SPECIAL ARTICLE

Relief after the wave

In the previous issue, dentist Bob Bhamra described how and his wife Sukhi found themselves caught up in the terrifying events of the Boxing Day 2004 tsunami. Here, in the second of our reports, UK dentist ***Nidhi Bhalla*** *reports from Sri Lanka on her personal involvement in a follow-up dental project to the survivors.*

In the face of a natural disaster, dentists are rarely the first people to spring to mind when organising a relief effort. After the tsunami of Boxing Day 2004 I, like many others, could not help but wonder if any skills I had could be made use of, once the initial phase of emergency shelter, food and medical care was under control.

As there was a general overwhelming response to the call for voluntary aid, and also in part because dentistry was not a skill that was a listed need, it proved difficult to find any organisations accepting new volunteers. Larger charity organisations are well prepared for these events, with many pre-trained delegates to send out as soon as the need arises.

I managed to join a team of volunteers that formed in response to the call for aid, with the aim of going out to Sri Lanka and setting up a number of medical camps where the need was greatest. Having very little idea of what these needs would be, however, made the planning operation somewhat difficult. It was important to be prepared to adapt to the situation that would face us once out in Sri Lanka, adopting our roles accordingly, be it in a manual or a healthcare capacity. Indeed, I was unsure whether my dental training would be of any use at all.

ARRIVAL IN SRI LANKA

In spite of these uncertainties, we were able to liaise closely with a team of helpers already out in Sri Lanka. Provisions were made for most eventualities, and we were given a better understanding of the areas we would be working in, which made the geographical logistics of our trip more organised.

Our team consisted of 150 volunteers, mainly from the UK, including doctors, dentists, optometrists, pharmacists, nurses, counsellors and general volunteers. We took in excess of four tons of supplies, which included medical and dental equipment, as well as items such as stationery for schools, clothing and games.

On arrival in Colombo, we split into five camps to be stationed across the worst affected regions of Sri Lanka. I was based in Trincomalee, a north east coastal town approximately 10 hours' drive from Colombo, where the coastlines had been badly damaged by the tsunami. Each day we travelled to different refugee camps and orphanages, setting up in the nearest available school facilities, and tending to the needs of the local population. By the time we arrived in Sri Lanka the emergency phase

had already been completed and it was clear this had been implemented effectively and promptly. The disease levels of cholera, typhoid and hepatitis A were low, and the anticipated pandemics had not developed.

CHRONIC LACK OF DENTAL CARE

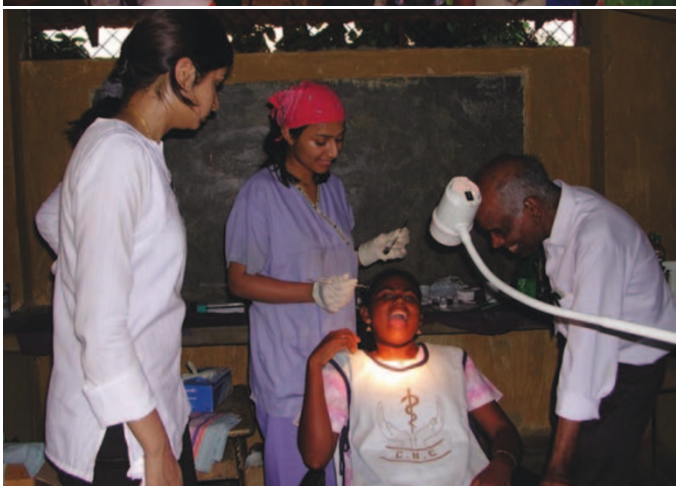
From the onset, it was evident that there was a chronic lack of dental care and we were inundated with patients with acute dental problems. Facilities were very basic and often consisted of simple shelter-like rooms with window holes cut into brickwork, many of which had been severely damaged by the force of the water. Often we had no electricity, and after dark we required portable generators so that we could work with a light source. As demand for dental treatment was so high on a daily basis, it was soon apparent that we had insufficient equipment and resources to cope. We were therefore extremely fortunate that one of the local hospitals lent us an adjustable chair and an autoclave, which proved much more efficient than the cold sterilising solutions we used previously.

A challenge in itself was to train a lawyer and an accountant to be my dental nurses. However, between us, and with interpreters on hand, we became a highly effective and very popular team. We were able to deliver reassurance, treatment and education in what I am sure was one of the most entertaining and friendly approaches possible. I found it remarkable how well we all adapted to make best use of the limited means available. Perhaps one of the most rewarding challenges was that we had to plan our set-up slightly differently every day, according to new limitations, in order to make each day a success.

LIMITED FOLLOW-UP AFFECTED DECISION MAKING

At times it was frustrating to compare the treatment we were able to offer the Sri Lankans with the sophisticated treatments we were used to providing at home. However, we did need to bear in mind that the patients we saw had limited access to follow-up which inevitably affected the treatment decisions made. As far as intervention was concerned, we found that the bulk of the problems stemmed from poor oral hygiene, particularly a high caries rate. As a result, many patients needed extractions and restorative treatment was limited to excavations and temporisation with glass ionomer cements when extractions were inappropriate. Simple periodontal treatment was easily carried out using hand scaling instruments.

A major focal point was to deliver an effective and lasting preventive programme for all the patients we saw. We gave oral hygiene instruction to all adults and children as a matter of course, using tooth brushing demonstrations, as well as supplying them with toothbrushes and toothpaste. It was an important consideration that future access to treatment would be unpredictable and hence it was vital that intervention



was not over-ambitious. Instead we offered good primary care treatment and focussed on a preventive programme.

SPECIALIST CARE SPARSE

Occasionally there were cases that required specialist care, such as undiagnosed premalignant conditions, and these were referred to hospital specialists which tended to be far away. This highlighted the chronic inequality of health care access, which, in part is due to the long standing civil war rather than the tsunami. There was also a lack of trained specialists, and these were located in major cities rather than the coastal towns where much of the Sri Lankan population live. Although we managed to arrange transport and accommodation for a lucky few, the problem is one that is unlikely to be resolved in the near future. This stumbling block was one reason for the large number of cases of untreated cleft lip and palate. We often found that parents came to us with a concern that their child was failing to thrive, only to realise poor feeding was secondary to untreated cleft palate, the lip having been operated on during infancy for cosmetic reasons.

A big challenge for the medical team was that it was difficult to implement new medication regimes due to a lack of guaranteed follow up. However, local ophthalmologists were successfully trained in the use of the phaco machines, used for cataract operations, which were donated to the hospital after the camps finished, allowing an improved level of care to be continued after our departure.

HARD WORK BUT GREAT SATISFACTION

Our days consisted of sheer hard work, but were mixed with many shared laughs, and I felt inexplicably humbled at being part of a team that saw sorrows turn into smiles. Far from being the poverty stricken people often portrayed, victims of the tsunami were typically educated individuals who had their homes, livelihoods and families taken from them in a disaster beyond anyone's control. At the end of a long day of work, we would often engage in games of cricket with local children, who, needless to say, taught us never to challenge a Sri Lankan at their national sport!

In hindsight we all felt that although the acute stage of the relief effort had been well executed, many of the problems we encountered were of a chronic and long-term nature. While an improved healthcare structure would go a long way to offer the chronic support needed, health promotion by voluntary organisations such as ourselves is also vital.

OTHER DENTISTS ENCOURAGED TO PARTICIPATE

Between us all we treated 5,096 patients in Trincomalee, and much of the remaining equipment was distributed for use to the local hospitals and schools after the camps were finished. Since returning we have been receiving updates on some of the longer term income generating programmes we initiated, in addition to our medical and dental work. This included clean water programmes, repairing fishing boats and creating infrastructure for schools, all of which are vital for the short and long term rehabilitation of the region. There have been delays in rebuilding the country in the aftermath of the tsunami, and a major obstacle has been the ban in building within 100m of the coastline.

It is difficult to express what I felt was achieved by the camp. It may be quantified in terms of the 22,000 patients registered in the six areas covered, or by the number of surgical, medical, and dental personnel we provided, supported by teachers and trained counsellors. On a personal level, the project demonstrated how a team of people from different backgrounds and cultures were willing to sacrifice personal comfort and learn from each other in order to serve a common purpose – to help the individuals, families and communities that survived the tsunami.

Dentists should be encouraged to participate in overseas volunteer work, although the routes are not always clear cut. The tsunami not only highlighted the need for more medical camps to be deployed in areas afflicted by natural disasters, but also uncovered a significant demand for dental care in many parts of the world where access to healthcare is difficult. With more than 30,000 dead and 500,000 homeless in Sri Lanka alone following the tsunami, the country is still having to work hard to ensure that the survivors do not remain victims.