

Operation Pakistan Assist

Paul McGinty

ON 8 OCTOBER 2005, an earthquake measuring 7.6 on the Richter scale hit the Azad Jammu and Kashmir region of northern Pakistan. Estimates were 73 000 dead, 70 000 injured, more than 4000 homes demolished, and 4.5 million people left homeless — and a cold winter was rapidly approaching.

Following the earthquake, much of the initial international relief effort was aimed at the larger regional centres, particularly Muzaffarabad, the largest city in the region. As Muzaffarabad had the most established infrastructure, it was the natural collection point for a population in crisis. Consequently, hospitals and other public facilities were overrun by masses of desperate people seeking assistance.

Part of Australia's response to this disaster was the deployment of four Black Hawk helicopters and a medical detachment consisting of four primary health care teams (PHCTs) and supporting personnel. This effort became known as Operation Pakistan Assist. Although Muzaffarabad eventually started receiving assistance from the international community, many outlying rural areas continued to struggle. Many roads were impassable, and these smaller communities were effectively cut off from traditional supply routes. The need for assistance in these areas was evident, and this was the focus of the Australian Defence Force mission.

The mission was to provide quality health care to a community in crisis following the earthquake. There were many injured people still untreated, and a health infrastructure that was all but destroyed, requiring potentially years before reaching pre-earthquake standards.

Task Group 632

Operation Pakistan Assist was unique. It was the longest continuous humanitarian relief effort that the ADF has been involved in, it was a bi-Service mission with a health focus, and it was performed in conditions to which Australian military personnel were largely unaccustomed.

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Abstract

- ◆ On 8 October 2005, an earthquake measuring 7.6 on the Richter scale struck the Pakistani provinces of Azad Jammu and Kashmir, and North West Frontier. Initial casualty estimates were 73 000 dead, 70 000 injured and up to 4.5 million people left homeless.
- ◆ As part of Australia's response, the Australian Defence Force committed four primary health care teams, four Black Hawk helicopters and more than 140 Australian service men and women in early November 2005, to provide humanitarian aid in support of the international relief efforts.
- ◆ The ADF's contribution over 4 months included the provision of over 9500 medical treatments, in excess of 4000 vaccinations, 74 aeromedical evacuations, and the delivery of thousands of tonnes of aid (food, shelter, clothing).

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Task Group 632 was formed from units throughout Australia; 5 Aviation Regiment (5AVN) provided the Black Hawks and personnel. This element of the task group was based at Qasim Air Base, just outside of Islamabad. The helicopters were used to support the multinational aid distribution effort, as well as providing support to the medical contingent, who were located on the side of a mountain, 25 km north-east of Muzaffarabad, in a small village called Dhanni.

Each PHCT consisted of one medical officer, one nursing officer and three medical assistants. Three teams were from the Army and the other was from 3 Combat Support Hospital at RAAF Base Richmond. Specialists in the task group included an emergency department consultant, an obstetrician, a professor of respiratory medicine, and midwives. They were supported by personnel with a wide array of experience in a variety of clinical settings, including the emergency department and intensive care unit.

Camp Bradman

En route to Dhanni, the scene was one of absolute devastation. From the air, one could see whole mountainsides that had collapsed and many roofs that were sitting at



Snow fell around the end of December. It was quite an experience getting out of bed at 2 am to scrape snow off tents that were struggling under the added weight. Needless to say, a snowman was constructed the following day.

ground level. Rivers had been diverted by the large rock falls, and makeshift camps for internally displaced persons had been constructed throughout the area.

When we reached Dhanni, the locals were delighted to see assistance arriving, and were very keen to assist in unloading the helicopters. They were interested in learning about the Australians, and an impromptu cricket game was arranged within hours. The beginnings of a new relationship were developing.

The camp (which became known as Camp Bradman) was previously a corn field. Animals and people had been using this same plot of land for ablutions. Hand-washing facilities were limited. Field hygiene was a challenge as the water supply was limited, and showers (from a bucket) were initially rationed to one per week. The area was very dry and prone to major dust storms both from prevailing winds and from the rotor wash from the constant stream of helicopters.

General, clinical and human waste was disposed of via a burning pit. All personnel rotated through the burning roster.

Diet was largely restricted to ration packs for the 4 months. This was supplemented by food sent from home and the very occasional barbecue. The lack of fresh fruit and vegetables was a dietary challenge. No refrigeration facilities were available.

Weather conditions varied. Early in the deployment, the days were warm and sunny. However, because the camp was on the side of a mountain, the sun would disappear around 2 pm and conditions would cool rapidly. As the winter progressed, the days became cold and wet. The dust turned to mud, and a lot of time and manual labour was spent constructing and maintaining drainage ditches.

The task group were provided with equipment that was appropriate for extreme cold weather. This included Gortex boots, cold weather jackets and pants, sleeping bags rated to -20°C , thermal underclothes, and fleecy windcheaters. All this equipment was put to good use during winter. Additional items, such as Gortex gloves, were sourced locally.

The accommodation areas of the camp were not heated, and respite was often sought in the heated work and recreation areas. People with weak bladders faced a difficult decision in the middle of the bitterly cold nights, as the ablution facilities were about 100 metres away.

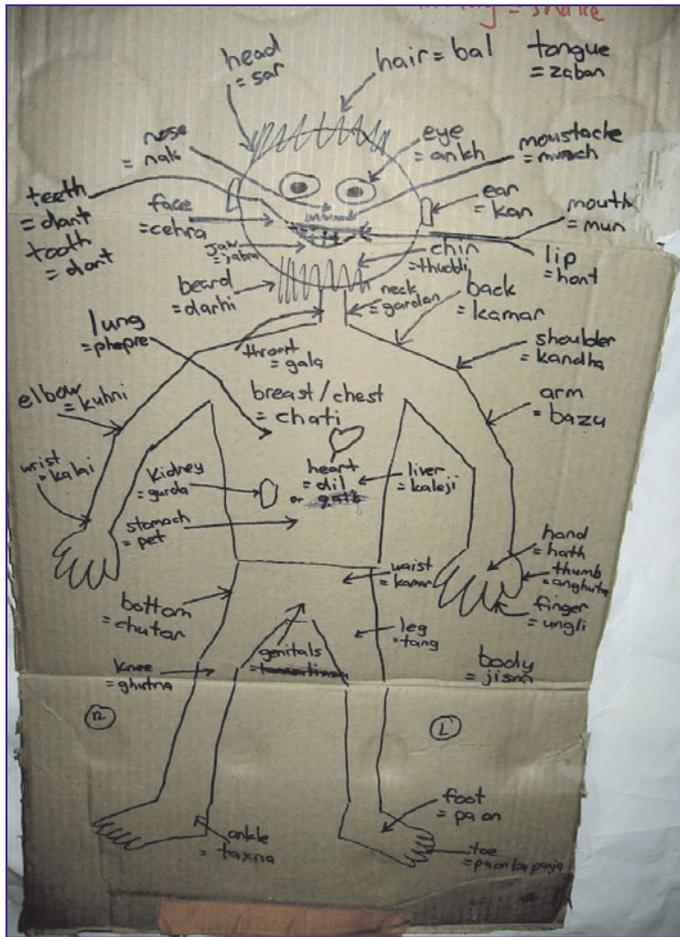
Threats

There were an estimated 1800 aftershocks in the Kashmir area following the major quake. Invariably, these shocks led to ongoing rock falls and further structural damage to surviving buildings. They also created an element of risk to the task group, as the camp was set up on a plateau halfway up a mountain.

Security threats to the task group were an unknown entity. Given the proximity of the region to Afghanistan, there was a high potential for anti-Western sentiment. This was exacerbated by the US bombing of a nearby Pakistan border town while the task group was in the country. Pakistani military units (28 Brigade and 25 Mountain Regiment) provided the immediate security. To minimise the security risk, movement of task group personnel in Dhanni was restricted to the boundaries of Camp Bradman.

Disease was another threat. Gastroenteritis was a common occurrence and affected all sections at one time or another. Preventive health became a focus for the task group, to minimise health risks to personnel.

Other threats included the isolation and the potential for being cut off from the outside world without access to tertiary health care. On several occasions the camp experienced a "lock down", with roads cut and no helicopter access because of inclement weather.



Translation chart used in the clinical areas.

Morale

Even though the task group were living on ration packs, morale at Camp Bradman remained high throughout the mission. This was largely because personnel were kept busy, positive clinical outcomes were seen regularly, and the task group commander, Colonel Andy Sims, provided excellent leadership.

Christmas is always a difficult time to be away from family and friends, and any thoughts of a relaxed Christmas for the medical team were abandoned as 94 patients were seen that day. The quieter days were the Muslim holy days.

The most significant issue affecting morale was uncertainty about the end date of the mission. Before leaving Australia, the task group were prepared for a 90-day operation. After a couple of months, the mission was extended to 120 days to cover winter. For some personnel, the mission was further extended to 150 days to allow 5AVN to complete its operations in Qasim. This led to some distress to members and, more specifically, to their families back home.

One positive experience for nursing officers and medical assistants was the opportunity to participate in a clinical exchange program with the US MASH hospital at Muzaffarabad, spending 2–3 days in various areas of the hospital.

Clinical care

Patients started arriving at the facility on the first day of operation. The major presentations were upper respiratory tract infections, musculoskeletal disorders, gastroenteritis, ear–nose–throat problems, and skin disorders. Scabies and lice were common.

Patients would often walk for up to 12 km over treacherous mountainous tracks to seek medical attention at Camp Bradman. Locals were hired to act as interpreters, and became an integral element in the success of the mission. Language skills improved on both sides and Urdu being spoken with Australian accents was frequently heard coming from the clinical areas.

Reliance on “high tech” medicine was impossible in Dhanni. We had no access to pathology or medical imaging. Many decisions were made on clinical evidence alone, and referrals to outside agencies were done so in the knowledge that the patient may never be followed up. Mental health posed a significant challenge. Loss, grief and depression were widespread in this devastated community. Frequently, patients would just want to come in and talk, a difficult proposition given our limited knowledge of the local language. More than the occasional tear was shed.

Most local women appeared comfortable to be seen by male medical staff. There were exceptions, and we could usually accommodate these preferences. The rate of obstetric and gynaecological presentations increased over time as locals came to trust the Australians. Pregnant women would often present under the guise of a different condition. Only after exhaustive questioning would the real reason for the visit become evident. “Are you pregnant?” quickly became a leading question to any woman of child-bearing age.

People who were deemed too ill to stay locally were referred to already overburdened health facilities in Islamabad or Muzaffarabad. Alternatively, the US MASH hospital in Muzaffarabad offered First World health care. Aeromedical evacuation (AME) was organised using dedicated helicopters,



The clinical area at Camp Bradman.



Locals leading the Australians to a thank-you function.

as well as any that happened to be passing through at opportune times. AMEs were coordinated through the headquarters staff liaising with the MASH and non-government organisations that were operating in the area. Patients requiring non-urgent referrals were often sent via local bus services when the roads were passable.

An outreach program was instigated with the aim of getting PHCTs out to the main outlying villages and providing a health clinic in those environments. Helicopters were the only means of transport. Vaccination was the focus of each outreach visit, but many other clinical consultations occurred. Local village leaders were integral in determining the need and timings for each visit, and for coordinating the advertising and support.

Lessons learned

Australians are very good at providing disaster relief assistance. Australia does not possess the large numbers of personnel and equipment that the United States does; however, we do possess the skills, flexibility, competence and attitudes that ensure a positive effect in niche areas, such as health care.

With the benefit of hindsight, a dental capability would have been very useful. A water supply without fluoride, and a generally poor standard of dental hygiene, resulted in 226 patients presenting for dental-related issues. Many of these had to be referred to dental services in regional centres.

The importance of a good logistics chain was reinforced on this operation. Being in an isolated environment with potential

for limited access to the outside world meant that our supplies had to be guaranteed. Few major issues evolved, owing to the hard work of the logistics personnel attached to the task group.

From a medical perspective, the RAAF and the Army teams worked side by side, formed strong relationships and achieved excellent clinical outcomes. There was very little tension between the Services, and the realisation that we were all there doing the same job was evident to all. This does not mean that there weren't the obligatory (friendly) jibes.

The delivery of primary health care in a disaster situation was new to most of the task group. Much of the medical training in the ADF is focused on managing critically ill or injured patients. If humanitarian aid is to become a core function of the ADF, there will need to be additional education and training of all health care professionals in primary and public health.

Conclusion

The Australian medical contingent stayed in Dhanni for 121 days. In that time, 9540 clinical presentations were managed, and 4063 vaccinations were administered. Vaccination rates among the local children increased from about 50% to more than 90%. Thousands of tonnes of aid (food, shelter, clothing) were distributed. Many new friends were made and personnel came away with a better understanding and acceptance of Pakistan, its people, religion and customs.

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