*By Dr Tan Chi Chiu*

# Lessons from the Pakistan Earthquake Medical Relief Mission –

## How can our civil sector do better?

*Parkway Group Healthcare team in Muzaffarabad*

### A CACOPHONY OF RESPONSES

In a disaster of the sort of magnitude that the South Asian earthquake was, numerous efforts from many different countries are mounted in short order to rush aid to the affected communities. It is also somewhat chaotic as numerous groups from everywhere all descend upon the disaster zone to offer help. Above all, most of it is short, sharp and non-sustained. In general, the most organised groups present the most coherent and structured assistance. Military medical units, when sent by governments, are the best equipped, often with comprehensive surgical and intensive capability, and excellent logistics support. Some non-governmental organisations (NGOs) are also very well organised, such as Médicins Sans Frontières (MSF) or the International Red Cross and Red Crescent. Many national Red Cross and Red Crescent societies, such as those from Japan, Korea or Turkey, are able to project hospital-sized emergency medical units staffed with volunteer medical personnel into disaster zones.

From Singapore, only the Singapore Armed Forces (SAF) has the capability to send field hospitals. NGOs in Singapore are perhaps not as well developed as might be expected of a de-facto first world nation. Medical relief efforts are limited to ad hoc constructions of outpatient healthcare units with minor surgical capability. Specialists such as surgeons and anaesthetists can only offer their skills in functioning hospitals of the host community, or in the field hospitals of other organisations. These civil efforts are also limited to short term engagements that provide some relief to a number of casualties, but do nothing to alleviate continuing and even more urgent needs such as those faced by the Pakistanis in the relentlessly advancing winter that promised a second wave of deaths.

Ironically, when the going got tough, the tough got going – home. Most volunteer groups went home by the end of November 2005 just before the full onslaught of winter, leaving NATO and the UN to carry on. No doubt, only the

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largest international organisations have the manpower, resources and airlift capability to sustain operations throughout winter, but the loss of local community support at a time of intensifying need could not but be felt and suffered by the displaced throughout the disaster zone.

## 'SUSTAINABLE' RELIEF

The concept of 'Team Singapore' in the Pakistani relief effort was a simple one: A series of tag-teams were sent to Pakistan for 10 to 14 days at a time, providing continuous, coherent Singaporean medical assistance at the centre of international humanitarian activity, in the city of Muzaffarabad, the capital of Pakistani Azad ('free') Jammu and Kashmir (AJK). These teams would be coordinated and supported by Mercy Relief and Red Cross, including logistics and financial support as needed. I thought it was a good idea, as a coordinated effort would concentrate and focus the modest efforts of numerous groups to provide a more substantial contribution in an area of greatest need, than small, disparate independent little groups distributed randomly about the region. The signature and image of Singapore would also be greater. This was an excellent start point.

The challenge in the future will be to find some way to sustain Team Singapore in operations for a longer duration. Although we were by no means a 'hit and run' mission, our continuing contribution would have been very valuable to the local community. As it was, we withdrew despite many appeals from the Pakistan Islamic Medical Association (PIMA) that we continue to send teams. They felt our departure very acutely.

## FINDING A NICHE

One way we can sustain longer operations is to become more organised, better supported and more capable of establishing ourselves in a niche within the affected community. Team Singapore, despite being coordinated, did not have the capability of mounting more than a field clinic if left to function independently. Team Singapore provided consistent medical coverage for the PIMA field hospital until 14 November 2005, when the fourth team disengaged. Team Singapore thus had a special status within the field hospital and PIMA looked to Singapore to manage large portions of its operations, such as the wards and treatment areas. In this way, Singaporean specialists were able to contribute their skills at a higher level, performing some surgery on patients in a containerised operating theatre.

But ultimately we did not have any real stake in the service. Medical volunteers from everywhere, as they showed up were allowed free reign to come and go, choose and manage patients as they pleased, without coordinating with the Singapore team that was ostensibly 'in charge'. While it was no doubt necessary to eventually do a phased handover of operations to local volunteers, there was no actual process for this and we had to be careful how we interacted with other volunteers in case patients ended up with duplicated care (even double doses of medicines) or no care at all.

I was given the task in Phase 3 of the mission, of trying to open another front for Team Singapore at the Abbas Institute of Medical Sciences (AIMS), which was largely spared by the earthquake and was a functional tertiary centre. But because we presented ourselves late, most of the surgical work was already covered by doctors of other countries, such as Kyrgyzstan, Bosnia and Cuba. The director of the hospital would have liked to have Singaporeans participate in the surgical work, but found himself overtaken by events. His deputy was already working with the existing foreign surgeons and was not at all keen that Singaporeans be given a major share of the surgical work at this stage. He requested that Team 4 provide post-operative wound care in the general wards, which they did for several days. But it was professionally very unsatisfactory because they had no relationship with the foreign surgeons (who largely ignored our presence), and had no say in how patients were managed. Indeed, because of poor documentation we often had no idea how they managed patients, and yet had to deal with their post-operative cases and any problems associated with them.

It would be ideal if Singapore could provide a standalone comprehensive medical facility, so that we have full responsibility and can ensure a high standard for the services we provide. It is not inconceivable for the Singapore Red Cross Soceity (SRCS) to set up emergency medical units like their counterparts elsewhere. That SRCS has not done so to date suggests that it does not see its role to be more elaborate than to raise funds to support overseas disaster relief work. Whether to mount field hospital units is a decision for our national humanitarian agencies to make. But I accept that this is a very expensive proposition and there is always the argument that Singapore

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is a small nation and should not be expected to provide more than a modest contribution (unless the government decides to send in the uniformed forces).

Assuming that Singapore's NGOs remain limited in their capabilities, it is very important during the assessment phase to determine where we are able to make the biggest impact and establish the opportunities to do so. Singapore teams should assume very clear-cut responsibilities, rather than participate through vague and tentative arrangements where lines of responsibility and reporting are unclear. A well-established area of responsibility will also allow Team Singapore to meaningfully provide a longer duration of support than ad hoc arrangements.

## THE CRITICAL ROLE OF LOGISTIC SUPPORT

Another critical area for development is logistics. A disaster relief mission is not unlike a military mission, where success depends on efficient transportation and provision of operational supplies, while personnel require proper shelter, food, toilet and provisions for personal hygiene. The more devastated a terrain is, the more coherent must be the logistics management. In Aceh after the tsunami, the SAF demonstrated what could be achieved with the backing of helicopters, ships, ground vehicles, engineering works, military tents, field hospital units and all the accoutrements that enabled military staff and attached volunteers to live in fairly civilised fashion in the midst of chaos.

In Pakistan, Team Singapore pitched tents on the grounds of the Army Public School alongside other NGOs and the UN. The tents procured from Singapore for Teams 1 and 2 turned out to be unsuitable for the weather. They let in the cold, wind, rain and mud. Team 2 was obliged to borrow from the relevant authorities two tents that were meant for villagers in the hills, a slightly embarrassing situation. Parkway's Team 3 was forewarned and we brought a couple of mountaineering tents, which turned out to be very comfortable. Nonetheless, Team Singapore's camp was the most amateurish and unprofessional looking, and was the most makeshift amongst all the NGOs here.

Though the teams did marvelously in adapting whatever was available to make it a livable campsite, it was never optimal. What made it even more embarrassing was that local volunteers and interpreters felt sorry for us! For any campsite, the most important facilities are quality shelter, toilet, washing facilities and a source of reasonably clean water. Lacking all of these for long periods of time made this mission more arduous than expected, and made it impossible for the team to contemplate extending its engagement.

The lesson to be learned from this is that logistics planning and management in a relief mission is critical and should not be left as an afterthought. Prior preparation involving establishing high quality in-country liaisons, securing vehicles and pre-purchase of supplies would go a long way in supporting a mission. It would be helpful to have in Singapore a store of good tents, portable toilets, generators, lights and other essential items that can be drawn upon when a mission is activated. Equally, logistics volunteer managers are not a luxury to be brought with a team, but vital members who will be responsible for keeping body and soul of a mission team together. Their jobs are difficult and lonely.

*Appendicectomy in progress in the container operating theatre of PIMA hospital.*

While medical team members work in a hospital, logistics members are left alone to maintain and improve the camp, get supplies, liaise with other NGOs or local officials for support and manage drivers and their vehicles.

## QUALITY ASSURANCE

We faced a number of philosophical and ethical issues during the Pakistan mission that could have impacted our contribution. Although I can safely say that the vast majority of international

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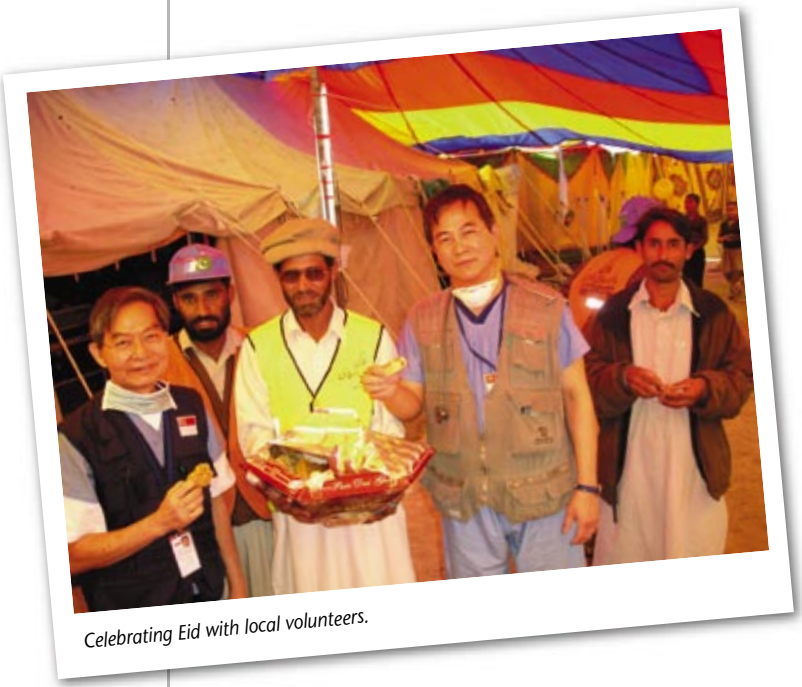
contributors to medical relief came with serious intent and a high level of professionalism, we discovered pockets of lapses as we worked in the PIMA field hospital and in AIMS. There were doctors who treated patients beyond their competence, caused harm, left no useful notes and subsequently abandoned their patients into our care. Some foreign surgeons appeared to treat this disaster as training ground for themselves to get some practice on hapless victims. My belief is that volunteers should bring with them high standards and treat disaster casualties with no less respect and consideration than their own patients at home.



Celebrating Eid with local volunteers.

On the other hand, I was disturbed that local authorities could allow such malpractices to go unchecked. A recipient of aid should nonetheless preserve his and his community's safety and dignity and admit only those whom they trust to administer relief. One could not be so desperate as to think that poor treatment is better than no aid. Volunteers must be screened at the door and once admitted, be made to abide by protocols and be answerable for outcomes.

My team had an ethical dilemma as to how to deal with some of the situations we faced. Conscience dictated that we should try to stop bad practices and wrong management for the sake of patients. On the other hand, we were not directly involved in managing many of these patients. We decided that wherever possible, we would approach the doctors involved to discuss the management, and make our recommendations to them. If they did not agree and persisted in their plans, we could take it up with the hospital authorities. If they did not take any action, then it was beyond us to influence events any further and we could not be responsible for the consequences. But if the patient fell into our care subsequently, we would do what we could to make matters right.
In the end, such unhappy circumstances only came about because foreign units were not properly coordinated and themselves had no plans for coherent, sustained operations in the field. This is another argument for well-organised efforts to be established in the community with sufficient support to ensure high standards and staying power to ensure continuity of care for a community beyond just the initial relief phase.

## TREATING THE WHOLE PATIENT

Another consideration is our attitude towards disaster casualties. We have been exhorted since medical student days to look at a patient holistically and not just treat a disease or injury. However, in a disaster situation, when casualties come thick and fast and where language is a barrier, it is tempting to just focus on the clinical problem and quickly deal with it. In our rush, we often forget that the patient has a lot more trauma inside than outside.

One day, a man brought his 7-year old daughter to us. She had been hit on the head by masonry in the quake. She clearly needed a CT scan and we referred her to Islamabad. A referral letter was quickly written. But the father stopped us in our tracks when he murmured his thanks in halting English, then added that he had lost three out of his four children all at once and he would go anywhere and do anything to save his remaining daughter. We could not heal the pain in the hearts of our patients, but we could perhaps lend a listening ear and give a bit of our time for them to ventilate their grief.

An 18-year-old girl, a Masters student in English, came to us and admitted plaintively that she was depressed and really needed to talk to someone. One of our doctors said that she would come attend to her soon, but suggested that in the meantime she wrote what she felt on some pieces of paper. This is what she wrote:

*"I was in my computer centre when earthquake struck. I stand up from my chair but I can't understand what was happening. My legs were*

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*stopped and fail to run as someone was holding my legs tightly, then after a few seconds I ran outside from the centre. There was noise everywhere. People were crying. I drive my car and came out on the road. There was dust everywhere. The road was blocked because of the land sliding. I park my car into the police station and walk on my foot towards home. I was worried about my father because he was alone at home and my home was not a safe place. I imagine that definitely my home will be turned into rubble. The whole situation was terrifying. There were dead bodies lying everywhere. When I reached home my father was waiting for me. He hug me. He was also worried about me. Gradually I heard about my city, my people they were no more. I went on various funerals but I can't cry. I want to but I can't. After a few days I heard about my bosom friend that she was no more. She was buried under her house. Her house was totally destroyed. My other friend that told me she said that her arms were stretched out of the rubble. I begin to see her in my dreams that her hands are stretched out of the rubble. It was horrible for me. My all friends leave the city and went away. I felt loneliness. My father loves me a lot and I love him too but I want to leave this place for a few days because I felt that death silence prevails everywhere. I can't bear all this. My whole city my people are no more. At night I can't sleep properly. I dream of rubble of the rabble of the dead bodies and many more. I usually wake up at night after every hour and I feel suffocation too. Previous night I saw a dream and I was weeping in my dream. When I wake up of my disturb sleep my face and my pillow was wet. After that I had a continuous headache and in the morning I felt dizziness and I fell unconscious."*

We could not have had a more poignant account of the disaster, and wondered what others must have bottled up, unable to express to us. But we could see it in the faces of our patients, sometimes anguish, sometimes blankness and sometimes spontaneous tears as we dressed their wounds or plastered their limbs.

## THE TRUE VALUE OF A MEDICAL RELIEF MISSION

In the end, as one of our volunteers put it, "It is not the big things we do but the little personal touches that count". This aptly sums up the value of our contribution. We, and the rest of the international community, were there as much to save lives and treat wounds or diseases, as to show that the world cared for this suffering community. What we could not offer in sophistication, we made up for in personal care and concern and the high quality of our work.

Camp Singapore, makeshift but home nonetheless.


A helping hand for a young earthquake casualty.

Recalling our volunteers in the hospital, we understood why they seemed so highly driven. It was beyond volunteerism. It was a way to make sense of their destroyed lives and world. It was a way to mentally survive the sudden catastrophic losses of lives amongst family and friends and losses of homes and property. It was an expression of their own post-traumatic stress. Helping in the hospital and being interpreters for foreign medical teams gave them a purpose and a direction for the moment. Getting close to us was a way of gaining some sense of comfort and solace, immersing themselves in the care and concern of overseas communities that had come to help them in their time of distress. If they seemed intense and almost emotional in their relationships with us, it was an understandable reaching out for emotional support.

The local volunteers' deep sense of gratitude for our presence manifested in a standard of hospitality that almost embarrassed us. Local volunteers who had very little of their own paid for and cooked several wonderful meals which they brought to our camp at night. Over the Eid holiday, volunteers offered us sweetmeats, had us visit their homes for lunch, and we joined in an elaborate communal meal. These were the best meals we had in Muzaffarabad.

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Everywhere we went, local people shook our hands and thanked us. Tuk-tuk drivers refused

*Local volunteers show their thanks by bringing a home cooked meal to Camp Singapore.*

to accept fares from our volunteers. Marketplace stall-keepers gave us valuable firewood for free. Random people on the streets invited us home for tea. This was a community dignified in the face of tragedy, steadfast in their religious faith, hospitable and generous in spite of their poverty and genuinely grateful for our presence.
The best testimony and source of satisfaction for Team Singapore perhaps came from a local patient who wrote a letter to us the day before we left Muzaffarabad:

*"Dear Dr Tan and your Team,*
*Asla -u-Alakum*

*We are very thankful to you and your all team for providing medical facilities and serving the affected people. We are all impressed by your good dealing, behaviour, sincerity, humanity, kindness and dignity. All of you make a good name for your country in the heart of Pakistanis and Kashmiris. No doubt you all are, and your country is great. Always we will say Singapore is Zandbad. We pray may all of you live long.*

*If God gives chance we will meet again.*

*Yours fain*
*Maqbool Hussain Yaad*
*Muzaffarabad (Neelum Valley)"*


*Nightly team debriefs around a campfire.*

## HOLISTIC RELIEF WORK

We need to appreciate that as volunteers, we are not there simply to treat cases, although immediate casualty management is the prime motive for mounting a relief mission. We form part of a very important system of psychological and emotional support for the community (which no doubt should be led by locals), while helping the community to bridge the gap towards normal medical services. Because of these twin obligations, our engagement must therefore not simply end with all the abruptness of an earthquake, but we should consider a more extended period of support before phasing ourselves out gradually and painlessly.

More than that, we must not forget that the needs of the community will continue well into the future. Team Singapore for Pakistan should not so quickly become a historical event for us. Medical volunteers can continue to have a role in the longer-term rehabilitation of the community. If we canot see ourselves working through the winter, perhaps we can consider returning in the spring to see how we can alleviate the problems brought about by the winter, as well as help with the restoration of medical services in the region.

But more importantly, it is high time for those who coordinate Team Singapore to consider how to make our efforts more structured, more professional, better supported and more sustainable, perhaps in a different format of engagement, over many months.

## WHY EVEN DO IT?

Cynics argue that 'charity begins at home'. For as long as there are social needs insufficiently addressed in Singapore, their argument is that we should not divert resources to helping foreign communities. This view ignores the reality that Singapore is actually a very affluent country, but it is no utopia and there will always be someone

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in need. So should we never offer assistance overseas? It also ignores the intrinsic value to the soul of our own community to express a spirit of humanitarianism as well as the importance of generating international goodwill for our country in an increasingly interdependent world.

Others have argued that until we see evidence that the government of an affected community has done everything it can, nothing should be offered to bail them out of their internal obligations. This view requires communities to suffer the incompetence or negligence of their governments. I think it would be hard to do nothing and allow thousands to suffer, just to show up the inadequacies of local authority. Certainly our government cannot take this attitude for as long as diplomatic relations are important. On a humanitarian basis, neither should volunteers.

## HOW CAN WE DO BETTER?

So when the next disaster strikes in our region and there are mass casualties needing relief, I have no doubt that Singaporeans will be there, alongside many others. Whether sent by government or not, collectively we will be there to express Singapore's neighbourliness and compassion.

But to do better, we should adopt two principles: Firstly, to provide assistance at all, we must do so with the highest standards possible to export. This not only provides the best service, but also enhances our reputation as a profession and as a nation. Conversely, a poorly put together effort, insubstantial and tentative, reeking of improvisation necessitated by feeble planning and lack-lustre support can only hurt our reputation as a country that does things well when it does anything at all.

Secondly, to subvert a phrase, we should not be only foul-weather friends. We should not appear only in the wake of a disaster and disappear as soon as we possibly can. To be truly helpful, we need a philosophy of comprehensive engagement with needy communities that sees us active in developmental assistance so as to strengthen communities and thus enhance disaster preparedness in 'peace time', while being willing to continue supporting the rebuilding process to help disaster-struck communities get back on their feet, for as long as that takes. ■