nailing; (3) plating; (4) amputation; (5) skin grafting; (7) malunion; and (8) treating the wound infections. The team also worked with Relief International of the US in different villages, such as Dudhai, Rappar, Baliari, and Chowbari. The team examined many pediatric patients—30% of them suffered from respiratory tract infection. The team examined about 3,000 patients within 10 days; 60% were trauma victims. The team also identified cases of anxiety, depression, and fear psychosis. Members felt that in the future, the team should prepare for better management in order to face such a disaster if they were to arrive suddenly with proper backup facilities, as are found developed countries.

Keywords: Gujarat earthquake; India; medical relief work; medical teams
Prehosp Disast Med 2007;22(2):s62–s63

(107) Lessons from the Banda Aceh and Kashmir Disaster Relief Efforts

D. Danschutter
University Hospital Brussels, Brussels, Belgium

Introduction: On 26 December 2004, an earthquake measuring 9.0 on the Richter scale buckled the Indian Ocean floor. More than 275,000 people perished in the Tsunami that followed. On 08 October 2005, the same tectonic plates were involved in an earthquake measuring 7.6 on the Richter scale in Pakistan and India, killing tens of thousands of people.
Methods: The Belgian Association of Pediatricians sent a medical mitigation team (BMT) to the tsunami-engulfed General Hospital of Banda Aceh (Northern Sumatra). Ten months later, the Belgian government sent a disaster relief team (B-FAST) to Kashmir.
Results: The BMT started a pediatric intensive care unit at Banda Aceh, which ultimately led to ethical discussions among international partners, as well as among team members. The most critical patients suffered and died from systemic Burkholderia Pseudomallei infection (melioidosis) caused by the aspiration of murky ocean water. In Kashmir, B-FAST dealt with severely infected wounds and fractures as a consequence of local folk medicine practice.
Conclusion: To avoid ethical issues with the disaster relief site becoming a terminal instead of a transit zone, critical pediatric patients should be fully supported medically, stabilized, and then transferred immediately to Western civilian and/or military-controlled intensive care facilities.

Keywords: Banda Aceh; disaster relief efforts; earthquakes; Kashmir; Tsunami
Prehosp Disast Med 2007;22(2):s63

(108) Youth Awareness in Disaster Reduction

C. Ntahomvukiyen
Youth Strategy for Disaster Reduction, Bujumbura, Burundi

This presentation will seek to explain how young people can contribute to disaster reduction. It has been proven that when there is a war, destruction, and other negative outcomes, young people are prominent. These young people are the future. Many people do not realize that young people also are able to use the same effort and potential energy in reconstruction and rehabilitation. For example, young people can use this effort and energy to address disasters caused by climate change. This is an innovative way to explore this force in contributing to disaster reduction. For young people, it involves them in the decision-making so that they can become players instead watchers in disaster-related issues.

Keywords: disaster reduction; young people; youth awareness
Prehosp Disast Med 2007;22(2):s63

Oral Presentations—Theme 7: Mass-Gatherings

Session 1

Chairs: Paul Arbon; M. Sabbe

Medical Planning for a Major Event: The Pope's Visit to Krakow on 26–28 May 2006

M. Starowicz;[1] A. Trzos;[1] P. Gula;[2] P. Wolak;[1] J. Koza;[3] J. Andres[4]
1. Collegium Medicum Jagiellonian Universit, Krakow, Poland
2. Specialist Hospital No. 5, Sosnowiec, Poland
3. Voiv. Headquarters State Fire Service, Krakow, Poland
4. Chair, Anaesthesiology and Internal Care Medicine, Krakow, Poland

Introduction: The Pope's three-day visit in Krakow between 26–28 May 2006 required a major exercise in medical planning. The largest gathering, at the Holy Mass participated by the Pope on Krakowskie Blonia, occurred on 28 May 2006 and attracted a crowd of 1,000,000 people. The medical coverage was organized on two levels. Basic first aid was provided on the first level by the scouts, the Polish Red Cross, and the Medical Services of the Order of Malta. The second level was responsible for basic life support/advanced life support (BLS/ALS) standards of care and was provided by the emergency medical services (EMS), which included the staffs of 46 ambulances and by personnel from seven field hospitals.
Methods: The analysis involved 939 medical interventions at the field hospitals and information was collected on the following: (1) age and sex of the patients; (2) type of intervention; (3) scope of assistance: first aid, BLS, or ALS; (4) time of intervention; (5) treatment received; and (6) transportation to the hospital.
Results: Most of the ailments experienced were: (1) headaches; (2) effects of heat; (3) blisters; and (4) and abdominal symptoms. The field hospital treated a wide range of conditions including: (1) cardiac conditions; (2) fractures; (3) premature labor; and (4) acute abdominal emergencies. There was a large age difference among the patients and the majority of those receiving treatment were women.
Conclusions: The Pope's visits required medical preparation for mass-gathering. An inventory of incidence of conditions was collected.

Keywords: crowding; mass gathering; medical intervention; planning; treatment
Prehosp Disast Med 2007;22(2):s63