The Crisis of Public Health Among East Bengali Refugees in 1971

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**Introduction**:

"Because of 'Operation Searchlight', 10 million refugees came to India, most of them living in appalling conditions in the refugee camps. I cannot forget seeing 10 children fight for one chapatti. I cannot forget the child queuing for milk, vomiting, collapsing and dying of cholera. I cannot forget the woman lying in the mud, groaning and giving birth."[1]

The situation of East Bengali refugees in 1971 was grim. The Bangladesh liberation war of 1971 witnessed 10 million people from the erstwhile East Pakistan (present Bangladesh), fleeing the persecution by Pakistani soldiers and coming to India seeking refuge[2]. In March, 17,000 people were crossing into India daily, in April, the number rose to 40,000 and by May India was receiving 60,000 refugees daily.

The influx of refugees created a mammoth humanitarian crisis. At one hand, the refugees were struggling to access food, water, proper sanitation, shelter. On the other hand, their lives were tormented by various health issues. The cholera epidemic of 1971 alone killed over 5,000 refugees.[3] Other health concerns were malnutrition, exhaustion, gastronomical diseases. "A randomized survey on refugee health highlights the chief medical challenges in the refugee population as being malnutrition, diarrhoea, vitamin-A deficiency, pyoderma, and tuberculosis."[4]

The Indian government was not adequately equipped to deal with a crisis of such level. Even though there was initial sympathies with the refugees, it quickly waned and by May 1971, the then Prime Minister of India, Indira Gandhi characterized it as a "national problem", in June she called it an "international responsibility"[5] and by July, she described the problem could potentially threaten the peace of South Asia.[6]Despite the grandiosity of the crisis, the Indian government continued to accept refugees, and provided relief. A reading through the Lok Sabha debates of 1971 would reveal the anxiety of the parliamentarians of the time against the brutality unleashed by West Pakistan and their eagerness to help the East Bengalis. The

[1]"War Crimes, 1971 Memories and Justice," The Daily Star, October 15, 2013, https://www.thedailystar.net/news/war-crimes-1971-memories-and-justice.

[2]United Nations High Commissioner for Refugees, "The State of The World's Refugees 2000: Fifty Years of Humanitarian Action - Chapter 3: Rupture in South Asia," accessed April 1, 2020, https://www.unhcr.org/en-in/publications/sowr/3ebf9bab0/state-worlds-refugees-2000-fifty-years-humanitarian-action-chapter-3-rupture.html.

[3]Peter Grbac, "Accessing Refugee: India and Its 1971 Refugee 'Problem,'" *Refugee Watch: A South Asian Journal on Forced Migration* 43 & 44 (December 2014): 10.

[4] Ibid

[5]Sandip Bandyopadhyay, "Millions Seeking Refuge: The Refugee Question in West Bengal:1971"," in *Refugees in West Bengal: Institutional Practices and Contested Identities* (Kolkaata: Calcutta Research Group, 2000), 35.

[6]Peter Grbac, "Accessing Refugee: India and Its 1971 Refugee 'Problem,'" *Refugee Watch: A South Asian Journal on Forced Migration* 43 & 44 (December 2014): 4

research paper studies the public health crisis among the refugees of West Bengal in 1971 and the government, international and local measures to alleviate the crisis.

This paper uses the term refugee in accordance with the definition of The 1951 Refugee Convention which defined refugees as who "owing to well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country."[7]

The research attempts to study the death and mortality in the refugee camps in 1971 West Bengal and measures to provide healthcare to the refugees including food, nourishment, shelter, and proper sanitation.

The rate of mortality and deaths were unmatched among the refugees. The cholera epidemic of the 1971 took 30 per cent of the lives of the refugees in West Bengal[8] but it was not the only health crisis faced by refugees. Due to unhygienic camps, poor sanitation, lack of nutritious food, heavy monsoon, the refugees would often suffer from other gastrointestinal diseases. Refugee children were among the most vulnerable. In case for the cholera epidemic, the doctors and health care workers assisted by the Johns Hopkins Calcutta Medical Research Training Centre (JH-CMRT), while working in Bongaon, found that 38 per cent refugee children were among the affected compared to 14 per cent adults. Malnutrition was another cause of concern among the refugee population. The paper looks at two main questions:

1. What was the situation of the public health among the East Bengali Refugees?
2. What was the reaction or response of the government, relief organizations, and local population to alleviate the health crisis? Public health of refugees is one of the most debated topics currently. However, in 1971, a short 20 years after the 1951 Refugee Convention, Public health was not a concern for the refugee regimes of the time. Standing at that point of history, and not being a signatory to the 1951 convention, India's response to the health crisis of the refugees were lauded internationally. This paper investigates the said response.

The analysis is mainly based on secondary sources in forms of books, academic research papers, journal articles, Lok Sabha debates, personal narratives. The research accessed various public documents like newspapers, political speeches and political memoirs, legislative debates to assess the health and mortality situation of refugees in 1971. The research also includes a personal interview of Julian Francis, a relief worker who worked with the East Bengali refugees in 1971 for Oxfam. The researcher attempted to access the state archives like intelligence files, archives from medical journals. But due to the sudden lockdown in light of COVID 19 the archives were closed and haven't opened at the time of writing this paper.It is imperative to mention that this is a working paper and the list of

[7] "The Refugee Convention, 1951," n.d., https://www.unhcr.org/4ca34be29.pdf.
[8] D Mahalanabis et al., "Oral Fluid Therapy of Cholera among Bangladesh Refugees," *Bulletin of the World Health Organization : The International Journal of Public Health 2001* 79, no. 5 (2001): 197–205.

material collected is by no means exhaustive. The paper will be improved upon as soon as access to state archives are granted.

The paper is divided into three major sections: the first gives a brief historical background of the 1971 refugee crisis. It tracks the genesis of the conflict to 1947 when India became independent from the British colonial rule and divided into two dominions. The history will help us contextualising the refugee crisis. The second section elaborates on the health crisis of East Bengali refugees. But before diving into the subject of public health of the refugees, the section briefly discusses the concept of public health as it is still invisible from the public eye. The section tracks the public health situation from colonial to post-colonial India and juxtaposes it with international developments of public health. It then proceeds to look at issue of public health of refugees which then proceeds to the health crisis of the East Bengali refugees. The next subsection deals with the response of the government, international organizations and NGOs in providing medical assistance, improving sanitation, battling malnutrition which are all necessary to fight a public health crisis. The third and last section , very briefly, looks into the response of the local population towards the refugees and the health crisis. The actions of the host population in 1971 have often been eulogized but sporadic cases of dissatisfaction with the refugees have been reported. The paper tries to coalesce such data or instances.

## Section I: Background

The 1971 refugee influx was a direct result of “Operation Searchlight” by the Pakistani army. The operation was initiated in March 1971 to carry out a genocide of Bengalis from the then East Pakistan which was administered by West Pakistan aftermath the partition of India in 1947. The 1947 partition of India resulted in the formation of India and Pakistan which was further divided between East and West Pakistan.

The ill-treatment, constant economic exploitation, and imposition of Urdu as official language in a Bengali speaking region, led East Pakistan to their struggle for independence since the 1950s. East Pakistan felt neglected by its Western counterpart since the birth of Pakistan. The eastern province was already suffering from poverty and wanted to draw West’s attention towards it. But the later did not engage and carried on exploiting the east.

P.N Luthra quoted Abu Mansur Ahmed, a politician from East Pakistan who debated against West’s neglect in the Constituent Assembly of Pakistan in 1956.

"I shall show, Sir, from statistics published by our Government that the share of East Pakistan to the Federal revenues from 1947-48 to 1954-55 has been Rs 168 crores and 14 lakhs. 'During this period West Pakistan contributed Rs 553 crores 53 lakhs to the Federal revenues. These figures may make our West Pakistani brothers, like MrGurmani, boast and say 'Look! East Pakistan is contributing only 18 per cent, West Pakistan contributes more than treble'. But, Sir, look at the expenditure side. This is the expenditure. The Central Government has spent during these 9 years, Rs 42 crores and 66 lakhs in East Pakistan as compared to Rs 790

crores and 67 lakhs spent in West Pakistan. There- fore, Sir, we have got 6ack much less than what we have contributed."[9]

In 1968, 55 per cent of the export was from East but 70 per cent import went to the West. From 1966-1970, 52 per cent of the country's finances were allocated for the East but only 36 per cent was spent.

Apart from the economic exploitation, what enraged the East Pakistanis, was the imposition of Urdu as the national language of the country and relegating Bengali a lesser status. In 1948, Muhammad Ali Jinnah, Pakistan's Baba-i-Quam (Father of the nation) declared in front of East Bengalis that Urdu will be the lingua franca and anyone who opposes that would be considered as the enemy of Pakistan. East Bengalis could not take this lying down and started a language movement. East Pakistanis wanted more autonomy in the East.

The struggle reached its climax in 1970 when Sheikh Mujibur Rahman's Awami League won a landslide victory in national elections which gave him a right to form government. However, the then President General of Pakistan Yahya Khan refused to accept Mujibur as the Prime Minister of Pakistan. On March 25, 1971, Mujibur declared Bangladesh as an independent country. The same day Yahya Khan outlawed the Awami League and called Mujibur and his supporters, the enemies of Pakistan. On the night of March 25, Pakistani army launched "Operation Searchlight" with an aim to exterminate the Bengali population[10] leading to the Bangladeshi Liberation war which continued for nine months i.e. till December 1971 until the Pakistani army surrendered.

In India, on March 26, a Lok Sabha debate was taking place when the news of the liberation war reached the parliamentarians. "Just now we have heard the radio news that civil war has started in Bangla Desh. After landing 60,000 troops from West Pakistan the army has taken position in almost all the big cities and in all key positions. Yahya Khan declared the Martial Law. His Government have promulgated curfew in Dacca and in all other big cities. They have taken possession of the Dacca Betar Kendra. They have issued orders to shoot at sight all Bengali people there. Not only so. The East Pakistan Rifle is in the midst of a grim battle with the Pakistani Army there. My report is that hundreds of people are being butchered and killed. An order has been issued to shoot at sight anybody in the street. There is another report that at the Karachi airport, hundreds and thousands of Bengali people have assembled to have passage to East Pakistan, there also hundreds of people have been killed."[11]

The lower house of Indian parliament witnessed impassioned speeches in favor of supporting East Pakistan. "Democracy is being murdered in East Pakistan by fascists. Let us pledge our

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[9] P.N Luthra, "Problem of Refugees from East Bengal," *Economic and Political Weekly* 6, no. 50 (December 11, 1971): 2469

[10] "Operation Searchlight: Genocide Unleashed on Bangalis in East Pakistan | Dhaka Tribune," March 25, 2017, https://www.dhakatribune.com/bangladesh/2017/03/25/operation-searchlight-genocide-unleashed.

[11] "Lok Sabha Debates," March 26, 1971, https://eparlib.nic.in/bitstream/123456789/770/1/lsd_05_01_26-03-1971.pdf, 105-106

support and say that we shall defend the right of the people in other countries also… I would request you and through you the Prime Minister to uphold the banner of democracy and to give more support to Mujibur Rahman. If Mujibur Rahman is dead, naturally, again, Yahya Khan regime, fascist regime, will come into being. We are opposed to this. Let the people of Pakistan know that India stands solidly behind Mujibur Rahman and that we condemn any action of the Yahya Khan."[12]

Their support for East Pakistan also translated into the support for East Bengali refugees fleeing persecution at the hands of Pakistani army. This was not the first time India's eastern states were witnessing a refugee influx. Refugees have started moving towards the west much before India's independence and partition. October 1946 saw the first movements across the borders as a result of communal riots in Noakhali and Tippera districts in East Pakistan. This was followed by the 1947 partition which led to a massive displacement of people. Immeditaely after the partition, in 1948, another round of violence in districts of Barishal, Pabna, Rangpur and Bagura resulted in Bengali Hindus crossing over to India. The communal riots of 1950 in Khulna resulted in another round of exodus.[13] 30 million refugees entered in West Bengal alone by 1960.[14]

The Bangladesh liberation war of 1971 witnessed another round of influx of refugees. An estimated 10 million refugees came to India according to the United Nations High Commissioner for Refugees (UNHCR). The East Bengali refugees started coming to India from March 1971 till the end of the war and subsequent freedom of Bangladesh from Pakistan in December 1971. Four Indian states received the refugees, namely, West Bengal, Tripura, Meghalaya and Assam.[15] There were 825 refugee camps, averaging around 8,000 refugees per camp.[16] Around 7.1 million people (76 per cent) of the 10 million estimated refugees came to West Bengal. Among them, 5 million were living in makeshift refugee camps.[17] Hostels, schools, even sewage pipes were used by them as places of living.

John Pilger, a renowned journalist, while describing the refugee crisis and criticizing the West over its inaction for the Daily Mirror in 1971, wrote:

"Usually we in the West, who are rich, can dismiss or rationalize famine, unexpected disaster and even mass extermination by simply noting that the poor, who are characterized by the

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[12] "Lok Sabha Debates," March 26, 1971, https://eparlib.nic.in/bitstream/123456789/770/1/lsd_05_01_26-03-1971.pdf: 107.

[13] Paula Banerjee and Sucharita Sengupta, "The Refugee Movement: A Founding Moment of Popular Movements," in *From Popular Movements to Rebellion: The Naxalite Decade*, South Asia Edition (New Delhi: Social Science Press, 2018), 25

[14] Ibid, 19

[15] Appendix I

[16] Navine Murshid, "Refugees, Women, and the 1971 War—a Reflection," The Daily Star, December 16, 2018, https://www.thedailystar.net/1971-the-battles-women-fought/news/refugees-women-and-the-1971-war-reflection-1674061.

[17] P.N. Luthra, "Problem of Refugees from East Bengal," *Economic and Political Weekly* Vol. 6, no. No. 50 (November 12, 1971): 2467–72.

people of Bangla Desh, are numerous and ought to be pruned. If only, we say, they could organize their own resources and subscribe to decent, Western politics. Surely they are expandable… Bangla Desh has called our bluff. The people of what was East Pakistan, who represented the majority of the State of Pakistan, voted to be a democracy and to be led by moderate middle-class Western-styled politicians. Foolishly perhaps, they chose our ways in pursuit of freedom, in spite of problems we have never had to face. And for this reason they are being exterminated and enslaved in a manner reminiscent of Adolf Hitler, over whom the world went to war. But, of course, he was exterminating Europeans."[18]

The millions of refugees that entered India were often living in precarious conditions. Due to their living conditions and other precarity like shortages of food, absence of sanitation, the mortality rate was unparalleled. In July 1971, after the refugee influx multiplied and the heavy monsoon rains wreaked havoc, cholera already took many lives and malnutrition plagued the refugee children, the Indian Home ministry was asked in a Lok Sabha debate whether they were planning to seal the borders to stop "refugees and other undesirable elements"[19] from entering India. To this, the home ministry replied that despite an acute shortage of food, shelter and other necessary supplies, the government of India will not return any refugees from Bangladesh. It will not close its borders on the East Bengalis. Apart from opening its borders, Indian government worked with international relief organizations and local population to provide for the refugees. Health care was among one of the main services provided by the government, NGOs and international relief organizations. The next section will look into the public health concern of refugees in depth.

## Section II: Public Health and East Bengali Refugees:

*Public health*: Before discussing the public health situation of East Bengali Refugees in 1971, it is important to look at the concept of public health and the situation of public health in colonial and post-colonial India as it is a crucial part of any country's development but often been confused with medical services. Public health services have a "…key goal reducing a population's exposure to disease, for example through assuring food safety and other health regulations; vector control; monitoring waste disposal and water systems; and health education to improve personal health behaviours and build citizen demand for better public health outcomes."[20]

Improving the public health of a population necessitates policy implementations which cover the 'public' collectively. Arranging clean water, sanitation, hygiene, sewerage disposal- all of it should impact a group of people. These are important to prevent the spread of disease or control the effect of epidemics. Factors like elementary education, gender relations, economic

[18] John Pilger, "The Testimony of Sixty on The Crisis in Bengal" (Oxford: Oxfam, 1971).
[19] "Lok Sabha Debates," July 21, 1971, https://eparlib.nic.in/bitstream/123456789/2321/1/lsd_05_02_21-07-1971.pdf: 57
[20] Monica Dasgupta, "Public Health in India: Dangerous Neglect," in *Social Policy* (Delhi: Orient Black Swan, 2016), 21

security and social norms also play important roles in maintaining good health.[21] But it is imperative to note that even though public health services are meant to be preventive and for the community, individual sufferers would still need particular attention and treatment as opposed to being treated as a herd. For the most part, public health services are invisible to the public. They only become aware of it when a problem like an epidemic occurs.

*A brief background of public health in India and the world*: The situation of public health in India has been criticized for being abysmal. It has not been a priority for India since independence which is a paradox considering the interventionist nature of Indian state. India's development discourse allotted little importance or resources to public health. Instead, it focused more on privatizing health care.[22] The situation of the colonial India did not fare better. But there was a concept of public health in the minds of administrators and subjects. The focus of public health policies under colonial rule was to protect the British citizens and army. An 1863 report of the Royal Commission of the sanitary situation of the British army is considered as the first document of public health policy in British India.[23] The colonial administration was initially only concerned with the health of the soldiers. More British soldiers allegedly died of cholera and dysentery than of the battles.[24]Slowly, they increased the ambit of public health to include the Indian subjects fearing unrest and social disruption especially after the famines of 1870s and 1880s and the mass mortality as results of the famines.

British authorities established institutions for public health training and research. Public health acts and legislations were drawn up. These acts were along the lines of the then European legislations on public health. The Royal Commission of 1895 recommended setting up sanitary commission in each Presidency and posting trained sanitary staff for rural and municipal areas. Sanitary departments were set up at national and provincial levels. Health of the military was put under the authority of military medical officers. The authorities also carried out regular policy making and planning regarding public health services. Nevertheless, these measures were not very fruitful as the ruling power's main focus was to control communicable diseases.

"Colonial public health policy was inherently limited and self-limiting; it focused on keeping epidemics at bay, responding to crises and not much more. A crucial institutional innovation came in the 1880s, when much of the responsibility for local health and sanitation was devolved to partly elected local government bodies, a responsibility shared by the 1920s with provincial governments. This is a division of responsibility that lasts into the present day, and

[21] Jean Drèze, "Introduction," in *Social Policy* (New Delhi: Orient BlackSwan, 2016), 3
[22] Sunil S Amrith, "Health in India since Independence," in *History, Historians & Development Policy*, ed. C.A. Bayly et al. (New Delhi: Orient BlackSwan, 2011), 125
[23] Sunil S Amrith, "Health in India since Independence," in *History, Historians & Development Policy*, ed. C.A. Bayly et al. (New Delhi: Orient BlackSwan, 2011), 128
[24]Imrana Qadeer, "Continuities and Discontinuities in Public Health The Indian Experience," in *Maladies, Preventives and Curatives: Debates in Public Health in India* (Kolkata: Institute of Development Studies Kolkata, 2005), 81.

puts significant limits on the capacity to enact public health policies: then, as now, the ability of local and even provincial governments to raise resources is very limited."[25]

The importance of public health in independent India remained a contested topic. The Congress Planning Committee deemed public health as a basic human right and an instrument for economic development but there was an absence of ability to bring it to reality. The refugee influx after the partition of India, revealed the weak health infrastructure of India.[26]

The concept of public health started waning from the mind of the public. The increased mass-production of antibiotics in the 1940s enabled the local elites to protect themselves from diseases without having to maintain a rigorously clean and hygienic environment which would have benefitted all the classes alike. The simultaneous advancement of medical technologies also drew attention and resources from public health to improving technologies and healthcare financing. Public health services were merged with medical services in the 1950s and curation attracted more attention than prevention. Around 1980s, the increased privatization shrunk the welfare state, profits and demands started shaping influencing services leading to a "neo-liberal public health" under which "biomedical perspectives overshadowed the role of socio-economic factors in health and the behavioural approach began to dominate".[27]

Internationally, much like colonial India, public health started gaining importance due to military concerns. Sanitary movements started in many developed countries. The twentieth century saw the eradication of malaria in the US, southern Europe and several Asian countries following multi-pronged efforts to reduce vector breeding and parasite transmission… By the mid-twentieth century, the institutions and procedures for assuring public health had become well-established in the developed world… although, public health services became very low-profile in the public eye, they remained firmly in place in the developed world." [28]

*Public health of refugees:*The World Health Organization published a report in 2018 named "Health of refugees and migrants: Practices in addressing the health needs of refugees and migrants" for the South-East Asia. The report outlines some cases of public health in the South-East Asia region and its implication on the refugee population. The report also provides a framework for a better public health of refugees and migrants in the region. For example: advocating mainstreaming refugee and migrant health in the global, regional and country agendas and contingency planning;promoting refugee- and migrant-sensitive health

[25] Ibid, 129
[26] Sunil S Amrith, "Health in India since Independence," in *History, Historians & Development Policy*, ed. C.A. Bayly et al. (New Delhi: Orient BlackSwan, 2011), 133
[27]Imrana Qadeer, "Continuities and Discontinuities in Public Health The Indian Experience," in *Maladies, Preventives and Curatives: Debates in Public Health in India* (Kolkata: Institute of Development Studies Kolkata, 2005), 90
[28] Monica Dasgupta, "Public Health in India: Dangerous Neglect," in *Social Policy* (Delhi: Orient BlackSwan, 2016), 21–34.

policies, legal and social protection and programme interventions that incorporate a public health approach;enhancing capacity to address the social determinants of health; reducing mortality and morbidity among refugees and migrants through short- and long-term public health interventions; promoting health of women and refugee children, etc. This document gives a guideline for the South East Asian countries to improve the public health of refugees.

The concern of refugee health is widely debated in the international circle in the present times. In 1971, the guideline that spoke about health assistance to refugees was the 1951 Refugee Convention apart from the Universal Declaration of Human Rights. "Article 23 of the Refugee Convention guarantees the right of refugees to public relief, that is, to access physical and mental health services at the same level as other residents. This fundamental right is also guaranteed by article 25 of the Universal Declaration of Human Rights."[29] However, these basic rights are not often met by host countries. India on the other hand, along with its South Asian countries, is not a signatory to the 1951 convention. Not having a strong public health system in the country might have also contributed to the burden of the country. As mentioned in the previous section that the refugee influx of the 1940s revealed a weak public health system in India. But that did not stop the country from arranging and caring for the refugees, at least in 1971. The next sub-section details the health crisis of East Bengali refugees and measures taken by various national and international actors to alleviate the crisis.

*Health Crisis of East Bengali refugees:* "The long line of bamboo huts flattened by rain become longer every day. In these hovels people sleep on the ground, defecate along the paths and giant crows hover above. Fifty children fight over an egg we had given because we didn't have the courage to eat it in front of them. In the milk queue a child vomits and collapses. In the mud a woman heaves, groans, and gives birth."[30]

The millions of refugees that entered India were often living in precarious conditions. Due to their living conditions and other precarity like shortages of food, absence of sanitation, the mortality rate was unparalleled.

To curtail a widespread public health crisis, it was crucial to house the refugees in places equipped with proper sanitation. When the refugees started arriving in March, the central government declared that they will be given relief assistance and the cost of which would be bore by the government. These excluded refugees who took shelter with their relatives or friends. The state governments of West Bengal, Tripura, Assam and Meghalaya were authorized to build temporary shelters at a cost of maximum INR 5 per square feet. Each family were allowed 100 square feet of floor area. By June, India witnessed a massive increase in the number of refugees. Out of 4 million refugees who came to West Bengal by the first week of June, only 1.9 million could be housed, 500,000 refugees took shelter in

[29] Mohamed Abbas et al., "Migrant and Refugee Populations: A Public Health and Policy Perspective on a Continuing Global Crisis," *Antimicrobial Resistance & Infection Control* 7, no. 1 (December 2018): 113, https://doi.org/10.1186/s13756-018-0403-4.

[30] Claude Mosse, "The Testimony of Sixty on The Crisis in Bengal" (Oxford: Oxfam, 1971)

schools and rest were out in the open. The heavy monsoon rains in June also added to the burden of refugees. Some camps in West Bengal housed more than 20,000 refugees, like in Hasnabad, Bhaduria, and Swaroop Nagar. The Nadia district of West Bengal, which received 1.2 million refugees against a local population of 2 million, had the largest camp in the state which housed more than 50,000 refugees.[31] In Meghalaya there were two refugee camps with 100,000 population each.[32]

The absence of proper mechanisms to house and provide appropriate care for the refugees increased their precarity. Even the over-crowding of refugees in each camp without adequate sanitation system added to the health crisis. Narayan Desai, from Gandhi Peace Foundation which worked with the refugees widely, described the over-crowding of the camps aptly. He wrote, "Twenty-three persons living in a tent measuring 12 feet by 9 feet. Sixteen living on a raised 8 feet square platform of bamboo chips, avoiding direct contact with knee-deep water. This is the rule, rather than the exception."[33] In Assam's Dhubri town, 500 refugees, mostly children died due to acute sanitation problem in the camps.[34]

The cholera epidemic of the 1971 which took 30 per cent of the lives of the refugees in West Bengal[35] gets more attention while discussing the health crisis of the East Bengali refugees. The epidemic opened the eyes of the West to this humanitarian crisis. "It took the bogey of cholera to stir the conscience of the world, but even this killer came and went. It left behind what was there before, suffering and despair-no homes, little or no food, insufficient medical supplies-and worst of all, no hope."[36]

The reports on cholera induced deaths varies greatly from source to source. A New York Times report from 1971 mentions that 2000 refugees died from cholera outbreak by the first week of June.[37] Within days of the previous report, the same journalist wrote that the then Health Minister Uma Shankar Dixit informed the parliament that 9,500 refugees were admitted in various hospitals due to cholera.[38] A report by the United Nations High Commissioner for Refugees (UNHCR) mentions that by September 1971, the number of cholera cases rose to 46,000.[39] Another data puts the figure at 46,752 and the death toll at

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[31] K.C Saha, "The Genocide of 1971 and the Refugee Influx in the East," in *Refugees and the State: Practices of Asylum and Care in India, 1947-2000* (New Delhi, 2003), 212-214

[32] Ibid, 223

[33] Narayan Desai, "The Testimony of Sixty on The Crisis in Bengal" (Oxford: Oxfam, 1971).

[34] K.C Saha, "The Genocide of 1971 and the Refugee Influx in the East," in *Refugees and the State: Practices of Asylum and Care in India, 1947-2000* (New Delhi, 2003), 221

[35] D Mahalanabis et al., "Oral Fluid Therapy of Cholera among Bangladesh Refugees," *Bulletin of the World Health Organization : The International Journal of Public Health 2001* 79, no. 5 (2001): 197–205.

[36] Michael Blackman, "The Testimony of Sixty on The Crisis in Bengal" (Oxford: Oxfam, 1971).

[37] Sydney H Schanberg, "Cholera Toll Among Bengalis Put at 2,000 by Indian Aides," *New York Times*, June 4, 1971, https://www.nytimes.com/1971/06/04/archives/cholera-toll-among-bengalis-put-at-2000-by-indian-aides.html.

[38] Sydney H Schanberg, "Refugees and Cholera Increase in India," *New York Times*, June 1971, https://www.nytimes.com/1971/06/08/archives/refugees-and-cholera-increase-in-india.html.

[39] "'Rupture in South Asia' in The State of World Refugees 2000" (UNHCR, 2000), https://www.unhcr.org/pubs/sowr2000/ch03.pdf.

5,834.[40] There is a lack of concrete data on the number of deaths due to cholera or any other disease that contributed to the mortality of the refugees. This can be attributed to a complete chaos in the initial period of refugee rehabilitation process, but the refugees often hid the news of deaths from local adminsitration. They used to get ration based on the number of people in the camps and feared ration reduction if they reported the deaths.[41]

During the summer of 1971, due to the cholera outbreak and high mortality rate, the Johns Hopkins Center for Medical Research and Training in Calcutta (JH-CMRT) offered to help local doctors in treating the refugees. They treated the refugees during the peak of the cholera epidemic in Bongaon, a border area between India and Bangladesh. The cholera affected patients were housed at the sub divisional hospital in Bongaon. The team of doctors and paramedics observed that "Two cottages with 16 beds, originally built to accommodate patients with infectious diseases, were used as cholera wards. When we arrived on June 24, 1971, an estimated 350,000 refugees were living in the vicinity of the town, with an additional daily influx of about 6000 more. The meagre resources of the town were strained to the limit."[42] By the end of June, the hospital was admitting around 200 patients per day. Soon the cottages used as cholera wards ran out of beds and patients had be placed on floors which also got overcrowded and makeshift canvas cots had to be brought from Kolkata which were put in a makeshift tent by the hospital.

Apart from cholera there were other widespread public health issues plaguing the refugee. A New York Times report from June 1971 mentioned "death from other diseases and afflictions—continues at a steady rate. Malnutrition, exhaustion and gastrointestinal diseases are striking down large numbers of refugees daily. As with all the other statistics about the refugees no exact death toll is available. Tuberculosis is also endemic in refugee camps and the dampness of monsoon season will aggravate this situation."[43]Other gastrointestinal diseases resulted in many deaths. For example, In Nadia, 800 refugees died due to acute diarrhoea and other health problems.[44]

Julian Francis, a relief worker with Oxfam who were in charge of organizing and handling the relief supplies in 1971, told in a personal interview that cholera was definitely a big threat for the refugees but it did not kill as many people as expected. Oral rehydration therapy (ORT) was successful in managing the epidemic.

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[40] K.C Saha, "The Genocide of 1971 and the Refugee Influx in the East," in *Refugees and the State: Practices of Asylum and Care in India, 1947-2000* (New Delhi, 2003), 228

[41] K.C Saha, "The Genocide of 1971 and the Refugee Influx in the East," in *Refugees and the State: Practices of Asylum and Care in India, 1947-2000* (New Delhi, 2003), 221

[42] Ibid

[43]Sydney H. Schanberg, "India Reports Cholera Is Easing, But Refugee Problems Mount," *The New York Times*, June 15, 1971, sec. Archives, https://www.nytimes.com/1971/06/15/archives/india-reports-cholera-is-easing-but-refugee-problems-mount.html.

[44] K.C Saha, "The Genocide of 1971 and the Refugee Influx in the East," in *Refugees and the State: Practices of Asylum and Care in India, 1947-2000* (New Delhi, 2003), 217

"The camps were extremely unsanitary and the refugees suffered from various health-related issues. We hear more about the cholera epidemic of 1971. It was a big threat but cholera did not kill as many people as expected. Oral rehydration therapy (ORT) successfully managed the epidemic. The first success of ORT was witnessed in the Cholera Research Lab, which is now known as International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDRB), in East Pakistan but wasn't mass produced. American doctors, who at that time, were working with the research lab, were evacuated in April 1971. Some of them came and trained the paramedics working in refugee camps in West Bengal. They were taught how to make saline. In the camps, where cholera took hold, 30 per cent of the infected people died. However, after the use of ORT, the deaths came down to 3 per cent. But we need to remember the other diseases also. Monsoon was extremely heavy that year. Refugee camps were flooded. It was a breeding ground of typhoid and different gastrointestinal diseases. The sanitation systems were problematic. In some of the camps, social workers from different relief organizations had managed the latrine situations as well as they could. But it was difficult."[45]

Malnutrition was another cause of concern among the refugee population. Around 14 percent of the children in refugee camps were suffering from malnutrition.[46] A description by the then US senator Edward Kennedy highlighted the macabre situation of the refugee children.

"Those refugees who suffer most from the congestion, lack of adequate supplies and frightful sanitation are the very young-the children under five-and the very old… You see infants with their skin hanging loosely in fold from their tiny bones-lacking the strength even to lift their heads, You see children with legs and feet swollen with oedema and malnutrition, limp in the arms of their mothers. You see babies going blind for the lack of vitamins, or covered with sored that will not heal… And most difficult of all, you see the corpse of the child who died just the night before."[47]

*Responses to the health crisis of the refugees:*

Government Response: To address the health crisis of the East Bengali refugees, the central government medical store depots at Kolkata and Guwahati were instructed to store adequate medicines and items like anti-cholera vaccines, rehydration fluids, bleaching powder, anti-malaria drugs, antibiotics etc. The government set up stores in Agartala, Karimganj, Tura and Dhubri. The government dispersed 500 medical and paramedical staff from Central Medical Service, Railway medical service and from state services. Two epidemiological unites were set up to prevent and control the spread of epidemics. The state governments employed medical and paramedical personnel from the refugees against a daily wage. In total, 800 doctors, 2100 paramedical staff and 72 medical students were engaged in addressing the health crisis of the refugees.

[45] Interview with Julian Francis, Skype, July 25, 2020.

[46] P.N Luthra, "Problem of Refugees from East Bengal," *Economic and Political Weekly* 6, no. 50 (December 11, 1971): 2472

[47] Edward Kennedy, "The Testimony of Sixty on The Crisis in Bengal" (Oxford: Oxfam, 1971).

Women refugees needed special treatment supply of sanitary products which were lacking. Oxfam's Julian Francis told during an interview, "Oxfam did consider the situation of women refugees but we were not very good at handling the issues specific to the women, like supplying sanitary napkins etc. It was the final year women students of Nil Ratan Sircar (NRS) medical college and hospital who pioneered the work with women refugees. They worked on a rotational basis in different camps with us and took care of their sanitary and health needs. There were a surprisingly high number of women medical students in Kolkata. As the news about refugees spread across the country, many medical students started coming from different parts of India, like Cuttack, Bombay etc. But they did not have as many women students as the Kolkata group did. This is of course, due to the fact that these teams were travelling far and many women students' families did not allow them to travel. Sanghamaitra Desai, now Dr. Sanghamitra Desai Gadekar, the daughter of the Gandhian leader Narayan Desai, was one of the students of NRS. She mobilized the medical students and arranged for them to work with the mobile teams of Oxfam on a rotational basis."

From the government side, there were 700 medical units in camps; 50 new and existing referral hospitals; 4,000 additional beds in hospitals; a 100-beded mobile hospital were provided. The government also launched mass-inoculation programs with jet-guns within 5 miles radius of the camps in towns which had a population of 20,000 and above.[48]However, treatment did not reach all the refugee population equally. In Shillong district of Meghalaya, cholera broke out in the camps. 20 refugees, mostly children died as cholera vaccination was not easy to procure due to the remoteness of the area. They had to be sent from Kolkata.

As sanitary measure, the government prescribed one tubewell per 200 persons. 43 tubewells and 21,000 latrines were built. Water tanks were arranged for regular distribution of water.[49]

The Indian government's economy of the time also went through a strenuous period while providing healthcare. By June 1971 when cholera endemic was at its peak, the estimated spending by the Indian government on refugees was about a million dollars per day. Foreign aid worth of 40 million dollars in cash and relief were not enough and the continuous flow of refugees would not wane.[50] The government gave 80 million rupees to the Food Corporation in India in April to procure food grains and other essential commodities for the refugees. The government had to levy new taxes on its local population to meet the crisis and asked for help from foreign organizations.

The Indian government also approved a scheme called "Operation Life Line" for 2 million refugee children and costed 4.1 million dollars. The program aimed at both preventing and curing diseases and cases of malnutrition among refugee children.

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[48] K.C Saha, "The Genocide of 1971 and the Refugee Influx in the East," in *Refugees and the State: Practices of Asylum and Care in India, 1947-2000* (New Delhi, 2003), 228.
[49]Ibid, 229
[50]Sydney H. Schanberg, "India Reports Cholera Is Easing, But Refugee Problems Mount," *The New York Times*, June 15, 1971, sec. Archives, https://www.nytimes.com/1971/06/15/archives/india-reports-cholera-is-easing-but-refugee-problems-mount.html.

International Actors: International NGOs and institutions like Oxfam, WHO, UNHCR provided support and often in many places worked with the government of India and the state governments to provide for the refugee population. For example, all WHO or UNICEF vehicles which were meant for normal programs were diverted to assist the refugees. The UNHCR acted as the focal point under the orders of the then Secretary-General. "It involved mobilization of international support and funds, procurement and delivery of relief supplies to India, and coordination with the Indian government, which organized the distribution of these supplies."[51] Through focal point, the UNHCR supplied 700 tons of critical medicines.

Oxfam played a crucial role in assisting the refugees. It was responsible for 11,000 refugee camps of various sizes. It used to provide medication, food, clothing, blankets etc. to the refugees. To improve the sanitary condition of the refugee camps, Oxfam came up with the idea of a "Super Latrine". The organization is currently more famous as a water and sanitation organization in the times of disasters, providing safe drinking water in emergency situation. But in 1971, they were experimenting to provide proper sanitation to refugees. They tried out this super latrine or what "we used to call it, the "super loo". It had a system where a butyl rubber septic tank was linked to line of 10 latrines. It was such a success that a number of units were brought to Bangladesh and used in Bihari refugee camps later."[52]

Oxfam was instrumental in bringing international attention to the refugee crisis. In October 1971, it published the "The Testimony of Sixty on the Crisis in Bengal", a collection of eye-witness accounts of the crisis. Mother Teresa, the then US Senator Edward Kennedy, journalists such as Anthony Mascarenhas, John Pilger, Nicolas Tomalin, Clare Hollingworth and Martin Woollacott-all provided their statements and accounts for the testimony. The testimony was distributed to foreign government heads, to the UN. Edward Kennedy also introduced it to the US Senate-which was supporting Pakistan- after it was published. The result of the testimony was such that the then United States senator Edward Kennedy plead the case for Bangladesh in the U.S. Congress using the "Testimony of Sixty". Julian Francis wrote:

"What is interesting to record is that, although the US was firmly supporting Pakistan in 1971, Senator Edward Kennedy, who had visited India and the refugee camps in August 1971, brought The Testimony of Sixty to the attention of the US Senate, and it was published in full on October 28, 1971 in the "Congressional Record," only one week after it was published by Oxfam in the UK. Introducing the Testimony of Sixty to the US Senate, the Congressional Record states the following: "Mr Kennedy: 'Mr President, the crisis in East Bengal is a story of human misery on a scale unequaled in modern times. It is a story of systematic terror and military repression, of indiscriminate killing and the killing and

[51] "'Rupture in South Asia' in The State of World Refugees 2000" (UNHCR, 2000), https://www.unhcr.org/pubs/sowr2000/ch03.pdf, 62.
[52] Julian Francis, Skype, July 25, 2020.

dislocation of millions of civilians. It is a story of death and disease, of too little food and water, of fetid refugee camps without hope and a countryside stalked by famine.""[53]

Oxfam also made sure to work in other states than Kolkata as majority of the organization were focusing only on Salt Lake area where around 250,000 refugees took shelter.[54]They covered the border areas extensively and other states.

Other international actors which assisted India financially or by providing assistance are: Food and Agriculture Organization provided 6250 million tons of milk powder, 850 million tons of butter oil. UNICEF gave 100,000 dollars for drugs and supplementary diets, 100,000 dollars for 40 vehicles out of which 20 were given to the Indian Red Cross Society and 20 to the Ministry of Health, West Bengal government. Foreign governments also aided India. The then USSR sent 50,000 tons of rice and 100 million doses of smallpox vaccine. The US through US AID sent 25,000 dollars. The money was used by US agencies like CARE, CRS etc. for their feeding programs. The UK sent tarpaulins and milk powder. Voluntary agencies like Norwegian Refugee Council sent 300,000 rupees for India to buy clothes for refugees.

However, in a Lok Sabha debate from June 10, 1971, it was pointed out that the Indian government was returning or requesting foreign governments and agencies to not send some material or doctors. The government rejected the assistance of Australia which wanted to send a team of doctors. Or in another case, the Norwegian Refugee Council sent codfish which were not helpful for patients of some gastroenteritis. In this regard, the unpreparedness of the government was questioned by the members of the parliament. In one such instance an MP asked:

"…the Norwegian Red Cross sent a big consignment of cod fish, which is lying in Dum Dum, and now we are telling them 'please do not send any more of this' because it is a very unsuitable commodity for people who are suffering from gastroenteritis. When these requests are made, do the Government of India have any clear conception about the specific things that they want for relief purposes? Do they specify these things to other countries or do they allow them to send anything that they like most of which we may find to be quite useless for our purposes?"[55]

Other Actors: Apart from national and international actors, many local organization, NGOs, and civil society actors came forward to provide assistance to the refugees. Mother Teresa established a camp hospital with assistance from Oxfam and later converted it to a permanent hospital for the host population. The Bharat Sevashram also worked closely with Oxfam. The

[53]"Why and How Oxfam Produced 'The Testimony of Sixty,'" Dhaka Tribune, October 22, 2018, https://www.dhakatribune.com/opinion/op-ed/2018/10/22/why-and-how-oxfam-produced-the-testimony-of-sixty-2.
[54] Julian Francis, Skype, July 25, 2020.
[55] "Lok Sabha Debates," June 10, 1971, https://eparlib.nic.in/bitstream/123456789/828/1/lsd_05_02_10-06-1971.pdf, 16-17

Marwari relief society ran 10 relief samps in Basirhat district of West Bengal and housed 318,000 refugees.

One of the main actors in controlling the health crisis or the cholera epidemic was Dr. DilipMahalanabis. Dr. Mahalanabisstudied cholera and other diarrheal diseases at the Johns Hopkins International Center for Medical Research and Training (JH-CMRT) in Kolkata and worked in the Bongaon refugee camp. His work in the camp proved that untrained people couldadminister oral rehydration salts (ORS) solution which is instrumental in treating cholera. He and his team from JH-CMRT went to Bongaon camp and soon realized that they would lose the battle especially with a small team. "When I arrived, I was really taken aback. There were two rooms in the hospital in Bangaon that were filled with severely ill cholera patients lying on the floor. In order to treat these people with IV saline, you literally had to kneel down in their faeces and their vomit. Within 48 hours of arriving there, I realized we were losing the battle because there was not enough IV and only two members of my team were trained to give IV fluids."[56]This was the time when he realized that he had to train non-specialists how to administer ORS. Till then IV saline was the norm for treatment of cholera and people had to be persuaded to use the ORS. The doctors started calling them oral saline to comfort the patients and soon untrained people started administering the ORS. This became a huge success and his work was recognized soon everywhere. After the successful administration of ORS in various other camps, the deaths of the refugees came down to 3 percent from 30.

Another group of actors which worked widely was the refugees themselves. Many young refugees refused to be passive recipients of relief and became active agents in relief and rehabilitation. Some medical and paramedical personnel from the camps were hired to work for the refugees. Some started working with international organizations. For example, Oxfam roped in many refugees for relief distribution. The organization also did not want too many foreigners in the relief team. "The field team did not want white faces to fly in and save the refugees. Instead, they wanted to find local people or people from refugee camps to work with us. Oxfam was close with many Gandhian organizations like the SarvaSeva Sangh and the Gandhi Peace Foundation. They helped us with our work. In fact, most of our team members were refugees themselves."[57]

One such person is Uday Shankar Das. He came from Chattogram or Chittagong as a refugee with his family. One day he came across the former principal of his alma mater, St. Placid's School, Chattogram, Brother Raymond Cournoyer in a refugee camp in Kolkata. Raymond introduced Uday to Oxfam. Soon Uday started working with them. He later became a journalist and worked with BBC Bangla.

[56]DilipMahalanabis, Miracle cure for an old scourge. An interview with Dr DilipMahalanabis., n.d., https://www.who.int/bulletin/volumes/87/2/09-060209/en/.
[57] Julian Francis, Skype, July 25, 2020.

Many young refugees like him were working with Oxfam which was considered as a big achievement.The organization's head office wasn't very keen on the policy because other relief organizations were getting all the attention from press. "In those days, there were staircases to board or de-board the flights. People coming from UK for relief work used to get photographed on those staircases by London Times, The Guardian, or Telegraph. Oxfam was losing that publicity because we were strict about not wanting many foreigners here. But this policy actually proved to be beneficial for us. Foreigners were initially allowed to visit the campsites near border but by the end of June 1971, the government of India banned the movement of foreigners near border due to security reasons. There were occasional shelling and cross-border firing from Pakistani army and to protect the foreign aid workers and journalists, the government banned us from going there. This did not hamper Oxfam's work. Other organizations could not work in those camps and only stuck to Salt Lake, whereas, Oxfam monitored the border areas with the help of their local staff. The language was also a big barrier which we could break by employing local population and taking help from local organizations."[58]

Many refugee women started medical training while staying in camps and assisted with medical relief. Maleka Begum, a Bangladeshi writer, penned down two such narratives of young refugee women in her book "*Muktijudhye Nari*" (Women of the Liberation War). Gita Majumdar, a young woman crossed over to Kolkata during the liberation war. She wanted to contribute to the war back home and started field training. Later, 40 women from the field training were chosen for first aid training. It was given by Saint John's ambulance at the Nil Ratan Sircar (NRS) hospital. Out of the 40 women, 16 were chosen and sent to a camp in Agartala. They worked in a camp hospital in Agartala which provided medical assistance to the freedom fighters from Bangladesh.[59]Similarly, Laila Parveen Banu, a doctor now, was a medical student from Rajshahi. She came to Kolkata during the war. She and other women from her camp were also trained by Saint John's ambulance and an army personnel would come and give them basic physical training. 16 women from her camp were selected for training at BR Singh Railway hospital in Sealdah. They were sent to the same hospital in Agartala which catered to the freedom fighters. She was also appointed to bring sanitary napkins and other medicines specifically for women refugees of her camp.[60]

**Section III: The Response of Host Population:**

While the treatment of refugees by the local government and host population have been applauded and eulogized by most narrators, there have been sporadic cases of discontent between the host population and the refugees. It is well known in refugee and migration studies that often the host population take a confrontational approach towards the refugees. They are viewed with suspicion and targeted for allegedly depleting their resources or spreading diseases. In fact, during the 1950s and 1960s, the local population of West Bengal

[58]Ibid

[59]Maleka Begum, "MuktijydhoShuru: NarirObosthan," in *Muktijudhye Nari* (Dhaka: Prathama Prakashan, 2011), 60.

[60] Ibid, 66-67

were not very keen on receiving refugees. They feared that the refugees would put a strain on an already weak economy.[61]

In 1971, the sentiment of the population was different. The local Bengali population could identify with East Bengalis. The latter's struggle for independence and fight for the Bengali language have often been valorized by people from this side of the border. Many young men and women from West Bengal crossed the border to Bangladesh and joined their war for independence. The positive portrayal of the war in local media also shaped the public mind in favour of the refugees and most importantly they were temporary. The refugees of 1971 were never meant to live in India permanently and most of the refugees repatriated to Bangladesh after the liberation of the country in December 1971. Considering all, the sentiment towards the refugees were different than that of 1950s. Local population eagerly helped the refugees and assisted local and national government and other voluntary organization.

However, there were some cases of discontent with the refugees. Three such cases are mentioned here. Peter Grbac pointed out that the refugee population were suffering from cholera, diarrhea, malnutrition, tuberculosis, pyoderma etc., but the local population were not immune to such diseases. He gave the example of infant mortality and child malnutrition rate in India. Infant mortality rate in the areas around refugee camps were almost as high as in the camps. Malnutrition among children, at that point was as high as 30 per cent while a field report by the All India Institute of Medical Sciences disclosed that roughly 50 per cent refugee children were suffering from malnutrition. The government should provide same care to the refugees and local population alike. However, Grbac used the example of "Operation Life Line", a public health program aimed at malnutrition children to argue that the government was reluctant to launch the operation only for refugees while the local population was also suffering from similar health issues.[62] Operation Life Line was an international relief operation and yet Indian government was hesitant in implementing it and only when the relief workers assured the government that they would not turn away severely malnourished local children, the government allowed for it to be launched.

Julian Francis mentioned in an interview that the local population were very generous the first few months. They genuinely helped Oxfam in rehabilitation. Gradually, however, they stopped being so welcoming. Oxfam workers did not refuse medical aid or any kind of help to the host population even though the refugees were more vulnerable. They could not get any medical help from the government hospitals or dispensaries. They were told to get it from the camps. So, the camps and relief agencies were their only hope. But if the local population went to Oxfam for help, they were not turned away, especially the lower-class non-refugees.

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[61]Subhasri Ghosh, "Representation of Forced Migrants: A Case Study of the East Bengali Migrants to West Bengal," *ConserveriesMémorielles [Online]*, no. 13 (2013), http://journals.openedition.org/cm/1490.

[62] Peter Grbac, "Accessing Refugee: India and Its 1971 Refugee 'Problem,'" *Refugee Watch: A South Asian Journal on Forced Migration* 43 & 44 (December 2014): 11.

In Meghalaya, the local Khasi people held some resentment against the refugees when they started entering. They were afraid that the refugees would never go back. Meghalaya already had lesser resources than West Bengal and Assam and housing the refugees was problematic. There were no lands available as the lands belonged to the villages and due to the autonomous status of Meghalaya- it became a full state in 1972-the governments could not take those lands. After several meetings with the local population, they agreed to help the refugees.

**Conclusion:**

The paper investigated the health crisis of the East Bengali refugees in 1971. The Bangladeshi liberation war resulted in 10 million refugees out of their 75 million population. From March 1971 to December 1971, scores of refugees crossed over to India while fleeing persecution at the hand of Pakistani army. The lives of these refugees were precarious. Absence of proper shelter, food, sanitation, at one hand and sweeping epidemic like cholera, severe malnutrition and death in the other hand created one of the worst humanitarian crises in the world. The paper tried to study the various disease that plagued the refugees and looked into the responses from various actors in alleviating the crisis. It also investigated the behaviour of the local population during the crisis.

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## Appendix 1