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REPORT OF CYCLONE RELEF WORK DONE IN ANDHRA PRADESH

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SUMMARY

We worked in association with the Catholic Cyclone Relef Organization (H.Q. - Vijayawada), as the Medical team. Both aspects of medicine- preventive and curative were practised.

INTRODUCTION

The first Medical team of volunteers left on 1/12/77. They joined the above organization and started Medical relief. The wnd team (with 10 members) led by Dr. Padmini Urs, of which we were a part worked from 12/12/77 to 29/12/77. We worked in the 4th team with 2 members from 9/1/77 to 31/1/77.

DATA REGARDING TIDAL WAVE AND CYCLONE ON 19/11/77

1. Tidal wave - 25 feet high, 60 km long, penetrated 12 km into coastal Andhra and lasted for 6-8 hours. It changed direction 4 times
2. Speed of cyclone - 120 - 200 km per hour
3. area hit by cyclone - 8,453 sq. km
4. Population affected by cyclone - 25,00.000
5. Krishna and Gunteer Districts were severly affected and adjoining districts to a lesser extent.

   In Krishna Dist - 53 villages affected

   Gunteer Dist. - 24 vilages

   West Godawari dist. - 4 vilages

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6. In the catastrophic zone covering Diviseema and part of Bandar taluq's over 50,000 people are feared dead and also 100,000 heads of cattle lost.

7. Havoc caused by cyclone related mostly to property. Tidal wave related to human lives, livestock, houses, property crops.

Camp and organization

Our camp was based at Nagayalanka, Divi Taluk Krishna dist, on the funge of the tidal wave affected area. It consisted of 60-70 people divided into 3 teams - i Relief team
ii Rehabilitation Team
iii Medical team

The aims was to take up certain areas for development which would consist of 3 phases - i Immediate relief
ii Intermediate phase
iii Long term development phase

at first an exploratory team with a representative from the medical want to survey a village as regards amount of destruction of life and property, and relief measures already taken by other agencies to avoid overlop of work. Information was obtained by meeting the village president/Sarpanch and by going around the village. The villages chosen were those in which no organization was working with a long term project. 6 villages with surrounding hamlets were taken up and alloted by the Govt. to this organization.

Method of work in a village :-

Immediate relief consisted of providing food, clothing and shelter ie building long community huts

a statistical team went around collecting baselive data viz

I Census
- Nuber of living
  - Male
  - Female
- Number of dead

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II Socioeconomic survey regarding

- Housing
- Occupation
- Property
- Education

(see charts)

on the basis of this, requirements were calculated and plant drawn up.

Medical work (during first stay)

When wer arived, there were 3 clinics established

i) At Nagayalanka population - 9000
It also covered surrounding villages

ii) At Mandapakala population - 1,311

iii) Mobile clinic - going from village to village covering a population of - 2,458

clinical work was done during the day. Daily statistics of cases were kept with a graph shows of the distribution pattern of diseases

This was classifed as follows:

1) Total number of cases
2) Diarrhoea and Dysentry
3) Gastroenterities
4) Respiratory Tract Infections
5) Other Infections
6) Miscellaneous

Our team leader kept in contact with the D.M.O. at the nearest P.H.C. at Avanigadda 18 km away. They were very helpful and supplied us with DDT, bleaching powder, lime and drugs to supplement out own stocks of medicine.

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Most of the population were already innoculated against typhoid and Cholera and there were no epidemics.

Preventive work done included - Remaining TABC innoculations, Tetrac innoculations, Chlorination of wells, spraying of bleaching powder/ lime constructions of trench latrines for the camps, health education to the villagers regarding environmental sanitations, nutrition, boiling of wate for children etc.

Observations/Discussion

1. The population covered was not a normal population having first suffered an enourmous loss of life and property.

2. Most people had returned or had to be coaxed back to their own villages as all they had left was their land without which they would become beggains or slum dwellors in same town.

3. These people were building life afresh and were ideal ground for community development.

4. Every family had been disrupted due to loss of same or other or many members causing a large social problem.

5. The mental health problem was large and acute, the people still dazed or depressed.

6. These people were fairly well-off prior to the cyclone/and poverty is new to them (see charts regarding property). To avoid them getting used to obtaining things easily first for the begging, some sail of cooperative ventive where they provide at least the labour is desirable.

   A team of village leaders could be the decision making and negotiating body a system was noted in one village (Etimaga) which was divided into 10 divisions, each of which had a leader who would put up the requirements of that area and get the work done. They themselves a had completed the hawesting and started rebuilding.

7. Illiteracy and ignorance were found to be very widespread ' (See charts) only 2-3 persone are educated above the 10th std. These could be involved in the development programme.

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8. The social problem of the Harijans was noted. They worked as coolies as they did not own any land. In one area they had land but without any irrigation facilities.

9. Health

- as this was a food growing area the gneral health of the people was good without much protein-calorie malnutritions. Anaemia were found to a accute mainly in women and children.

- There were no epidemics of cholera, typhoid or gastroenteritis due to early and complete innoculations. The reamining few were caused by us.

- There were no epidemics of cholera,
- Initially the graph showed a high incidence of respiratory disease especially U.R.T.I This was due to -
  i) exposure during tidal wave and cyclone
  ii) Lack of adequate shelter and clothing
  iii) Cold weather expecially at night
  iv) Dust and fumes

  This fact was brought to the notice of the organizers and priority was given to providing clothing and shelter. Large community huts were built immediately. Individual families also started building huts from palmyra leaves and bamboo provided by Govt.

  Water was obtained mainly from tube wells. The few open wells were cleaned out by the army and attainated by the PHC staff. subsequent chlornation was done by us. Tube well water was used without purification generally. Some of the tubewells were located close to drains/canals and were probably sucking in water from them.. In one area an outbreak of Gastroenbntis was found among usess of water of one such well. Cases presenting with diarrhoea and dysentry were advised to boil water, expecially for children -nor very proclied suggestion for whole families. Two cases of infective helpatits were seen.

- Enviornmental Sanitation was very poor following the hawoc were additional factors viz occasional carpses and carcasses uprooted trees, debris, staghout saline water. This combined with the ignorance of villages concerning the subject. Towards the latter half of out stay, there was a marked increase in the number of flies with a corresponding gradual increase in the incidence of diarrhoea and dysentry.

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Only spoiadic cases of gastreenteritis were seen who responded to treatment on follow up no furthur cases were found in the surrounding areas.

The D.M.O. at Avanigadda was informed of the fly menace. Bleaching powder and lime were obtained and sprayed around the villages by teams from the PHC and our camp.

A fairly significant number of evening fewers with chills presented to us. a few clinical cases of filaria with swelling were seen. The rest were ? Malaria ? Filaria Mosquitoes were more around nagagalanka and the canals of the Krishna river nearer the coast there were pools of salt water brought in the tidal wave.

- Mental Health

The majority of cases needed only a sympathetic ear, as everyone in the area has a story to tell. 4-5 cases of hystenia were seen. it is impossible to rub out the experience these people have had and many of them have told us that they wish that they too were dead. But the most important thing is to give them same hope to start life again and so the programme was called "Operation Hope". Two priests stayed at Geogepetta to encourage people to return to their land. In that village not a single house remained, 100 people had died and 146 were living comprising 40 families, in one large hut a kitchen garden was planted to prove that the sail could still be productive. Towls were kept to bring back same semblance of nounalcy and to provide eggs villagers

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7. Beliefs regarding auspicious times of entering and leaving the dispensary, quite common in most parts of India, did not interfere with our work. Except in one case when a women was brought in with prolonged labour due to hand prolapse and when we advised transfer to the nearest district hospital, her relatives insisted her on taking her back to the hut and then starting the journey to hospital again since the belief is that if a patient is asked to leave a hospital and go to another with being given any treatment then the doctor has given up hope and i.e., a bad omen.

The above observations helped us to understand the people we were working with and in any such situation this is becoming a very important factor. Dr. John Seaman in his paper in the Lancet (ii) (1972) P866 echoes this need when he lists the following as the first lesson learnt from the Bangladesh experience He says much more detailed information should be available about the nature of the society involved and that our ignorance of the society and attitudes of the poor people was a problem felt by all doctors in the camps.