Preparing for the next natural disaster — need for a WHO coordinating centre

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This month is the first anniversary of the 7.6 Richter earthquake which struck Pakistan on 8 October 2005. The medical community’s response to this tragedy was overwhelming. In the hardest hit areas — Bagh, Balakot, Mansehra and Muzaffarabad — there were no hospitals, clinics or trauma centers within 80 km. Initial estimates suggested a death toll of 70,000 with over 150,000 injured.

In the first 48 hours, 22 medical aid camps were established by local relief organizations in collaboration with the Pakistani Armed Forces in Balakot. Within 72 hours, physicians, surgeons, and nurses began pouring into other affected areas. Medical personnel of Pakistani origin working in Europe, the Middle East and the United States were among the first to arrive, followed by hundreds of doctors from Canada, across Europe, Malaysia, Turkey and the United States. In the first month, more than 1700 doctors from 23 countries came to the affected areas, either as self-motivated individuals or as part of an organized relief mission. We had no shortage of doctors or medical supplies in the affected areas; lack of coordination was our main problem. People did not know where to go and what to do.

A year later, medical relief efforts remain uncoordinated. Many people brought medications and surgical supplies that were never used. There were 165 doctors available at the PIMA field hospital, Bagh, in the last week of October 2005. They all came by themselves without any coordination.

In August 2006, we visited medical facilities in Balakot, Bagh, Mansehra and Muzaffarabad. There are nine active medical facilities in these areas, either as self-motivated individuals or as part of organized relief missions. We had no shortage of doctors or medical supplies in the affected areas; lack of coordination was our main problem. People did not know where to go and what to do.

Approach to medical relief could be usefully planned in three phases: acute (1–7 days; limited to trauma management); sub-acute (1–6 weeks; focused on prevention of infections, diarrhea and general medical care); and a rehabilitation phase (6 weeks–6 months). Each phase has separate requirements in terms of medical personnel, supplies and medications. We saw orthopaedic and trauma surgeons reporting to affected areas in Pakistan after 6–8 weeks had elapsed and people’s needs had changed from trauma to primary care problems. In the acute phase, perhaps we could manage without female physicians, but for the second and third phases female physicians are a must, especially in countries where women may not accept male doctors.

There are currently 635 patients enrolled in the Mansehra rehabilitation facility alone who are in need of artificial limbs. As there is only one orthotic laboratory in the area, it is going to take months — perhaps a year — to meet that demand. This is an example of phase three requirements that cannot be met by the thousands of injection vials and surgical supplies sitting in warehouses. Such unused equipment and medications need to be channelled back to base stations. There is much to learn from the disaster experience in Pakistan that could help us prepare for when disaster strikes next.


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*Editorials*