Report given by Chander JN 21/1/93.

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COMMUNITY HEALTH ~~CENTRE~~ CELL REPORT

The cyclone and tidal wave disaster that hit the Bangladesh coast during the last week of April 1991 left almost 150,000 dead in its trail of devastation. TV coverage of the disaster caught the attention of some doctors of St. John's Medical College, leading them to volunteer for relief work in the area. The Bangalore branch of the Service Civil International offered to take them across to Bangladesh. A team consisting of three doctors, two nurses and three paramedico left for Dhaka on 25th May, 1991. They spent roughly three weeks in the field, the extremely southern part of Bangladesh.

This report is a consolidation of the reports of three of the volunteers. One lady doctor, a male doctor and a community health staff. They were all located in different places and had different experiences. They have been summarised for convenience.

Report - 1

Dr. Anne-Marie Rego, the lady doctor, worked in the Boramohar village of Banshkali, the worst affected area in the whole disaster-hit region. She found the status of women in society pitiable. This made her decide to target her work towards women and children ONLY. She found that the women had never visited a doctor, (almost always male) all their lives.

She found that in the post-disaster condition, patients could not follow the most basic health practices such as boiling the drinking water, washing hands, and eating nutritious food. They could not even come back for review or buy the necessary drugs, in some instances. In addition, she found that

a. ORS packets supplied by UNICEF were often sold.
b. Paediative powders could not be reconstituted in the field.

She had the following suggestion to make in organising medical relief and supplies:

i) The patients should be told to drink sugar/salt water, and this should be made available along with general relief supplies.

ii) Since they cannot boil and cool water, a water purification tablet should be provided with each packet of ORS.

iii) Since pediatic powders cannot be reconstituted, only syrups can be sent for children.

iv) All drugs should be dispensed after opening, to prevent resale.

v) The basic diet of rice/chira is not nutritionally sound for more than a week. Groundnuts, germinated gram flour, vegetables and bananas could be made available.

She found that women were neglected in the relief operations. They were given a sari each. They only got relief as members of a family. Even though the most numbers of morbidity/mortality rates were for women, all relief operations: food, utensils, medical and rehabilitation - were male-oriented. In the essential drug list, no drugs relating to women's diseases were mentioned or made available. Therefore, she suggests that (a) more women volunteer's should be sent into the field, and facilities made for their stay. (b) a lady doctor should visit villages by rotation, accompanied by male and female paramedicos. (c) "Food for Work" schemes should cook one meal for mother and child, and (d) these women could then be a captive audience for health education. This arrangement could also help being the mother/child unit back for medical review. She found that roughly an equal number of male and female children were brought for treatment. 71.8% of the cases were under five years of age. She feels that the presence of a lady doctor would definitely draw this age group to the health centre for immunisation, Vitamin (A) prophylanis, etc. Diseases followed the expected trend of

gastro-intestinal diseases - Malnutrition - Respiratory tract infections

She also found a very surprising and interesting fact : there was a high incidence of Iodine deficiency goite among the women in the area, which is highly unusual because it is a coastal area and fish is an important part of the diet, and even vegetables are grown in saline conditions, she feels that a serious scientific survey should be conducted into the problem to identify the cause, and recommends the provisions of iodised salt.

Report - 2

Dr. Sanjev Lewin of the department of pediatrics of St. John's Medical college Hospital, was also a part of the relief team. He was sent to join a team heading for the Southern Islands within the Char Fassion Upazilla of the Bhola District, after an initial delay of three or four days. He spent 13 days in the area, treating the populations of the four ' Chars ' of Motahar, Manohar, Stephen and Nwelyn. He concentrated primarily on children. He also helped to make a survey and distribute relief. He made two field trips to be able to contact more patients. He saw over 500 patients, 64.7% of whom were male. 39.3% of patients were in the 116-50 year age group as they were most mobile. The under five age group constituted 25.8% of patients seen.

He found that the bulk of the cases were of Respiratory tract infections, followed by gastroenteritis and parasitic infestations. There was need for simple medication, such as Tetracycline and penicillin for the respiratory tract problems and ORS, cotrimexazole and Metrogyl for g-i tract problems.

Dr. Lewin has a number of suggestions to offer on the subject of organising medical relief in disaster situation.

1) A medical team with specific aims and objectives will be more effective, than individuals being distributed at random, as was the case with us. He would personally have preferred to work with SCI, which went to so much of trouble and expense on his account, rather than working with an NGO which was much less committed to them.

2) The best use of the team's time and energy could be saved for relief work if travel arrangements and field placements could have been planned in detail much in advance. SCI lost a lot of time and money in trying to redistribute team members to other NGO's.

3) Medical services should not be equated with distribution of relief material: medicines should not be handed out like rice. It is a criminal waste of expensive medicine, especially when used in nonindicated illnesses.

4) Medicines could be bought in bulk using generic names. This will work out much cheaper in the field. The WHO emergency mannual should be adhered to, instead of accepting whatever pharmacenticals try to palm off.

5) The preventive aspects of medicine were insufficiently covered. The use of a motivated paramedic to follow up causative factors would have been ideal. The following tasks could have been taken up by the paramedico:

- Chlorination of identified wells.
- More tubewells.
- Education on the use of safe drinking water, hygiene, nail cutting and hand washing.
- Clothes for children, especially as most respiratory cases could have been associated with exposure to the wet and cold elements.
- Regular medical services.
- Immunisation as a Priority.
- Diet and Nutrition advice and rehabilitation with locally available shrimp, fish, shegs and snails.

6) It is essential to have simple iron and Vitamin B complex tablets (only in such situations) to use as placebos.

7) The dedicated staff need periodic orientations in time and manpower utilisation. There should be stress on the fact that the leader is basically a member of a team. There is need for discussions on problems and strategies, acceptance of others' ideas, and active participation in even the most menial/mannual of work alongside team members.

8) With repeated visits to fixed destinations, ideal routes and modes of transport should be arrived at, and communicated clearly to the various groups involved in the work. This will enable a smooth use of manpower and goods everytime, instead of each trip being uncertain. Time Management is totally lacking as a value.

9) Internationally recognised treatment and diagnosis protocols/schedules should be used, in the field so that medicines can be used even without medical doctors being available. Medicine requirements should be standardised and only essential drugs used, which will lead to economical services, eg:

Acute watering diarrhoea : dehydration - ORS
Acute Blood/Mucus Diarrhoea - Metrogyl/Cotrimoxazole

10) School-teachers can be used to teach basic health and hygiene to children in makeshift schools, and these children can then spread the message back into their orthodox homes.

11) Feedback on people's needs should be given to the government officials at the upazilla levels ie, need for schools, visits by administrative officials to meet the people, weekly visits by doctors, Immunisation programmes etc.

12) He feels there is a total lack of personal hygiene and knowledge of nutrition education among people and volunteers alike. There is gross, widespread and chronic malnutrition in the area. Helminthiasis was widespread. Total immunisation failure since 1971, evidenced by children upto the age of 15 lacking BCG vaccinations. Medical services are totally lacking. Infants and children are exposed to the forces of nature, at a time when they need protection most.