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THE EARTHQUAKE RELIEF PROGRAMME - C H A I CAMP AT NANDURGA VILLAGE LATUR DISTRICT, A REPORT - Dr. Aruna Kasthuri M.D.

* Description of the camp and background
* Situational Analysis on 1-11-93
* The Shift in Focus and new direction
* The Initial Efforts

DESCRIPTION AND BACKGROUND

An Earthquake occured on 30-9-93 measuring 6.6 on the Richter Scale with its epicentre at Killari town in Latur district, Maharashtra.

See ..... for Schematic Map.

Relief Work commenced immediately with assistance from the police and Army depts. The response by the Maharashtra Govt was also timely and substantial.

The Catholic Hospital Association of India (CHAI) and Sanghi Group of Industries, Hyderabad set up a relief camp on the 10th of October at Nandurga village about 15-20 Kms from Killari. Relief work initially was hampered by heavy rain which stopped around the 20th of October.

From the Governmental side, following the initial hunt for survivors and bodies, the people of the region were resettled into temporary shelters made of metal sheets. Water and elecricity were made speedily available and food / clothing were distributed on a ration system.

SITUATIONAL ANALYSIS

A team of 12 volunteers reached the camp on 1-11-93. The situation at that time was---

a) Camp

The "Base Camp" consisted of a group of 4-5 tents with one large tent used as a OPD/Pharmacy in addition to serving a residential function. Messing and washing facilities were available. There were about 40 volunteers at the camp at that time consisting of

-Doctors
-Nurses
-Pharmacist
-Seminarians and general volunteers
-Security guards and Helpers.

The camp was being coordinated by two persons from CHAI Hyderabad.

b) The Work

Following the establishment of a base at Nandurga, a service area of 7 villages was taken up with a population of 9000-10000.

The Initial Objectives of the camp were-

1.To provide Medical relief to the injured and the physically ill.

2.To provide Psychosocial support to the mentally disturbed.

The method was

1.The personnel were divided into 3 Mobile teams which visited one village each day and conducted relief Clinics there.

2.A daily Clinic was held at the Base Camp which would function as a relief clinic for the surrounding area and as a "referral" clinic for outreach teams.

3.Houses were visited during outreach visits and links were established with the people with a view to provide psychological support.

This strategy proved successful in the initial period with many Orthopaedic and other major problems being tackled through the network.

It also helped to build up the credibility of the CHAI effort among the village folk and served as an entry point into the villages.

Other activitites undertaken at the camp were-

-Distribution of Food and clothing received from Donors.

-Enumeration of the people of the service area on a house to house basis,with the handing over of an Identity card to each household to serve as a future identification mark.

With the passage of time , the follwing features were noticed.

1.The attendance at the Outpatient clinics was dropping.

2.The type of medical problems handled were changing from injuries and traumatic conditions to more psychosomatic and minor problems.Also,diseases needing educational inputs like Scabies and gastroenteritis were being increasingly noticed.

3.There was a growing awareness among members of the team that the baseline Health status of the people was poor.

There was a question then raised as to whether CHAI would want to continue its efforts onto rehabilitation since that was the need that was being perceived.

THE SHIFT IN FOCUS

Following a discussion among coordinators and senior members among the camp staff, it was decided that the CHAI effort would continue into the Rehabilitation phase with the HEALTH of the population being the issue in focus.

Hence a new goal was framed - to attempt to restore the Health status of the poulation served to Pre disaster levels. Since there had been no assessment done of the health status of the population before the quake, this goal was arbitrary to that extent, but it served to broaden the perspective of the Effort.

The SPECIFIC OBJECTIVES were framed within the Primary Health Care framework.

Using * Available Resource
* With the Cooperation of the Govt., and
* Participating with the people of the area to the extent possible.

The Objectives were

1. To ensure that all people had access to safe water and had a knowledge of safe water usage.

2. To ensure that people had access to a hygeinic facility for bathing and washing clothes.

3. To assess the educational situation (schools) in the village resettlements and intervene where appropriate with provision of physical amenities (blackboard, chalk etc.) and training inputs to the teachers.

4. To ensure that Governmental Immunisation services reach children under 5 yrs and Antenatal mothers.

5. To ensure that people had access to a primary curative facility near their home.

6. To improve knowledge regarding concepts in Child Survival and Safe motherhood.

7. To extend Psychological support to the people in need using individual, group and mass therapy techniques.

THE INITIAL EFFORTS

With the framing of the new objectives, the method adopted was

-The Service area was divided into groups of 2-3 villages

-The personnel were divided into teams of 5-6 with at least one doctor and one nurse in each team and the village groups were allocated teamwise.

-The villages were mapped giving details of water sources, sanitary facilities etc.

-The schoolteachers were interviewed, the schools visited and a spot assessment made as to the need.

-Curative Clinics were to be conducted weekly at the villages, with a day fixed for the purpose. The daily Clinic at the base camp would continue unchanged.

-Under fives and Antenatal women were enumerated in each village and their immunisation status assessed. Cooperative immunisation sessions were held using the governmental infrastructure with the team acting as motivator, educator and facilitator.

-Health Education sessions were held on topics ranging from water-borne diseases to hygiene during pregnancy.

-House visits with counselling and psychological support were continued.

With the new strategy being launched, and an information base slowly being built up through rigorous documentation, the team that reached on November 1st 1993 left on the 14th of November 1993 with the hope that the camp would continue its rehabilitative effort and put the people back on the road to health.

SCHEMATIC MAP (Not to Scale)