



# Memo from Meulaboh

Behind the news bites what is it like for aid workers on the ground in Indonesia's tsunami zone. Robert Patton, with two years experience heading an Aid agency in Indonesia knows the environment well. He will report on his experience in our February issue. For now, here are some brief e-mail reports delivered on the run.

**2 Jan** The worst affected part of Indonesia is the west coast of North Sumatra. Much of it is cut off, with limited access by air and sea only. After making many enquiries and seeking information from various official and private sources I decided ADRA should be working in this area. I located the only airline that is chartering flights and running one scheduled flight in a small plane each day. I enquired at the desk about two tickets on the scheduled flight and was told the earliest I could get a seat was Tuesday. This was Saturday afternoon.

An American journalist approached me and said that she had chartered a flight with some others and was leaving 6 am the next morning, was I interested. I said yes. The price? Name your price she said, as a Japanese journalist was interested and had offered US\$1600. Although this felt so wrong I began to bargain. Weighing up the benefits versus the cost I got to US\$2500 over the next 30 minutes.

In the back of my mind was being told by an NGO they had been trying to secure a flight since Tuesday and had only just managed to get some tickets. As the American journalist was checking with the Japanese journalist for his latest offer, a man tapped me on the shoulder and said quietly, "I have three tickets on the early morning scheduled flight, I only need one. Would you like the other two?" Without hesitation I said yes. The cost? US\$100. In talking with him I found he was a local west coast man heading the same direction I needed to travel. He offered me a ride in his taxi and said he could give me good local information and contacts. To me this was an answer to prayer. Another NGO took 4 days to get tickets.

The American journalist had taken two days to charter her plane at a cost of US\$6600 whereas in the space of about an hour I got two seats for the next day for US\$100. To top it off, I received a call from Metro TV about 5 hours later offering to buy the tickets from me! I have no idea how they traced me, but they were desperate for tickets

**5 Jan** Heading out again today to Meulaboh and will be gone about a week. It is totally isolated there with only a dodgy sat phone connection. I am well, just chronically tired. I have attached a couple of photos. One showing the downtown area of Meulaboh and the other the plane and runway I am using to get in and out as the only access is by air. I can tell you, its pretty scary stuff landing and taking off. Things are still pretty desperate, mainly because the area I am working in is so isolated and cut off that it is difficult to get supplies in. The population of the town was about 45,000. Estimated 20,000 have died. I am working in makeshift camps housing about 15,000 people. Water supply is our biggest problem and currently working on getting equipment and experts in. Diarrhoea is now a problem.



**12 Jan** Just back from a week in Meulaboh where I did get amazingly violent diarrhoea (I'll spare you the gruesome details!) But ok now. Heading home next week, arriving Auckland 20 Jan

An earthquake cracked runway requires pilots to exercise slalom skills on take off and landing

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Utter devastation



In a ghost town



Laundry duty in a Meulaboh refugee camp

# Dead Bodies Pose No Threat of Disease In Disasters

We have all seen graphic footage of funeral pyres and mass burials following the "Indian Ocean Tsunami". Now authorities in the affected countries are having second thoughts and are going for a more measured approach, including the exhumation of those already buried. We can forgive them their response in a time of overwhelming stress. They may have reacted differently if they had the opportunity to read a Pan American Health Organisation booklet "Management of Dead Bodies in Disaster Situations".

In a September 2004 press release after the death toll from Tropical Storm Jeanne in Haiti had climbed above 1,013, the PAHO noted that contrary to popular belief, epidemics do not occur spontaneously after a natural disaster, and dead bodies will not lead to catastrophic outbreaks of exotic diseases. The belief that dead bodies pose a serious health threat often leads authorities to take misguided action, such as mass burials, which can add to the burden of suffering already experienced by survivors. The key to preventing diseases is improving sanitary conditions and informing people,

PAHO experts emphasize.

"Unfortunately, we continue to see the use of mass graves and mass cremations to dispose of bodies quickly, based on the myth that they pose a high threat of disease outbreaks,"

PAHO Director Mirta Roses writes

in the introduction to Management of Dead Bodies in Disaster Situations. The fact is that infectious agents do not survive long in dead bodies.

"The worst part of this is that these actions are taken without respecting the processes of identifying and preserving bodies, something that not only goes against cultural norms and religious beliefs but also has social, psychological, emotional, economic and legal consequences that add to the suffering directly caused by the disaster." Dead bodies must be managed in such a way that it is eventually possible to identify them.

"Denying the right to identify the deceased or suppressing the means to track the body for proper grieving adds to the mental health risks facing the affected population," writes Dr. Claude de Ville, former head of the PAHO disaster program, in an editorial in the May 2004 issue of the Pan American Journal of Public Health. "The inability to mourn a close relative, the lingering doubt on the whereabouts of the disappeared, and the legal limbo of the surviving spouse or child all contribute to the many potential mental health problems



A survivor watches over a funeral pyre

associated with disasters and the difficult rehabilitation process that follows."

Dr. Jean Luc Poncelet, chief of PAHO's Emergency Preparedness and Disaster Relief program, adds: "What also happens is that these forced burials hurt the credibility of the authorities."

PAHO has developed a list of recommendations regarding the management of bodies in the aftermath of disasters:

Ensure that citizens have complete access to bodies and provide as much support as possible for their final disposal.

Burials should be carried out in such a way as to allow later retrieval of bodies. This means that burials in mass graves and mass cremations should be avoided under any circumstances.

Burials in mass graves and mass cremations are unnecessary, as they violate the human rights of families and survivors.

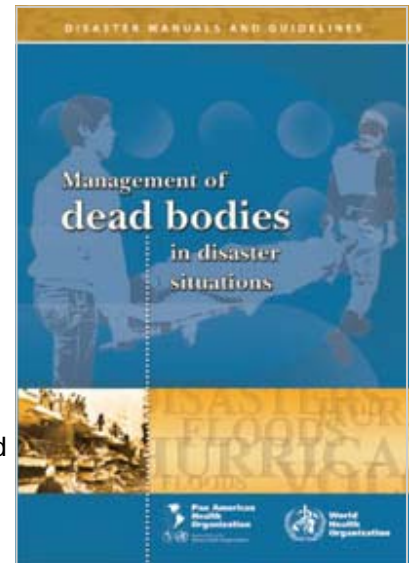
Generally speaking, the risk of epidemics as a result of cadavers is negligible. Dead bodies pose less risk of contagion than a person who is alive and infected.

Avoid subjecting relief personnel and the general population to mass vaccination against diseases supposedly transmitted by cadavers.

Respect cultural and religious beliefs, even when the identities of the dead are unknown, showing respect for the beliefs of those at the site of the tragedy.

The identification of bodies is a technical process to be carried out regardless of their numbers, in accordance with established procedures. Departing from these procedures can produce legal consequences that may result in survivors presenting claims for material and mental damages.

Don't be caught in the same situation as officials in Tsunami affected areas. Download Management of Dead Bodies in Disaster Situations from [www.paho.org/English/DD/PIN/pr040923.htm](http://www.paho.org/English/DD/PIN/pr040923.htm) and incorporate its recommendations into your plan. It is a worse case scenario but should we need to act there is no excuse for not doing it right the first time.



A woman searching for a family member

## Music key to Treating Children with PTSD

Children have been major casualties in both death and emotional trauma from the Indian Ocean Tsunami. There are regular media reports of children stunned into silence by the event. Some will receive treatment for their post traumatic stress disorder (PTSD), others will miss out. Where treatment is to be offered the International Blue Crescent has a model, trialled after the Bam earthquake, which might be used.

If PTSD is not treated shortly after the incident, long-term support and social skills training may be needed to help a child remedially gain the skills that were not developed during a period of months or years of withdrawal. Monitoring and educating the child and parents are important because symptoms may reoccur, even after resolution. The prognosis of PTSD varies widely. Although one half of persons with PTSD recover within 3 months, some proceed to develop a long-term problem with a post traumatic personality. This might be expressed through behaviour including impulsive behaviour, substance abuse, aggression, eating disorders, sexual acting out, labile mood, rage, panic attacks, and dissociation. Symptoms may reoccur months or years later in response to subsequent stressful or life-changing events.

Since the end of March 2004, IBC has been working with children victims of the Bam earthquake. In the 5 Turkish container camps in zones 3 and 10 (Isfahan1, Isfahan2, Qom1, Qom2 and Shehrdari) housing 750 families, IBC established 8 Children's Social Centres, with 16 classes, 16 instructors and 2 psychologists for psycho-social intervention.

Most of the children attending IBC Centres are cases of PTSD (post traumatic stress disorder) which require treatment of all associated problems (e.g., depression, anxiety, destructive acting out) and ongoing support for participation in the normal developmental experiences of childhood.

To enhance a sense of community IBC organized school-sponsored activities, such as play, sports, music activity, etc. The therapy – activity best accepted by the children was the music therapy, for which IBC provided bells and flutes and a specialist to teach the children to understand the rhythm, duration of notes, simple melodies and playing the instruments.



Body movements are children's most familiar means of expression. Communication via movement allows expression of an experience for which there are no words. Music can shape the group environment by soothing, empowering, grounding, and nurturing a sense of consistency, safety, and strength. IBC started the music program according to Orff method. Children were asked to pay attention to sounds and distinguish vari-

ous characteristics of auditory canal as same as: pitch, volume, and rhythm...

Teachers were first trained to play the flute because it was useful that class leaders were able to play music to the children.



IBC had some symbols for practicing rhythm and used appropriate music to help the children to feel calmer and focused. Rhythm has the capacity to organize individuals and groups, promote healing, and to powerfully change emotions. With music and movement used during play and creative activities, children experience the crucial importance of practicing balance between freedom and discipline.

Children are asked to practice music bodily, verbally, visually, and auditory. One of important aspects of the IBC psychosocial program is group work. Instead of individual activity, children are working in-group and this is very useful for encouraging interaction between them.

There are various characteristics of auditory information that are susceptible to change. After pitch and rhythm, duration was the third aspect worked on. Children learned simple symbols of duration as same as white and black notes and they practiced some plays for recognizing between different notes. For example, children were asked to perform two rows then walk according music notes: one step for black and two steps for white.

According to the Orff method it is very important that music programs start with simple scales and distance. The first melody for children had just two notes, G symbol of Sol and E symbol of Mi (G - E - GG - E / GG - EE - GG - E). After this step, children who have had enough exercise can play musical instrument easily.

IBC has also provided the centres with children's poetry books, song books and tapes. While waiting to play instruments children have also learnt appropriate songs.



Weekly teacher training

# Recovery via a “Do It Yourself Workshop”

What do you do if there is a workshop that you and your colleagues want to attend but just can't make due to other priorities? Why organise your own! And that is exactly what Liz Prior, Emergency Planning Manager at the Waikato DHB did. Liz and a number of other Health Emergency Planners missed the Ministry of Civil Defence and Emergency Management (MCDEM) sponsored Recovery Symposium, so Liz agreed to organise their own. With help from Robert Patton, Risk Management Adviser St John and some St John funding, Liz organised and facilitated a Health Recovery Workshop, based on what people said they wanted to discuss and learn about. More than 20 people from the health sector attended the October workshop held in Hamilton. This report by Robert Patton summarises the papers presented at the workshop.

The workshop had two main themes. The morning session covered the concept of recovery within a New Zealand health sector context to determine what recovery means for the sector. A key document for this session was “*A Holistic Framework for Recovery*”, recently developed by the MCDEM.

People with recent involvement of working with communities recovering from major disasters shared their experiences to ensure a practical aspect to the session. During the afternoon session, participants broke into three groups to begin the development of regional, DHB and local recovery plan templates. This process ensured a practical and valuable outcome to the workshop.

## Is there a recovery phase?

Robert's session was entitled ‘In reality is there a recovery phase?’. The four phases of the disaster management cycle, reduction, readiness, response and recovery have traditionally been shown in a circle, with one following the other. In this circle recovery comes after response and before reduction. Is there a discrete phase of recovery? The answer given was ‘no’. Factors present well before a disaster-producing event impact on recovery. Recovery starts while there is still an active response and continues while subsequent reduction and readiness activities are being implemented.

Robert cited a study by Bolin and Stanford following the Northridge earthquake and published in the journal *Disaster* in 1998. Bolin and Stanford found that recovery problems experienced by the affected community related to problems evident long before the disaster. Those most vulnerable at the time of the earthquake still had unmet needs long after the rest of the population had recovered. Robert discussed the risk management cycle, noting that it is only indicative and has no fixed boundaries. Recovery does not start on a set day and finish as the next phase starts. Disaster interventions will have an impact on recovery phase and the recovery phase time line will vary for different sections of the community.

## MCDEM Framework

Sarah Norman, MCDEM Advisor, presented a framework MCDEM have developed for recovery. This framework was disseminated in March 2004, for a six-month consultation period. Following feedback from this consultation, a number of changes to the framework are being considered.

Within this framework recovery is defined as “the coordinated efforts and processes to effect the immediate, medium and long term holistic regeneration of a community following a disaster”. To ensure a holistic approach is used, the framework identifies the key components of recovery as: psychosocial, community, environmental, infrastructure and economic. These components are further elaborated in the framework discussion document. Sarah emphasised that the structure of recovery in New Zealand runs from the national level down to a local level.

## Case Studies

### Thames

Ron White, Thames-Coromandel CDEM Manager, outlined the genesis and impact of a ‘weather bomb’ that dumped huge amounts of rain on the Coromandel in June 2002 causing severe flooding and erosion and badly damaging the infrastructure. Ron followed the course of this event from the initial impact, the response of local and regional organisations and groups through to recovery and mitigation activities. The underlying theme was that although there is a recovery phase, all other phases have a relationship and recovery cannot be considered in isolation. He concluded by highlighting a specific mitigation project in the township of Te Puru, emphasising that these mitigation activities will reduce the need for recovery in the future.

### Mid Central

Michelle Spiers, Mid Central Health Manager for Hospital Coordination, spoke about their experiences during the 2004 Manawatu floods. From a hospital perspective, the impact of the floods on the hospital was minimal and short-lived, with a very quick recovery. However, the impact and recovery for many communities was much greater.

Michelle reported that in the initial phases of the event CDEM groups did not contact or notify hospitals in the area so there was both a lack of information and misinformation regarding the status of hospital services. Hospital staff were not considered essential personnel and denied access on restricted roads. As a result there were staff shortages at the hospital. Motel accommodation was arranged for staff not able to get home. Without access to their homes patients could not be discharged home leading to a bed shortage. Dialysis patients couldn't access the hospital and adding to the confusion, tele-



Road closures stopped staff getting to work and restricted health care services

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phone lines were often out of order. District nurses were most affected as they were unable to visit many of their patients.

Lessons learnt from this event have been applied to improving planning and preparation for future events. CDEM groups are now aware of the impact of flooding events on the health sector and they need to involve the health sector earlier. Arrangements have been made with the Police for health staff with identification to be able to pass restricted access road blocks. A GIS project has been implemented so that roading networks, key installations and the location of staff are documented.

Michelle cautioned "don't give out free muffins!" As a goodwill gesture, free muffins were given out to staff who worked hard through difficult times. The gesture boomeranged because despite best efforts, some staff missed out. This caused resentment and a few challenges for management. The conclusion was that it would have been much better if no muffins had been given out!

### Bay of Plenty

Brent MacDonald, Manager for Quality and Risk at Bay of Plenty DHB, briefly described the July flood event, further compromised by an earthquake swarm that caused a civil defence emergency declaration in two Eastern Bay of Plenty districts. For this event he referred to the response phase as



Flooding is the cause of almost all civil defence declarations in New Zealand

"the sprint" and the recovery phase to "the marathon".

The response phase primarily dealt with flooding of residential areas, farming communities and road networks; major erosion and slips along the sea coast; closed roads; power outages and contaminated water supplies. For hospital and other health services the major impact of this event was staff shortages (staff could not get to work due to road closure, flooded homes or looking after children as schools were closed). Supply chains were interrupted causing shortages of some medical supplies; out-patients in some coastal and inland areas were isolated; in-bed patients could not be discharged to homes flooded or isolated by the flood. Clinics and elective services were deferred and there was an increased workload for public health.

The recovery phase formally commenced about a week after the initial impact of the event. The recovery structure had six components: welfare, rural, economic, infrastructure, environment, communications (primarily communication with

the public) and planning and reporting. Brent presented the aims for each of these components and examples of how they addressed recovery issues.

Although not identified for a few days, maraes and one-stop-shops where community members could see all the help agencies at one place proved to be very valuable resources. A specific health service initiated recovery measure was the assessment of staff needs. As a result, laundry and food facilities were provided and staff allowed time off to clean up their homes. One HR person was dedicated as the contact person to deal with all staff issues.

Vino Ramkisson, Social Worker for Bay of Plenty DHB Community Mental Health Unit opened with the thought, "recovery is not a goal, or a phase, but a journey; it is not a linear process". She then proceeded to outline how people often feel and react in a disaster situation, especially when their normal social structures disintegrate and they feel "debonded" from their community. The primary role of recovery workers should be to try and establish a sense of community and belonging for people.

Resources need to be made available to communities so they can be involved in their own recovery. Identify the strengths and capacity of a community so the recovery process built on expressed rather than assumed needs. To facilitate this Vino used her experience of the Eastern BOP floods to illustrate how to apply these principles in practice. Vino emphasised that the recovery planning is a collaborative process involving the community because recovery activities should be people-centred. The traditional roles of professionals and disaster-affected people need to be examined to better understand what enhances community recovery.

The focus of response and recovery planning is usually on CDEM-type events. Ann Esler, Community Liaison Officer at Lakes DHB, began by discussing the impact a fatal, multiple-car accident was still having on a family a year after the event. Recovery, for this family and the health care staff involved, will continue for some time yet.

Ann then linked the recovery planning for the Bay of Plenty CDEM Group to this case study. The CDEMG identified the building and fostering of relationships with key stakeholders as a key issues in recovery planning. For the fatal event the recovery process for hospital staff began with an operational debriefing and the development of an action plan to address identified problem areas. Progress with implementing the action plan has been frustratingly slow through difficulty in engaging staff.

While developing relationships with the people involved is critical, this is not always easy to address as relationship with key people is influenced by the relationship they have with other people in the organisation affecting their attitude and behaviour. Further, individual staff members attitudes are influenced by their experiences. Ann's recommendation is to always keep your eye on the big picture, using opportunities as they arise to continue work on relationship building and above all, don't give up! Ann ended with the following quote: "He aha te mea nui o te ao? Maku e kii atu "He Tangata! He Tangata! He Tangata!" (What is the greatest treasure in the world? I could only reply "'Tis people, 'tis people, 'tis people!)

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Liz Prior has developed a recovery planning checklist based on actual events at Waikato DHB. Liz shared this with the group and explained how Waikato DHB has used it. Liz is happy to share this checklist with anyone interested.

### Financial Issues

Sue Hadlington-Hight from Waikato DHB gave a very comprehensive overview of funding and funding arrangements. In the CDEM Act 2002 DHBs are designated as an emergency service, required to be active members of the CDEM group and have a responsibility to provide health care services to restore the health status of a disaster-affected population. Underpinning this are agreements between a DHB and health service providers to identify how the health service provider will continue to provide services following a disaster and meet the specific requirements set out in Part Six of the National Civil Defence Plan.

In the event of an emergency there is an implicit agreement between DHBs and the Ministry of Health (MOH) for funding additional service delivery required by the emergency and recovery but outside baseline funding. Major Incident and Emergency Planning is incorporated in baseline funding. This planning includes the reduction, readiness, response and recovery phases of major incidents or emergencies. Each DHB is required to cover the cost of services provided in relation to a major incident up to 0.1% of the DHB total budget. Above this 0.1% boundary, the MOH in consultation with the DHB will decide on a case-by case basis whether to provide the DHB with additional funding, having regard to the DHBs ability to fund additional services purchased and any impact this will have on the purchase of additional services.

These additional services are likely to include needs assessment and service coordination, emergency psychiatric services, community mental health services, primary care via General Practitioners, hospital emergency departments, and pharmacy and laboratory services. It is important that discussion between the DHB Planning and Funding Manager and the MOH happen before an event and that the outcomes of these discussions are reflected in the finance section of a recovery plan.

### Template development

The workshop then broke into three smaller groups. Each of these groups was given a copy of a generic recovery plan and asked to consider regional level recovery plan, DHB level recovery plan and health service provider level recovery plan. The task set was to consider the generic plan and discuss what changes were required to develop a template for a recovery plan. The workshop concluded with a plenary session where notes from each of the groups collected and given to Robert Patton. He has the task of producing a draft recovery plan template, based on the group work. This will be circulated for comment then the finalised recovery plan templates will be posted on the HEMNZ website. ■

## Aggression Management Programme

Aggression, causing staff injury, low morale and recruitment difficulties, is an escalating problem for healthcare systems world wide. Safety is often only reviewed in terms of access to security staff, alarm systems and environmental factors with most facilities ill equipped to effectively respond to actual or perceived aggression.

Patient, visitor and staff safety is a basic requirement for all healthcare settings. However, safety is often only reviewed in terms of access to buildings and car parks, safety glass in counters and whether staff have access to duress buttons or mobile phones. Mostly health care organisations are ill equipped to respond effectively to actual or perceived aggression other than having a security officer respond

Newcastle Mater Misericordiae Hospital is the tertiary referral centre for the Hunter region for deliberate self-poisoning patients and drug and alcohol patients. With over 850 admissions a year for this clientele alone and over 24,000 Emergency Department presentations, they identified as a significant issue the need to minimise and manage aggression because the hospital was experiencing more Code Black (Personal Threats) Emergencies that Code Blue (Medical emergency/cardiac arrests calls).

Through a collaborative multidisciplinary approach, recognising the worth and expertise of all staff, they have developed an effective response team lead by clinical staff to manage aggression. Staff have been educated on how to minimise aggression. Charts of patients who have displayed aggression are flagged and a personalised management plan developed. Yearly review of processes and outcomes has led to refinement of a system that is readily transferable to other organisations to improve staff, patient and visitor safety.

Meetings with Police, Ambulance and Mental Health Service managers were conducted to ensure timely response if required to deal with aggression and scheduling of patients. A direct line to Police and Ambulance services exists in the Emergency Department. Joint management plans have been developed with other services for some patients. (A gun safe has been placed into the Emergency Department for police guns).

There has Hospital wide acceptance of programme. Staff have gained confidence in dealing with aggressive situations. There is an increased understanding of the precipitants to aggressions and the signs of impending aggression. Concerns raised by security staff that they are requested to remain on standby for protracted periods do not now occur. Definitive management, which is supported by Medical Consultant notification, occurs in the same manner as a cardiac arrest event.

These practices developed at the Newcastle Mater are readily transferable to most other organisations. Read more and find a contact for the Hospital at [www.archi.net.au/content/index.phtml/itemId/170055](http://www.archi.net.au/content/index.phtml/itemId/170055)

## 2004 Through a Rear Vision Mirror

The Indian Ocean tsunami has captured our attention like no other show in town. Yet it is but the final movement in a symphony of destruction, destitution, despair and death for many of the world's population. This photo essay looks at a representative sample of some of the events of the past twelve months.

These events are now, at the best, relegated to brief comments on the inside pages of our papers. While they are "yesterday's news" they will remain central to those involved in their generational long recovery period



An Iranian woman stokes a fire in the rubble after the earthquake in Bam, south-eastern Iran, on December 27, 2003.

Most of the mud brick buildings in the historical city, including its ancient citadel, collapsed when the massive earthquake struck

at dawn. The quake destroyed 70% of the city's buildings. 26,000 people were killed and tens of thousands were injured and left homeless. .

The long-term cost of reconstruction is estimated to be \$1bn.



While the human toll was small by international criteria, flooding remains our bête noir. In February the Manawatu

and Rangitikei rivers reached their highest levels for over 100 years as the lower North Island was swamped under a deluge that reached out into neighbouring regions. 2300 people were evacuated from their homes and 9300km of roads closed.

In July the eastern Bay of Plenty was hit by a similar but less wide spread cascade from the skies. Who will be flooded this year?



About 1.7 million people are homeless and some 70,000 are estimated to have died in Darfur. The crisis was sparked in February 2003

when pastoral rebel groups took up arms against the government in a struggle over power and scarce resources. Khartoum retaliated by arming nomad militia, accused of conducting a campaign of murder, rape and arson. Despite this month's landmark peace agreement between Khartoum and rebels in the south fighting is still spreading in Sudan's Darfur region and may intensify in the short-run, said Jan Pronk, the special U.N. envoy for Sudan. He told the U.N. Security Council arms were flooding into the region, violence was spreading beyond camps for the homeless, banditry was increasing and rebel groups were launching attacks in the area of oil facilities. "We may move into a period of intense violence unless swift action is taken," Pronk said. "I do not exclude the possibility that the signature of the (north-south) agreement will be followed in the short term by an intensification of violence in and around Darfur."



In what was the most active hurricane season in a decade, residents of Florida, Alabama, Puerto Rico, and at least seven other states in the eastern third of the U.S.A. struggle to recover from the devastation wrought by four major hurricanes

— Charley, Frances, Ivan, and Jeanne. The two-month barrage of storms triggered the nation's largest natural disaster response effort. The Federal Emergency Management Agency has received more than 1.5 million registrations for federal assistance; Florida accounts for two-thirds of total registrations. Florida, directly hit by all four storms, sustained the most damage — 117 lives were lost, more than 25,000 homes were destroyed, and another 4,600 were heavily damaged. Damage has been estimated at \$42 billion, surpassing the \$34.9 billion from the nation's single most costly storm, Hurricane Andrew in 1992. Florida's citrus crop was severely damaged, forcing hundreds of small growers out of business.



A resident flees from a forest fire at the town of Malhao in the southern Portuguese province of Algarve. In July the government

declared an emergency after 6 days of forest fires. Hundreds of firefighters supported by planes and helicopters battled the fires across Portugal in a heat wave that reached a high of 40 degrees Celsius. At least 16 people died.

In some villages, residents fought fires by themselves, using sand or water from swimming pools, as firefighters were busy elsewhere.

In all, some 215,000 hectares of forest were burnt - an area about the size of Luxembourg. Portugal was recovering from huge fires in 2003 that destroyed 13 percent of its forests and woodlands



In August Typhoon Ranim killed at least 115 people with more than 1,800 others re-

ported to have been injured when the typhoon hit the coastal city of Wenling, in Zhejiang province of China. Officials evacuated 415,000 people from coastal areas to escape the storm. Most people were killed by collapsing buildings. More than 40,000 houses have been destroyed and 90,000 more damaged.

Pan Jinsong, from the Zhejiang Meteorological Observatory said Typhoon Ranim was thought to be the worst storm in China since 1997, when 236 people were killed. China's civil affairs ministry estimated direct economic losses of 15.33bn yuan (\$1.85bn) and that 271,000 hectares of crops were damaged.

In 2004 more than 650 people were killed by natural disasters in China, which cost more than \$4bn in damage, according to official figures. The north of China has suffered severe droughts, while heavy rains have caused flooding in southern and central areas.



In August a distraught Bangladeshi child cries as flood-hit people jostle for food rations being handed out at a relief centre in Dhaka



while flood victim Aleya Begum rests on a bag she carried from her village. Another Bangladeshi girl holds up two kerosene lamps as she makes her way through a flooded street in Dhaka.

Thousands of people made homeless by flooding were living in shelters and were need of food aid, the fallout of the country's worst floods in 15 years. Five weeks of monsoon flooding has killed some 815 people and affected over 33 million people in Bangladesh alone. More than 1, 750 people died in Bangladesh and eastern India from snakebites, disease, house collapses and drowning. The United Nations launched an urgent global appeal for \$210 million of emergency aid to feed millions of poor in impoverished Bangladesh.

Senegalese children run as locusts spread in the capital Dakar in September. The United Nations Food and Agriculture Organisation (FAO) warned that the locust swarms infesting countries from Mauritania to Chad could develop into a full-scale plague without additional foreign aid



In the far north of Senegal, swarms of voracious locust larvae not only devoured crops and pasture. They also munched their way through the straw huts of local farmers. Agricultural experts of the Inter-state Committee to Fight Drought in the Sahel (CILSS) said the organisation's nine member states would normally have expected a grain crop of 11 to 14 million tonnes. But they warned that the locust invasion could cut output across the region by up to 25 percent, dashing hopes of a food surplus and raising fears of localised severe shortages.

It is estimated that locusts could cause up to US\$500 million of damage to agricultural production in Senegal this year



Turkana women wait with empty bags for food distributed by aid agencies in northern Kenyan town of Kerio, near Turkana lake, September 29, 2004

during a emergency operation for people in need of food aid. The drought effects first seen in Turkana and Marsabit have now spread to 24 other districts affecting 2. 3 million Kenyans.

On 6 July 2004, the President of Kenya officially appealed for relief food assistance to aid people affected by the drought currently facing parts of Kenya. This follows a report from a two-week inter-agency assessment in some of the most severely affected districts that places over 1.4 million people to be in urgent need of food aid.

The prevailing drought situation is the accumulated effect of several years of poor rainfall in the country. The 2004 long rains effectively ended in May, one month earlier than usual. Although most pastoral areas benefited significantly from the generally heavy rains in April, the rains in May were very poor; save for parts of the northern western pastoral districts, very little rainfall was experienced in all the pastoral, agro-pastoral and marginal agricultural areas of the country. Similarly, the key growing areas in western Kenya, including the country's 'grain basket' districts, experienced exceptionally heavy rains in April followed by low and poorly distributed rain in May. Most pastoral areas projected are to remain characteristically dry, while the northwestern Turkana is likely to experience drier than normal conditions.



Flood-affected people walk past dead cattle after they were killed in the October floods in Kishnai, 120 km (73 miles)

west of Guwahati, the major city of India's north eastern state of Assam.

More than 100,000 people were left homeless and 180 died in a flood that affected 800,000 people in 1023 villages. At the time of this flood Assam had not recovered from a monsoon deluge that hit millions in South Asia this summer.



A Jamaican family are seen outside the remains of their home after it was destroyed by Hurricane Ivan, September 12, 2004 outside of Kingston. Ivan killed at least 47

people during its rampage through the Caribbean before moving on the U.S.A.

A French doctor looks a baby at a hospital in Gonaives, Haiti, September 25, 2004. where more than 1,000 people died in floods. U.N. troops had to fire into the air to prevent looting when the first beans, rice and other supplies were handed out to an estimated 20,000 desperate survivors of the flood.



Last but not least is the one man initiated event in this portfolio. Iraq has been by all criteria a ongoing disaster throughout 2004

How many have died? Certainly over 1300 Coalition armed forces personnel. No one seems to be counting the Iraqi civilian and armed force deaths.

Figures seem to vary from 17,000 to over 100,000.. The number injured is certainly far higher.

This is a classic case of a response and recovery rolling along side by side. When will it end?



The HEMNZ Bulletin is published monthly by the Risk Management Unit of St John Northern Region for all those interested in emergency management in health care settings

Articles and comment on emergency management issues are welcomed

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Check out our Web site at  
[www.hemnz.org.nz](http://www.hemnz.org.nz)

## Up coming Events

16 - 17 February 2005

### 4th Annual Emergency Management Conference

Wellington Town Hall

Cost \$1795 +GST early bird

More information from [www.conferenz.co.nz](http://www.conferenz.co.nz)

23 February 2005

### South Island Health Emergency Management Seminar

Sudima Hotel, Christchurch

Cost free

More information from

[graeme.mccoll@stjohn.org.nz](mailto:graeme.mccoll@stjohn.org.nz)

16 - 20 May 2005

### 14th World Congress on Disaster and Emergency Medicine

Edinburgh, Scotland

Cost £520 early bird before 2 March

More information from [www.wcdem2005.org](http://www.wcdem2005.org)

## Editor's soapbox

The Indian Ocean tsunami has been called the world's worst ever natural disaster. In terms of cold statistics, that is wrong, even as the estimated death toll climbs well past 150,000. Other earthquakes have killed more, especially in poor and populous countries such as China: probably 600,000 or more in Tangshan in 1976, and 200,000 or so on two occasions in the 1920s. It is not even the Indian Ocean's deadliest disaster, for cyclones have often brought worse, most notoriously in 1970 when the then new state of Bangladesh lost about 500,000 people.



What is special about this tsunami is the geographical extent of the devastation and the number of countries affected. Earthquakes produce terrible consequences, but normally of a highly localised sort. This time, particularly in Sri Lanka, Indonesia, India, Thailand and Myanmar, the damage stretches across thousands of miles and involves millions of people. That produces a huge logistical challenge for international organisations and aid agencies: how to get relief supplies and, later, reconstruction assistance to so many places at more or less the same time. Much more of the money and planning will have to be devoted to planes, helicopters, trucks and supply lines than in "normal" disasters and relief efforts.

The involvement in the disaster of so many resorts favoured by tourists from rich countries in the West has given it even more prominence in those countries than the sheer horror of the fatalities would have produced. Such selfish distortions are regrettable in theory—who noticed while millions were dying in Congo's wars?—but in practice they might as well be exploited. It has become possible to raise far more in charitable donations from individuals and organisations in rich countries for relieving this disaster than for single-country earthquakes or floods.

Now, as the immediate response wave flattens out, governments in the affected countries are beginning to demand their sovereignty over the relief effort. Ordinary Indonesians are bridleing at the idea that their country, the fourth most populous in the world, needs to be rescued from abroad. The speaker of parliament, among other politicians, has been urging the government to show foreigners the door as soon as possible. These views might not be shared by those in the disaster hit areas but it does highlight the political element of disaster relief.

As a nation of pragmatic "do it yourselfers" we are used to just going in and getting on with what needs to be done. Communities and countries need to be empowered to drive their own recovery. Big brother might know best – but in the long term, that is not necessarily going to produce the best recovery for the devastated community.

**Bruce Parkes**

## A little light relief in this gloomy month

Jim is driving past the psychiatric unit when his car gets a flat tyre. While he is changing the wheel, another car goes by, running over the hub cap in which he was keeping the lug nuts, & the nuts are all knocked into a nearby storm drain.

Jim is at a loss for what to do, and is about to call a cab, when he hears a shout from behind the unit fence, where one of the patients has been watching the whole thing. He calls out, "Why don't you just take one lug nut off each

of the other three wheels? That'll hold your wheels on until you can get to a garage or something."

Jim is startled by the patient's seeming rationality, but realizes the plan will work, and installs the spare wheel without incident. Before he leaves, he calls back to the patient. "You know, that was pretty sharp thinking. Why do they have you in there?"

The patient smiles and says, "I'm in here because I'm crazy, not because I'm stupid."