平成24年度入学者選抜個別(第2次)学力検査問題

外　国　語

注　意　事　項

1. 監督者の指示があるまで，この冊子を開いてはいけません。
2. 問題冊子は，全部で8ページあり，第1～3ページは下書用紙です。下書用紙は切り離してはいけません。
3. 問題は，第4ページと第5ページの間に，はさみこんであります。
4. 解答用紙は，問題冊子と別に印刷されているので，誤らないように注意しなさい。
5. 解答は，必ず解答用紙の指定された欄内に横書きで記入しなさい。
6. 各解答用紙には，受験番号欄が2または4か所あります。それぞれ記入を忘れないこと。
7. 解答用紙は，記入の有無にかかわらず，机上に置き，持ち帰ってはいけません。問題冊子は持ち帰りなさい。
8. 落丁または印刷の不鮮明な箇所があれば申し出なさい。

学科によって解答すべき問題が異なります。
説明に従って解答しなさい。

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◇M4(666—49)

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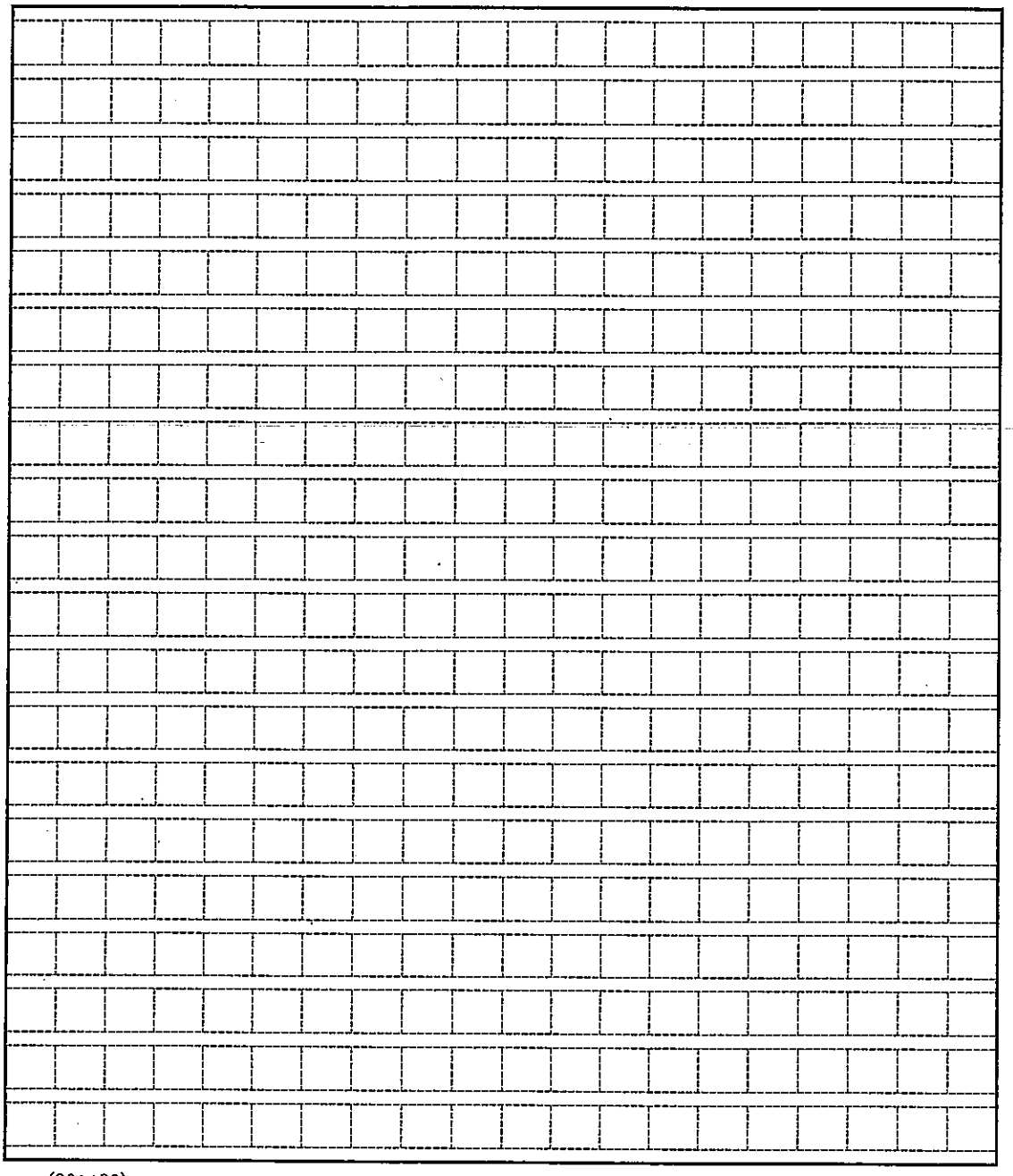

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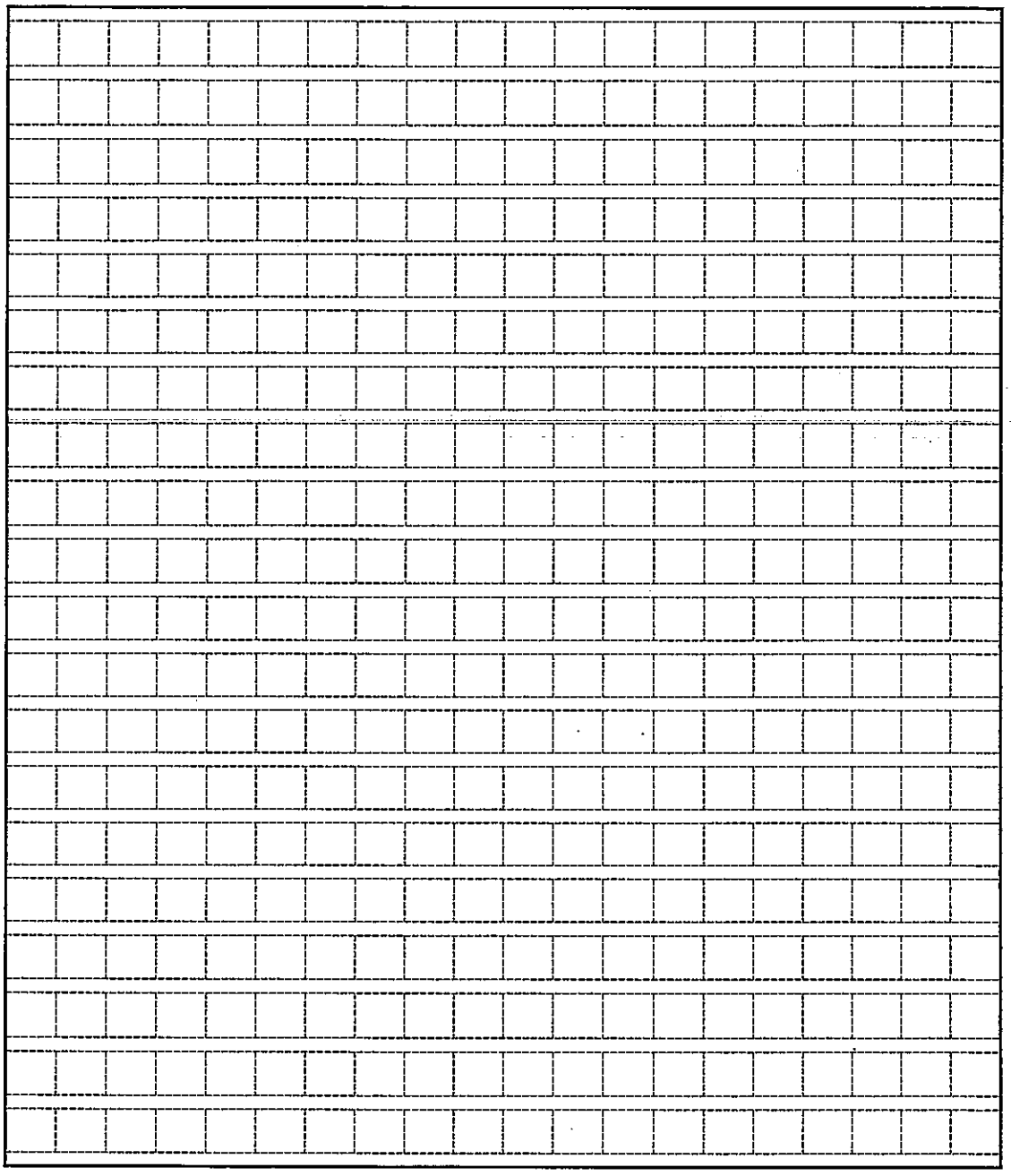

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外　国　語

次の英文は *The Lancet* 誌(1997年6月12日)に掲載された"Health Care in Disaster and Refugee Settings"(John P. Howarth, Timothy D. Healing, Nicholas Banatvala の共著)の記事を一部改変したものです。この文章をよく読んで，問題[1]から[6]のうち，医学科と歯学科の受験者は問題[3]，[4]，[5]，[6]に答えなさい。保健衛生学科(看護・検査)と口腔保健学科の受験者は問題[1]，[2]，[3]，[5]，[6]に答えなさい。解答は解答用紙の指定された欄に記入すること。

＊印のついている語句の意味は本文のあとの注に示されています。

Disasters, natural or man-made, are not restricted to countries in the tropics but **their**(1) consequences have become a significant part of tropical medicine.

A disaster has four phases. The acute phase, the disaster itself, may or may not be associated with a high casualty rate. In the immediate post-disaster phase the casualty rate steadies and then declines. It is in the intermediate phase that epidemic disease and malnutrition are likely. The late phase is when reconstruction begins. When the acute phase of a natural disaster is short (earthquakes, floods) local medical services have to cope. Outside agencies can seldom get to the disaster quickly enough so they tend to be involved in the later phases or when the acute phase is prolonged, as in a famine.

Every year between 1990 and 1995 at least 30 wars were in progress. In these disasters the acute phase may continue for years. Local medical services tend to ***decay*** and aid agencies find **themselves**(2) dealing with trauma and ***communicable*** disease and with the reconstruction of health services.

Many natural disasters and wars lead to population movements, as internally displaced persons (IDP) leaving their homes but remaining in the country or as refugees fleeing across borders. IDPs often ***constitute*** a hidden population. They may move into urban areas or remote areas to bush or forest rather than into

camps, and it is difficult to count them, estimate their health needs, or provide care for **them**. (3) When the return of refugees to their country of origin is poorly planned, these people may become IDPs, as happened in Afghanistan. Furthermore, those who stay at home but who are no longer supported by the original infrastructure may also require aid.

The relief system is complex and individual agencies cannot be wholly independent. It may be ***naive*** to try to ***cloak*** aid in political neutrality, as objectives may be unachievable in unfavourable political climates. (ア) Moreover, there remain concerns that donor governments may use humanitarian aid as a substitute for clear political direction and as a vehicle for self-interest.

* * *

In most wars more people die from illness than trauma. During the 1980s in Angola and Mozambique, for each person killed in combat, 14 died from other causes. Five conditions, acute respiratory infection (ARI), malnutrition, diarrhoea, measles, and malaria, consistently account for 60-95% of deaths in refugees and displaced populations. Children and pregnant women are especially ***vulnerable***. Other potential epidemics, such as meningitis or typhus, are less common. A ***crude*** mortality rate above 1 per 10, 000 per day defines a very serious situation in relief terms; more than 5 per 10, 000 is a major catastrophe.

Malnutrition remains a serious problem in conflicts, and food is a powerful political weapon. Food shortages are worsened when large areas of land are unproductive because of landmines or when atrocities are used as a military ***tactic*** to prevent people settling long enough to produce food (eg, Sierra Leone). An adequate general food ration is defined by the World Food Programme as at least 1, 900 kcal daily. Food aid is usually directed at treating or preventing protein-energy malnutrition (PEM). Population levels of PEM are based on sampling those between 6 and 59 months of age. When malnutrition rates are high, ***supplementary*** and therapeutic feeding programmes aimed at the vulnerable groups (eg, the under-5s and pregnant women) do decrease morbidity* and

mortality but **they** (4) are expensive. Micronutrient deficiency is now recognised too. Scurvy, pellagra, and thiamine, iron, and iodine deficiencies have all caused problems in different disasters. Most refugees' rations contain less than the recommended daily allowance of 2, 500 IU vitamin A: distribution of this vitamin to children is one of the most effective interventions in refugee populations.

ARI is the leading cause of death worldwide in the under-5s, and attack rates and case fatality rates are very high in malnourished children, especially **those** (5) in the overcrowded conditions of refugee camps. Recommended guidelines on the management of lower-respiratory-tract infections can be difficult to follow in emergencies. Key preventive measures include better shelter and nutrition, less overcrowding, and immunisation against measles.

Disasters provide the ideal setting for diarrhoeal disease. Proper disposal of waste and dead bodies and the ***provision*** of safe food and water reduce the risk. Large amounts of reasonably clean water should be given priority over small volumes of pure water. Organisations with specific knowledge of water and sanitation systems (eg, Oxfam) are often well placed to take a lead role. Health education is vital and community participation is an important tool in implementing such measures.

In 1994, one million Rwandan refugees in Goma, Zaire, were exposed to cholera and dysentery*, and over 50, 000 people died in the first month. Treatment is not primarily a clinic activity; decentralised rehydration* points with correct use of oral rehydration salts are essential. Surveillance is required to identify outbreaks quickly and laboratory confirmation with antibiotic sensitivity patterns is needed to ensure that appropriate treatment is given to those who need hospital care. Many of the deaths in Goma could have been prevented by more rapid rehydration, better use of oral rehydration, more appropriate intravenous fluids*, and better training of health workers in the management of severe cholera.

Measles was a major cause of death among refugees in the 1980s. In Wad Kowli camp, Sudan, in 1985, 32% of children with measles died. Immunisation

programmes, targeting those between 6 months and 12 years among displaced populations, can greatly reduce measles epidemics.

Population movements may expose non-immune individuals to malaria or bring infected people into areas previously free of the disease. Rapid treatment is essential, especially where falciparum malaria is endemic. Malaria control in camps is not simple because mosquito breeding sites may increase and operations will depend on the level of information and technical skills available. Spray programmes should always be an adjunct to health education, sanitation, and environmental health and biological control methods. Bednets treated with insecticide can reduce malaria rates in chronic refugee situations (eg, Afghanistan).

The first requirement is a rapid needs assessment, including an estimate of how well the local agencies and population can respond. All disasters have features in common but it is a serious error to assume that a useful response can be mounted without preliminary investigation. Disasters cannot be stereotyped and health needs and logistic input will vary between urban Grozny in Chechnya, the mountains of Afghanistan, the deserts of Yemen, and the jungles of Zaire. Needs change and programmes of assistance require reassessment. Most assessments are descriptive but cluster surveys are also used to measure needs. Priorities will follow from the needs assessment but the essential elements are: safe water, food (and utensils and cooking fuel), shelter and blankets; sanitation; measles immunisation along with vitamin A distribution; a simple surveillance system for epidemic disease (eg, diarrhoea, febrile illness*, and measles), using monitoring sites where necessary; and curative health care for ARI, diarrhoea, and malaria.

Curative services have lower priority than water, food, and shelter. In cold temperatures shelter and blankets are top priority; food requirements rise by about 5% for every 5℃ temperature drop below 20℃. Staff training and stockpiling of tents, buckets, chlorine, fluids, and so on are also priorities at the start of an emergency.

◇M4(666—59)

Later on in an emergency primary care, maternal-and-child health, and immunisation systems need to be established (or reestablished). Tuberculosis may become a problem but control programmes are complex, require long-term commitment, and may not be a suitable activity for all agencies. National health strategies that preceded the disaster may remain relevant and should be used in recreating health services.

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Disaster medicine is changing. Its disciplines include public health, primary care, refugee health care, trauma management, epidemiology*, nutrition, and infectious diseases but flexibility, diplomacy, and management skills are just as important as technical skills—and the demand is increasingly for dedicated professionals rather than enthusiastic amateurs.

Many recent disasters have had complex political, social, and economic backgrounds, and this complexity underpins the health-related challenges outlined in this paper. (イ) New models for the prevention of illness and the management of health services in disasters are required, and these models will have to be critically evaluated. In short, evidence-based disaster medicine is the theme.

注

morbidity　罹患率
rehydration　水分補給
febrile illness　熱病
dysentery　赤痢
intravenous fluids　輸液
epidemiology　疫学

問　題

保健衛生学科および口腔保健学科

1 ***The following words appear in bold italics in the text. On the answer sheet, circle the letter indicating the best definition for each word (based on how the word is used in the text).***

decay

a) adjust　b) break down　c) devalue
d) increase　e) survive

communicable

a) related　b) serious　c) spoken about
d) transmittable　e) treatable

constitute

a) become　b) escape from　c) include
d) make up　e) remain

naive

a) cynical　b) dangerous　c) incorrect
d) unlucky　e) unsophisticated

cloak

a) attempt　b) find　c) give
d) hide　e) replace

vulnerable

a) common　b) deadly　c) harmful
d) poor　e) weak

crude

a) average　b) minimum　c) rough
d) standard　e) typical

tactic

a) excuse　b) method　c) priority
d) problem　e) target

supplementary

a) additional　b) complimentary　c) comprehensive
d) generous　e) nutritious

provision

a) consumption　b) distribution　c) examination
d) promotion　e) treatment

保健衛生学科および口腔保健学科

2 *What do the following words, which are underlined in the text, refer to? Answer using one to five English words that can replace the underlined text.*

1) their　　2) themselves　　3) them

4) they　　5) those

全学科

3 *According to the text, decide whether the following statements are true (T) or false (F). For each statement, circle the correct answer on the answer sheet.*

1) The acute phase of a disaster is so named because a high casualty rate accompanies it.

2) Outside agencies are more likely to provide aid during the intermediate and late phases of a disaster than during the acute and immediate post-disaster phases.

3) Based on the information in the article, it is reasonable to conclude that rebuilding clinics typically begins during the late phase of a disaster.

4) Although they may be overwhelmed at first, local medical services typically become more effective over time, particularly when the acute phase of a disaster is prolonged.

5) The authors imply that it is necessary for individual agencies to be politically neutral when offering humanitarian aid.

6) The authors suggest that an individual aid agency is most effective when it has its own area of responsibility separate from other agencies.

7) Trauma is the most frequent cause of death in wars.

20) Curative services are of primary importance in disaster medicine.

21) IDPs or refugees being treated in cold-weather conditions have higher caloric requirements than people being treated in warm-weather conditions.

22) The authors imply that controlling tuberculosis is not a realistic priority at the start of a disaster.

23) The authors recommend that disaster medicine practitioners use emergencies as opportunities to replace prior national healthcare strategies.

24) Due to the complexity of many disasters, those engaged in disaster medicine need flexibility, diplomacy, and management skills more than they need specific technical skills.

医学科と歯学科のみ

4 ***Briefly (in 10 to 25 words) answer the following questions in your own words, using complete English sentences.***

1) How are refugees and internally displaced persons different?

2) How do military conflicts sometimes lead to high malnutrition rates?

3) How can disaster medicine practitioners prevent outbreaks of diarrhoea in refugee camps?

全学科

5 下線部(ア)と(イ)を日本語に訳しなさい。

全学科

6 災害時の医療において重要なことは何ですか。次のキーワードを用いて，日本語で400字以内にまとめなさい：局面("phase")，評価("assessment")。

8) Based on the information in the article, it is reasonable to conclude that most deaths among refugees and displaced populations during the 1980s in Angola and Mozambique were due to acute respiratory infection, malnutrition, diarrhoea, measles, and malaria.

9) Where disasters are concerned, a major catastrophe is one in which the crude mortality rate is greater than 5 per 10, 000 per day.

10) Based on the information in the article, it is reasonable to conclude that a daily food ration of 1, 900 kcal will lead to malnutrition.

11) In order to determine the level of protein-energy malnutrition in a disaster area, tests are conducted on children under 5 years of age.

12) Worldwide, very young children die more often from acute respiratory infection than from any other condition.

13) ARI spreads more easily when many people are put together in refugee camps with limited space.

14) Based on the information in the article, it is reasonable to conclude that limiting the spread of measles in a refugee camp will lead to fewer deaths from acute respiratory infection.

15) Due to the deadly nature of cholera and dysentery, the authors suggest these diseases require hospital treatment even during disasters.

16) The authors imply that cholera cannot be controlled effectively without the use of surveillance systems.

17) It is implied in the article that inadequate training of health care workers was a reason why so many Rwandan refugees in Zaire died of cholera in 1994.

18) Nearly one-third of children at the Wad Kowli refugee camp in Sudan died of measles in 1985.

19) The authors believe that due to the common features of most disasters, it is better to quickly implement a relief programme than to spend time conducting a preliminary investigation.