



# 14<sup>th</sup> World Congress on Disaster and Emergency Medicine

Jo Horrocks

Edinburgh, Scotland, was the venue for the 14<sup>th</sup> World Congress on Disaster and Emergency Medicine from 16-20 May 2005. Five of us made the trip over from New Zealand, and we joined the 400 delegates from 45 other countries for 56 sessions, 240 papers, and the odd bit of haggis – all in all, quite an impressive international effort.

The conference had an understandable focus on the Boxing Day tsunami in south-east Asia, but also offered an extremely large range of session topics, from education and training, to terrorism, to political and psychosocial aspects of disasters. Enough to keep me running between sessions for four full days.



This was my first international conference since I have been working in emergency management, and I was fascinated by it all. For me, the real value was in expanding my horizons beyond the focus of national health emergency plans, code whites, single points of contact etc., to see what the rest of the world is doing. It was actually quite re-assuring: for the most part, save for a few extra dollars and fancy kit here and there, we are all in the same boat, and all doing the same things. But a number of speakers did give me pause for thought, repeatedly stressing issues that, while not

wholly new, made me think about how we could, or *should* be applying them in our planning. What follows is four of the most talked about issues:

## Volunteers in Disasters

### Medical volunteers in disasters zones are often:

- western-trained,
- hospital-based,
- technology-dependent,
- procedure-oriented,
- invasive,
- monolingual,
- culturally-unaware,
- hazard-naïve
- and late-arriving

Recent crises in south-east Asia, Iraq, Dafur and Bali have lead some to observe that the motivation of volunteers in disasters seems to range from compassion (the vast majority) - to scientific interest - to pecuniary - to a voyeurism that verges on an 'I was there' disaster tourist mentality. It was further pointed out that medical volunteers in disasters zones were often: western-trained, hospital-based, technology-dependent, procedure-oriented, invasive, monolingual, culturally-unaware, hazard-naïve and late-arriving – damning indeed! These points were made not to attack altruism or compassion, but to illustrate some of the difficulties of sending people into unfamiliar surroundings and asking them to do a critical job. We were reminded of the fundamental medical precept of *primum non nocere*, or, 'first do no harm' – that if we are not careful, there may indeed be situations where more harm than good is done.

Instead, speakers advocated professionalism, and treating offers to volunteer almost as job applications. They believe there are legitimate questions to be asked, such as "Who are you?" (what are your qualifications, registrations, memberships and licences), "What do you bring?" (relevant skills, experience, knowledge, familiarity with hazard, environment, culture),

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and "How do you intend to help?" (a good understanding of jobs and tasks to be done). Volunteer databases should be set up, and all volunteers screened, preferably pre-event. That way there is a ready source of potentially available, qualified people prepared to assist in the event of an emergency – domestically or internationally. With the huge number of medical professionals in New Zealand who volunteered to go to Indonesia post-tsunami, this seems like something we could certainly look in to doing here.

**Emergency Response Teams**

Several sessions covered people's experience of organising or being part of emergency response teams, especially as part of the response to the south-east Asia tsunami.



Clearing drains can be as important as providing medical care



The importance of picking the right team was stressed over and over again, both from the point of view of composition (skill-sets and experience), and individual suitability (physical and mental toughness). Egos must also be checked in at the door, with all staff needing to be 'multi-functional workers' and if necessary prepared to undertake any task, from changing

bedpans, to cleaning floors.

Teams faced extremely primitive and challenging conditions with a lot of illness, mostly nasty gastric stuff. Maintaining team welfare was cited as the single biggest difficulty of working in a disaster zone. There were also the usual amount of trouble with coordination, communication and logistics. The clear message was: do not expect things to work the same as at home!

The cultural sensitivity (or lack thereof) of response teams was covered in some detail.

Successful groups respected local officials and didn't patronise them

Locals are professionals, intellectually as good as or better than us, just doing their jobs in different and more difficult circumstances.

The cultural sensitivity (or lack thereof) of response teams was the other issue covered in some considerable detail. Some locals in Sri Lanka and Indonesia developed a strong distrust of Aid groups and their motives because of a perceived insensitivity to their culture and religion. Successful groups were ones that were aware of and respected local traditions and customs, and did

not attempt to change them – sometimes easier said than done when it comes to opposition to certain medical procedures that seem routine to us. Successful groups also respected local officials and didn't patronise them in a 'we're here to save the day' fashion. Several speakers pointed out that these are professionals who are intellectually as good as or better than us, just doing their jobs in different and more difficult circumstances.

Lessons for emergency response teams and those organising them were thus: educate your team about local traditions and customs; accept religious beliefs and do not try to change them; seek to meet the holistic needs of victims and survivors; there is great value in having team members who can speak the language and/or are of the same religion; do not implement treatment or strategies that are not locally-sustainable long term; and, you are there to assist, not take over.

**Supplies and Aid**

There were numerous stories, sometimes humorous, of inappropriate donations and aid sent to the tsunami-stricken zones. My favourites

were breast implants, fur coats and carnival wigs! Clearly that is the most extreme end of the scale. But there were also many examples of impractical, or useless, medical supplies and equipment – out-of-date medicines,



A torn bra: donated for a torn body?

equipment that wasn't complete so it couldn't be used, intricate complicated equipment that no-one was trained to use, first aid type supplies that weren't needed by the time they arrived. The sheer volume was also an issue, with hospitals being overwhelmed with boxes of donations that often ended up sitting in storerooms and hallways, and disintegrating because of the heat and humidity.

Of course, there is no doubt that aid is needed; no-one is disputing that. Or, that it was sent with the best of intentions. But sorting through the mass of donations from around the world is a hugely time, people and cost-intensive operation. It needs a rigorous system around it, and the aid sent needs to be as



No, not a rubbish tip. A mountain of assorted supplies no one has time to sort

appropriate as possible in order to avoid wasted time and effort – in situations when both may be in short supply. I again wondered how we would handle an influx of international aid to New Zealand... do we have databases to support it? Do we have methodology around receiving, sorting and storing aid, particularly medical supplies and equipment? It seems to me that it's something that could be worked through fairly simply. Perhaps the most important issue will be getting good messages into the media about what is needed, and hence, rapid needs assessments will be crucial.

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**The Politics of Disasters**



What is the most important message on this package: What is inside - or who sent it?

A few speakers pointed out – somewhat cynically, but not unjustifiably – that disasters are excellent opportunities for governments to advance national interests and foreign policy. Whether it is relationship-building investments in

countries crucial to the ‘war on terror’, or countries looking for permanent seats on the UN Security Council, it seems self-interest can often be a key motivating force when it comes to international aid. And of course, the larger the disaster – for example, the tsunami – the more opportunity there is for propaganda, via the extensive and continuous media coverage. So it is we see boxes emblazoned with national emblems, diplomats doing walkabouts, flamboyant and public gestures of aid. It isn’t necessarily a problem in and of itself, for, whatever the motivation, if it releases some badly needed money and resources, so be it. But it is something we need to be aware of, whether coming from a donor or recipient stance.



Two former Presidents get a carrier deck guard of honour

For our part, we need to avoid the driving politics as much as possible, and just focus on the *appropriate* response – we need to change our approach from being *seen* to be doing good, to just doing good. I am reminded of a quote by Harry S. Truman, former president of the United States: “It is amazing what you can accomplish if you don’t care who gets the credit”.

So that’s just a few of the most interesting issues resulting from WCDEM 2005. There were many others, and all have provoked my thinking as to how we could improve our planning here.

Watching the response of the emergency services to last week’s bomb attacks in London, seeing and hearing from some of the same people who stood in front of me at the conference two months ago, reminds me that we never know what’s coming... we are only as good as our planning... and just maybe, it’s amazing what we can do if we don’t care who gets the credit. §

# Robot runs amok at hospital

The San Francisco Chronicle reports that Waldo, a robot that delivers medicines at the University of California San Francisco Medical Center, went berserk.

Where's Waldo?: Waldo the pill-dispensing robot apparently went berserk recently at UCSF Medical Center, sending a doctor and patient running for cover.

Whacked-out Waldo is one of three battery-operated, rolling robots that dispense pills at the hospital. The other two are named Elvis and Lisa Marie.

All three are programmed to roam from floor to floor, distributing medications to nursing stations.

At the end of their rounds, the robots are supposed to roll into the basement pharmacy for refills.

But Waldo shot past the pharmacy and barged uninvited into the examination room in the radiation oncology department, where -- according to an anonymous caller -- a doctor was examining a cancer patient.

According to the caller, Waldo wouldn't leave, and the startled doctor and patient felt obliged to flee the room. (Surely the thing has an on-off switch somewhere!!)

UCSF spokeswoman Carol Hyman said she didn't know anything about any doctor and patient having to beat feet -- but confirmed that the wandering Waldo did wind up in an examination room.

"This is the first time anything like this has happened," Hyman said. "Our technology folks are going to have to take a look."

That is, if Waldo will stand still for it §



“Waldo’s sister robot, EMMA” (which stands for Electronic Materials Management Associate), helping out at the Delta Regional Medical Centre in Greenville, Mississippi

# Terrorism: An Act of Communication

For the past week the images of 7/7 – the terrorist outrage in London has been seared into our minds through every form of media. Why? Is the question we all ask. Lee Wilkins and Fred Vultee from the University of Missouri School of Journalism, writing in the January 2005 edition of the *Natural Hazards Observer* don't provide an answer but they do point to the importance of publicity in the terrorist's cause.



Because the study of how terrorism is covered can usefully draw from the well-developed body of research on accidents and disasters, Wilkins and Vultee believe a typology for categorizing terrorist events should provide similar advantages. Their essay proposes a definition and a typology of terrorism in the hope of starting a theoretical conversation that can help to first isolate and then articulate research questions across a variety of disciplines

## First, some Definitions

Summarizing the various efforts to define terrorism is a topic for full-length articles. Regardless, most definitions of terrorism share some or all of the following elements.

Terrorism implicates the innocent in its randomness—the fundamental mechanism of “terror” being a coercive fear meant to bring about or prevent change.

Terrorism is generally considered a tool of the dispossessed. States and their agents are quite capable of coercive violence against the innocent, and state terrorism is a notion widely used in political science and international law. To avoid suggesting that official terrorism is somehow less repugnant than the non state kind, many scholars use the idea of “mediated terrorism” to distinguish violence meant for a general audience, usually initiated by actors outside of traditional governmental structures who incorporate the media into their arsenal of weapons, from violence meant to influence the next village. Terrorism itself is an act of communication—“violence aimed at the people watching”

Although terrorist attacks appear sudden, they are rooted in political, social, and economic contexts. Terrorism is goal-directed, hence (to them) rational, behaviour. Wilkins and Vultee add this proposed definition of terrorism to the ongoing conversation:

A goal-directed act of communication by a person or group seeking to promote or forestall political, social, economic, or cultural change. By using violence, primarily against non-combatants, to generate fear, terrorism seeks to communicate its goals tacitly or explicitly with audiences—government or civilian—in a form of strategic bargaining.

This definition, encompassing multiple levels of analysis and multiple disciplines, places communication, both literal and symbolic, at the base of understanding terrorism. It takes as a given that however evil or nihilistic a terrorist act appears, it is, in the terrorists' view, a rational way of addressing a rational goal. And, it suggests that access to the engines of power and communication may help promote responses that will make terrorist acts less likely. Such a view is both normative and optimistic.

## A Terrorism Typology

Valuable as they are for analysis, models of how terrorist events develop have in general remained primarily descriptive. A model that adds an ordering capacity could retain that descriptive power while moving toward theory building and predictive capability. So, borrowing from disaster research, the following is a suggested terrorism typology:

- Incubation
- Impact
- Immediate post impact
- Recovery
- Reorientation

This typology tries to avoid suggesting that terrorism is the province of any single discipline of study or focusing on one area of the problem to the exclusion of others. At the same time, it allows for discipline-specific research as well as the ability to link findings in one field to those in others.

## Incubation: Long-Term Warning and Problematic Signals

A central, though obvious, distinction from disaster studies emerges here: tornadoes do not plan. The distinguishing characteristic of this phase in the study of terrorism is that, even if indirect and distant, it is a warning stage within a strategic contest. Rival players are making real-time decisions in a constantly changing matrix.

If terrorism is considered an act first of communication, its overt signals are vital.

There was a lengthy period of incubation for the attacks on New York and the Pentagon—and one rife with signals, many of them appearing in media accounts.

The *9/11 Commission Report* outlines a lengthy period of incubation for the attacks on New York and the Pentagon—and one rife with signals, many of them appearing in media accounts. If terrorism is considered an act first of communication, its overt signals are vital. Incubation, though, is not always a long-term process.

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As with disasters, it can be a matter of days or hours rather than years. The ways people and institutions respond to warning messages are ripe for research—as are the links between specific grievances and the symbols for those grievances, the patterns of communication within cultures, and responses from political systems.

### Impact, Post impact and Recovery: Does Terrorism Resemble Hazards and Disasters?

Those who forecast and analyze terrorist events agree that at these stages, terrorist events will resemble disasters in their impact on people and the environment. Familiar patterns of media coverage will be ripe for reinvestigation, but since terrorism communicates in symbolic ways, the symbolic content of news accounts and how they are interpreted by multiple audiences, from victims to policy makers, and the interactive nature of those influences is significant and largely unexamined territory.



A picture clearly designed to communicate solidarity

During post impact, current hazards scholarship suggests event-oriented news stories focusing on official response will dominate the news, a pattern that should be reinvestigated when terrorism becomes the focus.

Because crises push normally veiled responses into the spotlight, multiple disciplines have the chance to examine the inner workings of institutions and the ways media accounts reverberate in the policy-making process. Theoretical approaches, such as “setting the agenda for the agenda setters;” the symbolic nature of terrorist acts and responses to them; and distinguishing the communication and response pattern in political vs. civil violence also provide important research opportunities.

The activities of recovery often have a greater long-term impact on audiences than the event of the disaster itself. Any of a number of disciplines could be kept busy with spin-offs from one overarching research question: whether terrorism promotes different sorts of communication, as compared to natural and technological disasters, about the policy-making process and its various outcomes.

### Reorientation: The Dance Begins Again

When building codes change after a hurricane or new regulations are put into place after a chemical spill, some form of reorientation is taking place. In the aftermath of a terrorist attack, reorientation becomes a strategic encounter: two or more sides are competing to attain their own preferences and thwart those of their enemies.

This phase is particularly important to communication study for two reasons. One is the scale of the outcomes reorientation can produce, such as the fall of a government or a

restructuring on the scale of the creation of the U.S. Department of Homeland Security. The second is the particular importance of communication itself. While it is frequently a point of pride among governments to proclaim a policy of never talking with terrorists, these opposing sides can easily talk to each other while talking past each other—often in newspapers or broadcasts. The communications between parties, whether tacit or explicit, mediated or non-mediated, and of political actors to their own constituencies, are some of the most important signals available in the study of terrorist events.

The reorientation stage poses particular challenges for analysis. Like mitigation, it can start within hours of the event or wait for years, and it involves multiple institutional actors as well as individual responses. Reorientation can also produce a hardening of previous outlooks or an opening for steps toward negotiation.

### Conclusion

None of this is bound by time. All of it reflects a reconsideration of one’s place in the world and a need to communicate it to friends, enemies, and neutrals. And however misplaced any optimism might appear in light of any particular terrorist attack, therein lies the relevance of applying the lessons of disaster research to terrorism. A systematic model built around the roles of communication will enable us to not only talk more about what communication is doing but to look more effectively at what it might be able to do.

Wilkins and Vultee ask for responses to their thinking at the University of Missouri School of Journalism e-mail addresses listed below.

[wilkinsl@missouri.edu](mailto:wilkinsl@missouri.edu) or [vultee@missouri.edu](mailto:vultee@missouri.edu)



Through its response, a community can also communicate a clear message



# Marburg Fever in Angola: An MSF Evaluation

By all accounts the Marburg fever outbreak in Angola seems to have been successfully contained. Medecins sans Frontieres (MSF), the main response agency has taken stock of the lessons they learned. The experience of the MSF teams in Angola can serve as a useful example for other aid agencies facing similar situations where a heavy-handed approach has been counter-productive. Despite the different disease and different population and environment, there are also lessons for us as we start to flesh out our pandemic response plans.



The backlash was that fear-inspired rumours quickly spread among the inhabitants of Uige, the town in northern Angola that was the focal point of the epidemic. Some of the inhabitants said the new foreigners were "stealing the dead" -- a serious charge given the local belief that people who are not properly buried will turn into bad spirits and take re-

Their report posted on June 11 states:

"In late March 2005, when MSF teams first arrived at the Marburg outbreak site in Angola, they were forced to take drastic -- seemingly uncaring -- measures to contain one of the most deadly and contagious viruses known to man. Four months later, the Marburg epidemic that has so far killed 350 persons out of 391 cases [89.5 percent fatality] seems to be grinding to a halt. MSF has ended its emergency intervention and handed over its activities. But teams are now busy taking stock of the lessons they learned.

One of the first questions people would ask us was: 'You're MSF, you're doctors, why don't you treat us? Why don't you have a cure'. "We had to deliver the message that, not only is the disease deadly, but on top of that, infected persons have to be isolated. That's a very bitter pill to swallow, and there's no sugar coating for it." It is a human reaction: every one of us would be overcome with fear and anger if members of our family were suddenly taken away from their homes by strangers dressed like astronauts; if they were brought to a hospital; and if they came out a few days later in body bags, only to be swiftly deposited 2 metres under the ground without so much as a burial ceremony.

But aid workers fighting against Marburg -- a highly infectious, rare, untreatable and deadly hemorrhagic fever resembling Ebola hemorrhagic fever -- had one clear priority in mind: to contain the epidemic and save lives by isolating contagious persons and bodies as fast as possible. The toughest challenge faced by MSF teams in Angola was how to adopt a sensitive, humane approach to one of the cruelest viruses on earth. Now that the number of new cases

has dwindled to a near halt, MSF is taking the time to reflect on the lessons it has learned -- sometimes the hard way -- over the past 4 months. "First we were overwhelmed. The situation we encountered when we arrived was horrible," said Peter Maes, an MSF water and sanitation expert who works for MSF's infection control unit. "We had to chase after corpses decomposing in houses and morgues. There was no time to talk to the families. No time for mourning. The risk of contagion from dead bodies is very high, so it was urgent to bury them."

Others claimed that: "Astronauts" (aid workers in full-body safety suits) were "demons" who were "confiscating the sick" or even worse, "killers" who had "come to exterminate us" by spreading the Marburg virus. "It was obvious that we had to change our approach," said Maes. "And we did this as soon as we could."

He explained how, in early April, a couple of weeks after the epidemic was officially confirmed, MSF began "humanizing" the burials, notably by allowing family members to attend and participate: Family members standing at a safe distance could see the face of the deceased when the body bag was briefly unzipped open, and those given protective gear could help carry and lower the coffin," he said.

To support MSF's medical teams, new reinforcements arrived, including staff members like Patrick Depienne, a sociologist who was given the task of informing and sensitizing the local population, explaining; how the virus is transmitted; what MSF is doing; why certain traditions such as washing the bodies of the deceased are extremely risky; and why isolating cases is crucial. "Sensitizing the population is a priority," said Depienne, who worked 6 weeks in the province of Uige. "But of course it takes time and resources, and usually the first people to get to the scene of a disaster focus on the medical response. I wish I had gotten a seat in that 1st plane of aid workers that flew to Angola."

"Many aspects need to come together to control an epidemic like Marburg," said Dr. Armand Sprecher, a public health specialist who worked as a medical coordinator for MSF at the beginning of the Marburg epidemic. "If you want

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to have an impact, you need good epidemiological surveillance, good contact tracing, good case management, good logistics, good communication, etc., and the failure of one thing brings the whole house of cards down. But I think that one of the most crucial, yet most neglected, elements is communication and sensitization. If you don't do that right, everything else falls apart, because Marburg is transmitted and amplified by certain human behaviours."



Healthcare can be frightening for both the patient and the carer

The problem is that the list of risky behaviours is long, as the virus is transmitted by contact with infected and symptomatic humans -- specifically, by contact with their body fluids, ranging from blood and breast milk to spit and sweat. Another problem is that, no matter how much effort is put into communicating about Marburg, for many reasons it is difficult to get persons suspected of having the virus to

come to health structures where they can be diagnosed and, if needed, isolated. The primary reason is that there is no cure for Marburg. MSF doctors and nurses can only treat the symptoms of the disease -- such as high fever and dehydration -- and reduce the suffering of dying patients.

Some Angolan authorities opted for a hard approach. "The government issued a decree saying that persons who refused to go to the hospital would be taken there by force," said Dr. Martin De Smet, MSF Emergency Pool Coordinator. "The problem with this strategy is that you'll get one person in the hospital, but all the others will run away. It might work in a small region, where there may be no way to escape, but Uige is a very vast province."

Another reason the beds in isolation wards can stay empty is that Marburg is hard to detect. Its symptoms, which include high fever, diarrhoea and vomiting, are non-specific and similar to those of common, tropical diseases such as malaria. Marburg fever is not as dramatic and gory as media reports portray it to be. "Patients don't bleed profusely from every orifice," said Dr. Sprecher who worked in Gulu, Uganda in 2000 and can compare Marburg fever to Ebola fever. But still Dr. Sprecher admits: "I think Marburg is even scarier. Because a person can feel a bit weak and look slightly ill but drop dead the next day. It makes you think the man sitting next to you in the bus might be infected."

While most infected persons unknowingly pass on the virus, some of them -- for example one of the nurses who was

working in the paediatric ward of a provincial hospital an hour's drive from Uige town -- endanger the lives of others because denial and the fear of death prevent them from telling what they know or suspect. As Marburg takes a heavy toll on health care personnel (16 died in Uige hospital, due to the absence or inefficiency of infection control measures), the disease can potentially lead to the collapse of a country's health care system. In addition, the stigma attached to medical personnel and structures, and the confusion surrounding symptoms means that many people with treatable diseases will avoid getting proper care and may end up dying at home. Allowing visitors to come inside the isolation ward is one way to help de-stigmatize it. In Uige hospital, MSF was able to enforce the use of safety suits by the family members of isolated patients and, according to Dr. De Smet, "We realized that we could have higher transparency without compromising bio-security and infection control."

The most effective "Marburg messengers" are patients who have been inside the isolation ward and come out alive. A 27-year-old taxi driver named Horacio was the 1st survivor known to MSF and in early May 2005, a few weeks after he was discharged and had regained his strength, Horacio was hired by MSF to raise awareness about Marburg and encourage other Angolans to come to the hospital.

As a last resort when Marburg-infected persons refuse to come is "home-based risk reduction". "It's a last resort option we can't afford to exclude and one that we began exploring in Angola," explained Dr. Martin Smet. "We make home visits, spend time with the family members, tell them not to touch the Marburg victim, and introduce hygienic measures. But of course we cannot observe if and how these measures are applied. We gave the head of the household a safety suit," he said, "and the neighbours, especially all the children, watched with curiosity as he dressed up outside and turned into an 'astronaut'. Then the head of the household went into the house with the MSF disinfection team, and together we made all the small judgement calls: we looked at all the objects -- the TV, the embroidered tablecloth, etc. -- and decided what to keep and disinfect by spraying chlorine and what to burn or throw away in a special waste pit."

Maes added with a smile: "Sometimes people would get a bit over-enthusiastic about the disinfection process, so we would do extra spraying, to please them and to reassure them that their homes were safe again." Ironically, a simple solution of chlorine and water is enough to destroy a virus that is such a potent killer once it finds an opportunity to spread. In Uige, this opportunity was fortunately contained and it seems that Marburg will soon return to its dormant state. But MSF will continue to closely monitor outbreaks of hemorrhagic fevers. And if it needs to intervene again, the organisation knows it can count on volunteers like Peter Maes, Patrick Depienne, Dr. Armand Sprecher and many others who have gained rare, 1st-hand experience and are willing to go "back to the field" as soon as they are called." §

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  
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## Up coming Events

8—9 August 2005

### Resilient Infrastructure 2005

Millennium Hotel, Rotorua

Cost: \$1100 plus GST

More information from; [www.caenz.com](http://www.caenz.com)

25—26 August 2005

### Managing Extreme Weather and Flooding

NIWA, Christchurch

Cost: \$600 plus GST

More information from;

[www.naturalhazards.net.nz](http://www.naturalhazards.net.nz)

26 28 October 2005

### Health Materials Managers Conference 2005

Wellington Conference Centre

Cost: \$190

More information from; [www.mianz.co.nz/conference.html](http://www.mianz.co.nz/conference.html)

## Editor's soapbox

Media attention on the London bombings has focussed on the death toll. The focus for health care is on the survivors. The majority of survivors were treated in the street or in improvised casualty clearing points set up adjacent to the scene.



The positioning of these casualty points seem to have been impromptu decisions made by health care professionals and others converging on the site when they became aware of the incident. I am sure that as the situation developed through the morning those responsible for co-ordination of the response gained control of the scenes and those working there.

From this distance, the response seems to have gone well. The lesson for us is that in a similar situation here we will have to work with those who turn up at the scene and often in a location they have selected before we arrive. Let's keep our planning flexible enough to accommodate that reality.

**Bruce Parkes**

## Links to Look At

All, and more than you ever wanted to know about the prevention and control of influenza is available in a CDC paper **Prevention and Control of Influenza: The Recommendations of the Advisory Committee on Immunization Practices (ACIP)**

This report updates the 2004 recommendations by the Advisory Committee on Immunization Practices (ACIP) regarding the use of influenza vaccine and antiviral agents (CDC. Prevention and control of influenza: recommendations of the Advisory Committee on Immunization Practices [ACIP]. *MMWR* 2004;53[No. RR-6]:1--40).

The 2005 recommendations include new or updated information regarding:

1. vaccination of persons with conditions leading to compromise of the respiratory system;
2. vaccination of health-care workers;
3. clarification of the role of live, attenuated influenza vaccine (LAIV) in vaccine shortage situations;
4. the 2005--06 trivalent vaccine virus strains: A/California/7/2004 (H3N2)-like, A/New Caledonia/20/99 (H1N1)-like, and B/Shanghai/361/2002-like antigens (for the A/California/7/2004 [H3N2]-like antigen, manufacturers may use the antigenically equivalent A/New York/55/2004 virus, and for the B/Shanghai/361/2002-like antigen, manufacturers may use the antigenically equivalent B/Jilin/20/2003 virus or B/Jiangsu/10/2003 virus); and
5. the assessment of vaccine supply, timing of influenza vaccination, and prioritization of inactivated vaccine in shortage situations.

After reading the 37 pages of the report, other information can be accessed at <http://www.cdc.gov/flu>.

The trauma department at Liverpool Hospital, a teaching hospital at the University of New South Wales has developed a web site to improve public and professional knowledge of trauma. The site includes interactive sections, educational material, public information and details of meetings and training. For further information visit: [www.swsahs.nsw.gov.au/livtrauma/default.asp](http://www.swsahs.nsw.gov.au/livtrauma/default.asp)