Rohingya in Bangladesh: an unfolding public health emergency

I am writing from Cox’s Bazar, Bangladesh, where a large number of Rohingyas have taken refuge and where our organisation, Médecins Sans Frontières, has been providing emergency medical assistance. I am working as the medical emergency manager in Kutupalong, a makeshift settlement in the Cox’s Bazar district, which borders Myanmar. Of the estimated 1.2 million people in the peninsula that connects with Myanmar, only 250,000 of them are local Bangladeshis. The rest are forcibly displaced Myanmar nationals, and refugees from prior to 1992, who have been fleeing here since the 1990s. As a result of the recent increase in violence in Rakhine state, pre-existing settlements have effectively merged into one densely populated mega-settlement of more than half a million people, who are crammed along a narrow peninsula trying to find what shelter they can. It is essentially a massive rural slum—and one of the worst slums imaginable.

There are hardly any latrines so people have tried to rig up their own plastic sheeting around four bamboo poles, but there is nowhere for their waste to go except into the stream below. That is the same stream that, just 10 m away, others are using to collect drinking water. This has all the makings of a public health emergency. Some people are using clothes that they have strung together to provide shelter from the elements. But after 2 days of torrential rain and tropical thunderstorms, some communities’ shelter and their few belongings have completely washed away.

I can only imagine how incredibly terrible it must have been in their home village, if this is what they chose. If this is the better option, the other must have been a living hell. Our highest morbidities right now are severe dehydration secondary to diarrhoeal disease and respiratory tract infections. We know when these morbidities are high there is a direct correlation to hygiene, water, and sanitation conditions. We are also seeing more than 100 outpatients a day needing wound care—and these wounds are not all violence related. People are injuring themselves living in this precarious environment, and the lack of hygiene and potable water means their wounds get infected.

People have been gradually fleeing into Bangladesh for a long time. The last large group arrived in October, 2016, and the Cox’s Bazar community was still coping with that. That was a fraction of the size of what we are seeing today. We thought we were stretched back then, but now, we routinely have around 115 patients in a 70 bed facility.

Most patients do not want to leave the facility once they have been discharged. The overcrowded hospital offers a much better living environment than what is outside. As a medical professional, it is so hard to send vulnerable patients out into what you know is a precarious situation. People cannot go and wash their hands because there is no clean water to do that. They cannot go and use the toilet in an appropriate place, because there are no toilets. Add to that the incredible loss of dignity they must feel to have to do everything in the public eye. Literally everything they do is in front of massive amounts of other people.

We need to work on managing all of the basics at once, in a coordinated effort with all the other agencies on the ground. Otherwise, we have no hope of stopping this from developing into a public health emergency. To have decent coverage we need to act fast. During this emergency phase, just to achieve relatively decent sanitation, we need to have 8000 latrines built—that is a ratio of one latrine to 50 people. The longer we delay that, the greater the risk of an outbreak of cholera, hepatitis E, Shigella infection, and other water-borne diseases.

We need to supply 2 million L of water per day just to provide 5 L of water per person, per day in one camp. We need huge amounts of food and emergency relief supplies to avoid considerable levels of malnutrition. We need everyone to scale up in terms of experienced people on the ground who can move fast. The numbers of forcibly displaced people from Myanmar arriving are massive and, to top it off, there are enormous logistical challenges to be able to meet their needs because there are no access roads into the camps, which means everything must be brought in on foot. You carry everything you can on your back through narrow paths and hilly terrain, up and down slippery, muddy hills to get to your destination. It is supremely difficult.

The Rohingya refugees who have settled in these areas in the last month will probably never have the sense of comfort that you and I know, and may not ever have a solid roof over their heads. But it is possible for us to make it better and more secure than what it is now. The risk is that without a massive increase in the humanitarian response, we will continue precariously dangling on the edge of a situation that has the potential to rapidly go from a crisis to a public health catastrophe.

I am an Emergency Medical Coordinator with Médecins Sans Frontières in Bangladesh. I declare no competing interests.

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Snake bite in India: a neglected disease of poverty

We are grateful to The Lancet for their Editorial (July 1, p 241) on snake-bite envenoming, an acute time-limiting, life-threatening neglected tropical disease affecting farmers, labourers, hunters, shepherds, snake