Reflections on ‘Relief’ing: Lessons from Pakistan and Haiti

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This commentary incorporates the author’s personal reflections to explore the nature of international relief work, and to provide suggestions for addressing problems that are commonly encountered.

In September 2010, six weeks into the floods that affected one-fifth of Pakistan’s landmass, I had the opportunity to travel and witness the disaster firsthand. I was part of a team of four physicians with the goal of initiating mobile health clinics. In our group was an emergency physician, an anaesthesia trainee, a urology trainee and myself, a pediatric trainee, all connected to Hamilton, Ontario through place of training or residence. Part of the mandate was to liaise with local physicians in order to establish a sustainable medical relief effort.

My personal motivation to be involved came from knowing the possibility of a disaster impacting my own community in Canada, and reflecting on the way I would want to be helped. Haiti’s earthquake had happened earlier in 2010, and I was involved in fundraising for the victims. Having travelled to Sri Lanka for relief work following the tsunami in 2004 made my decision to participate much easier. The umbrella organization for this trip was Islamic Relief Canada, based out of Hamilton, with its centre for operations in the United Kingdom. Our destination was Muzaffargarh, an area in the province of Punjab, six hours from Lahore. Situated between the Indus and Chenab Rivers, the area was used for displaced people in large numbers.

The trip was planned on short notice: I heard about it on a Friday while leading a fundraising campaign called ‘Hope for Pakistan’ and we were in the air the following Thursday. Our visas were arranged two days prior on an urgent basis, and that same day I picked up and filled prescriptions for Malarone, an anti-malarial drug, and ciprofloxacin, an antibiotic for traveler’s diarrhea. I had visited family members in Pakistan in June 2009, and had already received my Hepatitis A and typhoid vaccinations. My ticket confirmation was handed to me at the airport several hours before we were scheduled to fly out, highlighting the logistical uncertainty that comes with relief work!

KEY POINTS

- The shortage of clean water, food and shelter following natural disasters leads to a rise in health problems, including skin infections and diarrheal illness.
- Efficient mobilization of an adequate supply of resources, including personnel, is paramount in the immediate aftermath of natural disasters.
- Long-term sustainability of relief efforts is dependent upon collaboration and coordination between governments, non-governmental organizations and the local population of an affected area.

Through media and conversation, I had become aware that those living in the Muzaffargarh area had received warning of the floods, and had moved out to Internally Displaced Persons (IDP) camps set up by relief organizations, or onto the streets of nearby unaffected cities. There were a couple of issues on my mind as we flew to our destination: one was security, considering the political and religious instability of the country. My family lives in Karachi, the biggest city in the province of Sindh, and our team was far from this area of familiarity. I was also concerned that the team might not have enough resources to make a worthwhile contribution to its cause. I sent an email to my family, friends and colleagues asking for their prayers and donations for supplies, as news reports were highlighting a shortage of medications.

DISASTER IN PAKISTAN AND HAITI AND THE INTERNATIONAL RESPONSE

The Pakistan floods were not the only natural disaster brought to the attention of the global community in 2010. Amidst many smaller events covered in the media, the widely-covered January 12 earthquake in Haiti killed an estimated 222,000 individuals¹ and destroyed much of the country’s infrastructure—including healthcare outlets, schools and small businesses—within the span of a few minutes.²
In contrast to Haiti’s disaster, the flooding in Pakistan, where water makes up only 3.0% of the total area, happened gradually and much of it was unanticipated. One in 10 people, or roughly 20 million, were affected by the floods, in a country still recovering from the 2005 earthquake that killed 75,000 people and left 3.5 million homeless.\(^4\) As farmland was transformed into artificial lakes, an estimated USD $1 billion worth of crop was destroyed.\(^4\) Agriculture became the hardest-hit sector; one that contributes 22.0% to Pakistan’s GDP, and employed 43.6% of the population in 2007.\(^5\)

Access to clean water, food and shelter becomes a major priority immediately following natural disasters.\(^1\) In the absence of these necessities, a number of preventable health problems arise. For example, eight million people in Pakistan could not access clean drinking water following the flooding, and the prevalence of acute diarrheal illness was reported to increase from 5.0% at baseline to 14.0%.\(^5\) Similarly, cholera has claimed almost 3,500 lives in Haiti since the disaster.\(^6\)

With an event such as an earthquake, physical injuries also need to be addressed in the early aftermath.\(^2\)

Haiti and Pakistan are both considered developing countries, and their pre-disaster socioeconomic baselines, in comparison to developed nations like Canada, create unique challenges in dealing with such events (Table 1). Because of these differences, dependence on international aid through individuals, governments and non-governmental organizations (NGO) becomes a necessity.

| Table 1. Socioeconomic Differences between Pakistan, Haiti and Canada\(^4,7\) |
|-----------------|--------|--------|
| Population in Millions (2009) | 169.7 | 10.0   | 33.7  |
| % GDP on Healthcare (2006) | 1.3    | 29.8   | 17.9  |
| % Population Access to Improved Sanitation (2008) | 45     | 17     | 100   |
| % Public Spending on Education (2000-2007) | 11.2   | Not reported | 12.5 |
| % Illiteracy (1999-2007) | 45.8   | 37.9   | 99.0  |

The response from the international community is often directly related to the nature and extent of media coverage. There is an element of donor fatigue both within and between disasters over time,\(^1,3\) however, which hinders the long-term sustainability of reconstructive efforts. The sense of closeness between donor communities and affected nations, both in geographical location and in the political context, also plays a role. Pakistan, for example, is a U.S. ally in the War on Terror and is the second largest recipient of U.S. foreign aid—following the earthquake in 2005, the country received over USD $700 million for reconstruction efforts.\(^3\)

Unfortunately, in the case of both Pakistan and Haiti, the instability of their governments makes it difficult to efficiently direct aid from the international community.\(^1,2,3\) Coordinating relief efforts with NGOs is also difficult, considering each organization has its own policies, agendas and bureaucratic limitations. In 2008, the collective aid budget to 54 recipient countries was reported as USD $22 billion, funding 90 different initiatives.\(^3\) The multi-faceted global response to natural disasters creates a logistical challenge, making it difficult to ensure its intended impact.

Healthcare delivery is particularly difficult in light of the pre-existing poor health infrastructure in most developing countries.\(^5\) Each NGO recruits and trains its own health teams, and care is delivered in isolation, although with similar goals: sanitation, immunization, and provision of emergency healthcare, with a focus on women and children.\(^2,5\) For personnel working in these teams, various factors impact on the effectiveness of daily relief; including location of camps or villages, time of day, supply of resources, and security. A new phenomenon of ‘medical tourism’ has also emerged.\(^5\)

This trend, wherein individuals incorporate travel for personal reasons, is criticized for hindering the relief process as it reduces time spent on actual fieldwork.

Ultimately, the lack of resources and personnel is a major limitation in sustaining long-term relief efforts following natural disasters.\(^9\) Resource supplies are eventually exhausted when there is a strong dependence on external sources of aid. In Pakistan’s floods, 80% of relief funds have been channelled through NGOs,\(^7\) some of which only work in the acute setting. Personnel from outside countries may be stationed anywhere from a few weeks to several years. This transience highlights the importance of engaging local populations from affected communities, to enable a smooth transition into independent post-disaster management. One year following Haiti’s earthquake, media reports continue to describe extensive amounts of debris,\(^6\) but there are neither resources nor personnel to assist in its clearance.

Effective disaster aid requires two Cs: Collaboration and Coordination between the local populations, local governments, NGOs and the international community. From a healthcare perspective, having a standard model of delivery under an umbrella organization, such as the World Health Organization, has been suggested to facilitate such collaboration and coordination.\(^9\) This system will help to ensure an ongoing supply of resources and education to meet the demands of an affected community. The same principle can be extended to redevelopment of infrastructure including transportation, education and economy. In the end, the flow of responsibility is neither bottom-up nor top-down,\(^8\) but rather organized in a way where all players have equal roles in ensuring sustained relief efforts. This is yet to happen in Haiti or Pakistan.

**REFLECTING ON THE NATURE AND IMPACT OF RELIEF WORK**

Relief work in any disaster setting is a learning process that depends on reflection and the use of trial and error, with the goal of maximizing the number of beneficiaries of one’s...
work. It is tiring, but the satisfaction of making progress is a source of motivation for participants. By the time we arrived in Pakistan, it had been almost a month since the floods began. On our first day, we drove on roads traversing through farmland that had turned into lakes, with trees among them giving an appearance of an oasis. The scenery seemed completely natural to me, but I was reminded that, six weeks earlier, this was arid farmland.

We were told that some villagers had travelled back to their communities, while many were still living in the IDP camps. In an area that had previously been desert, these camps were set up to offer basic necessities, including tents for shade, straw beds and a water cooler. Food was delivered once a day. Given the population, anywhere between seven to ten people inhabited a tent.

We arrived at noon, and the mid-day heat scorched us. We waited in our air-conditioned cars, as the local villagers set up a tent where we would base our clinic. I felt guilty, but it was an environment I was not used to, and I wanted to preserve my energy to maximize the day.

Our team stayed in Multan, a relatively urban centre an hour away from the field sites in Muzaffargarh, where we commuted on a daily basis. The pick-up truck we travelled in was loaded with medications and IV fluids and another truck followed with stretchers and IV poles. I noted aid workers from around the world, travelling in logo-covered vehicles representing other relief agencies or governments, such as the Red Cross or the United Arab Emirates Disaster Relief Team, with their physicians in army outfits. On the field, however, all groups worked independently.

Over five days, our team assessed and treated approximately 1,500 patients. Demographics, working diagnosis, and treatment plan were recorded, and the majority of patients were between the ages of one and 35. The most common presentations were diarrheal illness, conjunctivitis and skin infections. There were also a large number of villagers with upper respiratory infections. As a pediatric trainee, I was delegated to assess children. I recall the case of a nine-year-old boy who was rushed in by his parents, unconscious, with an elevated temperature. We quickly moved him into another tent and treated him for heat stroke. Despite rapid initial IV hydration, he continued to be confused and required a prolonged course of fluids, continuing after we left the premises.

We faced a number of challenges common to relief work. My greatest personal limitation was the language barrier. Most villagers spoke Saraiki, a dialect unique to the province of Punjab, and outside my comfort of Urdu. There was little room to examine patients, and most diagnoses were based on history alone. Post-pubertal females preferred to be assessed by a female physician, who joined the team on our second day. I found that patient flow varied depending on location of the clinic and time of the day. Given security issues, everyone aimed to head back to home-base before sunset.

My pre-departure fear of a lack of resources was a reality. I blogged: “Medication distribution is never a pleasant process. One of our team members would sit in the ambulance which served as the makeshift pharmacy to fill the scripts given by the assessing physicians. As we packed up at the end of the day, it was hard not to quickly ask the patient about their symptoms and give them medications without scripts. But this highlights the problem: there will continue to be a huge demand, but there will also continue to be a limited supply of time and resources.”

Although we successfully liaised with local doctors and pharmacies in Muzaffargarh to ensure a steady flow of care over the next three months following our visit, the question that bothers me the most is: what will happen after these three months? Six months? A year?

REFERENCES

Author Biography
Mohammad Zubairi is a second-year resident in Pediatrics at McMaster University. He has helped organize McMaster Residents for Relief to mobilize resources for those affected by natural disasters.