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Responding in Aceh: A first hand account

Lots of New Zealand health workers answered a call from the Ministry of Health and registered as available for work in communities devastated by the asian tsunami. Few would have any idea what their working and living conditions might be like. At least one New Zealand observer sent to Sri Lanka enjoyed 5 star hotel accommodation but for most the reality was not being cocooned inside self-contained units and having to work and live in far less salubrious surroundings. Robert Patton, who was an early arrival in Aceh, provides a first hand account of what it was like at the "coal face"

"Four days after the massive killer tsunami had crashed into islands around the Indian Ocean leaving a trail of death and destruction, my Boeing 737 touched down at Medan airport. One journey was ending and another beginning. This last leg from Jakarta to Medan had included a two-hour wait in the aircraft on the ground in Jakarta and one hour circling the skies above Medan waiting for a space to land. Medan was the main entry point for relief teams and supplies heading to tsunami affected areas of Indonesia's Aceh province.

Medan airport's usual 20 planes per day had burgeoned to 300 per day and it was struggling to cope. Utter chaos reigned in an airport terminal filled with foreign disaster teams, garbed in overalls blazoned with their organisational logos and surrounded by large trunks plastered with big red crosses. After waiting an hour for my luggage I pushed through the mass of people and luggage to escape the oppressive heat and noise of the terminal building. Thankfully a familiar face was waiting for me outside the terminal building; we went in search of accommodation for me, but with no luck. The next two nights I slept in a hospital bed in a ward – the only bed I could find!

I had been sent to Indonesia by the Adventist Development and Relief Agency (ADRA) to coordinate their humanitarian response to the tsunami disaster. My initial task was to identify where ADRA would respond, conduct a rapid needs assessment and begin getting relief supplies in to meet the needs identified. As soon as I arrived in Medan I began to gather information on what had happened, where it had happened, the impact on people and what was being done. I quickly identified that the eastern and northern coastlines of Aceh, although badly hit, were accessible by air and road and relief teams and supplies were getting into those areas. The west coast appeared to be even harder hit and as there was little or no access, information was scarce and unreliable. There were reports that the main west coast town of Meulaboh had been largely destroyed. Helicopters were dumping food as they flew over because starving people were mobbing any aircraft that landed. For me, the decision was easy. The need was obviously greatest there and that was where ADRA would respond.

Rule of the road question
Does the boat or truck have right of way?

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Helicopters were dumping food as they flew over because starving people were mobbing any aircraft that landed

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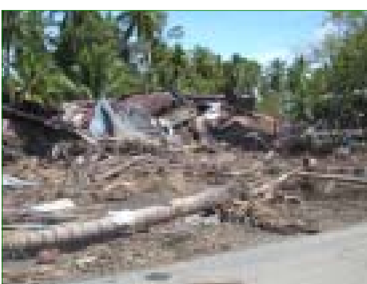
Amongst a multitude of other activities, the key things I now had to focus on were: finding transport to the west coast, procuring personal supplies to sustain me for at least four days, a means to communicate, and finding a translator. Within a short time I had purchased dry food rations, bottled water, located a satellite phone and arranged for an Indonesian friend, Rully, to accompany me as translator. Transport to Meulaboh was the biggest challenge. Tapaktuan, the closest operational airport, is about 150 kilometres south of Meulaboh. It took the best part of a day to secure a seat on a commercial flight, and that only by divine intervention!

Rully and I flew in to Tapaktuan Airport on an early morning one hour flight , landing on a very marginal runway. Surprise, surprise! There was no road access to Tapaktuan and fuel was in extremely short supply. With the help of a local we found a minivan travelling north towards Meulaboh so along with 15 others we crammed into this small vehicle and headed north. About 30 kilometres south of Meulaboh the van stopped and we were told the vehicle was going no further. The road was eerily quiet but before I had time to think what we might do a private car appeared and screeched to a halt as it passed us. There was a quick exchange in Indonesian with Rully and I was directed to climb aboard the already overloaded car. One of the car's occupants had recognised Rully from when they were at university. As far as I am concerned, this was more than just good luck.

Why the minivan had gone no further quickly became obvious. The road had been badly eroded by the tsunami and approaches to bridges had cracked and sunk away, probably as a result of the earthquake. The jumbled remains of buildings, surrounded by salt water burnt brown vegetation lined both sides of the road. The stench of rotting human flesh hung heavily in the air.

For kilometre after kilometre the devastation continued, increasing in intensity as we neared Meulaboh. Although I was seeing this incredible destruction firsthand, my mind just could not comprehend the magnitude of the disaster. Later, locals told me what it had been like; how there had been three waves with the second being the highest. An estimated 14-metre high wall of churning water, mud, broken buildings, rubbish and human bodies, racing inland. I just could not imagine it.



On arrival in Meulaboh we went straight to the military camp to meet with the Colonel coordinating the disaster response. In the queue ahead of me to register were a journalist from Time magazine and a TV crew from Asia News Today. As I was to discover, the place was crawling with the media and they took almost every available seat on helicopters in and out. As I registered I was told ADRA was the first international humanitarian agency to register in Meulaboh. However, this changed rapidly. By the end of the day two more had registered, 24 hours later 23 were registered and a further 20 the day after that. That's 46 separate agencies with a multitude of languages and agendas needing to work together.

As the number of international relief workers increased so too did the accommodation difficulties. We were allocated a six-room primary school adjacent to the military camp. The facilities consisted of two squat latrines and a well with a bucket for bathing. It was the middle of the rainy season so we experienced torrential downpours almost daily. The school grounds were often covered with 10 centimetres of water and drainage ditches were dug around tents put up to accommodate the increasing international population. One or two groups had small cooking stoves but there was no cooking fuel available. Our simple and occasional meals were mainly of dry food. Most of us had either a sleeping bag or a thin squab to lie on the concrete floor as our bed.

The days were long and tiring, starting at 6am and finishing at about 11pm, when the evening coordination meeting ended. The 'quiet' night hours were interspersed with the sound of loud voices trying to be heard on satellite phone calls to sponsoring countries.

The road north ended abruptly where a bridge had totally disappeared. Between Muelaboh and Banda Aceh 50 of the 70 bridges were either destroyed or badly damaged and much of the road non-existent. The road south was also badly damaged with some bridges out but within two weeks of the tsunami the road to Medan was opened to restricted traffic. All that remained of the town wharf were some poles sticking up in the water. The earthquake crazed the airport runway with large cracks which were then gouged out by the following tsunami.

The tsunami destroyed the entire Meulaboh business district. Half the residential buildings were gone, along with approximately 40 per cent of the

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population - at least 20,000 people perished in this town. There was no electricity, no safe water supply and no communication systems. Approximately 50,000 people were staying in temporary shelter in and around the town. Many had come in from nearby villages that had been totally destroyed.

The immediate relief needs for these people were water, food and shelter. Many also required medical attention. Some had major trauma injuries, more were developing an inspirational pneumonia from salt-water inhalation and many had severe skin irritation from salt water and abrasions caused by debris. One of the niche areas in which ADRA became involved was the sourcing of critical medical supplies and equipment.

Each morning a health coordination meeting was held at the hospital. Each agency would identify what they were short of and the supplies they had so we could establish what shortfalls there were for the health sector. After the meeting I would take the shortfall list and call the Adventist Hospital in Medan on my satellite phone, place the order and they would source these supplies through their existing supply chain. Once they received the goods they would take them to the Singapore Forces at Medan airport, who arranged for their delivery by the next helicopter flight to Meulaboh.

In most instances requested supplies arrived within 24 hours. The diverse range of supplies and equipment provided in this way included anaesthetic agents, anti-tetanus serum, antibiotics, testing kits for cholera and malaria, crutches, a microscope and oxygen concentrators. This last item was desperately needed. as there was no oxygen supply available for the many people critically ill with respiratory problems and following major surgery. Thankfully there was an electricity generator at the hospital that enabled the use of oxygen concentrators and the continuous refrigeration for many of the vaccines we were bringing in.

All responding agencies had a critical need for transport. Vehicles were in short supply and there were fuel shortages. With high demand and short supply, the market ruled and prices skyrocketed. When I first arrived a vehicle plus driver cost Rp150,000 per day. Within a few days this had risen to Rp500,000. Petrol is normally about Rp3,000 per litre. At one stage it got as high as Rp25,000 per litre. The effects of this type of inflation are many with the worst being the impact it has on a local, poor and extremely vulnerable population. Those who usually gain are most likely the already well-off. Personally, it irked me that the wealthy were gaining at the expense of the poor and that I was inextricably a part of this. There was no way to avoid it unless I was to severely compromise my ability to assist those in extreme need.

Although this was a tragic and sad event, there were some aspects that bolstered my spirit and kept me going throughout my time there. First and foremost was the courage and resilience of the local people. Despite losing so much they quickly turned to rebuilding their lives again and supporting and helping those around them. Etched indelibly in my mind is the meeting I attended with the District Education Director and his team of principals and senior teachers. It was the first time they had come together since the disaster. They hugged and cried as they shared their experiences - one of the teachers there had lost her husband, three children, home and all her belongings - then settled down to the business of planning on how they would get the schools open again for children. .

Another aspect was the great collegial spirit between all the responding agencies. We worked and lived together, supporting each other, sharing our stories, advice and resources. When my bedding went missing one of the guys from Mercy Corp gave me his sleeping bag to sleep on. The working relationship with the defence forces, notably the Singapore Forces, enabled us to achieve many things and highlighted the complimentary role that each took. Humanitarian agencies had funds for relief supplies but often could not access transport, whereas the defence forces had helicopters and trucks on the ground in Meulaboh. When my replacement arrived and it was time for me to leave it was the Singapore Forces that provided my ride out of Meulaboh to Medan.

It is difficult to express in a few words my personal experience of responding to this disaster. There is such an incredible range of sensory inputs that have an affect on your whole being. How do you express what it is like when a family who have had such devastation and hardship thrust upon them shares their home with you when you are extremely sick with diarrhoea? When you leave they hug you and thank you when all I want to do is thank them for what they have done for me. Regardless of race, culture or beliefs, we all have a common spirit of wanting to care for each other. ■

Regardless of race, culture or beliefs, we all have a common spirit of wanting to care for each other.

Sydney Mass Casualty and Disaster Symposium

What if' there was a large scale terror incident in Australia and Sydney in particular? A Mass Casualty & Disaster Symposium was held at St George Hospital, Sydney on the 7th February 2005 to try and find out. Keynote Speakers were Professor Shmuel Shapira from the Hadassah Medical Centre, Jerusalem, Israel and Professor Eric Frykberg from the University of Florida, USA. Keynote attendee was Graeme McColl from St John in Christchurch who provides his impressions of the symposium.

"The symposium generally confirmed what those of us involved in Health Emergency Planning are trying to achieve. It is always good to hear from those who have been involved in major incidents that broadly they share our views

Professor Shapira provided a good summary of the requirements for mass casualty management after a terrorist incident. Like any other mass casualty event, the core problem is the overwhelming demand on limited resources. The key element is to try and balance assets and personnel according to needs. A terrorist mass casualty event presents unique challenges for both the hospital and the community. Unique types of injuries, unusual mechanisms, heightened anxiety, special curiosity of the media and VIPs and more important the increased chance of a secondary attack, all dictate the need for unique preparations.

Continuous preparations and readiness on behalf of all components of the medical and paramedical establishment will enhance the strength and durability of society against both conventional and non-conventional terror. The balancing of resources v needs means that there will be a down grade in treatment for a while. It must be recognized that in the early part of a response there is likely to be chaos. Good communication between medical and paramedical staff and hospital management and EMS commanders is essential. Skilful event management by Standard Operating Procedures (SOPs) and checklists, will decrease the chaos involved, and hopefully decrease mortality, morbidity and permanent disability.

Shmuel Shapira

Eric Frykberg

A Basic Initial Action Checklist;

* Confirm incident, gather data.
* Call extra medical paramedical staff.
* Notify E.D., Theatres, X. Ray, Blood services etc.
* Assign a triage officer to be located at the ambulance unloading area. (Both key note speakers promoted senior surgeons as triage officers because of their understanding of trauma. An Australian speaker indicated that the College of Surgeons were taking an interest in this role for their members.)
* Open extra admission sites. (minor injuries away from main ED)
* Control/Command Station. (Gather Data)
* Identification. (Public Information, Digital photos, descriptive forms linked to other agencies)
* Organise treatment.
* Avoid the "Butterfly Syndrome" where medical staff flit from patient to patient without doing anything.
* Debrief as soon as possible, in Israel this is important because next incident is always likely before any delayed debrief.

Planners should remember that in times of response a checklist is better and more likely to be followed than a textbook type length plan.

Professor Frykberg was involved as a Navy surgeon in the on scene response to a Marine Barracks bombing in Beirut in the 1980s. He advises that facilities/organisations should plan to be self sufficient for at least 6 hours before expecting any help. He defined the response phases as:

* Chaotic
* Reorganisation
* Site Clearing
* Late.

The greater the preparation the quicker the reorganization phase takes over from the chaotic.

The keys to an effective disaster response are: good communications - between scene and hospital, internal & external, clear authority and responsibility (who is in charge of what), good security at the scene and hospital lockdown, well organised medical care, and attention paid to planning tests and drills of the "Disaster Plan"

Frykberg nominated two truisms in responding.

We always under estimate the number of resus beds required and the CT and X ray use.

We always over estimate the number of medical personnel available, the number of operating theatre staff available, the number of critically injured (always less), and the level of triage expertise.

He emphasised a need for responders to get rid of good intentions and concentrate on good care. The impediments to this are;

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* a desire to help,
* too many care providers,
* taking blood donations – they are a feel good for donors and media but are not required and tie up keys staff,
* intrusion by the media
* a lack of education in MCI care often brought about by complacency or arrogance.

For Frykberg the key components of an Emergency Plan are:

* Clear lines of authority
* Secure Communications
* Public Information and Liaison
* Transport and evacuation
* Security of the hospital and the scene
* Protect staff
* Knowledge of individual responsibility
* Medical management strategy and tactics
* Regular drills and exercises.

Lt. Colonel John Crozier, senior lecturer in Surgery in NSW reflected on his experience in the tsunami medical response to Indonesia. He spoke on organising the Operating Theatre and the Surgeons. He found when organizing a response to Indonesia that there was no current database for surgeon contact details. There was also a lack of an organised system for locating critical care beds. He emphasised that surgeons must be involved in the planning process and accept the triage role. The best person for the triage role may be a 'bilateral upper limb amputee' who can't do anything else and waste time by treating patients.

The ABCD syndrome must be avoided. Arriving, blaming, criticising and departing. The plan should establish an Operations Cell prepared to function 24 hours per day for the first 72 hours. Colonel Crozier advocates that a senior Surgeon should be the Controller, an anaesthetist the Planning officer and an Operating Theatre Manager the Logistics officer (For a Theatre Suite – perhaps, for the whole hospital???)

Dr David Cooper, The Director NSW Health Counter Disaster Unit, spoke on the State context response. He said the lessons learnt and the gaps identified from incidents such as the Bali Bombing response show a need for:

* engagement of health early in the process,
* national health co-ordination,
* a burns infrastructure,
* access to transport,
* the involvement of the whole of health, including Public and Mental Health,
* the involvement of the whole of Government
* the involvement of clinicians.

In summary, the speakers really confirmed the work that health emergency planners already have in place or currently underway. We now have a challenge, as indeed do they of getting surgeons involved in the planning and exercise process. ■

Californian Mud Slide

While the attention of the world was fixed on the asian tsunami California was hit by storms brought chaos to western US states and claimed more than 20 lives. Chris Greenfield, Performance Improvement/Trauma Coordinator at the Santa Barbara County EMS Agency sent this e-mail and an accompanying photograph.

Hi Bruce,

I have been enjoying your bulletin for the past year or so and sharing it with my colleagues in disaster response in our office. We have been kept pretty busy here in the past few weeks with record rainfalls saturating the countryside. I thought you might be interested in a picture of a mudslide in the little "hamlet" of La Conchita that killed ten people last week. It's about 30 miles south of us. We were virtually cut off as the highway was closed for five days, and many of the alternatives routes were closed due to washouts, sinkholes, bridges out etc.

It never rains in southern California, as the song goes, but when it does, it pours! My Dad lives in Kerikeri and says you are having a cold summer down there due to the iceberg floating around too close to NZ... Seems like the world's weather is going crazy rapidly! Stay warm,

Other than the six lane highway by the sea, this scene from the other side of the Pacific Ocean looks remarkably like a number of New Zealand seaside villages. Between 15 and 20 houses were destroyed or damaged when the slide hit. Some houses were piled on top of each other and covered with up to 9 metres of mud, rock and debris. Ten people were pulled out alive. Eight of them were taken to hospital, two in a critical condition. Hundreds of fire fighters, aided by sniffer dogs and local volunteers, worked around the clock to try and find 12 people unaccounted for.

Governor Arnold Schwarzenegger toured the site and expressed support for plans to rebuild the village ■

WHO argues over bird flu drug rules

World Health Organization members meeting on January 24th struggled to find common ground on how countries should tackle any future influenza pandemic, especially a potential human variant of deadly bird flu. The session of the 32-nation WHO executive board was bogged down on the issue of whether countries hit by a massive outbreak could override patents on anti-flu drugs, and the meeting was halted to let delegates call their governments for guidance.

Fears of a new human pandemic have been fuelled by Asia's bird flu outbreak, prompting WHO's executive to discuss an international plan to tackle what experts say is a long overdue global crisis. "As a global community were are still ill-prepared - and as long as one of us is not prepared, none of us is prepared," said Dr. Anarfi Asamoa-Baah, who heads the WHO's communicable diseases division.

Last year, the avian influenza virus spread to 10 Asian countries, killing or forcing the slaughter of more than 100 million birds. Since the start of that outbreak, 12 people have died in Thailand and 29 in Vietnam - including five in a recent resurgence of the virus, known also as H5N1. Around 70 percent of those infected have died.

The resolution debated by the WHO executive included ways to strengthen disease surveillance, boost research on a vaccine and stockpile the drug when it comes onto the market. In coming months researchers at seven U.S. universities will start the first ever human testing of experimental bird flu vaccines made by Chiron Corp. and Aventis Pasteur, the vaccine division of French-based Sanofi-Aventis.

Executive delegate Dr. Viroj Tangcharoensathien, a Thai Health Ministry official, said poor countries worry they won't be able to afford a new vaccine, saying most already have trouble paying US$120 (euro93) for a six-week course of anti-viral medicines to fight regular flu. He suggested adding a clause to the resolution that would allow countries to ignore patents in case of an outbreak and buy cheaper generic drugs, a system known as "compulsory licensing." Similar measures have been taken to allow poor countries hit hard by HIV/AIDS to get drugs for their citizens.

But the U.S. and French delegates objected to that idea. Western pharmaceutical companies, supported by their governments, have expressed concern that compulsory licensing could lead to smuggling and be used by generic manufacturers to boost their profits rather than for humanitarian reasons.

At the same time, ahead of a regional meeting to be held in Ho Chi Minh City from 23 to 25 Feb 2005, under the sponsorship of the United Nations's FAO and the World Organisation for Animal Health [OIE] discuss the fight against the virus, Bui Quang Anh, head of its agriculture department's animal health department said, Vietnam's latest bird flu epidemic is showing signs of abating, and the country hopes to have the current outbreak under control by the end of February 2005.

An international expert dismissed the statement and said bird flu in parts of Asia is here to stay. "What is happening this year is not an outbreak, it is an endemic recurrence of a

We have used this graphic before but it seems to symbolizes the attitudes of many who sit on United Nations and the WHO committees.

disease that is here to stay," said Anton Rychener, representative of the Food and Agriculture Organisation. "I would not pay much attention to this statement.

Vietnam declared in October 2004 that it had brought its latest outbreak of avian influenza under control. It first made such an announcement in March 2004 but had to admit later that the declaration had been premature. Experts say avian influenza has entrenched itself in much of Asia and is unlikely to disappear anytime soon.

Anh said a new decree issued by Prime Minister Phan Van Khai on 3 Feb 2005 controls more strictly the rearing of ducks, which are considered a reservoir of the virus. "The breeding of waterfowl and quails, the main source for bird flu transmission, is banned throughout the country between 9 Feb and 30 Jun 2005," he said, adding some provinces could extend the ban.

"Anyone who wants to restore poultry flocks this year must firstly register with the local animal health department," Anh also said, implying that the rampant raising of poultry in 2004 might have contributed to the spread of the virus. The slaughtering of poultry in small markets around the country will be banned and major abattoirs established in the longer term, Anh added.

Vietnam also said it would soon try to use vaccines produced in China and the Netherlands on its poultry flocks. Vietnam had about 208 million poultry in December 2004, according to official estimates.

"If tests are successful, we will use the vaccine on the poultry en masse by the end of 2005," said To Long Thanh, vice director of the National Centre for Veterinary Diagnosis.

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While officials pontificate and disagree, in Vietnam, chickens continue to roost at home: Few people appear concerned about threat of Asian bird flu.

Nguyen Thuy Lan sits on a tiny plastic stool just inches from the sidewalk, crouched over a steaming bowl of duck noodle soup at a street-side restaurant. As she works her spoon and chopsticks, chickens peck the ground for scraps at her feet. One scraggly white bird even steals a couple of bites from a nearby pan of freshly made fritters for sale. No one bats an eye. This is life in Vietnam.

While some say they've stopped eating fowl until the current bird flu outbreak wanes, many defiantly vow not to change their habits. "I've heard of bird flu, but I'm not scared," said Lan, slurping the last bit of juice from her bowl. "There may be bird flu outbreaks elsewhere, but not here."

Poultry, especially chicken, is everywhere in Vietnam. Birds hang by the neck, roasted golden brown, for sale on bustling sidewalks. They roam freely inside dirt-floor huts in the most remote countryside villages.

Prized fighting cocks are a common sight in parks or on grassy medians as their owners squat beside them, egging them on in fierce, often deadly battles. Owners will even suck blood or phlegm out of the birds' mouths following a fight.

In January 2005 two brothers tested positive for the disease after eating raw duck blood pudding, a delicacy in Vietnam. The older brother died, while the younger man, Nguyen Thanh Hung, fought the disease for a week before recovering. From his hospital bed, Hung said it was a tradition to eat the dish while drinking rice wine at family reunions. Since the duck showed no signs of disease, no one thought there was cause for worry.

"When I was first admitted, I did not remember I had duck blood pudding," said Hung, who now insists he'll eat only blood pudding that's cooked. "I thought my older brother and I suffered some kind of acute pneumonia."

Vietnamese health officials and the World Health Organization have tried to tell people they must give up certain habits to protect themselves from the virus, which has killed about 70 percent of those infected. Scientists have said they believe people become infected through physical contact with sick birds -- dead or alive -- and their droppings, though it is still a mystery exactly how the virus is transmitted. However, well-cooked poultry is not a risk.

"We have no problems with these cultural habits, but in these circumstances we think that the people should be more careful," said Peter Cordingley, spokesman for WHO's Western Pacific Regional Office in Manila. "It seems to suggest to us that perhaps the messaging still needs to be made a little bit stronger -- that there are some cultural habits that might be best temporarily suspended."

Poultry is a major source of cheap protein for much of Vietnam's 82 million population. Nearly every household in the countryside raises a handful of chickens or ducks to supplement meagre incomes or to keep for eggs or food. Chickens roam freely in most yards, and flocks of ducks waddle or swim in rice fields, fattening themselves while spreading their own natural fertilizer -- and potential disease. "In certain parts of Asia, ducks are being moved from field to field, from rice paddy to rice paddy," said Malik Peiris, the Hong Kong University professor who discovered the SARS virus. "This dramatically increases the opportunity for the spread of infection."

Most human bird flu cases have been traced back to contact with sick poultry, but the WHO fears the virus will eventually mutate and become easily spread person-to-person, sparking a global flu pandemic. So far, there is no evidence the virus has changed. Despite nearly 3 dozen deaths among their countrymen, few Vietnamese have been seriously deterred from consuming poultry.

Le Thi Sang lost her 3 children during last year's outbreak after the family served 66 pounds of chicken at her son's wedding. Her 2 daughters tested positive for bird flu, while her son died of similar symptoms. Despite her loss, Sang still buys poultry a couple times a week and insists her children were not infected with avian influenza. "My son and daughter died of pneumonia, while the other daughter died of stomach [bleeding]," said Sang, 58. "It's not bird flu."

The WHO has also warned that slaughtering poultry can be risky if protective gear isn't worn. A 35-year-old woman and her 13-year-old daughter both died of bird flu in January 2005 after they killed a chicken together. But in a busy Hanoi market, vendor Nguyen Kim Hue says she's not worried. Standing over a mound of chicken carcasses at her stall, she says she slaughters about 50 birds a day, a routine she's been following for the past 20 years. "I do not wear protective gear -- no mask, no gloves. I'm OK because I bought healthy chickens," she said. "I'm selling traditional Vietnamese chickens."

In 2004, Vietnam banned the sale and transport of poultry over the holiday season as bird flu raged across 10 Asian countries, killing or forcing the slaughter of 100 million birds. No such bans are in place this year, but some wary shoppers say their ancestors will have to accept another dish instead to ring in the Year of the Chicken.

"I stopped eating poultry a long time ago when I heard about the flare-up," said Tran Thu Ha who stood in a marketplace near a heaping pile of chicken carcasses. She selected a plump fish from a tub of water. ■

HEMNZ Health Emergency Management New Zealand

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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Up coming Conferences

16 - 17 February 2005
4th Annual Emergency Management Conference
Wellington Town Hall
Cost $1795 +GST early bird
More information from 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

16-17 March 2005
Managing Coastal Hazards
Alcamo Hotel, Hamilton
Cost $600 + GST
More information from
www.naturalhazards.net.nz/courses

21-22 March 2005
3rd Annual Enterprise Wide Risk Management Conference
Spencer on Byron, Auckland
Cost $1795 + GST
More information from www.conferenz.co.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

Editor's soapbox

It is only seven weeks and the Asian tsunami has long disappeared over the radar screens of news organisations. It's not their fault. They report what we are interested in and for many, there is only a limited capacity to absorb the horrors of the event.

It was only an exercise, but when I rang the Ministry of Health seeking authority to use an open cheque book following a major mass casualty event at Hamilton I was told to ho ahead and spend.

That is the nature of the beast. Politicians and others with the control of the purse strings have a very short attention span. Dollars are always a key to recovery from a major event.

Make sure your plans have processes for using the media to grab the attention of those who can provide financial support. And while you have their attention present a clear case for aid they can not refuse.

Remember, your crisis is fish and chip paper tomorrow

Bruce Parkes

Infection control put to one side

After arriving in Indonesia's tsunami-shattered province of Aceh, the Australian surgeons did what they'd been taught never to do. In a building with no running water and under hand-held lights powered by faltering generators, they picked up their instruments unsure if they were sterile and began to operate.

."We just had to lower our standards and deal with what we had to deal with," Dr Annette Holian said "We had to accept that the infection patients were already suffering was much worse than anything we were about to put on if our instruments weren't sterile."

Dr Holian and her colleagues returned home on January 9th after becoming the first emergency team to leave Australia for the provincial capital Banda Aceh.

"You were confronted with an overwhelming and vast area of destruction cars on their sides, buses still with the remains of deceased in them, and mud," team leader and medical director of the NSW Ambulance Service Dr Michael Flynn said yesterday. "It was one of the most austere environments that I have ever worked in and it was a tribute to my team that they went through that and they still performed in an exemplary manner."

Dr Holian said the ability to improvise had been crucial, as the team struggled under unsanitary conditions, hit by frequent blackouts when operations were underway. "Once we were in there trying to operate, we had very little to actually work with," she said. "With our first patients, we were really just tipping water into wounds to wash out the infection."

About 240 patients came to the hospitals emergency ward each day, infectious diseases physician Dr James Branley said. Many of them had huge lacerations from corrugated iron and other debris ripped from buildings when the tsunami struck. "You've seen some of the footage of black, oily stuff flowing through the streets and that was all washed through these patients lacerations," Dr Branley said. "People had been bathed in a mixture of salt water and what could only be described as open drain fluid. Many of them died."