ミャンマー難民緊急救援医療プロジェクト

１）ミャンマー難民緊急救援医療

（目的）

１９９２年２月すえ以来、一日５０００人を越えるミャンマー難民がバングラデッシュ国境に新たに流入しており事態は極めて深刻である。現在では難民の数は約２０万人以上にもなろうとしている。食料事情、水の確保の困難さ、住環境の劣悪さなどによりマラリア、栄養失調、消化器性疾患が多く、このままの状態では雨期に入ってから伝染性疾患が流行する可能性がある。

この難民のいる国境地帯は以前より治安状況の悪い所であるが、私達は駐日バングラデッシュ大使館及びバングラデッシュ政府保健省と密接な協力関係の上、緊急救援医療チームを派遣することを決定した。

１９９２年３月２７日より現地の事情に詳しいバングラデッシュ医師を筆頭に、ネパール人医師と日本人医師の３カ国の合同医師団による国際緊急医療救援活動を開始した。また私達の現地支部の医師団もこの派遣された医療チームと合流して円滑な救援医療活動を支援している。

活動は難民キャンプ内での医療や衛生教育に加えて高度な緊急医療機材を整備した医療用自動車を使用して外傷患者や救急患者への迅速な検査と治療をなどを可能にする「Mobile Clinic」である。

（内容）

１）医療サービス

難民医療キャンプ内で国連難民高等弁務官（UNHCR）と密接な連携のもとに難民の健康管理と疾病管理にあたる。

２）衛生／健康教育

昨年のクルド難民およびピナツボ火山噴火被災民救援医療活動の経験を生かした疾病予防と健康水準向上のための衛生／健康教育を実施する。

３）Mobile Clinic

a)救急医療サービス

「動く診療車」の利点を活用した場所を厭わない医療活動の実践

b)必要に応じ車にて出向いて様々な検査、処置を行う

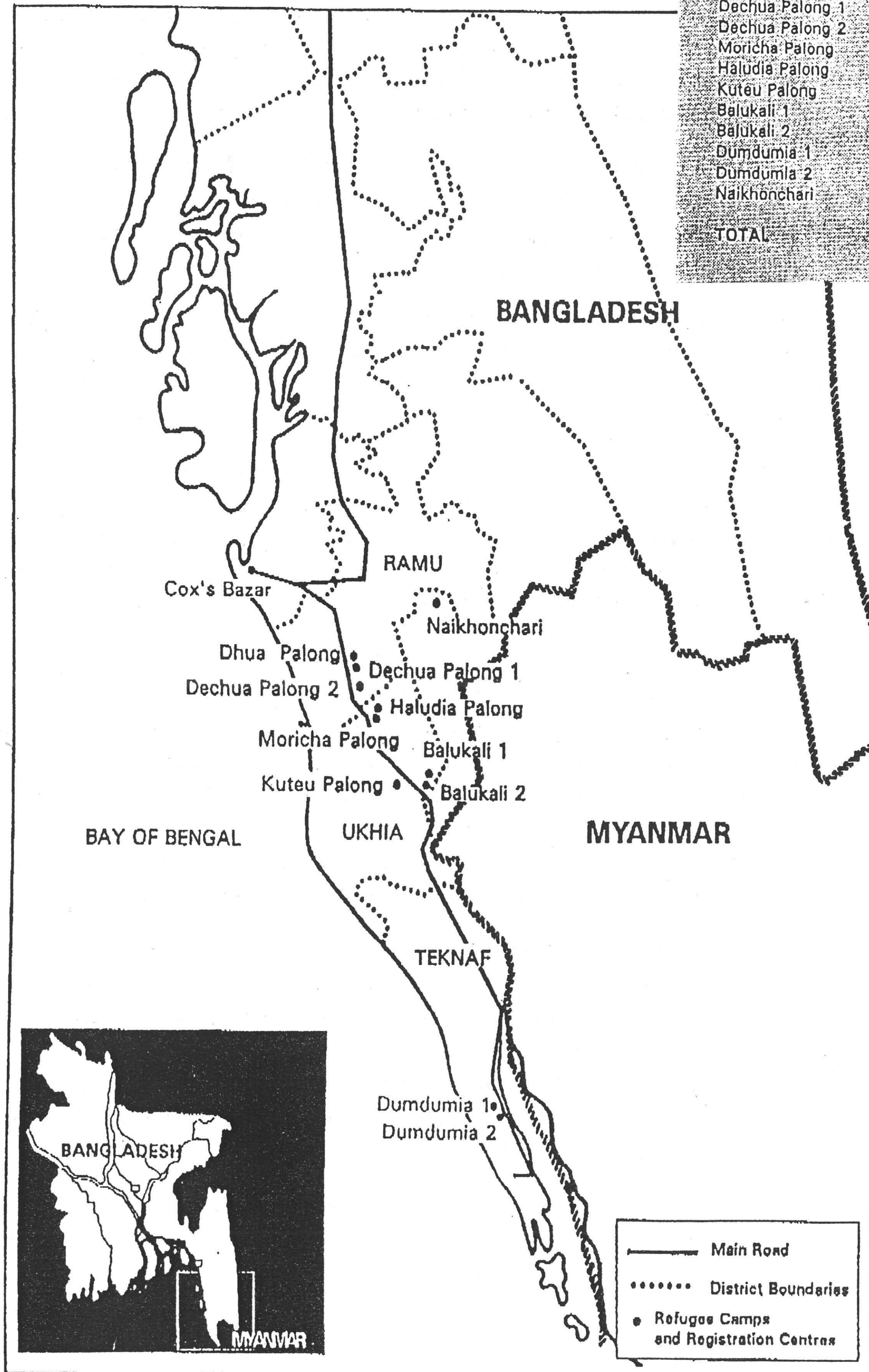
他の医療を行っているNGOの求めにも対応し、お互いに助け合って医療を行う

c)小規模紛争などによる不慮の事故にも即応できる活動を可能とする。

Bangladesh

Refugees in Bangladesh as of 1 April 1992

Camp	Total
Dhua Palong	17,219
Dechua Palong 1	4,667
Dechua Palong 2	25,179
Moricha Palong	11,196
Haludia Palong	7,523
Kuteu Palong	12,759
Balukali 1	20,788
Balukali 2	11,028
Dumdumia 1	60,558
Dumdumia 2	10,000
Naikhonchari	10,120
TOTAL	191,047



Disaster relief for Myanmar refugees: a new challenge for AMDA.

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Disaster, either natural or man-made, has ravaged the human settlements since time immemorial. Concerted and coordinated challenge, however, has always minimised the damage and sufferings. Increasing international cooperation and understanding, as well as the improved transportation and communication system, has made the disaster management of today much more effective. AMDA's new challenge is a step ahead to face a man made disaster in a coordinated manner.

Refugee problem is an emergency situation, and associated with mass exodus of population for a relatively safer place, and subsequent establishment of relief camps which often are large and unplanned. Many a times, the relief camps suffer from insufficiency of food , shelter, safe drinking water, and sanitation which leads to malnutrition and worsening of the morbidity and mortality states.

In case of medical aid for the relief camps, earliest response, promoted by emotive media reports, often results in an over emphasis on curing patients, whereas, the epidemiologic assessment and public health services remain neglected; the source prevails and the disease perpetuates. Many a times, there is stockpiling of costly, unnecessary, and useless medicines and equipments.

AMDA has made a planned move by sending a need assessment team to the camp sites. The team is presumed to identify the priorities for the short and long-term requirements. As epidemiological assessment followed by intervention programs has been successfully used during the various stages of relief operations in the Ethiopian and Cambodian relief camps, establishment of a surveillance system involving collection of data, identification of the problems, and planning for intervention will be very helpful for AMDA's relief activities.

Data on the prevalence of diseases and malnutrition may be collected. Prevalence of diarrheal diseases, respiratory infections, parasitic infestations, anaemia , malaria, otitis media, skin infections (e.g. scabies), infectious diseases: like, tuberculosis, measles, diphtheria etc., vitamin deficiencies(e.g. vitamin A) may be assessed along with other prevalent diseases. In the initial stage, disease diagnosis may have to be based on clinical grounds only. Later on, however, some field laboratory facilities may be introduced. Data on demographic characteristics and vital statistics figures along with the level of ignorance and the attitudes of the population on health issues will be helpful.

Finally, on the basis of the epidemiologic findings, both clinical and public health intervention programs may be planned . Based on the problems and priorities, probable interventions may be in the form of regular clinical services, provision of safe drinking water, taking care of the sanitation, ante-natal and post-natal care, supplementary feeding programs for moderate to severe degree malnourished cases, immunization against communicable diseases, vitamin A supplementation , health education, training of volunteers for participatory health care delivery service etc. Priorities and preferences of interventions may, however, change from time to time.

Besides the services and interventions, AMDA's venture in a new frontier will be able to diversify its acquaintance. Sharing of ideas and experiences with the new friends may be helpful for AMDA's march towards its cherished goal of better health care for Asia.

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