

Donated Goods: So often the Second Disaster

Christmas is approaching and throughout the land we are setting ourselves up for a lot of grins or groans on Christmas morning. With good communication and/or a good understanding of what people want, grins will abound. A lack of communication or forethought and the groans will abound. Most of us have been disappointed at some time – the roaring post Christmas trade in exchanged goods is ample evidence of this.

A little personal disappointment and the inconvenience of holding on to an unwanted gift is the small price we pay for social cohesion. This is not so for disaster victims. Unwanted and unasked for gifts are often a burden that drags down their recovery efforts.

Although disasters are probably no more frequent, by courtesy of TV and the web the immediacy and horror of the event is beamed right into our living rooms. We have an emotional need to be seen to be doing something. Traditionally, we empty out our pantries and garages (of “used but still useful stuff”) in response to our neighbours need.

However, the stuff in our garage is not always of use to disaster victims. Even worse, when the aid is to another country with a different culture and living habits we send quite inappropriate stuff or we send equipment and supplies of no use to those responding on the ground. And when we do have the sense to first ask the victims what they want, their wishes take second place to political pressure and “commercial realities.”

A recent survey of 376 non-governmental organisations responding to tsunami needs in India and Sri Lanka found that 60% of NGOs in India and 40% of NGOs in Sri Lanka reported a flood of unsolicited relief supplies. Sixty percent of those working in India did not have adequate warehouse facilities and 40% lacked transport to carry relief supplies to affected people. Fifty five percent of Indians said the clothes they received as aid were culturally inappropriate or undignified, while 33% of Sri Lankans thought the same. (A shipment of heavy woollen sweaters exemplifies the point)

The media often highlight shortages of medicines, and donating medicines can seem a tangible way to express concern and solidarity. Drug donations do play an important part in humanitarian relief efforts, but they are not always the most effective way to help. The requirement for drugs must be determined with a comprehensive assessment of health problems.

If the medical needs of the affected population are not clearly specified, responses from hospitals and pharmacies in donor countries are unlikely to be helpful. Surplus drugs from hospitals and pharmacies are rarely what are most needed in emergency settings. Surplus drugs often include free samples or drugs returned by patients or health professionals, such as cardiovascular drugs, gastrointestinal drugs, hormones, and anti-rheumatic remedies. Some drugs have reached or are near their expiry date.

Two quick examples from the Asian Tsunami of ten months ago:

There are multiple references on the web to a caring and enterprising NHS nurse manager who gained considerable publicity for an appeal to donate spare hospital equipment. A container load of medical equipment and supplies was quickly gathered and transported to an

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This article is drawn from a presentation made to the Health Material Managers and Medical Industry Association combined conference in October 2005

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Asian destination by a generous shipping firm. Was the stuff in the container what people needed? Almost certainly not. The web is strangely silent on where or how it was distributed and used.

A relief doctor assigned to the Maldives commented, "The pharmacy was paved with so many cartons of humanitarian relief that I could no longer enter the room. It was a striking display of foreign generosity, yet the rationale for what had been dumped here was sometimes hard to decipher. Chest-drainage systems, blood-transfusion sets and oxygen tubing lay about, irrelevant in this basic environment. Drugs labelled in foreign languages were piled in an unused corner.

Despite most relief organisations stating emphatically on their web sites, "Please do not send un-requested goods" and the World Health Organisation issuing guidelines for drug donations the tidal wave of unwanted donated goods rolls on.

Katrina, Rita, Wilma and their sisters have given countries around the Caribbean and Gulf of Mexico a particularly nasty season. For them, disasters are annual events. Dr. Claude de Ville, disaster relief director for the Pan American Health Organization (PAHO) states that unwanted medicine is a continual problem. "When a transport arrives with 15 pallets of pharmaceuticals," he says, "three-quarters of them will turn out to be trash and one-quarter will be essential. The challenge is to quickly find the medicines you need. It takes time and it is a serious problem:

There is a 70-30 rule. 70% of the donated goods are junk; 15% can be used immediately; and 15% can be used later in the recovery

How big is the problem? Here are some examples that lead to the WHO issuing guidelines.

Armenia, 1988

After the earthquake, 5,000 tons of drugs and medical supplies worth US\$55 million were sent. Far more than needed. It took 50 people six months to gain a clear picture of the drugs that had been received. Only 30%

were easy to identify and only 40% of those were relevant for an emergency situation.

Eritrea, 1989

During the war for independence, despite careful wording of appeals, many inappropriate donations were received. Examples include: seven truckloads of expired aspirin tablets that took six months to burn and 30,000 half-litre bottles of expired amino-acid infusion that could not be disposed of anywhere near a settlement because of the smell.

Sudan, 1990

A large consignment of drugs was sent to war-devastated southern Sudan. Each box contained a collection of small packets of drugs, some partly used. All were labelled in French, a language not spoken in Sudan. Most drugs were inappropriate, some could be dangerous. These included: contact lens solution, appetite stimulants, X-ray solutions, and expired antibiotics. Of 50 boxes, 12 contained drugs of some use.

France, 1991

Pharmaciens Sans Frontières collected 4000 tonnes of unused drugs from 4,000 pharmacies in France. Only about 20% could be used for international aid programmes, and 80% were burnt.

Guinea-Bissau, 1993

In September 1993 eight tons of donated drugs were sent; all were collected from pharmacies in quantities of between 1 and 100 tablets. The donation contained 22,123 packages of 1,714 different drugs which were very difficult to manage and greatly interfered with government efforts to rationalize drug supply and drug use.

Bosnia and Herzegovina, 1992-1996

Between 1992 and mid-1996 over 17,000 metric tons of inappropriate donations were received with an estimated disposal cost of US\$34 million.

Albania, 1999

A WHO audit of humanitarian drug donations received in Albania during May 1999 revealed that 50% of the drugs coming into Albania during the Kosovo refugee crisis were inappropriate or useless and would have to be destroyed.

These stories are not confined to poorer countries.



An ideal (for a dry climate) and a common reality



A cornucopian collection of surplus donated goods in a Palmerston North warehouse after the 2004 floods.

In the Katrina response, after the authorities in Baton Rouge had prepared a field hospital for victims of the storm, FEMA sent its first batch of supplies, all of which were designed for use against chemical attack, including drugs such as Cipro, which is designed for use against anthrax. "We called them up and asked them: 'Why did you send that, and they said that's what it says in the book'," said a Baton Rouge official. (Cipro was actually useful for treating infections, but that was not why it was sent.)

A team of officials from the pharmaceutical company Eli Lilly just loaded a private jet with antibiotics, tetanus shots, and insulin and took off for the Gulf Coast region looking for a friendly airport to leave it on.

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Why is so much useless or unusable medicine donated? The answer is simple – money. A company with an excess of drugs about to expire can save the cost of destroying or storing the drugs by shipping them to a stricken region, thereby avoiding destruction costs and as an extra bonus claiming a tax deduction for their trouble.

It costs about US\$2,000 to destroy a metric ton of medicine. So the donors responsible for giving approximately 17,000 tons of inappropriate medicines to Bosnia received some hefty tax deductions and transferred \$34 million in drug destruction costs to the recipient country or humanitarian groups operating in the field. In Bosnia, Great Britain compounded the problem by sending a destruction incinerator that did not meet EEC emission standards.

Handling drugs that are useless, improperly labelled, or do not conform to the needs of the recipient country severely strains the already limited human and financial resources of the recipient country and international emergency-relief organizations.

Better coordination and adherence to the WHO guidelines by donors and charities would allow more successful use of available resources. The core principles for a donation are:

- Maximum benefit to the recipient
- Respect for wishes and authority of the recipient
- No double standards in quality
- Effective communication between donor and recipient

Management of drug donations by the recipient

This is all good stuff but just a bit academic to those of us sitting on the sidelines. But we will not always be on the sidelines. When the next big earthquake rattles and rolls its way through Wellington, or the plains of Canterbury are liquefied by a jump in the alpine fault, we can expect to be the recipient of a mountain of aid from all round the world.

What will we do? I could be retired — but would hate to miss the “fun”. The WHO guidelines offer a clear pathway for developing national guidelines for drug donations (and medical supplies).

Recipient countries need to develop administrative procedures to maximize the potential benefit of donations. Important issues, which have to be addressed in each country, include:

- Decide who is responsible for defining the needs, and who will prioritize them.
- Decide who coordinates all drug donations.
- Which documents are needed when a donation is planned; who should receive them?
- Which procedure is used when donations do not follow the guidelines?
- What are the criteria for accepting/rejecting a donation, and who makes the final decision?
- Decide who coordinates reception, storage and distribution of the donated drugs.
- How are donations valued and entered into the budget/expenditure records?
- How will inappropriate donations be disposed of?

Recipients should indicate to their prospective donors what kind of assistance they need, and how they would like to receive it.

Now we are too smart not to have done our homework on this. We know the risks we face and we pay attention to WHO guidelines. We know someone must be doing all this. We just don't know who it is—Is it YOU? To expect our, or any other Ministry to have this sorted out would take quite a big leap in faith.

The reality is that, in good Kiwi fashion, we will probably make it up on the day.

John Titmus, MCDEM advisor and leader of an UN Disaster Assistance team to the USA in response to Katrina, makes this observation:

“Logistics management is a very complex business and is best managed by those who manage logistics on a day-to-day basis.”

In the past, we have looked to Defence Force logistics experts to

manage disaster logistics. We will do so in the future - but they are a finite resource and in a major earthquake Health Material Managers will be called in to look after incoming drug and medical supplies.



Turning this—into this



Now while they are supermen and women, they are not trained for the job and telephone booths where they can change into their super costume are a vanishing species. But help is at hand. The WHO and PAHO have available a well tested completely computerised logistics management system, with manuals on how to use it.

SUMA - Humanitarian Supply Management and Logistics in the Health System is available free on the net at www.paho.org/english/ped/supplies.htm or via a CD

The question is – who is going to access this resource, or something like it, and become familiar with using it? #



Study shows personal hygiene is best defence against respiratory infections

Confirmation of the value of personal hygiene as our first defence in a pandemic scenario can be drawn from a paper published in this month's *Emerging Infectious Diseases*.

The paper, *Respiratory Infections during SARS Outbreak, Hong Kong, 2003*, by Janice Y.C. Lo, Thomas H.F. Tsang, Yiu-Hong Leung, Eugene Y.H. Yeung, Thomson Wu, and Wilina W.L. Lim, from the Department of Health, Hong Kong Special Administrative Region, People's Republic of China; set out to identify whether the increased personal hygiene measures in place in Hong Kong during the SARS outbreak significantly reduced the incidence of various respiratory viral infections in the community.

Although the study was observational and thus could not establish a causal relationship, it suggests an association between population-based hygienic measures and the reduced incidence of influenza and other acute viral respiratory infections.

During the height of the SARS outbreak in Hong Kong, schools were suspended, social activities were curtailed with the closure of various public places, and the community was engaged in a sustained and intense hygiene campaign. Population education on personal hygienic measures was spearheaded by the government with concerted efforts from various organizations and the community. Surveys conducted in April and May 2003 showed that most of the population wore a face mask (76%), washed their hands after contact with potentially contaminated objects (65%), used soap when washing hands (75%), covered their mouths when sneezing or coughing (78%), and used diluted bleach for household cleaning (>50%). Another survey on health-seeking behavioural traits conducted in June 2003 showed that >70% of respondents practiced some of these hygienic measures more frequently during the SARS outbreak than during the pre-SARS period.

The effect of these community hygienic

measures during the outbreak was studied by comparing the proportion of positive specimens of various respiratory viruses in 2003 with those from 1998 to 2002.

Lim et al postulated that these population wide anti-SARS measures would have effects on other infections spread by the respiratory route. They examined whether such measures also affected the incidence of some common acute viral respiratory infections, including influenza, parainfluenza, respiratory syncytial virus (RSV), and adenovirus. They checked the proportion of positive specimens (PPS) for each virus between each month of 2003 and the mean PPS in the same month of the preceding 5 years (1998–2002), which served as the reference period.

During March to July 2003, compared with the reference period, marked reductions in PPS occurred for influenza virus, parainfluenza virus, RSV, and adenovirus, particularly in the months of April, May, and June. This reduction corresponded to the period when anti-SARS measures in the community were most rigorous.

The authors note that pandemic planning for influenza is being undertaken with renewed efforts on a worldwide basis. They accept the common wisdom that control measures focusing on the use of antiviral chemotherapy and the expedient development of an effective vaccine is counter effective. Because an effective vaccine would probably become available only during the latter phase of the pandemic and be of limited use in countries with limited resources a more effective strategy is required.

They say that information concerning the effects of increased social distance and communitywide hygiene measures on the incidence of common viral respiratory infections at a population level has been lacking. The SARS outbreak offered a unique opportunity to study the association. While the relative contribution of each of these measures could not be estimated in their study, they conclude that the effective imple-

mentation of such measures requires determined and sustained educational efforts from health authorities with collaboration of the public. They propose that stockpiling personal protective equipment and having public education campaigns on infection control practices should form an integral component in pandemic planning for the emergence of novel influenza virus strains in humans. #



Basic messages—coupled with a little public fear—obviously works



Methamphetamine -- A health problem that won't go away

What a difference a year makes. Twelve months ago methamphetamine was the focus of our attention. So much has happened since – tsunamis, hurricanes, earthquakes, floods and birth flu pandemic – that the 'meth' problem has sunk below our radar. But it has most certainly not gone away.

Publicity usually centres on the behaviour of addicts and the mindless crimes they commit; so it is timely to run a refresher on this little nasty. Amphetamines were first synthesized in 1887 and like many recreational nasties were used for therapeutic purposes. Various amphetamine compounds were licensed and marketed for medical conditions ranging from weight loss to asthma.

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'Meth' is a synthetic psychomotor stimulant closely related to the decongestants ephedrine and phenylpropanolamine. 'Meth' can be injected, smoked, snorted, or taken orally or rectally with effects lasting for up to 12 hours. Administration results in feelings of euphoria and increased energy.

'Meth' is synthesized by converting ephedrine or pseudoephedrine into 'meth' via a series of steps usually in-

volving additions of phosphorous and iodine. This distillation process is commonly employed in "meth labs," which have been the focus of most law-enforcement efforts to control its use.

While backyard 'meth' manufacture is favoured by innovative New Zealand "cooks", the US Drug Enforcement Agency (DEA) estimates that 80% of 'meth' available in the United States is manufactured in other countries, primarily Mexico. However, given its criminal roots, definitive data on 'meth' distribution and supply are not available.

Overseas, epidemics of amphetamine abuse date back to the 1930s. The current epidemic is world wide. In the United States, methamphetamine now accounts for the majority of amphetamine used, with an estimated >12 million adult users in 2003.

The "rush" that follows methamphetamine use is associated with the release of neurotransmitters, including dopamine, serotonin, and epinephrine. While acute use of methamphetamine results in increased dopamine levels, prolonged use results in chronically depressed dopaminergic activity. In animal studies, repeated exposure to methamphetamines results in degeneration and destruction of dopamine axon terminals within the central nervous system. Other animal studies show depleted brain stores of dopamine and long-term decreases in biochemical markers of dopamine.

Methamphetamine use can lead to substantial morbidity and mortality. While 'meth' dependence may be characterized by daily use, many 'meth' users go on intermittent "binges" that last 24-72 hours during which they are hyper-vigilant, do not sleep, and often engage in high levels of sexual activity. Persons using 'meth' can exhibit severe intoxication symptoms that include agitation, anxi-

ety, and acute paranoia, and these conditions can progress to mimic acute schizophrenia. 'Meth' use is associated with rapid weight loss and severe dental decay; skin lesions are common due to the obsessive, excessive picking and scratching. These lesions often become infected and develop into bacterial cellulitis that requires antibiotic treatment. 'Meth' use has been associated with methicillin-resistant *Staphylococcus aureus* (MRSA) infection.

Whatever the underlying causes, the combination of weight loss, skin lesions, and dental decay can lead to a decline in general appearance and is likely to account for the rapid aging effect often seen among heavy 'meth' users. Additional consequences of acute use, while rare, can be severe and include convulsions, stroke, cardiomyopathy, myocardial infarction, and pulmonary compromise.

Methamphetamine withdrawal is well characterized and is associated with increased anxiety, agitation, and depression. Symptoms may persist, to varying degrees, over several months. In animal studies, depressive behaviour following 'meth' withdrawal has been linked to decreased dopamine levels in the nucleus accumbens. It is postulated that methamphetamine relapses are due primarily to the need to alleviate symptoms by restoring dopamine levels in the CNS to levels that can be observed in the presence of drug.

The strategy for beating the methamphetamine epidemic is really little different from that we plan for a pandemic. Keeping it out is the purview of laws enforcement agencies. However, initial reductions associated with enforcement activity gradually rebound, reflecting 'meth' manufacturers' abilities to find new ways to obtain precursors. Ironically, it may be the 'gangs', concerned at the way 'meth' is wreaking havoc with their membership, who will be able to ring fence and cap this epidemic.

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1998



2002

'Optistepsmism': A silent epidemic

A silent epidemic is sweeping the nation - and it has nothing to do with avoiding raw chicken, but pandemic planning may be a causal link.

The symptoms are aching shoulders, headaches, upset stomachs, sleepless nights and lacklustre days. The illness is stress, and many of us could be at risk. The good news is that there is a simple way to find out if you are open to infection and a simple cure for those prepared to follow a few words of advice.

A newly-devised test aims to sort out the seriously stressed from the hopelessly laid-back (which, by the way, is not the best state to aspire to either).

Optimism and openness to change are two of the key factors in determining your vulnerability. Having a network of people who care for you and are close is also a good safeguard.

Stress specialist Dr David Lewis said: "One of the most important things is optistepsmism - the difference be-

tween seeing the glass as half empty and half full.

"Stress arises when you want to achieve something but feel you can't. Optimists might believe they have a greater degree of controlling events.

"It is also very important to be flexible and realise that the world is constantly changing and that you have to change in order to keep up.

"If you can ride the waves of change rather than drown in them, you will be better able to cope with stress."

Optimism is gauged by questions such as attitude towards unexpected phone calls, while your reaction to surprise visitors at inconvenient times shows how flexible you are.

Other questions cover how well you sleep and other lifestyle issues. For those who do turn out to be highly stressed, psychologists believe the key to relaxation lies in three steps.

Dr Lewis, a fellow of the charity the International Stress Management Asso-

ciation, said: "The key thing is to recognise when you are under stress and take positive steps to try to reduce it. The first thing I would suggest is to try not to worry.

"Then, if there is something that needs to be changed - at work or in a relationship - change it. The third thing is to learn to be more relaxed, perhaps through breathing exercises."

Those who score at the other end of the scale might also want to make some changes. Studies have shown that a little bit of stress is good for you, boosting your immune system.

'Good stress' is associated with short bursts of activity, such as redecorating the front room in a weekend or packing a suitcase in a hurry to reach the airport in time.

Author Liz Hoggard, who devised the test, said: "People who are really laid back are maybe in danger of being bored."

[Take the test #](#)

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Health gets the dirty end of the stick. Both in site clean up and cleaning up those addicted.

Behavioural counselling is the current standard of care for 'meth' dependence. Programs may be inpatient, outpatient, or a combination of both approaches. Persons who enter behavioural programs generally decrease their methamphetamine use during treatment. Unfortunately, drop-out and relapse rates are high.

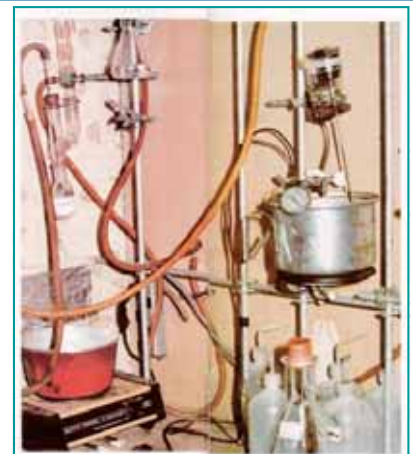
Most treatment approaches have not been evaluated in randomized controlled trials. Whether abstinence or harm reduction approaches are effective in reducing use remains largely unknown, as does the optimal number of sessions, session length, and session content. A non-counselling behavioural intervention that has shown some favourable results among 'meth' users is contingency management.

Contingency management involves providing vouchers in response to participants' supplying drug-free urines. Voucher values typically increase as

the number of consecutive drug-free urines increases. Contingency management has also been shown to be effective in treating other drugs of abuse. Pharmacologic treatments remain an active area of research, yet there are no current FDA-approved pharmacologic treatments for methamphetamine dependence despite trials of various candidates, including antidepressants, stimulants, amino acids, and anticonvulsants.

Clinicians should ask all patients about their current levels of methamphetamine use. The medical consequences of methamphetamine, particularly the neurologic, dental, and dermatologic sequelae, should be discussed in detail. It is imperative that all methamphetamine-using patients be offered treatment for their substance use. If patients initially are unwilling to participate in treatment programs, at subsequent visits clinicians should continue discussions about drug use and offer treatment referrals.

Clinicians should familiarize themselves with the treatment resources in their communities, including whether both



A "tidy" lab

abstinence-based and harm-reduction approaches are available, as well as the characteristics (gender, sexual orientation, age) of patients served by specific treatment programs. Careful consideration of the patient's current level of 'meth' use and receptivity to treatment will help determine the optimal treatment strategy. Although relapse rates are high, it is important to remember that duration of treatment for methamphetamine use is strongly correlated with better outcomes. And we must strive for better outcomes. #

Pandemic Planning in Asia

As we get our wagons in place to ward off a future pandemic it is interesting to look at what is happening in south eastern Asia – the incubator of the current avian flu H5N1 outbreak. Keeping with an avian theme, it may be that the planning is a little like the “curate’s egg” - excellent in parts and a little off elsewhere.

Robert noticed that on the property where he was running the programme chickens were dying for no apparent reason. - Sleepy in the morning and dead by the afternoon.

Robert Patton, leading a training programme near Manila in the Philippines earlier this month noticed that on the property where he was running the programme chickens were dying for no apparent reason. - Sleepy in the morning and dead by the afternoon. Birds were being sent to Australia for testing – as there has been no further publicity one must assume the cause was not H5N1. Getting any answers from health authorities during the public festival to celebrate the end of Ramadan, proved difficult.

Robert later made contact with the Philippines Department of Health (their function/role seems to be similar to the MOH in NZ) and found that the person managing infectious diseases was currently in Australia attending an Asia Pacific pandemic planning meeting. He was referred to their website: www.doh.gov.ph and there found a Preparedness and Response Plan for Avian and Pandemic Influenza dated 6 October 2005. The strategies in the plan for managing a pandemic are not too different from New Zealand’s strategy. The Philippine plan requires:

- Management of avian and pandemic influenza cases: isolation and management of cases, judicious use of antiviral agents, infection control, quarantine of contacts
- Slowing of spread from humans to humans in an influenza pandemic: entry and exit management of passengers, border control, quarantine of contacts, isolation and man-

agement of the sick, social distancing, personal hygiene

- Management of explosive spread: social distancing, personal hygiene, efforts shifted to maintenance of essential services
- Management of public anxiety: public advisories and information dissemination, regular updates and briefing of media

Robert comments that the plan appears to be quite comprehensive; however the focus is on both bird flu and a pandemic. Within the plan there is an action plan to complete pandemic planning and preparedness within the next 12 months.

Robert contacted the Infection Control nurse at a 200 bed University Hospital on the outskirts of Manila and asked her about their planning and preparations for a pandemic. He was told that, so far, there had been none for a pandemic and there had been no communication, directives or information from the DOH regarding pandemic planning. What was being communicated from the DOH was specific to bird flu and the posters they were displaying in the hospital all related to bird flu.

Moving on to Chiang Mai in Thailand, Robert met with Dr. Surasing Visrutaratna, Deputy Director, Chiang Mai Provincial Public Health Department and was hugely impressed with their pandemic activity. Chiang Mai, with 24 districts and approximately 2000 villages has more than 40 hospitals to serve a population of >1.6 million

They have two components to their public health planning and preparedness; - avian influenza, and influenza pandemic; with a relationship between the two. Intensive planning and preparedness activities have been implemented over the last four months. The key strategies for preventing/controlling avian ‘flu are:

1. Use grass roots approach
2. Communication to households down to the village level on how to reduce their risk of contracting avian ‘flu; and modify what is a usual way of life to reduce risks e.g. separate humans from birds.

3. Screening procedures at all hospitals. If patient presents with a fever, immediately isolated and investigated to identify cause of fever.
4. Pre-positioning of medicines (primarily Tamiflu) and equipment (primarily PPE)
5. Training for all staff in procedures e.g. use of PPE

Surveillance and reporting systems.

Pandemic planning has been based on an estimate of 30% of the population falling sick. This does not include mortality rates as their concern is more for the sick than the dead.

400 doses of Tamiflu are held in Chiang Mai province for immediate emergency use with further supplies available from a stockpile in Bangkok. The figure of 400 doses has been determined on the basis of: if there is a reported case of influenza it is presumed that there would be an initial cluster of two people in the same family (if laboratory positive) and each would receive Tamiflu. Approximately 10 medical staff and 10 investigation staff would require Tamiflu for this cluster. For each cluster of two, approximately 50-60 “contact people” would also receive Tamiflu. Therefore, an allowance of 80 doses of Tamiflu is made for each reported case and on this basis the province has enough Tamiflu locally to immediately combat 5 clusters.

PPE equipment consists of overalls with hood, boots, mask, face shield, and gloves. There are 20 PPE sets at the Public Health department. Each hospital also has the same PPE sets, the number determined by the number of beds. The Public Health department has 15 people who could be used to form an investigation team.

Each hospital has developed its own avian ‘flu and influenza pandemic plan, based on a template put out by the Provincial Public Health department. Once the plans have been completed they are sent to the health department for approval.

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All hospitals had completed and approved plans. Some plans have been tested by an exercise; and all plans will be so tested by this December.

Part of the Provincial Public Health department's plan is to prepare schools, temples and stadiums to be used for health purposes in a pandemic . Preparation for this is currently underway.

The Chiang Mai Command centre for is already partially activated. Every morning Dr. Surasing meets with the command centre staff and reviews the current avian flu / pandemic status in the province, Thailand, and internationally. Every evening there is a meeting with the Chiang Mai Governor to brief him on the current situation.

Last year there was one confirmed case of avian flu in an animal in Chiang Mai province - but no human cases. This year, to date, there have been no cases of avian flu in animals or humans.

Avian 'flu / pandemic surveillance is in place. As soon as a positive influenza case is identified the command centre will be fully activated and operational within 2 hours.

Surveillance and reporting systems for both animal and human surveillance are well developed and computerised for real time status reports. They are available at www.chiangmaihealth.com All patients with influenza-like symptoms are rigorously investigated and monitored until test results are received.

Initially, the surveillance approach was passive e.g. only visiting those animals with symptoms. Surveillance is now active and teams visit every village. The Provincial Public Health department has partnered with veterinary department for surveillance – this includes taking samples from migratory birds.

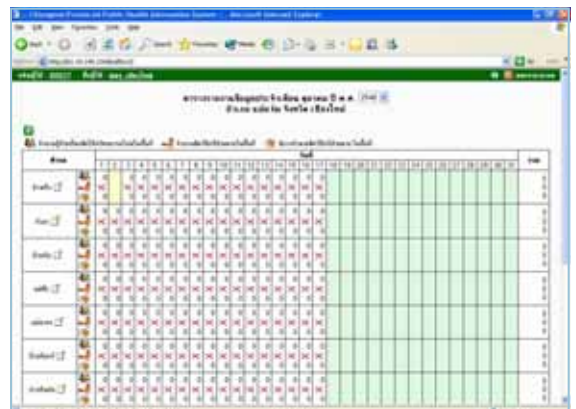
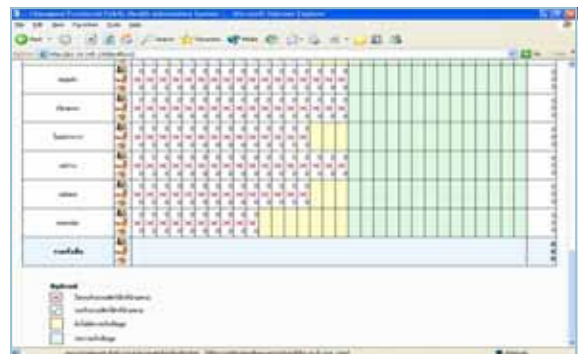
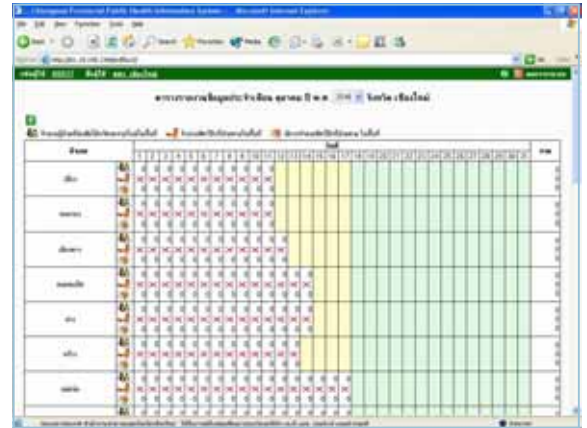
The web based surveillance reporting system has been developed by Dr. Surasing. The language is Thai, which makes it a little incomprehensible to those who struggle with that language. On a series of spreadsheets there is a record of:

- reported human cases of influenza
- reported animals/birds cases of influenza
- number of animals/birds culled.

Human cases are hyperlinked to another spreadsheet which shows all the hospitals, clinics etc. in the district where the case occurred, and shows which hospital/clinic the cases presented to. Another link leads to a summary report on the patient, documenting their signs and symptoms; clinical history; tests ordered, test results; etc.

Data is entered into the system as soon as the patient presents, so it can be interrogated at any time, from any location (even New Zealand) to get a complete picture of what is happening in the province.

All staff likely to input information into the system or to retrieve information from their system have been trained to use it. #



Information: A life saving resource

Today, information technology helps aid agencies gather and store huge amounts of information, but do people affected by disasters get enough information?

This year's Red Cross World Disasters Report 2005 focuses on information in disasters and considers the quality of the communication between those involved in disasters and what impact this information has on the people caught up in a crisis.

The Report, in its 13th year of publication, highlights ways in which accurate, timely information can save lives and reduce suffering during disasters. But it also raises the question whether the affected populations get early enough warnings of an impending disaster, whether these communities are involved in what aid agencies are planning on their behalf and whether aid organizations are as good at sharing information with the affected people as with their donors. The Report underlines that the right kind of information leads to a much deeper understanding of people's needs and the best ways to meet those needs.

The Report underlines the importance of recognizing information as a form of disaster response in its own right. Few read about the desperate plight of those trapped in New Orleans without a sense of horror. The deadliest natural disaster to strike the United States for a century, Katrina exposed the vulnerability of some of America's communities. Yet in the face of disaster, the difference between life and death is as simple as possessing the right information – and acting on it.

The risk of a hurricane flooding New Orleans has been known for decades. Authorities had previously estimated that 65,000 people could die in New Orleans, if a slow-moving category 3 hurricane made a direct hit. But how many of the city's poorest residents, or those caring for the infirm, knew the risks or how to react? By the time Hurricane Rita arrived three weeks later, blanket media coverage of Katrina had electrified the public's awareness of hurricanes. With the images of New Orleans fresh in their

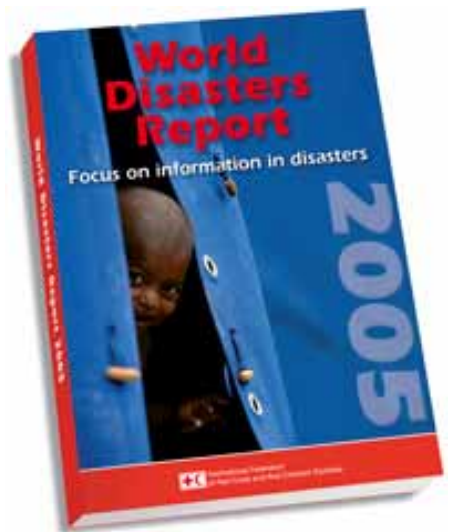
minds, around 3 million citizens began fleeing north, days before disaster struck.

It's vital to put those people most vulnerable to disasters at the centre of early warning and evacuation plans. Where do they live? Do they even get the warnings most of us take for granted? Do they know where and when to evacuate, or who to ask for help? This kind of information has saved countless lives during disasters from Baton Rouge to Bangladesh.

Greater public awareness brings greater trust and urgency to react when the warnings are raised for real. Civil society – whether national Red Cross and Red Crescent societies, non-governmental organizations or youth groups – can play a vital role in building risk awareness among vulnerable people and helping them escape the worst effects of disaster. This is especially true in countries facing the same hazards at the same time every year.

Many countries at risk from windstorms prioritize risk awareness-raising. In Jamaica, June (just before the hurricane season) is 'disaster preparedness month', when awareness days, practice drills and displays are organized for schools and businesses. In Cuba, schoolchildren are taught about hurricane warning and evacuation from an early age. In Bangladesh, 33,000 Red Crescent volunteers prepare their communities for disaster before every cyclone season. The lesson from these countries is: you don't have to be rich to be well-prepared – but you do have to be well-informed.

However, accurate information – while crucial – is only part of the answer. We must also *act* on the information we have, in time to avert possible disaster. The food crisis that continues to devastate lives and livelihoods in Niger and neighbouring West African countries was preventable, because it was predictable. The telltale signs emerged in late 2004: precious livestock began to die, food prices soared, pastoral families migrated to urban areas and children succumbed to malnutrition in ever greater numbers. But it was not until images of emaciated infants ap-



peared on TV screens in mid-July that funds flowed in and a major humanitarian response was launched – by which time hundreds, if not thousands, had already died and the costs of rescuing survivors had soared.

Information bestows power, whereas the lack of information can make people victims of disaster. Do we use information to accumulate power for ourselves or to empower others? The report calls on agencies to focus less on gathering information for their own needs and more on exchanging information with the people they seek to support.

This surely is the big issue as we bear away at our pandemic planning. All the information on what might happen is available to us. How we package and share it to allow communities to build their resilience is the task before us.

Markku Niskala, Secretary General of the Red Cross Federation comments:

"The capacity for resilience in the face of adversity shines through all the stories in the report. People continually adapt to crisis, coming up with creative solutions. They prioritise livelihoods and household assets rather than the quick fix. Supporting resilience means more than delivering relief or mitigating individual hazards. Local knowledge, skills, determination, livelihoods, cooperation, access to resources and representation are all vital factors enabling people to bounce back from disaster. This implies a paradigm shift in

(Continued on page 10)

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how we approach aid. We must focus on the priorities and capacities of those we seek to help.

Mapping vulnerabilities and meeting needs is no longer enough. The idea is not new - it's been enshrined in The Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief for the past 10 years. So why do humanitarian organizations still fail to assess - let alone harness - the capacities of those at risk?

Three things need to happen. First, we must understand what enables people to cope with, recover from and adapt to the risks they face. Second, we must build our responses on the community's own priorities, knowledge and resources. Third, we must scale up community responses, by creating new

coalitions with governments and advocating changes in policy and practice at all levels.

If we focus only on needs and vulnerabilities, we remain locked in the logic of repetitive responses that fail to nurture the capacities for resilience contained deep within every community.

We have talked about building capacity and resilience for decades. It is now time to turn rhetoric into reality: to dispel the myth of the helpless victim and the infallible humanitarian, and to put disaster-affected people and their abilities at the centre of our work." #



There is a need to recognise information as a form of disaster response in its own right.

*Photo: Till Mayer
German Red Cross,
Sri Lanka*

The NHS Emergency Planning Guidance 2005

The UK Department of Health, Emergency Preparedness Division, has issued a new set of general principles. The purpose of the guidance is to describe a set of general principles to guide all National Health Service organisations in developing their ability to respond to a major incident or incidents and to manage recovery, whether the incident or incidents has effects locally, regionally, or nationally within the context of the Civil Contingencies Act 2004

The Principles, downloadable as a PDF document, are a useful addition to a practitioner's library but offer little in the way of a toolkit for someone setting out to develop or review their plan. Underpinning the plan are six further documents with more direct guidance for ambulance, acute hospitals, non acute hospitals, primary care, scene care, and strategic trusts. A 20 page bibliography, 17 page glossary and 9 page list of acronyms round out this suite of documents. #



CBAC Number Crunching

The viability of CBACs will depend on numbers - the number to process and the number required for staffing them. For those of us who are mathematically challenged the very thought of having to work it out can be a little mind numbing.

Somewhere in your organisation there will be people conversant with queuing models and how to apply them but you

will still be left with a sense of unease over whether than queuing model will stand up to an operational reality.

Work, driven by the need to prepare for bioterrorism emergencies, has seen models developed and tested in real life and exercise applications. Those models are equally applicable in a pandemic situation and provide a useful reality check for your community based assessment centre planning.

One set of tools worth further consideration is **Bioterrorism and Other**

Public Health Emergencies: Tools and Models for Planning and Preparedness - Community-Based Mass Prophylaxis A Planning Guide for Public Health Preparedness

Produced by the Agency for Healthcare Research and Quality in the States, it is available at www.ahrq.gov/research/cbmprphyl/index.html#Contents

Try it out. #

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

Up coming Events

27 - 30 November 2005

RedR Personal Security and Communications Training Course

Waiouru Military Camp

Cost: \$600

More information from; www.redrnz.org.nz

28 - 29 November 2005

Risk Management Conference

Copthorne Hotel, Wellington

Cost: \$1950 + GST

More information from;

www.brightstar.co.nz

14 - 15 February 2006

Emergency Management Conference

Duxton Hotel, Wellington

Cost: \$2195 + GST

More information from;

www.conferenz.co.nz

23 - 24 March 2006

HEMNZ2006

Novotel Hotel, Ellerslie, Auckland

Brochure available in December

from; www.hemnz.org.nz

Editor's soapbox

I have never known the health emergency management sector to be so exhausted. The prolonged demand to pick up the pace and deliver reiterations of pandemic plans while still delivering on our normal range of tasks has become quite tiring. Knowing that one can always get a colleague at their desk on a Sunday afternoon is a measure of their dedication but a worrying trend in work-life balance. How are you holding up? If you have not taken the optimestepsmism test (page 6), do it now.



Our glass is more than half full. The National Pandemic Action Plan is now up to version 14 and coming to a state where it becomes useful as an umbrella for our planning. We have the attention and chequebook of the government and the whole community. The links we are forging now are, if regularly oiled, going to keep us in good shape for years to come. Around the world there are some real smart uses of technology we can piggyback on to reduce our risks and enhance our response.

While preparing this Bulletin I have been listening to a session on the radio where the Beethoven 9th was used as a frame to discuss the history of early 19th century Europe. What a fantastic way to communicate joy and hope for the future in what was a rather grim time for most Europeans. Who could walk away from a performance of the Ninth Symphony and not believe everything would work out.

Now to a 21st century antipodean ear, Schiller's Ode to Joy is a piece of turgid Teutonic prose that could not stand on its own. But sheathed in Beethoven's music it has inspired millions for over 200 years. The key is the packaging of the information; a lesson we must never forget as we communicate risk (and our solutions) to our communities.

The theme for HEMNZ2006, will be "capturing communication" - the key to the risk management cycle. I am just finalising an exciting overseas speaker and will have a conference programme to you in December. Linked to the conference are our second HEMNZ Innovation Awards. An opportunity to celebrate the creativity and hard work of the past few months. I look forward to you sharing your success and joining with us on March 23-24 next year.

Bruce Parkes



This has been an extremely busy year for emergency managers and we have accomplished so much. There has been many exciting and innovative developments as we have geared up for the pandemic war we hope will never come.

The HEMNZ Innovation Awards are set up to recognise those achievements. Take a few minutes to reflect on what you have done then fill out an application form before you break for a summer respite.

Besides gaining recognition for your work and the acclaim of your

peers, there are tangible rewards for those judged most worthy by an independent judging panel.

Applications close on January 30th and the winners announced at the HEMNZ2006 dinner on March 23rd.

Application forms are available as Word documents on our web site