result of its mixed heritage. Though SmithKline provides lab services, it hasn't previously ventured into making diagnostic test kits.



George Poste, SmithKline's chief science and technology officer who also has been named Diadexus chairman, acknowledged that the venture plans to recruit a third partner with proven production prowess. He said negotiations are under way with potential candidates, but he declined to identify them.

Ironically, SmithKline raced to the vanguard of genetic research through a previous partnership with **Human Genome Sciences** Inc., another U.S. biotech highflier that is Incyte's archrival. Diadexus will be obliged to pay an extra royalty to Human Genome Sciences on eventual sales of diagnostic tests based on genes fished out of the company's huge database. Dr. Poste also pledged that fire walls would be installed to prevent leakage of the biotech rivals' secrets.

Dr. Poste has always predicted that the earliest, major commercial application of genetic research would come in diagnostics. To that end, he secured rights to diagnostic applications of Human Genome's genes in the companies' original 1993 pact.

Diagnostics is an $18 billion-a-year global industry, and its proponents are betting on a revival fuelled by the $3 billion Human Genome Project and other international efforts to unravel the structure of human DNA. By applying genetic data, scientists believe they can uncover the underlying causes of diseases ranging from cancer to Alzheimer's disease and schizophrenia.

In late May, Roche Holding offered $11 billion to acquire Germany's **Boehringer Mannheim Group** and become the world's No. 1 diagnostics company. The transaction remains subject to regulatory approval in the U.S. – but once the Federal Trade Commission gives its approval, Roche officials plan an aggressive investment binge to speed development of new genetic tests.

Abbott Laboratories, deposed by Roche as industry leader, responded six weeks ago by teaming up with Paris-based gene research specialist **Genset** SA to develop test kits based on genes that play key roles in the way patients respond to prescription drugs. By weeding out the relatively high proportion of patients who won't respond to a drug before therapy begins, such tests would save health-care systems huge sums, analysts say. Such tests also could reduce the cost and time it takes pharmaceutical giants to develop new drugs by reducing frequency of side effects – the main reasons drugs flop in clinical testing.

Like Abbott and Genset, Diadexus plans to hunt for genes that determine how people respond to drugs – or don't respond, in the case of almost 50% of patients who receive certain expensive treatments for hypertension or viral diseases. At the same time, Diadexus will attack two vexing medical riddles: the spread of antibiotic-resistant strains of bacteria – and cancer.

SmithKline is one of the world's biggest producers of antibiotics – but Dr. Poste frets about "a window of real vulnerability between the years 2000 and 2005 when resistant organisms will be prevalent but new antibiotics classes" will still not be available. During that period, he expects a return "to the [days before] penicillin when much of infection control had to be based upon very stringent public health measures – vigilance in mapping the spread of infection and identification of carrier status."

Such measures would require rapid diagnosis of infections – and identification of resistant bacteria strains before treatment begins. Neither is possible today – but SmithKline scientists have some promising leads.

150 prisoners, many diseases daily

EXPRESS NEWS SERVICE
NEW DELHI, SEPT 6

TIHAR JAIL SUICIDE FOLLOWUP

THE Leila Seth Committee report on the death of biscuit baron Rajan Pillai, which was tabled in the Assembly in the recent session, seeks inspiration from last year's K.K. Jain panel report, which is yet to see the light of day.

Set up with the idea of 'Strengthening the medical facilities at Tihar jail', the Leila Seth Committee says it should be implemented on an urgent basis and not meet the fate of most committees.

The Jain report is a chronicle of the basics that are sadly missing inside Tihar, a jail where yearly 60,000 prisoners are brought in every year. The report says: "At present, investigative facilities including laboratory and radiological diagnosis are either non-existent or only a skeleton service is in operation," which is important, as the report notes, because not only are most of the inmates from the lower strata of society but also because communicable diseases should be identified quickly.

About the state of Tihar hospital, it says: "Since the Central Jail Hospital is at present hardly functional, it has to be made functional by upgrading the staff, space and equipment. The hospital should be able to provide basic clinical services including investigation services...."

On sudden illnesses, the report notes: "At present, there is no communication system either for calling the doctors or for sending messages at the time of the sudden illness of any prisoner."

The Leila Seth Committee report establishes that there are only six doctors for 9,000 inmates. The Jain panel report makes the picture even grimmer.

"At Tihar, every day about 150 prisoners are admitted and their medical examination is conducted. The examination of one prisoner would nearly take 20-30 minutes. If all the prisoners are to be properly examined, 15 doctors should conduct the medical examination."

The report also points out that: "Special attention needs to be paid to prisoners who are addicted to drugs. Three wards of 30 beds each need to be maintained at Tihar jail for de-addiction." And for the women prisoners, the reports recommends: "There should be preferably two women medical doctors as women and children are also admitted to the jail."

MEDICAL WORK LOAD AT TIHAR JAIL

Prisoners admitted in a year	60,000
New prisoners admitted per day	150
Total OPD attendance per day	1,400
Prisoners referred to outside hospitals per day	40 to 50
Prisoners at one point of time	8,500 (APPROX)
Females	350
Children	55

THE PIONEER 3

Stench sickens doctors, no food for sick

Staff Reporter
New Delhi

HOSPITALS WERE in a filthy state with overflowing dust bins, unclean toilets, dusty and littered corridors as the strike by the Group C and D staff and nurses entered the second day on Thursday.

The kitchens were closed, surgeries postponed and OPDs paralysed. Only limited number of patients were admitted and those who were brought in a serious condition.

The strike, called by the Joint Action Committee of Health Karamchari Unions, would end today. The unions are protesting against the recommendations of the fifth Pay Panel and have been demanding a dialogue with the Government since long.

Attendants were seen getting vegetables and milk in LNJP Hospital. The authorities had to request private guards to supply milk, bread and fruits to the patients.

OPDs and operations theatres in Safdarjung Hospital, Guru Tegh Bahadur Hospital (GTB), Lok Nayak Jai Prakash Hospital (LNJP) and GB Pant remained closed. Hospitals were trying to discharge as many patients as was possible.

The passages in Safdarjung were littered and the casualty had blood stains all over the floor. Dust bins were overflowing with bandages and cotton. Private security guards in the casualty were pushing stretchers and doing the work of ward boys. A doctors added that the Hospital normally receives 800 patients in any normal day. But the numbers had trickled to 100.

In Safdarjung Hospital, employees poured tarcoal into the keyholes to prevent locks from being opened. They also put more locks on gates and doors. Resident doctors bore the brunt of the strike of the karamcharis and the partial strike of the nurses.

Agitated doctors in RML and Safdarjung Hospitals complained that the administration had failed to put the back-up mechanism in place in the wake of the strike call. Rather, the HoDs put up duty lists asking the residents to put in more hours of work.

President of the Resident Welfare Association (RWA) of the Safdarjung Hospital, Dr Lalit Madan, in a letter to the Medical Superintendent warned the administration, "against issuing any threats to the resident doctors or forcing them to do duties other than the prescribed duties."

President of the RML RWA, Dr AP Singh also said some HoDs had verbally asked residents to put in more hours without assuring them of any compensatory offs.

In Safdarjung Hospital, resident doctors were changing the nappies of babies, and IV fluids.

A resident doctor said, last night residents were left to man the wards without a single ward boy, nurse, orderly or even a consultant for assistance.

EXPRESSNewsline
NEW DELHI ■ WEDNESDAY ■ SEPTEMBER 10, 1997

City emergency services out of breath

EXPRESS NEWS SERVICE
NEW DELHI, SEPT 9

WHEN a man in the prime of his youth dies for want of oxygen at a premier city hospital even after being brought in time following a severe attack of asthma, it speaks a lot about the state of emergency health care services in the country's Capital.

But if the man happens to be the son of the state's Director of Health Services, with an entire family of doctors accompanying him who watch helplessly in absence of even the bare minimum infrastructure, it should amount to a criminal negligence on part of those in-charge of the services.

On Friday night, Dr Jeevan Jha's 24-year-old son, Viranya, suffered an attack of asthma while the family was attending a ladies sangeet function held in prelude to his cousin's wedding inside the campus of Maulana Azad Medical College (MAMC, residential quarters).

The family rushed him to the casualty of the Lok Nayak Hospital where he was advised immediate resuscitation.

But in a hospital where the emergency care has been paralysed for over two weeks now due to its crumbling building, precious time was lost in wheeling him to the ward on the first floor since the lift was not working.

Even after reaching the ward, the doctors could do little as the vital incubation equipment and the oxygen cylinders were not available since they had been locked up by the nurses who had then proceeded on strike without handing the charge over to someone else.

Even as the doctor's family watched helplessly — Dr Jha's brother, his two daughters and even sons-in-law are all doctors themselves — the patient suffered a broncho spasm and collapsed. Dr Jha is now planning to take up the matter with authorities at the highest level and is even considering filing a legal suit.

But the hospital administration, in a bid to cover up, has been issuing a series of frantic orders. The administration held telephonic discussions with Dr Sumit Ray, president of the Resident Doctors' Association, and Dr Kapil Kochhar, and decided that the keys of the emergency operation theatre will stay with the Casualty Medical Officer or the Chief Casualty Medical Officer.....(presumably, so that the above situation doesn't arise again).

Three weeks ago, the hospital sources maintain, a former head of the radiology at the Lok Nayak Hospital, Dr M.M. Saha, was similarly wheeled in the casualty ward and died of haemorrhage by the time he reached the resuscitation ward which, then too, was located several hundred metres away from the casualty.

The situation is particularly bad these days as the nurses go on strike after their morning shift itself, and take away with them the keys to all the inventories that they maintain with them. That's precisely what happened on Friday night. What more, even the trolleys are not available since they are also locked up.

In an earlier order of August 29, the hospital MS, Dr Bharat Singh, had asked the doctors to accept only "very serious" cases for admission in the departments of paediatric surgery, neuro surgery or orthopaedic surgery, in a clear violation of the recent Supreme Court order that prohibited the government hospitals from refusing admission to any patient who requires it.

And even after the August 22 orders, making the posting of anaesthetists mandatory in the emergency ward, none is available in the hour of need.

If all these things, in addition to the general chaos at the hospital due its crumbling building, are not reasons enough to shake the administration out of its slumber, nothing would ever possibly do.

"If the handpicked team of our health minister, comprising doctor Bharat Singh and Dr Preeti as the heads of such a premier hospital, are finding the situation too hot to handle, it is time either for the minister to give up or change the administration," an irate faculty member said, while reminding that the minister was gracious enough to suspend a house surgeon of this very hospital in 1994, when he had refused admission to a burns patient for want of referral papers.

Stir benefits private hospitals

RAJESH KUMAR
NEW DELHI, SEPT 4

PRIVATE hospitals and nursing homes in the Capital have, perhaps, never had it so good.

With employees at nine municipal hospitals also deciding to join their 25,000 counterparts in 23 city hospitals in their stir against the Fifth Pay Commission, a complete collapse of Delhi's public health care system today compelled harried patients to turn to expensive private health shops for help.

The nurses at the Government hospitals also stayed away from work after the morning shift, as part of their countdown to a complete strike on September 10. Consequently, while Government hospitals wore a deserted look for the second day today, their private counterparts were seen choc-a-bloc with critically ill patients needing immediate medical care.

Since Wednesday, private hospitals are reporting a sharp spurt in the number of patients approaching them for treatment. In Jaipur Golden Hospital in North West Delhi, for instance, at least 18 patients were being attended to in the casualty wing alone, which has a capacity for only 12. Two of those who were not too serious were accommodated on a single bed to make space.

According to the casualty in-charge, Dr Atul Kohli, half the patients thronging there had viral fever, while the rest were accident victims and those suffering from routine ailments. "Viral and malaria seem to be the most common ailments in this part of the Capital," he said.

At Batra Hospital in South Delhi, similarly, the doctors reported double occupancy while a large number of patients were enrolling themselves in the waiting list, hoping for their turn when the recovering patients got discharged.

Dr Nand Kishore, casualty medical officer, said they had already exhausted their free beds for poor patients as a large number of trauma cases, mainly the accident victims, were arriving after being sent back from Government hospitals.

"Those whom we still cannot afford to admit are being sent back after first aid," he said.

At Ganga Ram Hospital in West Delhi, where an accident victim later identified as S.K. Tuteja arrived in a critical state after being turned back by the DDU Hospital today, also reported full occupancy. Dr B.K. Jawa, casualty in-charge, however, maintained that the patients' rush was considerably less than on Wednesday.

The striking employees at the National Institute of Communicable Diseases and the National Malaria Eradication Programme in North Delhi burnt the effigy of the Union Finance Minister.

Elsewhere too, the health care services remained paralysed on the last day of the 48-hour strike. While the employees are scheduled to resume their normal duties from Friday morning, it is unlikely to remove the miseries of the Capital's ailing since the nurses have decided to work on one shift only. On September 10, they have threatened to resort to a complete strike.

Polio takes epidemic form in U.P.

Biswajeet Banerjee
Lucknow

OUTBREAK OF polio is taking an epidemic proportion in Uttar Pradesh as hundreds of cases have been reported from various parts of the State including Capital Lucknow.

Over 50 cases were registered at St Mary's Polyclinic in the State Capital in last two months. A seven-month-old child has already succumbed to the dreaded disease at the Polyclinic.

The State Capital tops the list as far as the number of reported cases are concerned. As many as 89 polio cases have already been reported from Shantinagar Hospital, Gonda.

Patients from Chinhat, Bakshi Ka Talab and even the main city have been visiting the St Mary's hospital with polio cases.

Chotkkan, a Lucknow resident whose one-and-a-half-year-old son Sallaudhin is in a critical condition, admits he had not given any polio drop to his son. "No one came to our locality to give polio drops," he said.

St Mary's records reveals that 19 children, afflicted with polio, are from Lucknow district alone. Majority of them have not been given polio drops. Parents of most of them have not even heard about Pulse Polio programme, which was lauched with much fanfare with an aim to eradicate this dreaded disease.

Parents of Himanshu, a two-year-old boy from Ram Snehi Ghat, Bara Banki, have given him only one drop of polio. "Nobody told us that another drop is to be given to the child," his father said.

Patients from neighbouring districts including Allahabad, Bara Banki, Gonda, Bahraich, Sitapur and even farout Akbarpur have come for treatment in the St Mary's hospital. The director of this missionary hospital, Dr Brigeetha VV, admitted that the number of patients pouring in is much more than the previous year.

Incidently, the maximum number of cases are of Bulbar spinal type, which has mainly a crippling affect. "A few of the them have the Bulbar form, essentially a lethal type polio in which death is certain," Dr Brigeetha said. The seven-month-old child, who died in this hospital, was a Bulbar polio case.

Dr Brigeetha told *The Pioneer* on Thursday that the child was brought to the hospital at a very critical stage. The Bulbar form of polio chokes the respiratory system. Doctors from various hospitals point out that polio has taken an epidemic form in the State. Going by the general norm, a polio-affected child in a particular locality could threaten potentially as many as 1,000 children between the age group from infancy to 5 years.

Best of Luck, Polio kids !

Pioneer 5/9

Scores of specialist posts vacant in govt hospitals

Staff Reporter
New Delhi

AT LEAST 100 posts of specialist doctors are lying vacant in three Government hospitals in the Capital, of which only 18 posts were filled on ad hoc basis, the Union Health ministry admitted before the Delhi High Court.

The ministry, through its counsel Adish Aggarwal, informed Justice C M Nayar that as many as 42 posts of specialists were lying vacant in Safdarjung Hospital, while there were 32 vacancies in Ram Manohar Lohia (RML) Hospital and 14 in Lady Hardinge Medical College (LHMC).

The court had expressed displeasure over the sorry state of affairs in the Government hospitals, where patients have to wait for hours to get treated and had asked for a list of specialist posts lying vacant in these hospitals.

The worst sufferer were the patients who needed plastic surgery, required mostly in burn cases. Out of 20 posts of plastic surgeons sanctioned in the Safdarjung Hospital, only four (two on ad hoc) are filled, while out of five existing posts in RML, there is only one plastic surgeon, the Central Government said.

The Government passed on the buck to the Union Public Service Commission (UPSC) saying that though the authorities had informed the Commission for filling up of these posts, recommendations had been received for five posts only. There are no urologists in the urology department of RML Hospital, as the two posts sanctioned were lying vacant. Similar is the situation in the gastroentrology and nephrology departments.

The state of affairs in Safdarjung Hospital was no different. Of the seven posts in the cardiology department, only one post is filled on a regular basis and four are lying vacant, according to the Health ministry.

Referring to JIPMER at Pondicherry, the Health ministry said of the 133 posts of specialists sanctioned, only 99 were filled on regular basis, while four were recruited on ad hoc basis. The rest 34 are lying vacant.

The High Court had also taken strong exception to the way top politicians and senior bureaucrats were availing treatment abroad and had asked the ministry to provide a complete list of those who had availed treatment in foreign countries during 1992-97.

The court had asked for the details of vital diagnostic machines lying idle in the Government hospitals. The Health ministry had filed the lists before the court.

Move to revive mosquito control plan in TN

By Our Special Correspondent

NEW DELHI, Sept. 3.

The Government is considering a proposal to revive the project for eradicating mosquito through the "sterile insect technology.

The technology is based on the principle that the female mosquitoes, which transmit malaria, could be eliminated at one go by releasing millions of sterilised male mosquitoes from aircraft or ground- based machines.

The mosquito control project had been proposed to be launched in Delhi as early as the early 1970's but was given up by the Government following allegations that it had connections with biological warfare. The allegation was prompted by reports that instead of focussing on malaria, the project scientists had been genetically manipulating Aedes Aegypti mosquites that spread yellow fever. It is now set to be revived in Chennai and other towns of Tamil Nadu, to tackle Anopheles Stephensi, the mosquito species that thrives on water in overhead tanks and thus most prevalent in urban areas.

The proposal for reviving the project has been mooted by the Department of Atomic Energy, which has a strong biomedical research team. The plan is to use mosquitoes sterilised by nuclear radiation. The proposal also came up for a detailed discussion at a special session as part of the global conference on malaria which was organised recently in Hyderabad to commemorate the centenary of the epoch making discovery by Sir Ronald Ross that malaria was transmitted by mosquitoes.

Parasympatholytics no help in asthma

The cornerstone of treatment for acute asthma is inhaled sympathomimetics, but the value of the concomitant use of inhaled parasympatholytics, such as ipratropium, is unclear.

Researchers from Case Western Reserve University used a prospective, sequential study design to compare the use of multiple albuterol inhalations alone and with the addition of ipratropium bromide. *American J. Med (Jan. 97).*

An expert commented: While there probably will be further studies on the use of parasympatholytics in acute asthma, this study seems to tip the balance of previous, conflicting studies against their use.

Interestingly, this study did not require subjects' approval because the use of ipratropium was considered an accepted and effective approach to treating asthma.

Rheumatic heart disease may have genetic origin

A STUDY in Srinagar has found that rheumatic heart disease (RHD) that is common in Jammu and Kashmir, affecting six our of 1000 children, may be linked to a genetically inherited protein, reports PTI Science Service.

Patients with rheumatic heart disease in Kashmir were found to have significantly high levels of a particular type of antigen called HLA-DR4 which is inherited genetically.

Groups of HLA (human leukocyte antigen) proteins are found on the outer membranes of all body cells.

The study by a team headed by Dr. Mohd. Saleem Bhat at the Institute of Medical Sciences, Srinagar, found that susceptibility to RHD was related to the same HLA-DR4 which has already been linked with rheumatoid arthritis.

RHD occurs in some persons who develop rheumatic fever — characterised by fever and severe joint pains — after repeated sore throat problems caused by Streptococcus bacteria.

According to Dr. Bhat, susceptibility to RHD is related to a poor immune response to Streptococcus. The poor immunity has been linked to presence of HLA-DR4 gene.

The study group included 50 rheumatic heart disease patients aged between 15 and 50 years, and 50 normal persons in a similar age group. The DR4 antigen was present predominantly in patients with the disease.

Low-cost herbal drug for thalassemia

A HERBAL drug for the management of thalassemia which can be taken orally and does not have any side effect will be a boon to thousands of victims of this genetic blood disorder, claims its developers at the Council of Scientific and Industrial Research (CSIR), according to PTI Science Service.

About 100,000 thalassemic babies are born each year the world over, 8000 in India alone. The thalassemics require monthly blood transfusions but this results in excessive accumulation of iron in the body — the main cause of early death in patients with thalassemia.

Till recently Ciba Geigy's desferal (deferoxamine methane sulphonate) has been the only drug available for removing the iron overload. But this needs to be injected twice or thrice a day using a Rs. 10,000 pump. The injections are not only painful but cost about Rs. 14,000 a month. Hopes were raised two years ago when the less expensive oral drug deferiprone, developed by a British scientist, went into commercial production in India.

But according to Dilip Chopra, president of the Thalassemia Society of India (TSI), most of those who started on this drug have discontinued because of the side effects.

The new herbal drug, on the other hand, costs less than Rs. 350 a month and has no side effect, said Ajit Kumar Sarkar, a CSIR chemist and one of the five persons in whose names the patent has been filed.

A few drops of the herbal preparation taken twice a day removes the excess iron as efficiently as desferal, a six-month study on 50 patients has shown. Some 2000 thalassemics are already on this drug.

According to information provided to the U.S. patent office, the herbal preparation contains the chemical 'anemonin' that forms a complex with free iron in the blood stream and gets excreted through urine. Addition to quinine sulphate enhanced the drug's efficacy of mopping up the iron but the exact formulation has been kept a secret by the CSIR.

Although India is the birth place of many useful medicinal plants this particular herb known as 'windflower' plant grows wild in parts of Europe, Russia and Turkey.

Certain places in the Himalayan range have been identified for cultivating this plant in India but right now the medicine is prepared with the herb or its extract imported from abroad.

Despite its growing popularity among patients, the TSI is yet to endorse the herbal drug for use in thalassemia clinics across the country because the drug has not yet been evaluated in a hospital based study.

Threat from forest fires

JAKARTA: As many as 20 million people are facing health problems from thick smoke emanating from hundreds of forest and brush fires in drought-stricken Indonesia. "Big bosses" from logging and plantation companies are blamed for starting fires to clear land on the islands of Borneo and Sumatra. Smoke has produced thick haze in cities and towns across Indonesia and has also polluted the skies above neighbouring Malaysia, Singapore and Brunei. Some airports have been forced to close because of lack of visibility and cars have been forced to drive with lights on during daytime. Indonesian officials estimate that 100,000 hectares had been burned. — AP

TOI
THE TIMES OF INDIA, MUMBAI

AIDS spreading fast among heterosexuals

4/9

The Times of India News Service

NEW DELHI: The acquired immuno deficiency syndrome (AIDS) is no longer restricted to what are known as high-risk groups, like sex workers, truck drivers and intravenous drug users. Now the heterogeneous population poses the biggest challenge.

This was disclosed at a panel discussion and presentation called "AIDS Update," at the India International Centre on Tuesday.

Manager Prakash Jha of the AIDS control programme at the World Bank said, "The pattern of the spread of the AIDS epidemic throughout the world has been from high-risk groups to intravenous drug users, and then to the heterosexual population."

Recent trends on the transmission of the HIV virus in India show that 74.3 per cent is through heterosexual activity, 7.4 per cent through intravenous drug use, 8.6 per cent through blood transfusion and .7 per cent through homosexual activity. Apparently, the latest figures show that the contribution of blood transfusion in the spread of the virus has fallen to 6.8 per cent.

Additional project director, National AIDS Control Organisation, S.K. Satpathy stated that, "Stringent measures in both, giving licences to blood banks and in their functioning, have brought down the figure. Our emphasis would now be to do away with professional donors."

Till July 1997, the number of reported AIDS cases in the country was 4,828. Of them, most were in the age group of 15 to 44 and one fourth were women. "The most affected age group being the sexually active and economically productive," added Dr Satpathy.

As the presence of HIV virus in one's blood stream brings down the immunity level of a person, he or she is prey to a variety of diseases. "Most of us have the tuberculosis virus in us. But we would probably not get affected by the disease in our lifetime. But the presence of the HIV virus increases the risk," he stated. Figures show that 62 per cent of the AIDS cases have tuberculosis.

The Indian EXPRESS
■ NEW DELHI ■ TUESDAY, SEPTEMBER 9, 1997

Life-saving fluids threaten patients at RML Hospital

Doctors have seized three bottles contaminated with a massive fungal growth

RAJESH KUMAR
NEW DELHI, SEPT 8

HIGHLY-CONTAMINATED supplies of the life-saving intravenous (IV) fluid are posing a serious health hazard to unsuspecting patients at the Capital's Ram Manohar Lohia (RML) Hospital.

Doctors at the Central Government-run hospital yesterday seized two bottles of the vital fluid, bearing the manufacturer's label of Ahmedabad-based Core Healthcare Limited, that were found to be contaminated with a massive fungal growth.

Even as a shocked administration issued an urgent order for the immediate withdrawl of the entire supply of that particular batch, yet another bottle bearing a different batch number was today found to be similarly infected with a large, black ball of fungus.

The seizures were made in the nick of time by alert doctors on duty, before they could be administered to critical patients. The doctors said it could have been fatal for the patients had they received the transfusion of the fungus-infected fluid. The transfusion, they said, could have caused symptoms such as severe chills, rigour and subsequent death of the patients.

Around 5 p.m. yesterday in the surgical emergency wing of the hospital, as the doctor in-charge, Dr Rajiv Sood, took out a bottle of 'Improdex' solution to give it to a patient of head injury, he discovered to his horror a whitish fungal growth in the clear liquid. The drug inventories are currently being handled by the doctors themselves, with nurses routinely striking work after their morning shift.

Another bottle later taken out of the drug inventory by Dr Sarma turned out to be equally infected. The doctors in all the emergency and recuperative wards were asked to reject the solution bearing batch no 023-3410, manufactured in October 1995 and expiring in 1998. The sealed bottles were later handed over to the medical superintendent, Dr C.P. Singh, who in turn issued the orders banning their use.

With nurses routinely striking work after their morning shift, drug inventories are currently being handled by the doctors themselves.

This morning, in another ward, the bottle of a different IV fluid (KIDRAL multiple electrolytes and dextrose injection, Type-I USP) also manufactured by Core Healthcare but bearing a different batch number was found to be infected with black fungus. The sealed bottle (bearing batch number 2.25.1815, manufacturing date: December 1996, and expiry date: November 1999), which is currently in possession of *Newsline* has a ball of black fungus growing at the bottom.

What make the two discoveries particularly shocking is the fact that the contamination has been noticed in different products of the same company bearing different batch numbers. The doctors said this had raised serious doubts about the quality of the entire range of life-saving drugs that are being supplied by the company.

The doctors do not even know how many products could be similarly contaminated as the company has been supplying an entire range of IV fluids to the hospital for a long time. And if all the supplies are withdrawn, it could lead to a crisis situation in the hospital since only one company supplies the fluid. The patients at several other city hospitals where the same supplies go are also at risk.

"The contamination of a single batch usually indicates a breach in the product's manufacturing or sterilisation process at its particular stage itself. But the same breach in case of different products manufactured at different times suggests that something is inherently wrong in the quality control process at the manufacturer's bottling plants," another medical expert today commented.

Dr Sood, who detected the first bottle, when contacted today, refused to comment on the issue while Dr Sarma was not available in the hospital. Dr Singh, however, said the defective stock had been withdrawn and was being sent back to the Drug Controller of India (DCI), who will examine the complaint and take necessary action. He, however, appeared to be ignorant about today's seizure.

India, EU sign $200m. aid agreement

By Batuk Gathani

BRUSSELS, Sept. 3.

India and the European Union signed an agreement in Luxemborg on Tuesday envisaging a $200-million E.U. aid for the country's primary health care programme. The two sides discussed a wide range of issues of bilateral interest. They also utilised the occasion to discuss the political parameters identified by the European Commission - a "communication" on EU-India relations in June 1996, and the "conclusions" drawn by the European Council on the same theme in December. For the first time, the political aspects of these documents were discussed in depth.

The Indian side was represented by the Minister of State for Foreign Affairs, Ms. Kamala Sinha, and the European Commission by Mr. Jacques Poos, Luxembourg Vice-Premier, who is also Minister for Foreign Affairs, Trade and Co-operation. Luxembourg is currently president of the E.U.

According to E. U. sources, the dialogue focussed on South Asia- specific issues such as Indo-Pakistan relations, the South Asian Association for Regional Co-operation and the developments in Afghanistan. The European officials gave an overview of developments in Europe such as the proposed expansion of the E. U. and the recent reforms in the E. U. treaty. United Nations reforms and steps to develop a future bilateral relationship in "new multipolar world order" were also discussed.

Other officials present were: Mr. Derek Fatchett, the British Minister of State for Foreign and Commonwealth Affairs, Mr. Hans Van Mierlo, Deputy Prime Minister of Holland and also Minister for Foreign Affairs, and Mr. Mannuel Marin, Vice-President of the European Commission.

The meeting took place in the Senningden castle and lasted over three hours.

For some time now E. U. officials have been talking about holding a special bilateral "political dialogue" with India. The idea gained ground, especially after India was kept out of the orbit of the "Europe-Asia" dialogue initiative which culminated in a summit of European and Asian leaders in Bangkok last year. The controversial meeting was held under the auspices of the Euro-Asian dialogue and was organised by ASEAN countries which excluded India, but included China, Japan and South Korea. As if to make amends for the lapse, it was agreed that India could be invited to the next summit, to be held in London in 1998.

DPA, Reuter report:

The E.U. has promised to build a more "substantial relationship" with India, covering trade, investment and political issues.

Separately, the union officials also unveiled the aid programme to upgrade primary health and population control programmes in India.

The officials said this was Europe's largest-ever aid programme in Asia. The aim was to move away from traditional family planning projects to what the E.U. aid expert called a more advanced approach, including maternal education, pre-natal care and contraception.

Speaking at the meeting with Ms. Sinha, Mr. Marin and Mr. Poos said the E.U. wanted to inject a new dynamism into Euro-Indian relations.

Mr. Poos, said Europe's relations with India must reflect the country's growing international clout.

Europe's contacts with India should be in line with the importance of this country and its real and potential influence in the world, Mr. Poos told a news conference.

Mr. Marin that while the E.U. was India's largest trading partner and biggest source of foreign investment, both sides needed to boost their geopolitical dialogue.

The E.U. has suggested that senior Indian and European officials must hold more frequent high-level discussions to reinforce political links.

WHO alert on new influenza virus

By P. Sunderarajan

NEW DELHI, Sept. 3.

The World Health Organisation (WHO) has sounded an alert over the emergence of a new strain of influenza virus in humans, which was till now known to infect only birds.

The warning has come following the isolation of the virus in a three-year old boy in Hong Kong, who died of Reye Syndrome during an attack of acute respiratory illness last May.

(Reye syndrome, which affects the central nervous system and the liver, is a rare complication in children, who may have ingested aspirin (salicylates) and occurred mainly in children with influenza type B, and less frequently in children with influenza A or chicken pox).

According to WHO officials, as of now, the boy's case was the solitary incidence of infection with the new virus strain that has been detected in a human being. But, nothing could be left to chance.

The WHO is monitoring the developments closely, in collaboration with the Influenza Centre and the Department of Health in the Hong Kong Special Administration Region, and the WHO Collaborating Centres for Reference and Research on Influenza in the U.S., U.K., Australia and Japan, besides the National Influenza Centre in the Netherlands.

Efforts are particularly on in Hong Kong and other parts of southern China to determine whether any other person had been infected by the strain.

OXFAM
Working for a Better World

OXFAM (INDIA) TRUST

Dated : 10th November, 1997

Dear Dr. Ravi Narayan

Please find the enclosed set of photocopies of the newspaper clippings in connection with India Disasters Report.. We will be sending you the next set of clippings very soon.

Thanking you, with regards,

Udoy Sankar Saikia
Consultant
India Disasters Report
OXFAM (India) Trust
B-3 Geetanjali Enclave
New Delhi- 17

Please send to Umesh
immediately for further action

RN

released 11/11/97

11/11/97

DM-10

From: Ravi Narayan

Subject: From: Ravi Narayan
Date: Mon, 19 Feb 2001 15:23:51 +0530
From: Community Health Cell <sochara@vsnl.com>
Organization: Community Health Cell
To: Sanjiv Lewin <lewin@vsnl.com>

Dear Sanjiv,

Thanks for your report from St. John's, which was an excellent one. Congratulations not only on the good work done but also on the methodical way it has been listed out in the de-briefing report.

We are forwarding 2 reports we have received from two of our sources in Gujarat which we thought may be of interest to you. You must have received the report from Unni and Ramappa. Many people have been in touch with us including the junior doctors from BMC. Could we meet soon to discuss how we all could liaise with each other's efforts for the phase of rehabilitation that will be starting up soon. It would be great if the Disaster Relief & Training Cell of St. John's would be willing to consider more than just St. John's response. And perhaps become the planning cell for the Bangalore Response as well.

We need to discuss this soon. All the best,

Ravi / Arjun.

✓ (1) Shridhar's Report (mfc)
✓ (2) Sudarma's Report

RN
Sent
19/2

DM-10

\\P550\f\Rita Lobo\EC Letters-Minutes\EC Letter 9.3.2001.doc

Earthquake update

Subject: Earthquake update
Date: Mon, 19 Feb 2001 15:43:17 +0550
From: VINIYOG PARIVAR TRUST <viniyog@bom3.vsnl.net.in>
To: PREMDASS <SOCHARA@blr.vsnl.net.in>

Dear Friends,

Fifteen days after the earthquake, life is still haywire for many families in Kutch and Saurasuthra. 224 mild tremors of aftershocks are reported in last 15 days, continuing the reign of terror.

300 volunteers of Viniyog Parivar distributed and/or guided in distribution of over 1000 truck loads of food material at different places. This work was done in the first five days. Hunger is partially overcome. Affected people now need psychological rehabilitation. A team of five senior volunteers visited devastated villages and talked to the affected people, discussed their problems and considered how we can be helpful to them. Such 30 teams visited 994 villages in 10 talukas of Kutch district. A detailed report of all these 994 villages is published by "Gujarat Samachar", Ahmedabad. Those who are interested, can reserve their copies. Those who are having internet facilities can visit the site "www.gujaratsamachar.com"

Jain Sangh is also badly affected due to this earthquake. A large number of temples upashrayas, Gnan Bhandars, Pathshalas are also affected. A detailed report about the latest position of these is also prepared.

Animals are worst affected. Animals have not died so much due to earthquake, but they are dying due to hunger because there is no one to take care of them. Govt. figures put animal deaths at about 19000, but Viniyog's survey reveals that more than 40000 animals are dead due to hunger out of 110000 animals in Kutch. The unfortunate part is that due to drought conditions prevailing since last year there is no fodder available in the State. Govt. has brought 3 lakh tons of fodder through railway but there is no proper distribution channel.

Animal Welfare Board of India has taken this matter seriously and has arranged 1000 MT of wheat and 161 MT of rice for cattle feed from Food Corporation of India. AWBI Chairman Justice Gumanmalji Lodha has informed that he is much worried as animals are the lifeline of Kutch. Shri Lodhaji will be visiting Gujarat from 19th to 24th February and he will assess the situation and take decision for further assistance.

Earthquake update

Viniyog has started sending trucks of dry fodder (Gawar chunni from Punj=
ab)=20
to affected areas with volunteers. One such truckload of fodder costs Rs.35=
000/-.=20
Smt. Maneka Gandhi, Minister of State, Ministry of Social Justice & Empow=
erment,=20
also holding charge of Animal Welfare, Govt. of India. has sanctioned gran=
t=20
for 15 truckloads of fodder from her Ministry, to be distributed through =
Viniyog=20
Parivar Trust. Animal lovers worldwide are requested to help for fodder imm=
ediately.

A scheme for rehabilitation of quake affected people is under preparation.=
=20
Eco-friendly and economical houses with indigenous material will be constr=
ucted=20
by Viniyog Parivar. The cost of each house will be approximately one lak=
h=20
rupees. A detailed scheme will be placed before you shortly after the an=
nouncement=20
of Gujarat Government's policy.

Please visit our website at "www.viniyog.org"
Thanks and regards,

Girish Shah
Viniyog Parivar

Ravi

DM-10

Re: [mfriendcircle] The quake: an update from the field

Subject: Re: [mfriendcircle] The quake: an update from the field
Date: Mon, 19 Feb 2001 10:39:50 +0530
From: "Amar Jesani" <jesani@vsnl.com>
Reply-To: mfriendcircle@yahoogroups.com
To: <mfriendcircle@yahoogroups.com>, <pha-ncc@egroups.com>

Dear Sridhar,

Thanks for the earthquack updates.
There has been explosion of info in the cyberspace on this subject. Some points are confusing. For instance, there has been a consistent allegation of bias and discrimination. I happened to see the following petition of individuals and NGOs. It would help to learn about the exact nature and extent of such bias and discrimination. If you have more onfo, please do send it.

Amar

Amar Jesani
(Home) 310 Prabhu Darshan, S. Sainik Nagar
Amboli, Andheri West, Mumbai 400058, India
Tel:(91)(22) 623 0227. Email: jesani@vsnl.com

EARTHQUAKE AFFECTED RELIEF & REHABILITATION SERVICES (EARRS)
C/o. SXSSS, P O BOX 4088, Ahmedabad 380009 (Tel: 079- 7410764)

***EARRS Documentation February* 13:**

EARRS is a secular and non-sectarian civil society initiative by several NGOs and social action groups converged

- to provide relief to quake victims,
- respect the efforts of other NGOs and networks in earthquake relief
- evolve long term reconstruction & rehabilitation,
- facilitate compensation claims,
- monitor relief efforts by the State and others to ensure that relief reaches all irrespective of caste, religion, gender and age,
- advocate and campaign for disaster policy and management.

Please Forward

Joined EARRS:

53. AWAG
54. IFIE
55. SANCHETANA
56. SAHR-WARU

KN

Next Meeting of EARRS

Wednesday Feb. 14, 5.30 p.m.
Venue : SXSSS, Opp. St. Xavier's School Loyola.

19/2

Agenda:
- Review relief efforts.
- Discuss the caste/ communal or other biases in relief/ rehab. efforts, work out future action programme.
- Discuss the strategies for rehabilitation and disaster management policy.

EARTHQUAKE RELIEF: ISSUES OF CONCERN

organisations, in connivance with the State administration are systematically ensuring that these vulnerable groups do not get proper relief and compensation. Complaints have come from dalit and Muslim dominated areas of Bhuj, villages in Kutch, Maliya-Miyana town, villages in Saurashtra. We are planning to compile a detailed report on these discriminations in relief work and represent before the NHRC and State/Central authorities. Any specific grassroots experiences or cases (with details) are welcome:

Is there discrimination on the basis of localities in a village, town or city?

Is there discrimination between urban and rural areas ?

Is there discrimination against dalits and the areas they live in versus non Dalits?

Is there discrimination on communal grounds? Need to examine the position of Muslims and Christians (eg. Muslim citizens who had taken shelter in the Mundra mosque)

Is there discrimination against women and children ?

Whether the cash doles from the Government and/or relief in respect of lost household effects, have reached or not reached the concerned localities?

In respect of temporary shelters - have they been provided to all ? If not, to whom have they been provided? Whether there is any aspect of discrimination involved (communal or casteist bias?)

Memorandum to the government on principles and provisions for rehabilitation and reconstruction policy in earthquake affected areas of Gujarat:
12 February, 2001

To: Shri Keshubhai Patel
Chief Minister of Gujarat
New Sachivalaya,
Gandhinagar, Gujarat

Dear Shri Keshubhai,

We, the concerned citizens and representatives of various people's organizations, recognize the stupendous task of rehabilitation of the earthquake affected regions of Gujarat, particularly Kutch and Saurashtra.

We are and will be with the people in rebuilding their lives and communities.

We welcome the government's efforts in coordinating and harnessing the work of different organizations committed to this task.

We, having worked in the various fields of society, and in times of calamities, both natural and human-made, and having experienced the happenings in the recent earthquake affected areas in Gujarat, firmly believe that there are certain fundamental principles which should govern the process and plan of rehabilitation which will give a real opportunity to the people to build a self-reliant and sustainable community.

We would urge that the government and all other stakeholders should keep these principles in mind while determining the policy and program for the same. These we believe, should also serve ad the criteria for entering into any understanding and plans for collaboration among the various agencies including the State, NGOs, and also any private corporation.

Sincerely,

Jst. (Retd) Ravani, Ahmedabad

Girish Patel, Advocate Lok Adhikar Sangh, Ahmedabad

Haroobhai Mehta, Advocate, High Court, Gujarat

Mahesh Bhatt, Advocate, Ahmedabad

Medha Patkar, Narmada Bachao Andolan & National Alliance of People's Movements

Charul Bharawada, Architect and Planner, Abhigam, Ahmedabad

Re: [mfriendcircle] The quake: an update from the field

Ravi Kuchimanchi, Civil Engineer Association for India's Development, Mumbai

Rupal & Rajendra Desai, Architects, TARU, Ahmedabad

Dinkar Dave, Samanvaya Guajrat, Ahmedabad

Rajni Dave Manviya Technology Forum, Ahmedabad
Tushar Shah Cardiac Surgeon, Ahmedabad

Cc: Shri A.B. Vajpayee, Prime Minister of India
Cc: Shri Jagmohan, Urban Development Minister, Union of India
Cc: Smt. Menaka Gandhi, Minister of Social Justice and Empowerment, Union of India

Principles and provisions suggested for rehabilitation and reconstruction policy in earthquake affected areas of Gujarat:

1. Now that the emergency and the first phase of rescue and relief is almost over, we urge that all the governmental and non governmental agencies must urgently shift to the employment generation plans and programs with food-for work arrangements, ensuring livelihood opportunities for the earthquake affected.

2. Every group involved in the social, economic, & physical reconstruction of Kutch and Saurashtra - the earthquake affected region must grant and respect people's right to information and right to participate in the planning process, with full freedom of expression at every stage of planning and execution. There should be complete transparency and accountability on the part of the State and the donor agencies.

3. Community participation must be sought through representatives of various socio economic sections within as a precondition for design, planning, site and material selection, material procurement, construction, and utilization of resources.

4. The earthquake-affected members of the community should be given the top priority in skilled and unskilled livelihood opportunities arising during the reconstruction and rehabilitation process.

5. Whether for cities, towns, or villages, relocation should as far as possible, be avoided.

6. New community location should be planned with clear consent from each mohallas / falia [vaas] and as far as possible, the village commune.

7. Where there is even partial, minimum relocation of a community, forcible, unjust land acquisition should be avoided. The scheduled castes, scheduled and nomadic tribes, other socially and economically backward class communities, should be especially protected against land alienation.

8. No urban relocation, if any, should be at the displacement or deprivation cost of the rural communities.

9. Reconstruction planning should include apart from housing, community amenities [health, education, water supply, grazing ground, etc], all of which can be part of the final village resettlement plan.

10. New housing and community reconstruction should have facilities for land conservation, maximum rainwater harvesting, soak pits & drainage, along with other appropriate technology measures to fill water and energy requirements.

11. It is not the choice of material but choice of house-building technology that is one of the main factors determining the scale and nature of earthquake impact. In reconstruction, therefore, the choice of technology should necessarily be based on multiple criteria, including self-reliance of the community, availability of the material, and earth-quake proofing technology.

12. There should be no forcible, stereotype housing imposed on people, killing or rejecting their diversity of type of technology, and cultural aspects.

13. Wherever possible, such as in the villages of Saurashtra, retrofitting should be a priority over new construction.

14. Not big companies or builders, but the representatives of affected communities, people's organizations, NGOs, and the local government should form a body for decision making at every level of planning and execution of a project, where funds and inputs are to come from outside the community.

15. All funds received from any agency, national or international, including the collection of surcharge, must be deposited into a separate fund / account related to the earthquake disaster and must be utilized only for the purpose for which it is assigned.

16. An independent high power committee with eminent persons from various walks of life should be immediately

Re: [mfriendcircle] The quake: an update from the field

constituted to monitor the planning and execution, including expenditure at each - national, state and local - stage.

—

DM-10

31th January 2001
Gujarat earthquake shatters lives.
Timely response can minimise misery

We are rushing this to you at a time when we are working round the clocka earthquake ravaged and deeply traumatised people in Gujarat.Disasters are not new in our country, but rarely we have witnessed a devastation that is so huge and so painful.

The death toll has already crossed 20,000 and more deaths are being reported with each passing day. There is a strong feeling that a large number of people are still buried under the debris of collapsed buildings.

The most urgent need of the hour is to mitigate the suffering of those who managed to survive, but are now highly vulnerable. The earthquake couldn't have chosen a worse time for its onslaught as most of the quake affected areas in Gujarat have already been reeling under the third consecutive year of drought. People's economy is already in shambles and they are in no position to recover from this tragic blow on their own. Worser, parts of Kutch are still to recover from the 1998 cyclone that devastated the area.

The earthquake has left behind over one hundred thousand people with broken limbs and multiple injuries. They are now desperate for emergency medical relief.

With nearly 90 per cent dwellings completely damaged in many places,temporary shelter has become the most pressing need of the people. Chilly winter nights are further accentuating the woes of survivors, especially the poor children, women and the elderly. Many of them have no other option, butto spend their nights under the open sky with very little or no clothing for keeping themselves warm.

Needless to say that the earthquake affected people in Gujarat are desperate for help to overcome their shock and misery and start rebuilding their shattered lives.

We at Oxfam India are among the first ones to reach the affected people. At present, the teams of doctors that Oxfam India facilitated are meeting the most urgent medical needs of the people. They are located in Rapar, one of the worst affected pockets, initially for the first 15 days.

Oxfam India is also working towards the deployment of mental health experts and health workers to respond to shock and mental trauma. We are working with specialist mental health institutes like National Institute of Mental Health and Neuro Sciences (NIMHANS) to formulate a long-term psycho-social intervention in the area. Oxfam India, along with NIMHANS have made similar interventions in Kutch (1998) and in Orissa (1999) after the cyclones and the programme has helped to alleviate the trauma of the affected people and has facilitated to get the rhythm of their life back.

We are equally concerned and working towards to help people arrange temporary shelter with our limited resources. We have a highly effective network of our local NGO partners to reach out to the most vulnerable and neglected people, mainly because of our work in the aftermath of the 1998 cyclone and during droughts in the last two years. Oxfam India, in close co-ordination with the network of voluntary organisations (such as Gujarat Janajagaran samithi, Samerthan, Medico Friend Circle etc) is facilitating coordinated approach for relief and rehabilitation in the worst affected area.

To highlight the plight of the survivors and their long-term misery and needs, Oxfam India is also issuing regular situation-updates to the public and media.

We struggle for appropriate words to thank you for your concern. We highly appreciate your humanitarian gesture and offer for financial assistance in these trying times. In addition to funds, you may also consider contributing in kind depending on the needs, which we can communicate to you in the coming days.

At present, we recommend only blankets and high-density polythene and tarpaulin sheets to make temporary shelter for those left homeless by the killer earthquake. Past experience shows that it

will take at least more than six months to start rebuilding the shattered houses.

Our approach and plan
Oxfam India's response will be at three levels. Firstly, it has facilitated immediate relief for the most needy. We have also facilitated a coordinated approach to ensure effective relief and rehabilitation of the earthquake affected.

Secondly, we are working on a time bound programme- (a) immediate relief for the next 30 days; (b) 3 months to 1 year rehabilitation programme to deal with psycho-social consequences and physical disability especially to deal with the needs of children, women and the elderly. It may be mentioned here, these three groups have to bear the brunt in any post disaster situation (c) long-term development work in the area. This component will have disaster preparedness and response programme.

Oxfam India also works towards a national disaster management policy at the national level and state level policies in the most vulnerable pockets. This will involve long-term advocacy and lobbying work at various levels, mainly ordinary people and policy makers.

Please be reassured that your contributions will go a long a way to alleviate the sufferings of the earthquake-affected people. We will take extra care to ensure that the resources are used properly and that too for the most needed and neglected. As in the past, we will retain a very transparent and accountable financial system for the whole earthquake response.

We hope our regular updates will help to fine tune our initiatives and your concerns.

If you need any further information or clarifications please call us on our office numbers 080-3692964; 3693274 or any one of these numbers
Sriramappa on 98451-78829;
Kalpana Rao Deswal on 98451-78814;
Dr.Unnikrishnan on 98450-91319
Lorraine on 98451-63757

We look forward to a fruitful collaboration for this initiative.

Thank you and with warm regards,

yours sincerely

Sriramappa

****

OXFAM INDIA WORKS TOWARDS AN EQUITABLE AND JUST SOCIETY FREE FROM HUNGER,EXPLOITATION AND POVERTY BY FACILITATING PEOPLE-CENTRED, RESPONSIVE,TRANSPARENT GOVERNANCE SYSTEMS, ENSURING BASIC RIGHTS AND SUSTAINABLE DEVELOPMENT.

****

Oxfam India is an Indian society registered under section 80-G of the income tax act and all donations to Oxfam are subject to tax relief under this section

DM-10

Are Earthquake Deaths Overestimated?

Assessment for Kutch Villages

There is some reason to believe that the number of earthquake-related deaths in Kutch may be lower than the first estimates.

H S Shylendra

The January 26 earthquake along with the large-scale devastation has created much confusion and controversy about the number of people who have died on the day under the rubble. The total number of deaths in Gujarat estimated by different sources vary from 15,000 to even 1 lakh. The widespread nature of the devastation and the delay in clearing the debris especially in the major towns has made it really difficult to arrive at any realistic estimation about the number of deaths. While all the attention is focused on major towns like Ahmedabad, Bhuj, Bachchau and Anjar there is no clear information available about the extent of loss of life in the villages, particularly in Kutch which has suffered major devastation. There are fears that the deaths in villages are equally high and the final figure may be a staggering one. Partly the attempt to sensationalise the impact by some section of the media is also to be blamed for the confusion.

As a member of the National Dairy Development Board (NDDB)-led team from Anand distributing milk and milk powder to quake hit people of Kutch, I got an opportunity to tour in some of the worst-affected villages. The insights gathered during the discussions we had with the affected people in these villages were quite revealing in terms of the death statistics. While so much confusion surrounds death statistics in the cities, surprisingly a clear picture was emerging from the villages.

The rapid survey we did in one of the milk routes to assess the need for milk took us to 11 villages in Bhuj and Anjar talukas. The villages covered included Kukuma, Lakhond, Chapreli, Kalitalawadi, Mota Varnora, Nana Varnora, Lodai and Dhaneti in Bhuj taluka, and Pashuda, Bimasar and Padana in Anjar taluka. All these 11 villages are totally devastated. Almost all the houses have collapsed with only a very few structures able to withstand the tremors. The villages are located within a radius of about 50 km from the epicentre, with Lodai village being the closest of all to the epicentre (2-3 km).

Given the sensitive nature, we exercised considerable care in examining the issue of number of deaths that occurred on January 26 due to the quake. To our surprise, in all the villages people could clearly give us information about the number of people who died in their villages. The information was largely confirmed by the cross-checking done with more than one person. The number of deaths varied from just one in Mota Varnora to about 35 in Kukuma which is one of the biggest of the villages surveyed with an estimated population of about 3,062. The number of deaths reported in the other villages are as follows: Lakhond – 16, Kalitalawadi – 10, Chapreli – 6, Nana Varnora – 2, Lodai – 23, Dhaneti – 4, Pashuda – 5, Bimasar – 10, and Padana – 8. In some of the villages there was a marginal variation in the figures given by different people. In those cases death figure on the higher side has been taken. The average number of deaths in the villages comes to about 11. The Bhuj villages which are closer to the epicentre seem to have much higher deaths (average of 12) than Anjar villages (average of 8) which are relatively far away from the epicentre. A cursory analysis shows that there is a clear relationship between the number of deaths and the size of the village; higher the population higher is the number of deaths implying a uniform kind of an impact of quake at least in these villages.

The reported number of deaths partly belied our fears that the loss of life could be also as high in the villages as it was estimated to be in towns. Two or three factors seem to have contributed for the relatively moderate number of deaths in the villages as compared to the towns. Kutch as a whole has a low population density. Second, unlike Latur in Maharashtra, the time (8.46 am) at which the earthquake struck in Gujarat has made a significant difference. Most villagers were awake and were even out of the houses at that time. Once the tremors started, many could come out of their buildings before they collapsed. Third, the simple housing structures in the villages helped even those trapped under debris to escape though with varying degree of injuries. The impressions gathered also suggest that those who died are mostly aged, weak and infants who could not escape easily. Interestingly, the livestock did not suffer any major loss unlike during the last year's drought. Here again the timing of the quake seems to have worked to the advantage as most cattle were out of their sheds by that time for grazing. Though there are reports of deaths of livestock the figures are much lower than the human loss. In Lodai, the epicentre village, people reported deaths of 12 animals and 23 people.

Another concern which has been belied is the fear of dead bodies rotting under debris and spreading stench and diseases in the villages. In all the villages we visited, the villagers have removed all the dead bodies and disposed them on the first day itself. Of course, in one village they said they have not been able to trace the body of only one person. This is in contrast to a large number of bodies buried under the debris for more than a week in the towns. Further given the relative lightness of the materials used for construction, the villagers do not seem to have faced any problem in removing the bodies from the debris. Moreover, most of the houses in these villages are single-storeyed structures. The quantum of debris hence is much lower in the case of rural houses than in urban areas.

Based on the above understanding and clarity that was emerging with regard to the nature of deaths in the villages, I have made an attempt to estimate the total possible number of deaths in the villages of Kutch district. The assessment made during the visits to the above villages convinced me that one can arrive at a fairly realistic estimation of the extent of deaths. The estimations made below however are to be considered as only rough approximations till the actual figures are available. The purpose is only to reduce the level of prevailing confusion about the deaths in Kutch.

If we take the estimated population for 2001, the deaths in the surveyed villages account for 0.62 per cent, i e, less than 1 per cent of the population. The 2001 population figures for the surveyed villages and for Kutch rural district were arrived at using the 1981-91 rural population growth rate. The villages surveyed, as mentioned earlier, are some of the worst affected in the district. Not all the villages in Kutch come under the worst affected category. This implies that the overall deaths in rural areas are bound to be less than 0.62 per cent. Assuming that all the villages (884) in Kutch have been affected uniformly and the rate of death to be 0.62 per cent, the maximum possible deaths in the villages would be around 6,100. Since the damage is not uniform across different talukas in Kutch, the actual number of total deaths would be certainly less than 6,100. According to one assessment only about 400 of the 884 villages are worst affected. This is also partly confirmed by our understanding based on the feedback given by other team members that villages to far west of Bhuj are relatively less affected than those to the east and south-east.

Going by the reasons discussed above for the extent of deaths, one can safely assume that the number and rate of deaths in the villages, not as severely affected like the surveyed villages, should be much less than the rate in the worst affected villages. By assuming a slightly lower death rate of 0.5 per cent, the total number of deaths in rural areas of Kutch would come to about 5,000. If the death rate is lower than 0.5 per cent, which I vouch for based on the field insights, the total deaths would be less than 5,000. Subject to any exceptional villages with very high deaths and any error in the population estimation, one can put the actual range of deaths at 4,000-5,000 for the Kutch villages; 4,000 being the extent of deaths in the worst affected villages. However it should be pointed out that irrespective of the number of deaths the devastation in the area is enormous. The death debate should not undermine in any way the urgent need for relief and rehabilitation. EPW

[The views expressed above are solely personal.]

Torture in Custody

Method in Sadistic Madness

The endemic practice of torture in police custody – which is making India a pariah of sorts among civilised nations – can be held up as an example of our lasting adherence to tradition, both indigenous and colonial.

SUMANTA BANERJEE

In December last year, Amnesty International sent a note to the government of India alleging torture and killing by its police and security forces of individuals held in their custody – a habit which has become pandemic among the minions of law all over the country, making India a pariah of sorts among civilised nations. Amnesty also sent a set of recommendations for the prevention of such crimes. Predictably, New Delhi has not yet publicly responded either to the allegations or the recommendations. But according to the government's own official monitoring body, the National Human Rights Commission (NHRC), between 1999 and 2000, at least 1,143 deaths in custody (including deaths in jails as well as police custody) were reported to them. The latest instance of such custodial killing was in Kashmir in mid-February, where a medical shop-owner Jaleel Ahmad was picked up one day by security forces who handed over his bullet-riddled body to his family a few days later. Protest demonstrations in Kashmir against the custodial killing were met by indiscriminate firing by security forces, resulting in further deaths. The impact of torture is no longer confined to the victims within the police lock-up. It is provoking mass protests, leading to massacres by a trigger-happy gang of cops, paramilitary forces and army personnel.

There can be two ways of viewing the situation. One is a charitable view, that believes that the Indian government is sincerely committed to international covenants like the Convention against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment, which it signed in October 1997, but it then excuses the government for its failure to implement it by blaming its minions – the Indian police and security forces – for the violation of the convention. The excuse is that no government in India, however well-meaning it might be, can ever control and train the personnel of its vastly complicated network of law-enforcement machinery according to the guidelines of any human rights manual. Go to any police station with an FIR naming a suspect for even a minor offence like theft, the officer-in-charge will tell you that 'third-degree-methods' (the euphemism for torture) are essential to make the suspect confess. Some among these police personnel would pass the buck on to their senior officers, or political leaders, blaming them for putting pressure on the police to solve a crime as early as possible. This, they claim, forces them to extort from the arrested person a tailor-made confession that would help them to nail the suspect. Thus, torture in custody although never acknowledged, determines from behind the bars the legal process of accusation and conviction of the arrested, whether the latter is guilty of the crime or not.

The other view is that the government itself lacks the political will to stop torture in custody. The sanction, or even encouragement, of such torture flows from the higher echelons among the decision-makers and administrators. The latest incident involving a Bihar minister who tortured a dalit employee, and managed to evade arrest for days together till he himself decided to surrender, or reports about senior government officers torturing their domestic help on suspicion of petty offences, indicate the propensity towards corporal punishment that is widely prevalent among the powerful and the privileged sections in India. True to the tradition of hypocrisy that rules our society, these people would pay lip service to human rights in public, but in private would defend torture on the ground that criminals are tough nuts to crack and need to be 'broken down'.

That torture or ill-treatment of prisoners to mete out instant justice is becoming increasingly acceptable in society was acknowledged some time ago by the government-appointed Police Reforms Committee, which submitted its report in October last. "A large section of people", it said, "strongly believe that the police

DM-10

Oxfam India

TOGETHER WE CAN OVERCOME POVERTY

Oxfam India works towards an equitable and just society free from hunger, exploitation and poverty

Vijaya Shree, 4th A Main
Off Bellary Road, Hebbal
Bangalore - 560 024, Karnataka
Phone: (80) 363 2964 / 363 3274
Fax: (80) 363 1371 (pp) (Attn: Oxfam India)
email: oxfamindia@vsnl.com
Web site: www.oxfamindia.org

Friday, 16 February 2001

Attn.: Mr. Sanjay Kaul, Health commissioner Fax No. 2285591

To,
The Chief Secretary and Karnataka State Govt Relief Committee for Gujarat Earthquake
Vidhan Soudha
Bangalore-1

Dear Sir/ Madam,

Bangalore response briefing meeting on 17th February2001, Saturday

Bangalore response to Gujarat earthquake - teams have returned after doing the initial relief work and assessment for the longer term needs during last few weeks.
A briefing session is organised to consolidate our learnings from the experiences so far and plan for the future work.

Venue: Ashirvad, No.30, St Marks Road, opposite State Bank of India
Time:10 am to 1 p m

If you have any difficulty in reaching the venue please call on 2210154

We are hereby inviting you to the meeting as an observer. If it is not possible for you attend you may kindly depute one of your officers for the meeting. As Karnataka Govt has been involved in the relief efforts so far and planning rehabilitation programme it might be useful.
Looking forward to your participation

Yours sincerely,

G.Sriramappa
Director

(202) 16/2 jrs

DM-10

Some more info on Earthquake in Kutch - Gujarat

Subject: Some more info on Earthquake in Kutch - Gujarat
Date: Mon, 19 Feb 2001 11:36:26 +0530
From: Vijay Pratap <ritupriya@vsnl.com>
To: ritupriya@vsnl.com

Dear friends,

Here again we are forwarding you some more information on Gujarat Earthquake relief work.

Thanking you,
Kusum
For Vijay Pratap

From: "Thakker" <thakker@vsnl.com>
To: <ritupriya@vsnl.com>
Cc: <bidada@hotmail.com>, <anita@bom5.vsnl.in>
Subject: Earthquake in Kutch - Gujarat
Date: Sat, 10 Feb 2001 14:22:57 +0530

Date: 10/02/2001
For : Vijay Pratap & Lokayan friends
From : Deepak Mepani, Bidada, Bhuj/Mumbai

Dear Vijaybhai,

The Kutch quake situation demands every ounce of help from every corner of the world. And fortunately this has been forth coming. But our efforts must be kept up till Kutch is back on its feet as early as possible.

The Bidada Sarvodaya Trust (in association with Bhojay Sarvodaya Trust) is fully geared to meet the situation in a fundamental area medical relief and rehabilitation with their full-fledged hospitals, the only ones in this region.

Hence, I appeal to you to please approach all your contacts and resources to seek and secure help in cash and kind. Please have them contact us as under for all coordination needs.

1) Mr. Deepak Mepani, Pandit Villa, Ground Floor, Third Gauthan, Near Chembur main Post office, Chembur, Mumbai 400 071.

Phone : (R) 528 8258/5298748
(O) 200 8290/200 8550
E-mail : thakker@vsnl.com

2) Mr. Babubhai Thakker, Trustee, Chandu Memorial Trust., 301-305, Jolly Bhavan No.1, 10 New Marine Lines, Mumbai 400 020.
Tel. no. : 200 8290/200 8550/200 3828
Fax : 200 8290
E-mail : thakker@vsnl.com

3) Mr. Liladhar Gada/Dipak Mepani, Maru Hospital, 286/B, Dr. Ambedkar Road, Off. Bharat Mata Cinema, Near H.P. Petrol Pump, Parel, Mumbai 400 012.
Tel no. : 414 6111/6112

RN 18/2 RL 19/2

Ans 19/2

Some more info on Earthquake in Kutch - Gujarat

E-mail : anita@bom5.vsnl.in or bidada@hotmail.com

The Trust enjoys both 100% Income tax exemption and FCRA (Foreign Contribution Regulation Act) Authorisation.

With your vast contacts of well wishers, both individual and corporate here and abroad, we look up to you to mobilize substantial support. Any donor is welcome to visit us and see the work being done.

I must add here for your information that we are now conceiving the quake relief in a totality of its own and planning rehabilitation work comprehensively on a long term basis till all the affected ones return to normal life as early as possible. We wish to tailor and undertake specific end-based programmes to deal with cases of a) the physically paralysed and crippled; b) mentally affected who need psychiatric help and c) Homeless and destitute covering the aspects of shelter, employment, education and ongoing medical assistance.

I shall write shortly to you in greater details. But this is only to indicate that our work is not temporary or adhoc but aimed to be comprehensive and lasting needing substantial and continuing support from all.

With best regards,

MEPANI

DM-10

DISASTER RELIEF

To rebuild Kutch

A major challenge in the reconstruction of Kutch is to find solutions that are suited to people's real needs and are easy to adopt.

BY SPECIAL ARRANGEMENT

Putting up dwellings in Bhuj. There is a need to take into account the climatic conditions while drawing up schemes to provide shelter.

MARI MARCEL THEKAEKARA
in Bhuj

MONEY is not the problem. It has poured into Gujarat in an unprecedented manner. The problem is how it will be spent.

The dust of the debris has not quite settled, but the people of Kutch, a strong, resilient community used to drought and famine in a hostile terrain, have begun picking up the pieces.

In Bhuj, sitting in a small maidan under crudely pitched tarpaulin tents, the headquarters of Abhiyan, a relief effort of 22 Kutch-based organisations started three years ago in the wake of a cyclone, this writer was privy to innumerable discussions on what needed to be done, how, when and where. Abhiyan was the most organised group in the area, and District Collector Anil Mukim made it a point to join the meetings held at 9 a.m. every day. The meetings were attended by a host of disaster relief and donor agencies from different parts of the world – the United Nations, the World Bank, non-governmental organisations, and so on. Together they tried to formulate plans and strategies to put in place an effective rehabilitation policy. Many of those present were experts in relief work – they included those who had worked in Latur after the 1993 earthquake and in Orissa and Gujarat after devastating cyclones hit the States. The international groups had worked in Turkey, Bosnia and Rwanda. In short, they had seen it all.

The discussions covered issues that needed immediate attention, such as shelter, livelihood, environment, child protection, equity, health and, most important, the process of rehabilitation. Understanding the importance of the process may be a slightly complex task, but it is crucial if development is to take place in a manner that is suitable and easy to adopt.

The main concern is that the victims should get the kind of houses and rehabilitation programmes that they want and that will work. For instance, take the issue of shelter. State governments and well-meaning groups have rushed thousands of asbestos sheets and corrugated tin sheets to the earthquake-affected areas. Already it is unbearably hot in Gujarat during the day. By April, temperatures will soar and by May and June, it will be over 48°C. Who can survive under a tin sheet or an asbestos sheet? It is clear that the scheme for shelter has been drawn up without taking into account the climate.

Every disaster brings in experts who offer solutions that are not entirely suitable. Most of the experts do not see the genius of indigenous construction techniques. In the Kutch area, traditional *bhungas*, circular houses made of mud, grass and sticks, with a conical roof, have withstood the test of time and are testimony to local skills and knowledge. In the quake-prone Himalayan Garhwal area in the Himalayas, traditional houses have withstood tremors.

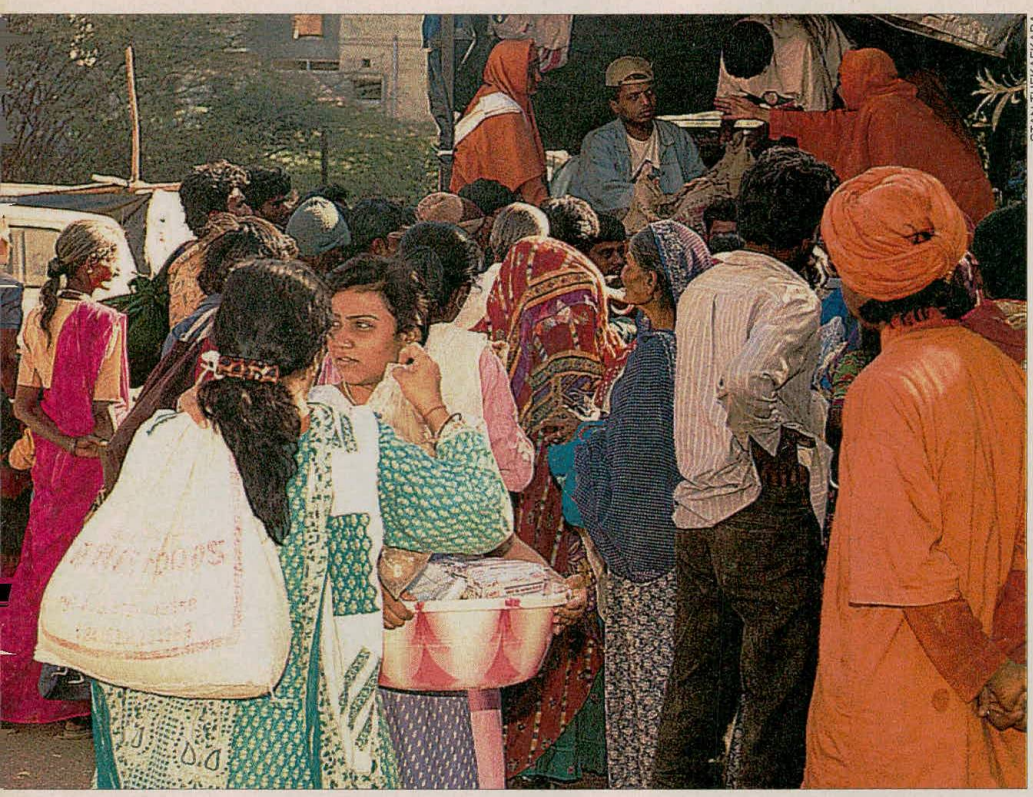
The Abhiyan team, in consultation with the District Collector, architects, structural engineers and international experts, has come out with a document on shelter with a set of guidelines that will help avoid the mistakes committed in Latur and Orissa.

Relocation is a major issue. People in rural and semi-urban locations do not wish to be relocated, being more comfortable and secure near their original homes. The argument offered is that the removal of debris is prohibitively expensive. Shelter experts point out that the infrastructure that needs to be put in place for a major relocation programme is even more expensive.

Removal of debris can become the first component of a shelter package. This would provide work, and thus food, for the people. They would be engaged in reconstruction. Involvement in the process of restarting life would help relieve their trauma and give them control over their lives. After Latur, Anna Hazare, social worker, said: "Unplanned flow of aid into the area has crushed the spirit of self-help of the people of this region, and people in many villages have taken to drinking."

The shelter document of Abhiyan states:

"The process of rebuilding earthquake resistant houses should be demystified. It needs simple techniques which people are more than capable of handling. The process should be informed by a larger vision of building self-reliant and sustainable communities. The process of reconstruction is not merely one of rebuilding houses but of rebuilding the lives and communities of the people of Kutch. Local communities must have a stake and a sense of ownership in the process of rebuilding Kutch, and emerge from this crisis with a sense of dignity,



STAN THEKAEKARA

There is a plethora of agencies, organisations and groups that have been working on disaster relief in Gujarat, but there is a need to coordinate the work with the aid of a coherent plan.

self-reliance and self-respect.

"The reconstruction project must have a multiplier effect on the economy of Kutch. Importing pre-fabricated materials would be a quick-fix solution but may prove costly in the long run since it would enrich outside economies at the cost of the local one."

The use of local materials is imperative because they are the only sustainable medium. They would be available for upkeep, repairs and maintenance. The people should not become dependent on outside sources for their basic building materials.

Another imperative of the shelter policy is that masons, carpenters, artisans and other skilled workers must be trained in building earthquake-resistant structures. T. Krishna, an architect, said: "Earthquake resistance techniques are essentially very simple techniques that any rural community can understand and grasp quickly."

The policy document points out that work on pilot projects using a range of designs, building materials and technologies should begin quickly so that communities may see the possibilities on offer and choose the most suitable one. The pilot projects may start with the building of community structures, such as a school and a panchayat office. Where the community is in a state of preparedness to undertake reconstruction, pilot projects could take up entire villages. If the people are involved in the design and construction of their new homes, they are likely to overcome the fear and trauma caused by the earthquake. Abhiyan proposes to create model sub-centre structures at 27 locations in the district.

The document points out that rehabilitation provides an opportunity to upgrade and improve on the infrastructure and the village layout that existed before the earthquake. Drinking water could be a part of the shelter package. It can also provide an opportunity to regularise land titles, issue legal pattas to landless farmers and remove illegal encroachments. Grazing lands could be developed, afforestation taken up and dams repaired.

The main premise around which housing is to take shape is that "one structurally sound room as a semi-permanent structure should be built in the same location where the original house stood, to which later additions may be made." This is the best way to combine medium- and long-term shelter requirements.

The policy on child protection is of paramount importance. Neeraja Phatak of Save The Children (STC) observed that the people of Bhuj, Anjar and Rapar were insistent that there was no child in the areas without someone to take care of it. This community does not give its children away, say the people of Kutch. Uncles, aunts, grandparents, cousins and so on make up a protective clanship. The government of India, being aware of the dangers of hasty adoptions, has announced a moratorium on adoptions and stopped children from being taken out of the district. STC and the Abhiyan have c[illegible] for a "no orphanage" po[illegible]. They believe that as far as possible orphaned children should not be moved away from areas where they had their homes. On the other hand, there is the fear that some relatives may opt for the guardianship of minors in anticipation of any compensation from the government.

The question of orphaned children's inheritance also needs to be looked at. On no account should sibling orphans be separated.

Adoption queries have been pouring in. The question is: "Whose need is adoption – the parents' or the child's?" STC believes the child's need comes first. Children affected by the earthquake will still be in a state of shock and m[illegible] them out of their familiar environment will not help. Restarting schools is a priority on the government agenda. There have been discussions on putting up community structures on an emergency basis for schools, hospitals, and so on. Getting back to school might help children come to terms with their situation.

The Health Department has been flooded with offers of support. The priority is to get the workable hospitals going in the affected areas. In the immediate aftermath of the earthquake a large number of doctors rushed to Bhuj and worked under gruelling conditions for long hours. The need now is for a follow-up on their work. Artificial limbs and orthopaedic and physiotherapy specialists will be needed to take care of the injured. Many of the disabled will need not just medical care but also long-term support and rehabilitation.

Long-term trauma counselling is also necessary. In Orissa, ActionAid invited the National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore, to train a cadre of barefoot counsellors from the community who can take care of the victims who were in a state of shock or depression. A series of manuals brought out by NIMHANS on trauma and counselling are being adapted and translated into Gujarati by the National Institute of Design, Ahmedabad.

THE Self-Employed Women's Association (SEWA), a well-known women's cooperative in Gujarat, has begun work on producing livelihood kits for craftspeople who have lost their equipment. With about 60,000 members, SEWA has a sound network throughout the State. Apart from craftspeople, shepherds and herdsmen are in distress because Kutch was reeling under drought even before the earthquake occurred. Fodder and water are urgently needed for their animals. But the most pitiable plight is that of salt-pan workers. Predominantly Dalits and Muslims, they are in near bondage to salt traders. Even the pittance they used to earn in the salt pans has now stopped. When they deal with these groups, the government and the NGOs should go beyond mere rehabilitation, bearing in mind the exploitative conditions in which they lived in the pre-earthquake days.

A few thousand migrant workers from poorer States live in conditions of bondage and exploitation. When many of them died in the cyclone that hit Kutch a year, the bodies were disposed of by their masters without proper identification and without informing their relatives. Migrants need special attention. As most of them do not have any papers that help establish their identity, they are often not eligible for any kind of aid. There have been instances of bureaucrats demanding proof of identity from people who lost everything in the earthquake. Intelligent, sensitive officials need to be deployed, to cut through the red tape and reach out to the needy.

Kutch is a fragile ecosystem, a unique one. It has a special kind of soil, which produces grass that supports its sparse population of birds and animals. A community of nomadic herdspeople moves around in its distinctive, jaunty attire, feeding cattle, goats and sheep.

Local people say that the Indian Army, in an attempt to prevent infiltration from Pakistan, planted a thorny shrub along the border, which has spread alarmingly and threatens to wipe out the indigenous species of grass. This has reduced the natural fodder available to the hardy, indigenous cattle.

It is in this context that the question of afforestation assumes importance. Nikhilesh, a young volunteer from the National Tree Growers Federation, said: "If we're starting from scratch, we may as well get it right." Any afforestation programme should be taken up keeping in view the fragile ecosystem of the Rann.

In its strategy paper, ActionAid India has raised certain other issues as well. On the basis of its experience in Orissa, it has noted that women and the aged are vulnerable groups. In a patriarchal society, women are often physically or sexually abused and their inheritance is usurped by powerful older men in the clan. ActionAid proposes to deal with this and other issues by attempting to create Sneha Samudayas, that is, community-based rehabilitation programmes for vulnerable groups such as widows, their children, the aged and the disabled. They will also form Asha Samudayas, or "communities of hope", under which people from local communities will be trained to help the affected cope with the trauma and rekindle their hope in the community. Samudaya ka Adhikar groups will help survivors assert their rights and insist on transparency, accountability and information. Local people will be trained as

Structural questions

MARI MARCEL THEKAEKARA

"DELHI is sitting on the ridge and could collapse if there is an earthquake. There has been no preparedness for an earthquake of this dimension in any of our cities," said T. Krishna, a Gudalur-based architect, and Yogananda, a structural engineer from Bangalore. The two were in Khavda, close to the epicentre of the quake, on the fateful morning of January 26. "It was a cold morning and we were outside, freezing, when the ground began to shake. It was the most frightening experience of my life," Krishna recalled. "Six of us held on tightly to each other. We couldn't stand upright. It seemed as if the ground would open up and swallow us." One of them was Meena of the Abhiyan team who learnt later that her mother had been buried in the rubble in Bhuj town.

This writer accompanied Krishna and Yogananda through a tour of the debris-filled Bhuj. They examined each building technically. "Finally," they explained, "you can't come to any conclusion. On one side of a street every building is standing and on the other side every single one has collapsed. It is probably owing to the intensity of the shock and the pattern or path the tremor travelled. Some buildings are definitely substandard. But some prefabricated structures, which ought to have survived, have collapsed. All in all, no one was prepared architecturally for this kind of a shock. Seismic zoning is not at all scientific. They are relying on pre-Independence data to predict quakes. Often they declare an area earthquake-prone after the event."

Yogananda and Krishna directed this writer to Professor Jagadish of the Indian Institute of Science, who has been working on earthquake-proof solutions. Jagadish said: "The two essential components for earthquake proofing are connectivity and ductility. Concrete, brick and stone masonry have poor ductility. They need small amounts of ductile materials such as bamboo, timber or steel in a strategic combination to enhance the connectivity and ductility of buildings. The rehabilitation process can use the materials of the fallen buildings with appropriate design modifications to produce ductility and connectivity for safe structures."

Krishna said: "We (India) had brilliant design ideas and aesthetics. But from the 1950s we gave it all up in the rush to be modern. We aped even expensive Russian buildings of concrete and steel, which are climactically and economically unsuitable for India. Concrete houses proved to be death traps. There has been a trend in architecture to move back to suitable, effective, local, low-cost buildings, incorporating traditional design. Hopefully we'd have learnt some lessons from this disaster." ■

From Gudalur to Gujarat

MARI MARCEL THEKAEKARA

THE Adivasi Munnetra Sangam (AMS) is an organisation of tribal people based in Gudalur, Tamil Nadu, struggling for land rights and equity since its inception in the late 1980s (*Frontline*, January 7, 1989) Moved by television images of death and destruction, many Adivasis of Gudalur volunteered to go to Gujarat for relief work. "For years people, strangers from India, Germany, the United Kingdom, the United States and Europe, have helped us. Now maybe we can help someone who is more in need of help than we are. We do not have money to give but we can give free manual labour."

The government had dumped thousands of tonnes of bamboo in Kutch. The people of the region have no knowledge of bamboo craft. Krishna, an architect belonging to ACCORD, a voluntary agency based in Gudalur, called from Bhuj asking for help. Five young persons well-versed with working on bamboo and skilled in making soil cement blocks – Maran, Chandran, Balu, Arumugam and Chandru – left for Bhuj along with ACCORD members Manoharan and Durga. They were cautioned that the food and weather would be different, but nothing would deter them. Krishna reported from Bhuj that the team offered to work day and night so that as many structures as possible could be put up. Its members were excited that their skills could be of use to people of another community in distress.

Another group of 100 young Adivasi volunteers, all daily wage earners, are waiting to go to Bhuj. They have nothing to offer except their love and labour for the people of Bhuj. ■

STAN THEKAE

Traditional Adivasi houses, which generally stood up to the disaster.

Sneha Karmis to give legal advice to villagers on their rights and to protect vulnerable groups. Sneha Committees will be set up to protect the long-term interests of women, children and the disabled.

There is a plethora of well-meaning NGOs, donor agencies, commercial groups and religious groups working in Gujarat. A great deal could be achieved if they are brought together by the government with a coherent development plan.

An innovative idea of ActionAid is to run a campaign through posters, pamphlets, village meetings, folk theatre and so on to spread information on various government schemes. Redress mechanisms must be in place so that people are aware of what is happening to the money meant for them. A special communication package on women's rights will be evolved shortly.

"Equity" is a sensitive issue. Martin Macwan, a Dalit leader, wryly observed. "Nature is a great leveller, but even in a disaster they will discriminate in rebuilding society." Dalits, Adivasis and Muslims, disabled people, single women and orphaned children are the worst affected in a disaster and they must be compensated fairly and justly. The only way to achieve this is for people who fight for the rights of the minorities and other vulnerable groups to form watchdog committees and demand fairplay, transparency and accountability. People who donate money should form pressure groups to fight for equity. The media have a role too. It will be a hard battle.

Anyone who is prepared to fight this battle should perhaps remember Mahatma Gandhi's words: "Recall the face of the poorest and most helpless person whom you may have seen. Ask yourself if the step you contemplate is going to be of any use to him. Will it restore to him the control over his own life and destiny? In other words, will it lead to *swaraj* or self-rule for the hungry and spiritually starved millions of your countrymen? Then you will find your doubts and your Self melting away."

Epidemics as Disaster; Epidemics following disasters

(Public Health System)

1) Introduction

2) History

3) Extent: geographical; intensity
extent of human lives lost (mortality)
extent of human lives affected (morbidity)
acute/chronic diseases
consequences.

4) Causes of the Epidemics - pandemics

5) Impact : economic
social
development
Focus groups: poor, gender, children, Dalits, migrants
(internal ; external)

6) Responses : Government : Central, State, District
Non-Government : Local, National, International
Aid agencies : bilateral, multilateral, others
Community
Media
Researchers
Policy makers ; politicians
Drug issues ; diagnosis ; treatment ; surveillance ; control and eradication
Innovative approaches in response, in partnership building, capacity building, seminars/workshops, rehabilitation (long term).
Publications ; Debates (policy, parliament, etc) ; Legislation ; Court Orders.
Quarantine
Panic responses
International responses
Epidemic preparedness

7) Other issues (miscellaneous)

8) Conclusions
SWOT analysis
Recommendations

Epidemics as disasters ; epidemics following disasters

Interview : Questions

(Proceed in a natural way from the answers. Do not be rigid in sticking to the questions)

1) What have been the major epidemics in the country?
   Have you been involved in epidemics (practically or intellectually or emotionally)?

2) what has been the magnitude (extent) of the epidemic?

3) How did it affect the people? Focus on the poor, women, children, elderly, Dalits.

4) What was the impact on the social and economic aspects?

5) What was the response? by the people, ~~by the people~~, by the Government, NGOs, media and others?

6) What do you think should be done (the response - short term and long term)?

7) Other remarks and observations.

DM-10.

GUJARAT EARTHQUAKE : *HEALING THE WOUNDS*
OXFAM INDIA'S INTERVENTIONS

"A mission to put people back on their feet":
Community Based Rehabilitation of physically challenged / disabled people.

Introduction:

The devastating earthquake in Gujarat in January 2001 is one of the worst disasters in India's history. Many were left injured critically and "disabled". With spine, pelvic and lower limb injuries dominating incidents of fracture and a sizeable number of amputees and paraplegics, it is a daunting task to provide care and assistance at the community level.

Oxfam India's innovative response to Gujarat earthquake has been operational from March third week onwards to reach out to the people at their doorstep. In collaboration with the Indian Association of Physiotherapists and other collaborating agencies and mostly, the affected community, three base stations (to cover around 200villages) have been established- at Anjar, Bhuj and Morbi. There is a team of two physiotherapists, a social worker and other logisticians at each of these centres. In addition to this, four experienced and senior physiotherapists are coming from Bombay for 3 days a week. Community helpers from the community are currently being recruited.

Oxfam India believes that "this is a mission to put people back on their feet". A visionary approach- the programme aims primarily to reach out to the community and the affected disabled people at their door step, keeping in mind that these are people who are no longer in a position to move around, most of them having multiple fractures, mainly of the lower limb, pelvis and spine. Lack of medical records in many places is hampering follow up care. To correct the situation, Oxfam India has pressed the services of a mobile X ray unit for, mainly for the villages were it is working, but also will be available for other patients and organisations. The model that Oxfam India has developed with I.A.P. is replicable, and some agencies are considering this model that will be taken up in other villages. Advocacy and lobbying, both with policy makers and in the media continue. Realising the fact that disability is a missing agenda in disaster situations today, lobbying and advocacy work to place this as an agenda will continue.

The financial support for this programme comes from the employees of WIPRO.

Oxfam India
" Vijaya Shree", 4th A Main
Near Baptist Hospital
Off Hebbal, Bangalore-24, INDIA
Ph: 91 (80) 363 2964 & 363 3274
Fax: 91 (80) 391 4508 (PP)
E-mail: oxfamindia@vsnl.com
Website: www.oxfamindia.org

Oxfam India
TOGETHER WE CAN OVERCOME POVERTY

Oxfam India
Gujarat Earthquake Field Office
I Floor, Manav Chambers,
(Opp) Kenia Hospital, Varsamedi Road
Anjar- 370 110 ; Gujarat, INDIA
Ph: 91 (2836) 45798
Mobile: 91 (0) 98251 90583
Fax: 91 (2836) 43008 (pp)

AN UPDATE on activities (9th July, 2001) :

(1) **Project survey** to identify the cases and analyse the situation has been completed way back in April last week. This was happening simultaneously along with the intervention that was happening in some villages. Over 1256 individual cases, including around 60 paraplegics, have been identified in over 200 villages through this process and subsequent field visits.

Future action: *The survey report will be cross-checked during the mid term review.*

(2) **Co-ordination office and Base stations to implement this programme and field based activities:** One multi-purpose office that will serve as a co-ordination office for the entire programme as well as a base station has been operational at Anjar from mid March onwards. Another base station has been set up at Bhuj from April mid onwards. We also have arrangements at Morbi to carryout the activities in and around Morbi. We are reaching out to the people in over 200 villages through this intervention. We have been providing community based services to 1256 survivors out of which 833 people don't need intensive care any more. There are over 36 paraplegics who are receiving our services.

HR / TEAM : In each of these base stations, we have a team comprising of two physiotherapists, one social worker, driver/s, logisticians and care takers. There is one x-ray technician to take care of the mobile x-ray unit. (Volunteers that Oxfam India mobilised have also been supporting the intervention). Moreover, every week for a period of three days, a team of 3 to 5 experienced and senior physiotherapists are coming from various hospitals in Bombay and Gujarat. This team has been mobilised by the Indian Association of Physiotherapists who has an "exclusive" understanding with Oxfam India. Moreover, around 30 people have been identified through community meetings from the villages where we are working. Some of these community helpers are working full time and some of them part-time, in villages to do the follow-up work. It may be noted here that these people come from various background and their skills are being synergised for the best results.

Oxfam India's professionals from the head office at Bangalore continue to direct the programme and make periodic visits to the area. The last visit was undertaken from July 2nd to 8th.

Infrastructure: The field offices also have communication and computing facilities. There is a jeep (one *Tata Sumo* / one *Toyota Qualis*) and other logistical and infrastructural arrangements in each of these field offices. Needless to say, as this Community Based Programme actually takes place in the villages, the professional team sets off to the villages by morning and come back late in the evening/ night depending upon the case load.

Future action: *The programme will continue as scheduled and village visits will take place uninterrupted.*

(3) **Mobile X- Ray, Ambulance unit and corrective surgery:** The mobile X-ray unit was launched on May 13th at Sukhpar, a village near Bhuj by Dr. D. Dastoor, President of Indian Association of Physiotherapists. The mobile X-Ray unit is located in a *Tempo Traveller* that also serves as an ambulance. It is in this ambulance patients (referral) are often taken to hospitals for a detailed medical check-up, screening for surgery, corrective surgical operations and to fix artificial limbs. This ambulance has also been used to transport patients (not earthquake related) in emergency cases to ICU units located in nearby towns.

Over 60 x-rays were taken initially. The X-ray reports have been helpful to identify those who need corrective surgery. A leading Radiologist from Mumbai has examined these x-rays in July first week. Some need repetition.

2 people have been taken for corrective surgery till July first week.

Future action: *The mobile x-ray unit and the ambulance will continue to be used for follow-up examination. X-rays those need repitition will be updated by July second week to enable the orthopaedic surgeons to conduct a diagnostic camp. The orthopaedic camp is scheduled tentatively for the third week of July.*

Moreover, this unit will be made available to other agencies working in other affected villages. NGOs working on public health issues have found high prevalence of tuberculosis amongst the survivors (need not necessarily be earthquake induced) in certain pockets. They are organising a health camp and thereafter a health programme to address this issue. The mobile x-ray unit may be used for the screening programme and this may be done without hampering our prime activity.

(4) Provision of artificial limbs, equipments like crutches and wheel chairs : These needs are met on a case-to-case basis and as per the felt need. Altogether, over 25 people have been provided with artificial limbs, over 5 people have been given crutches and other mobility appliances, 2 were given wheel chairs and tricycles. This activity is undertaken in collaboration with PNR society, specialist agency based in Gujarat.

Future action: *We may continue this as and where it is required.*

(5) Health care center for paraplegics:
The onset of monsoon has thrown us a challenge- the bedsore that is bothering paraplegics is a pressing concern. We are just setting up a temporary health care center for paraplegics where over 20 paraplegics, who have shown interest, will be moved for advanced medical/ health care for the next 3 to 9 months.

Future action: *The long-term plight of the paraplegics is a major concern. Oxfam India is committed to respond to their needs. We are putting a multidisciplinary team that comprises of rehabilitation specialists, physiotherapists and livelihood/ income generation programme people to make a realistic assessment and suggest long term rehabilitation plans. The team may conduct field visit and feasibility study in August / September.*

(6) Documentation: A professional documentationalist, with periodic support from students and other volunteers, have been documenting the intervention process and the external environment from April onwards. (Please see annexure for the documentation on the paraplegics). A video camera has been placed in the area and efforts are going on to document the intervention, the improvement in patients etc. This footage may facilitate documentaries on this issue. ***" The news you missed",*** a compilation of press clippings of the first three months, is being published in collaboration with the development resource Centre, Mumbai and Institute of Social Research and Development, Ahmedabad and has been circulated. Photo documentation also continues.

Future action: *The documentation work will continue on a regular basis. The compilation of press clippings also will continue.*

(7) Printing of records and education materials : Records have been printed. Educational materials, especially focusing the care of paraplegics and amputees is under production. It will be ready by July last week.

Future action: *The educational materials to sensitise the families and orient the practitioners and planners will be circulated widely from July onwards. Efforts will be put to place it in local newspapers and other periodicals. We may put efforts to hold a photo exhibition in January 2002.*

(8) **Co-ordination and networking with local, national level and international agencies and the government:** Oxfam India has left its footprint on the larger canvas. The organization is in regular touch with local community based organizations and national agencies. We are also very much in touch with the government, academic institutions, the media and international agencies. The Tata Institute of Social Sciences, Mumbai has collaborated and it may be continued in future as well. Some of our updates, newsletter and other communication material have been circulated through national and international e-groups, United Nations and other international web sites.

Future action: *This will intensify in the coming months.*

(9) **Advocacy, lobbying and policy making work:** Efforts have been put to advocate rational policies, lobby this theme at the parliament and policy making level. Numerous interviews were given to the general media and special health/ medical/ corporate magazines like the Lancet, Reuters Health, Overseas Development Agency Newsletter, CIO etc. Oxfam's opinions have been highlighted widely in the TV and electronic media as well. A 24-minute interview in a leading Indian TV Channel on the Gujarat intervention in specific and humanitarian issues in general have been telecasted in May 2001.

We have lobbied to place physical disability as an agenda for the ***Indian People's Tribunal*** who is expected to visit Gujarat in August second week.

Future action: *Efforts are made to publish scientific papers in academic journals and present papers in national and international seminars. Dr. Dastoor, President of Indian Association of Physiotherapists will be highlighting the details of this intervention at the Asia Pacific conference of physiotherapists at Singapore in July last week. Papers about our intervention and their results will be presented in other seminars as well.*

An international workshop is scheduled between Jan and May 2002. Opinion articles are expected to appear in leading newspapers and TV networks in the coming days.

(10) **Advisory committee, mid term review and evaluation:** The suggested advisory committee includes eminent persons like David Werner, Prof. Ali Baquer, Dr. CM Francis etc. However, apart from individual consultations, the committee has not attained a formal structure yet. A review is suggested in October. The advisory team is likely to give a critique of the programme after this. Evaluation is planned in March 2002.

Future action: *We will be putting efforts to energise and formalise this committee.*

Apart from the physical disability intervention, Oxfam India's interventions to respond to the psychosocial needs (undertaken in collaboration with the National Institute of Mental Health and Neuro Sciences, Bangalore and Basic Rights Programme (undertaken in collaboration with *Indian Centre for Human Rights*, Mumbai) and other agencies is picking up momentum.

unni/ 9 july 2001/

DM-10.

DN

Madhu the film - was quite informative though depressing - seeing the apathy of the Guj. Govt.

VOICES FROM A DISASTER

VOICES FROM A DISASTER is about the plight of the earthquake survivors in Gujarat. Voices that call for urgent attention...

"The officers treat us like animals because we are illiterates. Despite such treatment, I am trying to get the required documents. We are emotionally drained. Yet they insisted on police certificates. But my son didn't die in an accident for them to be asking for these certificates. He died due to chest injuries after suffering for four days. The medical team from outside treated him. But they didn't issue any certificates. Where can we get them from?" **Umarbhai Ghoda (60), Kutch.**

A devastating earthquake left thousands dead in the western Indian state of Gujarat in January 2001. It left a long trail of mortality and morbidity...Eight months after the devastating earthquake, the plight of people like Umarbhai and many others reads like an unending tragedy. Official apathy, unclear policies, discrimination and above all disrespect and disregard for human lives compound their misery. Survivors and voluntary agencies working in the area complain about lack of transparency and accountability of the system. Claiming rights and entitlements is difficult because appropriate information is inaccessible. Many of the survivors feel that this is just the beginning of a long and endless tragedy.

The ***Indian Peoples' Tribunal*** assisted by a panel of experts working on critical issues related to disasters like health, shelter, disability, human rights, disaster management etc. visited the earthquake-affected areas during August. The visit was organised and facilitated by numerous community based organisations and voluntary agencies. The survivors raised their concerns and grievances during a series of public hearings.

Duration: 28 minutes Language: Gujarati and English
Direction: KP Sasi
Facilitated by: *Indian People's Tribunal* and *Oxfam India*

This film is made possible from the contributions received from the Indian Public by Oxfam India.

RN/Lib Room - we could purchase the English version of the video after the soundtrack has been improved.
RN
20/11/07

AK/MS - Please check with Oxfam India (Ranoppa or Unnikrishnan) and find out how to get a copy. We can pay from our AV funds if necessary
RN
20/11

DM-10

Subject: Bhopal testimony - urgent
Date: Sun, 25 Nov 2001 14:46:48 +0000
From: pamzinkin <pamzinkin@gn.apc.org>
To: mirashiva@yahoo.com ravchara@vsnl.com

Dear Mira and Ravi
I have managed to get all the testimonies together at last and am about to pass them to Sarah Sexton as agreed at the recent GK meeting.
Rebeca Zuniga typed up the Bhopal one from a photocopy of the original testimony. I also have a copy. We were unable to read some of it so would be glad if you could either
a) read this and let me know if it is OK (I have out the very doubtful words in italics) as soon as you can Thus would be the quickest.
or b) communicate with Satya and see if she can correct it. We can't alter it as it was testimony publicly presented but we do want it to be as accurate as possible.
It is urgent as we wanted to get the stories out as soon as we can (this year)
Thanks
Pam
Pam

AK - Please print out the Testimony on Bhopal

Pam Zinkin tel:44 (0)20 7609 1005
pamzinkin@gn.apc.org fax:44 (0)20 7700 2699
45 Anson Road
London N7 OAR
UK

Name: BhopalStory Version 2.doc
Bhopal Story Version 2.doc Type: Winword File (application/msword)
Encoding: base64

PHA-2001 →

26/11

Dear Satya
Greetings from CHC
Please correct this Testimony and send it back or Re enclosed along with a small paragraph about how you would like to be described in the publication other than Re first line already in your story. The book may have short notes on all those who shared testimonies. Keep in touch
Best wishes to you, Yogesh and Re JSS team
from all of us at CHC
Rani Narayan
CHC Bangalore

RN 26/11

RN 26/11

Sent RN 26/11

Sent RN 26/11

cc. Mira Shiva
Pam Zinkin

DM-10

DOCTORS AND PEDIATRICIANS REQUIRED

We are just back from our assessment visit to the earthquake affected areas. We were in Bhuj and we were informed by "Abhiyan" that they are setting up over 23 "health/vigilance "centres.

Each centre will be the base from where health issues will be taken care. Individual medical care and preventive and promotive care will be the focus. Each such centre will be run by a three member team that consists 3 of the following professionals :

(1) General physician
(2) Gynecologist
(3) Community medicine expert
(4) Pediatrician
(4) Nurse
(5) Lab technician

Abhiyan needs support from the Bangalore group. Will it be possible for the Bangalore Response or any one here in Bangalore to mobilize upto 5 teams who could work in the above mentioned centres for the next three months starting from next week (Feb 26th onwards).

1) The three member team may comprise of any of the three professionals out the above mentioned five.
2) Only Hindi speaking people are required.
3) Each team may have to spend atleast one month continuously.

Ps: These centres may be endorsed by the government as their referral centres. They are awaiting conformation.

Message from Dr. P.V.Unnikrishnan (OXFAM) 19 Feb 2001

GUJARAT SHATTERED BY A KILLER EARTHQUAKE:

Long-term rehabilitation is a challenge for the survivors and the humanitarian agencies.

OXFAM INDIA'S LONG TERM INTERVENTION STRATEGY AND PROGRAMME

(Strategy note dated Feb 15th).

Responding to the immediate relief needs of the earthquake- devastated people in Gujarat was/ is a daunting task for relief agencies and the government. The first two weeks witnessed overwhelming relief assistance. However, we also found how some remote places were neglected. The scene is changing fast.

Oxfam India responded to some of the very basic survival needs like food, warm clothes, temporary shelter and specialised medical assistance in some of the neglected pockets. It also facilitated the organisation of response in Bangalore and Mumbai. It also highlighted critical issues in the media to facilitate appropriate relief and advocate humane policy directives.

RAPID NEED ASSESSMENT BY A MULTI-DISCIPLINARY PROFESSIONAL TEAM:

Oxfam India also put together a multi-disciplinary team to conduct a rapid need assessment of the earthquake-affected areas to develop our long-term interventions strategy.
The multidisciplinary comprised of

- **Dr. Jacob VC, Mumbai**. He is lead physiotherapist and Vice President of ***Indian Association of Physiotherapists.*** He has experience of working in Latur.
- **Mr. Santosh Kalyane, Latur**. He is an engineer and development resource person who has worked with communities and women's groups. He is associated with ***Swayam Sikshan Prayog***, an organisation working in Latur for the last 7 years.
- **Mr. Gabriel Britto, Mumbai**. He is a social scientist and is also the director of ***Development Resource Centre.***
- **Ms. Philomina Christi,Ahmedabad.** She is a gender activist associated with ***St. Xavier's Social Service Society.*** She has worked on gender, rights and dalits issues.
- **Dr. Unnikrishnan PV, Bangalore.** He is ***Oxfam India's*** co-ordinator for Disasters & Emergencies. He is a medical doctor working on health and humanitarian issues, both at the policy and field implementation levels.

Note- 1: Inputs from a specialist mental health team from ***National Institute of Mental Health and Neuro Sciences, Bangalore*** and other experts who are currently in the area are also incorporated in this note.

Note-2: Inputs of the teams from ***Swayam Sikshan Prayog, Mumbai; Peoples' Science Institute , Dehradun*** and ***Anandi, Bhavnagar*** are also incorporated especially on sections related to reconstruction, information dissemination and exchange programmes.

METHODOLOGY:

The team visited the affected areas and hospitals in Ahmedabad; remote and other villages; spots where the disaster affected displaced people are located at present, make shift health centres and relief tents. The team also had extensive interviews, interactions and focussed group discussions with affected people- mainly women, children, elderly, ignored sections of the community and other vulnerable groups such as migrants, dalits, minorities; NGOs and international agencies, government, army, medical and health experts, and others working in the area.

THE RAPID ASSESSMENT SUGGESTS THE FOLLOWING INTERVENTIONS. (FOR DETAILS, PLEASE READ THE FULL REPORT).

One: Interventions to provide Community Based Rehabilitation for the disabled.
Paraplegics and those with limb, multiple and spine injuries, fractures and other disabilities will need physiotherapy assistance to get their lives back into action. Without this intervention and assistance of physiotherapists, the paraplegics and the like will end up their lives in wheel chairs. This service may be required for the next 6 to 12 months and that too at the doorsteps of the needy people as they are immobile and can't commute to hospitals.
This is not a visible agenda for NGOs and government at this stage. Even after 8 years, there are over 20 paraplegics still awaiting rehabilitation in Latur, where a killer earthquake (of a less devastation) struck in 1993.

We need to act fast. Oxfam India is committed to take up this challenge and is finalising a work plan in collaboration with the experts associated with the Indian Association of Physiotherapists. We are also working out the details of setting up a rehabilitation centre at Ahmedabad in association with St. Xavier's Social Service Society, Ahmedabad.

Two: Intervention to provide psychosocial support for the earthquake affected people who are under shock and trauma. Left unattended initial trauma develops into manifestations that have a long lasting negative impact. School children drop out, increased incidents of divorce; alcoholism and even suicides are some of the manifestations. Moreover, Post Trauma Stress Disorder is common amongst disaster-affected people. Oxfam India's assessment also confirms the increased incidence of premature deliveries in the area.

There are a considerable number of children who have been affected. A specific case is of a 12 year young Nancy Takkar (from Anjar), the only survivor when the killer quake killed over 300 of her schoolmates. She is seen smiling and doing routine regular work! Mental health professionals who have been assessing the psychosocial implications reiterate that her smile is a short-lived phenomenon. They say that she is passing through what is known as the *"heroic phase"*. The survivors need assistance to overcome the trauma and psychosocial problems they face.

The assessment and observations by expert and experienced mental health professionals call for a long- term psychosocial intervention for the disaster affected. This service may be required for the next 6 to 12 months and that too at the community level. This is not a visible agenda for NGOs and government at this stage, especially in some of the remote and *"not-so publicized"* villages. Even after 8 years, in Latur, the incidence of mental health problems is upto 30 % according to recent scientific reports.

Armed with experience of dealing with such situations in the past, Oxfam India is working out a community-based intervention programme to address the psychosocial needs of the survivors. We are working out a collaborative work with mental health professionals in NIMHANS.

Three: Awareness campaign to provide appropriate information. Accurate and scientific information will go a long way in rebuilding the lives and homes that the earthquake shattered. Unfortunately need based appropriate information is not available easily. The situation calls for an information and dissemination campaign to meet this urgent need, especially when the reconstruction phase begins. Information regarding earthquake resistant houses will be one focus.

Oxfam India is working towards a strategy to take up this issue actively in select pockets. We are associating with institutions and experts who have experience on this issue. We will bring out information materials like posters, leaf-lets, video films and others in local language.
We are working out the details with other organisations such as (a) Development Resource Centre, Mumbai; (b) Swayam Sikshan Prayog, Mumbai; (c) Peoples' Science Institute, Dehradun and (d) Anandi, Bhavnagar.

Four: Building community centres and people-exchange programme. There is wealth of knowledge in pockets affected by past earthquakes like Latur. Ordinary people and communities have a wealth of knowledge that can go a long way to improve the rehabilitation process. We are keen to facilitate an exchange programme between people, especially women, masons from other earthquake-affected areas of India and Gujarat.

We will facilitate the building of a multi-purpose community centre with the active participation of the local people. This activity will also will be a demonstration to train the people in building earthquake –resistant houses and other structures.

We are joining hands with organisations like Swayam Shikshan Prayog (Mumbai) to facilitate this.

Five: Basic Rights Campaign: Earthquake affected people have basic rights. When agencies and NGOs move in a charity mode, they tend to ignore that disaster relief and long-term assistance is a basic right. Rights related to health, education, rights of children and women are issues that Oxfam India will highlight in its basic rights campaign. This will help the communities to be aware of their rights and thus work towards to achieve this.

Six: Advocacy and lobbying for a disaster management policy and preparedness programme. Looking at the fact that an earthquake hit Gujarat this year; a devastating cyclone in 1998 and an ongoing drought in certain pockets, Oxfam India realizes the need to respond to disasters in a holistic way. We will work towards to develop and lobby a people-centric disaster management policy for the state of Gujarat. We will also work with institutions and NGOs to develop preparedness programme.

The interventions are designed in such way that the local skills could be used to its optimum levels and external interventions minimized. An owner-driven approach, with the active involvement and ownership of local communities will be the spirit of the programme.

Notes:

Apart from the organisations mentioned specifically in each section, we have an understanding with Action Aid to collaborate on some of the above-mentioned issues. The details will be worked out soon.
We have also had discussions with other NGO networks such as "Janvikas/ Janpath Citizen's Initiative", Ahmedabad and Kutch Nav Nirman Abhiyan, Bhuj the need and our limited support to develop an intervention plan for some of the above mentioned activities. More directly we work with our partners like Samerth, Gujarat jana Jagaran Sangh, (GJJS), and Manav kalyan Trust(MKT)for integrated work relating to most of the above interventions particularly in Bachau and Rapar blocks. Such activities will be taken up jointly on a case- to- case basis. Details are still to be worked out.

We are also discussing our initiatives with other agencies that have been part of a co-ordinated relief response at Bangalore and Chennai, especially professional and other organisations. We will be able to make a statement about this, once we work out the details. However, Oxfam India is committed to go ahead even if the response for long-term work from these agencies (in Bangalore and Chennai) is not encouraging.

(Note prepared by Dr. Unnikrishnan PV, Co-ordinator-Disasters & Emergencies, Oxfam India, Bangalore, in consultation with the director and other colleagues in Oxfam India, assessment team and collaborating agencies.)

An update from the field ..

The Earthquake: An update
The situation as on 15 Feb.

Overview:

Life in the quake-hit devastated regions of Gujarat is returning to "normal" amazingly fast. People still live out in the open, with usually not more than a plastic sheet to protect themselves, but have tried to make the best of what structure was left standing to shelter themselves. Small trade and transport, and agricultural work, where irrigation is available, are all in full swing. All kinds of relief material and supplies have reached all affected areas, although in uncertain quantity and quality. People do complain, but a sense of hurt pride is unmistakable in having to accept alms, and the legendary warm hospitality of Kutchis continues to flow from their hearts despite the monumental tragedy that has befallen them: milk, buttermilk, tea, and even food is offered to anyone who shares a moment of concern with them. As the first wave of grief ebbs slowly away, they face up to the daunting task of piecing their lives together once again, with considerable apprehension, but determination. At many places we were told, "it is only circumstances that have made us extend our arms to take what is gifted, but we are not beggars".
As a village wit put it, (aptly at Dholavira village, on the edge of a once magnificent Harappan city), "the real beggars are those who run these [charity] organisations - they beg for ever!". Insecurity stalks the survivors in their makeshift shelters, particularly at night: peaceful sleep is still uncommon. Continuing aftershocks contribute to a feeling of uncertain future.

The flood of relief flowing in has slowed. Many groups leave once they see that immediate relief has reached. The government functionaries in the field are somewhat better geared now, with fairly substantial cash doles reaching most villages at least once so far, and the supply of essential commodities beginning to reach some places through the public distribution system. Telecommunications and power supply are largely restored, though still overburdened. Government health staff remain active, though at times they appear overwhelmed by the earnestness of voluntary health teams doing rounds of the villages, more than by the situation itself. Veterinary staff has been kept more than busy by focal outbreaks of epidemics in cattle. The revenue officials have "completed" an assessment of the damage and this assessment has been used by the government to rig up and announce a "package" for rehabilitation surprisingly earlier than expected. At these higher levels, confusion reigns, a result perhaps of politicking and leg-pulling, and a lifetime habit of reducing everything to ritual. There is virtually no coordination between the four major districts affected (Kutch, Surendranagar, Rajkot and Jamnagar) - each of them speaks only with the state capital (if at all).
Within Kutch district, however, the administration is performing rather well in some areas at least. Senior most bureaucrats hold a common meet with all agencies - NGO and transnational - once everyday to review and plan all aspects of relief operations and reconstruction work. Decisions are made and implemented swiftly, within several limitations.

Relief

Mal-distribution of available resources continues to be a major problem, but given the tendency among villagers to share, one can be fairly certain that no community will starve. Save some honourable exceptions, there is no record of which family has got how much, since all material relief (and there is virtually no exception to this rule) has been thus far distributed by non-government agencies. The plan now (at least in Kutch district) is to slowly wean off non-government agency-driven relief distribution, and replace it with a vigorous PDS-driven distribution, overseen by NGO-run monitoring teams. (No one is able to understand why the government had not distributed any relief material whatsoever in the first two weeks: perhaps it was content to observe other agencies, including the RSS, doing the needful.)

How long will relief work need to continue?

Some items needed to be given once only - blankets, canvas / plastic sheets for shelter, utensils for cooking and storing (foodgrains and water), etc. Most have by now received these, but gaps have to be looked for and filled. If some needed items are not available stored somewhere in the vicinity, they will need to be requisitioned. These operations are not happening uniformly everywhere, and systems that are being set up will have to organise themselves for this work.

Since the area was in any case facing severe drought, items like foodgrains and water were in short supply even before the earthquake. In many villages, existing meagre stocks have been ruined in the rubble. Most places will thus need a steady supply of foodgrains till after the rain-fed crop arrives about 6 months from now. Cash-doles being given by the government should help people buy what they need, provided inexpensive grain and other commodities are supplied through mobile fair-price shops. In this case, cash doles will need to be given regularly, or people will need to be provided sufficient gainful employment immediately (for which reconstruction work is an attractive proposition).

The alternative is an ongoing free distribution of foodgrain - a logistical nightmare. NGOs probably need to do both - push for resuming a vigorous PDS, while being prepared to continue to distribute grain to communities which receive nothing.

Water continues to be supplied by tankers - and there are no quick alternatives in sight. Cattle fodder is another item is severe short supply, resulting in cattle owners letting their cattle loose in large numbers, to fend for themselves. Fodder is being organised from many places by the government and NGOs alike. The requirements are huge, however, and at least I have no idea how sufficient quantities will be provided.

The damage:

Virtually every group and organisation that is out in the field has its own assessment of the extent of loss of life and damage to property, based on surveys of varying degree of rapidity and depth. Most of these are naturally not detailed household studies, but one or other kind of "gross" estimates. Error is added to by varying informants - a lot of the population in villages is currently "floating", since people movement in and out for various reasons, and families have moved out of main villages to the fields.

The figure of the dead is fairly certain for the villages - around 6000, according to an independent survey. Estimates for mortality in the badly affected towns - particularly, Bhachau, Anjar and Bhuj - are difficult to put, at best:

there is no record of the number of cremations in the first few days,

an unknown number of bodies are yet to be found from beneth the debris,

most families have gone away and are not available for giving information, and some are perhaps totally wiped out.

The government figures stand at around 18,000 dead, overall. Many observers estimate the actuals to be at least twice that figure.

One factor that caused high deaths in some areas was the congestion - closely packed buildings around narrow lanes: those that escaped their own roofs were buried under their neighbour's walls. And one frequently heard reason why survivors survived was that they were out in the open celebrating Republic Day - one never realized this celebration was so popular in the villages!

The figure of the injured is another riddle, again in the case of townspeople. A few hundred paraplegics have been counted lying in various hospitals. One can only extrapolate from this to estimate the extent of less severe trauma.

The damage to houses and other structures has been very severe. The government has come up with its own assessment, which says that 229 villages in Gujarat are severely affected - to the tune of more than 70% of the houses being irreparably damaged. It proposes total relocation of these villages. NGOs have begun contesting this number - as being too small. The apparent reason for the underestimate being that the government revenue officials have only considered houses that were reduced to rubble as totally damaged, whereas, a large number of houses, though partly standing, are uninhabitable, and will need to be redone just as much as those totally destroyed. It is unclear yet what will come of this.

In an area relatively far from the epicenter, Surendranagar district, an NGO estimates the number villages that will need to be completely rebuilt as being at least twice as many as government estimates. One can predict chaotic times ahead. Apart from the extent, what was it that caused so much damage? For an untrained eye, it is difficult to come to a generalization. Every type of construction, traditional and modern, using cement or otherwise, of every shape and design, seems to have been badly damaged at one place or another. One possible explanation has to do with the soil the buildings were built on - those built on rocks have withstood the quake better.

Experts say that at some places it is traditional earthquake-resistant designs that have survived. What is clear, however is that such designs were nowhere near widely used, even in old 30-40 year old structures. Particularly pathetic are the stone walls in village homes - virtually, piles of rough-hewn stones with thin layers of ordinary sand and mud to cement them. They stood no chance. About the only structures as consistently damaged as these poorly-strung stone walls are structures built by the government - schools, hospitals, health centers, electric substations, administrative offices at all levels (including the collectorate), and staff quarters of all departments - each and every one of these that we saw in Kutch district were either rubble or damaged badly enough as to be unusable. A large number of government employees and their family members were killed or grievously hurt when these buildings collapsed. If this can be confirmed by a systematic survey, there is a good case for prosecuting the Public Works Department as a whole - being professionals, they have much to answer for. The upshot of this for the moment is that virtually every government department in the region is functioning out of a tent.

Organising for the next phase: Reconstruction

The task ahead is benumbing: rebuilding thousands of villages and many towns. I do not know if there was ever a need on this scale in history. Where are we to find so many masons and carpenters? The money? The material? At the moment, no one knows. There are many groups working out designs and offering technical assistance. The government has in principle accepted responsibility for rebuilding everything, and has announced a set of four "package deals" each for a different location and extent of damage. It has also in principle agreed to involve NGOs in the process, and to take all assistance that comes. At a meeting in Ahmedabad recently, few NGOs or corporates came forward to take up villages for reconstruction: they are probably suspicious of the government's integrity, but also unsure of their own capacities. The government has issued directives to districts to initiate relocations and reconctructions in conjunction with village-committees. The administration has reportedly begun going about this in its usual ham-handed way, and may end up causing more harm than good.

The ray of hope lies in a continuing NGO effort at the grass-roots. A federation of NGOs in Kutch district (called Kutch Nav Nirman Abhiyan) is attempting to set up a network of decentralised village clusters having 10-20 villages each, manned by a group of NGO coordinators who will oversee all work in that area. These "subcenters" will channelise and coordinate all help through democratically functioning and well-represented village committees. There is also a move to constitute village endowments, out of which families will be given soft loans for rebuilding, so that at the end, the village is left with a large fund that can be utilized for further development in the long run. Large scale training programs for masons and other artisans are being planned. Similar schemes are being worked out in other districts. How well these schemes work will depend to a large extent on what kind of people are available to man the "subcenters" and organise the effort. And it is going to take a hell of a lot of time. A lot should become clear in the coming days, but more of that later.

From Sridhar - Medico Friends Circle. Dated 18 February 2001

Gujarat Earthquake

Strategy Building for Rehabilitation and Reconstruction: A Preliminary Appraisal

The Gujarat earthquake has left a trail of devastation and death. It has also generated tremendous sense of generosity from people of all walks of life. The initial phase of relief inspite of all its limitations has helped the people to tide over the situation. The next phase of rehabilitation and reconstruction is the demand of the hour. All those individuals and the organizations that were involved from the day one are raising questions about the process and the perception that need to be kept in mind during the phase of rehabilitation and reconstruction. What is presented here below is a preliminary appraisal of some of the areas that need our attention in terms of rehabilitation and reconstruction. This is only a preliminary appraisal aimed at initiating a broader discussion and deliberation so that we arrive some common thrust that is beneficiary to the affected people and in a special way the marginalised groups in the society.

1. **Semi-Permanent shelters**: Due to the consistent work of many groups and individuals most of the affected people have 'tents' which at present serve as temporary shelter. But those who are aware of the situation of Kutch would realize the seriousness of the matter with regard to shelter. This is the third consequent year of draught. The scorching heat is already felt in the noontime though this is only the second week of February. The whole summer is still ahead. Just after summer the monsoon is expected. Hence, the urgency to build the houses in the traditional models based on the experience of the people. If that is not forthcoming then the other alternative of semi-permanent shelters has to be constructed to manage the summer and the monsoon. This would mean a seven months of waiting for the people for a permanent home. While doing this, the Latur experience -both positive and negative- need to be kept in mind. The positive aspect of Latur experience is that the traditional construction means, methods, and material was brought to the fore once again. These came to be forgotten with the anvil of modern construction technologies and material. The negative aspect of Latur experience is that even here the socio-cultural and economic aspects seem to have been overlooked. Hence, it is imperative that one looks at the design, cost, and material to be used with the environmental and socio-cultural aspects.

2. **Legal provisions and awareness**: there is a need to identify the loss due to the devastating earthquake in all its totality.
   - People lost;
   - People wounded - whatever nature of the injury may be;
   - Lose of property;
   - Lose of working days/earning of all the members of a family.

The means to identify these areas has to be seriously thought of and simplified. But to insist on documents like ration card etc would be inflicting greater pain on the affected people, who will look at the debris for documents.

Land for housing also needs to be kept in mind.
-those who have land;
-those who do not have land.

Agricultural and allied activities. The capitals lose as well as capital investment needed to begin the process again.

3. **Land for Reconstruction of Houses:** the houses have been turned into debris. Now debris are being removed and dumped in open spaces. But most of the people are saying that they do not want to build their houses where their relatives have been 'buried alive'. They are also saying that it is not good to remove the debris and dump it on open spaces. Hence, it has to be worked out with the people in each village and a one to one policy need to be worked out.
   - In many villages the marginalised communities are living in the tents erected on the lands of landed castes. Since this is not the agricultural season, it is allowed or even tolerated. But once monsoon comes and agricultural activities begin then those who lost the only household land they had will be displaced. This would lead to conflicts in villages, which is already struggling to cope with the trauma of the earthquake. Hence, on priority basis identify land for reconstruction of houses for those who do not have household land.
   - With regard to agricultural land, the media is trying to project that one of the after effects of the earthquake is the new springs that are found in some places. This is a welcome sign in a region that has witnessed successive draughts. But this can have evil consequences especially on the marginalized communities. Most of the people living on some of the uncultivable land or barren land or people from deprived section of society. They tried to get some agricultural output from this land. But with the media hype on new springs, there could be mad rush to grab this land. This would lead to social conflict.

4. ***Sneha Samuday* or Community Centre:** Based on the experience of relief and rehabilitation after the Orissa super cyclone, some of the NGOs are trying to set up sneha samuday for those who are dispossessed. The idea behind this concept is providing a space for the dispossessed (single women, children who are orphaned by the earthquake) to come together and grieve over the death and destruction and find strength to carry on their lives.

The concept in itself is a progressive one from the earlier idea of opening up orphanages for those who were affected the most by the disasters. But one needs to broaden the concept to make this sneha samyday as centre for multi-pronged activity centre. The immediate economic need like food, water, clothing also needs to be addressed by the sneha samyday. It also should be an information centre primarily to these sections of people but also for the entire village.

Here information on matters like compensation announced means and place where these can be obtained from etc need to be provided to all. This would also serve as a legal aid centre especially in terms of land to be provided protection from land alienation etc.
This centre also has to provide space for cultural activities, which would also revive the energy and the spirit of the people.

Above all the centre will function as an 'empowerment' place for the dispossessed people of all the communities, the marginalized social groups like the Dalits, the Kolis, the Rabanis, the Muslims, the most backward castes and the poor among the backward and upper castes in the order of priority. This can not be achieved unless village and if need be *tola* or hamlet level meetings are not conducted.

This calls for a discussion on the location of the sneha samudaya. In a caste society, this issue of location of the centre needs to be kept in mind.

If this has to be done, the officials, agencies and organizations need to train their volunteers not for relief alone but for rehabilitation and reconstruction. They have to be in a sense bare-foot counselors, bare-foot legal advisors, bare-foot mobilisers. This would also demand a short-term training or initiation into the entire dynamics.

5. **Correct Information:** Rumours are spread about water level rising in Kuchch, epidemics spreading, snatching of food and other material in the area. When one verifies these rumours often they are false. Hence, through handbills, posters, slogans correct informations need to be circulated and wrong informations need to be condemned or disproved. Handbills also need to be printed for passing information about relief package, rehabilitation plans, and availability of various services at different places.
6. **Compensation Package**: At present the following agencies are involved in relief and rehabilitation activities: the affected people themselves, the government, the NGOs, corporate sector, trusts, individuals and international agencies. The relief operation will have to be phased out, except continuing it for most vulnerable and dispossessed groups in the rural areas. Leaving this out all the above mentioned agencies have to put their heads together to work out a 'Relief Package'. One of the most important criterions for relief package is to insist on the principle of 'Replacement Value'. The government can not work out its compensation package on the basis of the money and the material at its disposal but it has to take into the account this fact of replacement of the entire loss. Unless this is done rehabilitation and reconstruction will only be a slogan. At the most by dolling out something we would have arrested only the discontent of the people.

7. **Relief Code:** The devastation caused by the earthquake is extensive. But the generosity shown by everyone has also been overwhelming. Due to the fighting sprit of the people of Kuchch and other districts and due to the generous support and empathy shown by people from various walks of like, the disaster affected people are slowly but steadily limping back to normal life. At this stage it is imperative that a Relief Code be envisaged and the government be pressurized to enact and enforce it with utmost political will. It is only by this we will be able to pay homage to many of our brothers and sisters who lost their lives in this tragedy. And it is only in this way we can stand by those who lost their near and dear ones, property and above all continue to suffer the trauma. Few areas that need immediate attention are:

- In relief, rehabilitation and reconstruction the socio-cultural aspects of the people affected by the earthquake should be kept in focus. Otherwise it will be a rehabilitation of our own conscience and not being part of the struggles of those who are affected;
- The dignity of the people affected by the earthquake also should be kept in mind. It is only because they are affected by the earthquake that we are tying to be part of them and not because they are 'victims'. This should colour our entire thought, word and action;
- While carrying out relief and rehabilitation the government should be pressurized to come out with a Replacement Value package and not be determined by the amount of relief supply it has at its disposal. If there is political will the government will surely find the necessary means.
- Every Taluka should have committed IAS/GASA officers directly incharge of relief and rehabilitation operations. They should be given the necessary official permission to assess the situation, plan out strategy and to carry out the operations.
- Every village should have bare-foot officer who like the Taluka level officers take care of the assessment of the situation, plan out tragedy and to carry out the operations. One of their primary jobs would be to form village level committees, tola level committees so that the entire process is streamlined, wastage is avoided and speedy and smooth operations take place. Since this involves round the clock work they should be given special provisions. A network should be workout with the district level officials, Taluka officials and the village level officials and the NGOs.
- If the above two actions are taken care then all the relief material should be brought to base camps set up at Taluka or panchayat levels and from there they should be dispatched to different hamlets, villages, and places where people have taken shelter temporarily. This would avoid duplication, saturation of relief material and rehabilitation processes and would greatly enhance equitable distribution of all types of resources. This would also ensure the maintenance of dignity of the people who are trying to emerge out of the trauma of a massive nature.
- People affected the earthquake are refusing to rebuild their houses in the same place where their home was once. Their sentiment is that 'We can not rebuild our house on the same location where our near and dear ones were 'buried alive' infront of us". This sentiment of the people should be respected. If this has to be kept in mind, land for reconstruction need to be identified in every locality, village and hamlet. While doing this few important facts need to be kept in mind.

- Common Property Resources should not be touched at all. Because these are the property which is the central focus of all the villages. Efforts should be made to maintain intact all the common property resources. Only as a last resort these should be taken for reconstruction of houses.
- The government has to seriously consider and plan to take hold of ceiling surplus land and redistribute it among all the people who have lost their house. If need be the government has to enact new legislation in this regard.
- There is rumours spread around that in Kuchch region the water level has gone up and new springs have come up due to earthquake. This needs to be verified. But the most important fall out of this type news is that land grabbing would become a common phenomenon. Sale and purchase of land often forced by powerful and dominant section of society will become an uncontrollable development. Hence, the government has to enact legislations to prohibit land alienation, sale or transfer of land for the next two years. Exception: sale, transfer of land should be allowed only for reconstruction of houses for the people affected by the earthquake.

The above presented observations and observations are preliminary in nature. They could be simplistic or based on naïve understanding of the situation. Yet they are presented for generating wider discussion and deliberations so that all the efforts are geared to rebuild the earthquake affected people to spring back to life.

Note: The state government was supposed to announce a relief package on the 12th. But this did not take place though a press conference was held by Mr.L.K. Advani. Instead of announcing the package, Mr.Advani announced that he has asked the state government to work out a comprehensive relief and rehabilitation plan. Even before the central or the state government comes out with any such package, it may be appropriate to present a comprehensive plan to the public so that those who are affected by the earthquake and the people in general exert pressure on the government to keep people in focus when they work out a plan.

(Mohamad Asif)
Action Aid

(Prakash Louis)
Indian Social Institute

(Prasad M. Chacko)
Behavioural Science Centre

13.2.2001

Gujarat - 21 Days Later

RELIEF:

1. OVERALL:

From most accounts, the RELIEF phase is almost over--the Collector of Kutch and the NGOs may officially say so in a day or two. No more supplies lying on the roads; material is beginning to reach interior villages; and the government's Public Distribution System (PDS) is finally about to kick in, we are told. Janpath's warehouses have been emptying out almost as quickly as supplies come in from different parts of the country. Abhiyan volunteers, some of whose family members were among the dead and injured, are planning to take a couple of days off to be with their families, prior to getting back to work on the Rehabilitation phase. (Most people seem to feel the necessity for a physical break between the Relief and the Rehab phase. "Otherwise, the relief operations could go on for ever," said one volunteer.)

2. PROBLEMS:

This does not mean that everyone has received sufficient food and shelter--at least, not yet. There are still problems. From most newspaper accounts, and our first hand look at one relief camp, there are still fissures along caste and class lines. We are not suggesting overt discrimination by relief organizations, but local customs and power structures may be complicating their work. In some villages, local leaders are apparently determining the distribution of supplies. Also, the reluctance of the middle class to stand in relief lines with the "lower classes," and the reluctance of Dalits to stand in lines with the "upper classes," has been an issue. (When asked why they were personally delivering supplies to the middle class, one volunteer said something like, "You know how proud these people are, they won't stand in lines. The poor people, on the other hand, they can always come to our camp and collect supplies." Notwithstanding these problems, we are convinced that between the government, the NGOs and the religious sector, short-term food supplies will indeed reach most people soon.

3. JANPATH/ABHIYAN/SEWA:

From our own observation, these organizations have done an exemplary job in providing relief, under the circumstances. This sentiment was echoed by several international agencies as well. This is because these organizations have been working in the affected area for years, especially among the poor. Their volunteers know each household in their villages by name, and we were told that Janpath volunteers are physically delivering the One-month Ration Kits to each family on their list. To all those who so generously contributed to the Ration Kit Initiative supported by Indians For Collective Action, California and The Bhoomika Trust, Chennai: contrary to press reports which talk incessantly of relief not reaching the poor, Geetha and I have every confidence that our rations have or will soon reach the needy families.

4. HOW CAN YOU HELP?

We are told that tents, especially larger tents for schools and community centers, are still in SERIOUS SHORT SUPPLY. People are already tired of staying under tarps; they are unable to get schools started; and some of them do not have access to larger spaces for community meetings. ANY ONE WILLING TO PAY FOR or DESPATCH SUCH TENTS (poles can be procured locally), dhurries and chatais (bamboo mats) ARE ENCOURAGED TO DO SO IMMEDIATELY. PLEASE CONTACT SEWA (they need about 50 large tents) and UNNATI at the numbers given below. Suggestions: a. Foreign donors, please do not ship expensive tents. Coordinate with an Indian NGO to purchase canvas tents locally and ship them ASAP, b. If you can't ship tents, ship double-layered canvas cloth, and local NGOs such as UNNATI can have tents custom-stitched in Ahmedabad (provides employment), c. No more tarps, as they won't survive the monsoon! [BHOOMIKA TRUST and ICA California: After paying for the 1,000 ration kits from Chennai (approx Rs. 10 lakhs), we will have Rs. 5-6 lakhs left. Should we invest part of it in supplying tents? We can discuss this later among our e-groups. Also, we can coordinate with the Indian Express people and the Round Table to see if they want to help ship tents.]

5. LESSONS LEARNED FROM RELIEF OPERATIONS:

Know the local culture before shipping relief supplies. a. People affected were not looking for cooked puris and chappathis from Tiruchi, or for CARE food packets beyond one or two days! They were looking for foodgrains and water so they could start cooking their own food ASAP, b. Old clothes, definitely a NO, NO. As for new clothes, miniskirts, jeans and sarees, for people who wear gagra/cholis? We were told that boxfulls of inappropriate clothing were still lying in warehouses all across Gujarat (some may have even found their way to markets in Mumbai.)

REHABILITATION

While a sense of URGENCY was important to the RELIEF phase, most NGOs and the local government are urging patience while rehabilitation plans are worked out in the coming days and weeks. For those of us from the outside, our appeal is to WAIT, but NOT FORGET (there are a few areas in which we can help immediately, see below).

Most of the NGOs are beginning to seriously look at plans for long term rehabilitation of the affected people. While there is recognition that only the government and international agencies can come up with the level of funds required for long term rehabilitation, they are at the same time very very skeptical that such aid will reach the needy in a timely or appropriate manner. They point to the experience of Latur and other disasters overseas where it took years before providing permanent houses to the affected.
Nonetheless, they are continuing to work closely with the government, while working out their own plans for the rehabilitation phase. Here are some highlights from our conversations:

1. ORPHANS/CHILDREN:

NGOs, international organizations such Save the Children, and the RSS, each for their own reason, are asking people to place on hold the rush to seek out kids for adoption! Adoptions are NOT a priority. The focus is to provide trauma counseling, and bring back a certain routine in the lives of the kids, IN THEIR OWN ENVIRONMENT. There seems to be plenty of professional guidance in the area of psychological/trauma counseling (e.g. NIMHANS, Bangalore), however, the need for more Gujarati-speaking counselors has been expressed by several NGOs. (Let us remember that our help in procuring large tents, already mentioned, can directly help the communities restart classes for kids ASAP). Also, SEWA is asking for help in procuring simple playthings such as, play dough, scribble chalk & boards, simple toys, etc. for their 2,000 kids. This can be in cash or kind, but please no barbie dolls or other high-tech dolls. Most of what they need can be procured right here in Ahmedabad.

2. ADOPTING VILLAGES: NO! NO?! NO!!!

As one NGO put it, all the affected villages have been "taken," with more "adopters" than eligible "adoptees." The notion of adopting villages is being decried by the NGOs as well as the Collector. For one, it is very condescending, implying long term dependence, whereas most villagers want to get back to a routine quickly, and want gainful employment. Secondly, it is obvious that the concept of "adoption" is ready-made for all the publicity hogs, who are falling over each other to "adopt" villages, without a clue as to what it is supposed to mean. In our opinion, long term partnerships with local NGOs, who are focusing on livelihood issues, is a more sound concept (see SEWA's priorities below).

[Exception: "adopting" a village may be OK if the adopting organization has deep roots in the village, is adopting it with the blessing of the village, and has a clear plan on what they plan to accomplish there.]

3. LIVELIHOOD SECURITY:

SEWA is not an NGO in a strict sense, but is a Women's cooperative consisting of over 60,000 women. Most of their members have been severely affected by the quake. Nevertheless, their focus today is how they can move their membership from a relief mode to an employment mode. This week, they are providing craft kits to their members, most of whom are craftspeople, so that they can get back to embroidery and start marketing their products ASAP. While it may be hard for many of us to imagine that women who have been so traumatized by the quake would want to be sitting in their temporary shelters knitting all day long, this is EXACTLY what they want to do. Another example of a livelihood security issue is helping salt workers rebuild their damaged salt pans (approx Rs. 30,000 per family of capital expense involved, we are told.) Whether they are craftspeople, or laborers, or salt workers, all they want to do is get back to work. Volunteers who have been wanting to come here in large numbers and "help" should keep in mind that a better option may be to provide moral and financial support from where they are to the large labor pool right here. We don't want to put them out of work, do we? For anyone wanting to focus on long-term livelihood issues, SEWA or UNNATI or ABHIYAN are good places to start. (We are carrying a paper by SEWA on this issue, if you are interested.)

4. PERMANENT SHELTERS:

The government apparently approved a plan by one group two days ago to put up a large number of shelters, with corrugated iron walls and roof-in a place where the temperatures in summer can reach over 130F degrees! NGOs are aghast but not surprised that such things happen, and hence they are taking their own initiative in designing low income, earthquake-resistant structures quickly. We met several knowledgeable people working with the NGOs on this issue. Support to these efforts will go a long way in getting people into more permanent houses. Wewill provide details of these later. (We are carrying a proposal on shelters from Abhiytan/Janpath if anyone is interested--the plan emphasizes use of local labor in areas such as casting tiles, etc.)

SUMMARY:

NEED:
More tents (especially larger ones); dhurries/chatais; support for livelihood security (e.g. crafts, salt pans, local labor opportunities); expertise in low-income e/q resistant housing; and MONEY to local NGOs to support these initiatives. [Some NGOs are already seeing the initial hype of financial help fade quickly, with very few checks actually received to date.]

DO NOT NEED (for now anyway):
More village adoptions, general-purpose volunteers, medical supplies, food, doctors, etc.

Impressions from Raju & Geetha Rajagopal dated 18 February 2001.