Health Emergency Management in New Zealand

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Disaster Capitalism: making money out of misery

Over the past 25 years our publicly owned works infrastructure has withered on the vine. Private/Public partnership is the new model with efficiencies and economic savings over the bloated government departments of old. With those efficiencies has come a cost. No longer is there a contingent capacity of under utilised machinery and personnel to plug in to disaster response and recovery. Now one company may serve a number of councils and the battle is on to see who will get the service when the chips are down. With calls for an increased public/private partnership in health, surge capacity will become an increased risk to consider.

There are obvious advantages in a public/private partnership in disaster response. In this country Red Cross have a long standing strategy of using The Warehouse as the supplier of emergency clothing in preference to holding stock in warehouses around the country.

In the U.S. the Red Cross has announced a new disaster-response partnership with Wal-Mart. When the next hurricane hits, it will be a co-production of Big Aid and Big Box. This, apparently, is the lesson learned from the US government's calamitous response to Hurricane Katrina: businesses do disaster better. "It's all going to be private enterprise before it's over," Billy Wagner, emergency management chief for the Florida Keys, currently under this season's hurricane watch, said. "They've got the expertise. They've got the resources."

But before you shout, "way to go," write Stephen Tindall's name into your plan and head out for a long lunch, reflect on the thoughts of anti-corporate globalisation guru Naomi Klein, whose book on disaster capitalism will be published in early 2007. In an opinion piece published in the Guardian on August 30th she observes, "The privatisation of aid after Katrina offers a glimpse of a terrifying future in which only the wealthy are saved."

According to Klein, the first step down the road to privatisation was the U.S. government's abdication of its core responsibility to protect the population from disasters. She says that under the Bush administration, whole sectors of the government, most notably the Department of Homeland Security, have been turned into glorified temp agencies, with essential functions contracted out to private companies. The theory is that entrepreneurs, driven by the profit motive, are always more efficient (please suspend hysterical laughter).

New Orleans one year ago was a picture of this brave new world order: Washington was frighteningly weak and inept, in part because its emergency management experts had fled to the private sector and its technology and infrastructure had become positively retro. At least by comparison, the private sector looked modern and competent.

But the honeymoon doesn't last long. "Where has all the money gone?" ask desperate people from Baghdad to New Orleans, from Kabul to tsunami-struck Sri Lanka. One place a great deal of it has gone is into major capital expenditure for these private contractors. Largely under the public radar, billions of taxpayer dollars have been spent on the construction of a privatised disaster-response infrastructure: the Shaw Group's new state-of-the-art Baton Rouge headquarters, Bechtel's battalions of earthmoving equip-

Naomi Klein

(Continued on page 2)

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ment, Blackwater USA's 6,000-acre campus in North Carolina (complete with paramilitary training camp and 6,000-foot runway).

Klein calls it the "Disaster Capitalism Complex." Whatever you might need in a serious crunch, these contractors can provide it: generators, water tanks, cots, port-a-loos, mobile homes, communications systems, helicopters, medicine, and men with guns.

This state-within-a-state has been built almost exclusively with money from public contracts, including the training of its staff (overwhelmingly former civil servants, politicians and soldiers). Yet it is all privately owned; taxpayers have absolutely no control over it or claim to it. So far, that reality hasn't sunk in because while these companies are getting their bills paid by government contracts, the Disaster Capitalism Complex provides its services to the public free of charge.

But here's the catch: the US government is going broke, in no small part thanks to this kind of loony spending. The national debt is $8 trillion; the federal budget deficit is at least $260bn. That means that sooner rather than later the contracts are going to dry up. Insiders call it the "homeland security bubble". (And we all know what happens when bubbles burst – lots of little people get hurt).

When it bursts, firms such as Bechtel, Fluor and Blackwater will lose their primary revenue stream. They will still have all their hi-tech gear giving them the ability to respond to disasters, while the government will have let that precious skill wither away - but now they will rent back the tax-funded infrastructure at whatever price they choose.

Here's a snapshot of what could be in store in the not-too-distant future: helicopter rides off rooftops in flooded cities at $5,000 a pop ($7,000 for families, pets included), bottled water and "meals ready to eat" at $50 a head (steep, but that's supply and demand), and a cot in a shelter with a portable shower (show us your biometric ID, developed on a lucrative homeland security contract, and we'll track you down later with the bill).

The model, of course, is the US healthcare system, in which the wealthy can access best-in-class treatment in spa-like environments while 46 million Americans lack health insurance. As emergency-response, the model is already at work in the global Aids pandemic: private-sector prowess helped produce life-saving drugs (with heavy public subsidies), then set prices so high that the vast majority of the world's infected cannot afford treatment.

Bring in the Marines—is that Marine offering a helping hand or clipping the tickets? An invidious position for those on the ground to be in.

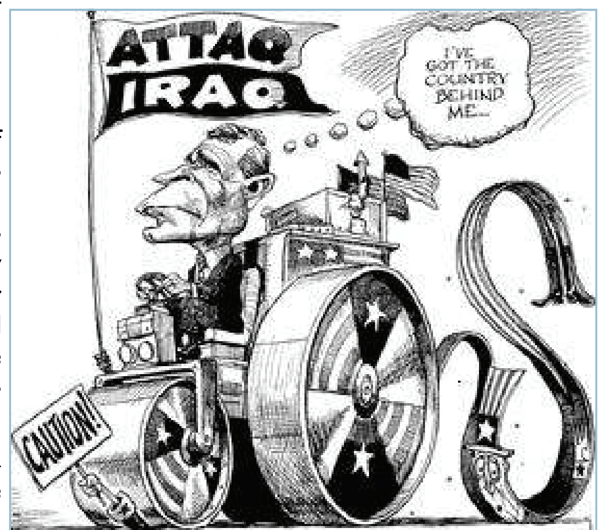
If that is the corporate world's track record on slow-motion disasters, why should we expect different values to govern fast-moving disasters such as hurricanes or even terrorist attacks? It's worth remembering that as Israeli bombs pummelled Lebanon not so long ago, the US government initially tried to charge its citizens for the cost of their own evacuations. And, of course, anyone without a western passport in Lebanon had no hope of rescue.

One year ago, New Orleans's working-class and poor citizens were stranded on their rooftops waiting for help that never came, while those who could pay their way escaped to safety. The country's political leaders claim it was all some terrible mistake, a breakdown in communication that is being fixed. Their solution is to go even further down the catastrophic road of "private-sector solutions." Unless a radical change of course is demanded, New Orleans will prove to be a glimpse of a dystopian future, a future of disaster apartheid in which the wealthy are saved and everyone else is left behind.

The growing involvement of the private sector in development and humanitarian relief is a fact. But the nightmare vision posited by Klein isn't inevitable. For starters, accountability and regulation could go some way to curbing profit-making from disasters.

Klein's article has drawn a flood of mostly favourable comment and you can read it all on the Guardian website www.guardian.co.uk/comment/story/0,,1860673,00.html A number of commentators discuss the differences between NGOs and corporations. They say the NGOs operate on a shoe string but sometimes take on projects they are not equipped or trained to handle and NGOs are just as competitive in their scramble for donor dollars as the corporates are for government contracts.

And before you rush to Amazon to order Klein's book note this comment posted on the website, "the opinion piece starts with the headline "Disaster capitalism: how to make money out of misery", and ends with: "Naomi Klein's book on disaster capitalism will be published in spring 2007". "Says it all, really," observes the writer. #



Popeye vs E.Coli

That legendary comic hero Popeye may have met his match. A humble little bug is taking spinach of the menu in many American homes.

The Food and Drug Administration (FDA) is advising consumers not to eat fresh spinach or fresh spinach-containing products until further notice due to E. coli [O157:H7] infection.

The FDA has narrowed down the culprits to a California-based grower, Natural Selection Foods, and at least one of its distributors. So far, 171 people in 25 states across the country are ill (and one in Ontario, Canada), some very seriously. Half of the victims have been hospitalised, a high rate that may indicate an especially virulent strain of *E. coli*.

Investigators continue to search for the cause of the outbreak. They have scoured the company's processing plant as well as the farms that grow the spinach, looking at everything from irrigation water to the proximity of livestock, with no sure connections made so far. The fact that Natural Selection is in California's Salinas Valley, an American food basket, has raised alarms. According to the FDA, fresh produce from the valley, including spinach, has been the source of nine *E. coli* outbreaks since 1995.

Natural Selection, which supplies several supermarket chains across the United States with conventionally produced fresh spinach, is also the nation's largest grower and shipper of certified organic produce, under its Earthbound Farm brand. If organic spinach becomes implicated, the financial consequences for the organic sector of the fresh produce market, which prides itself on its purity, could be severe.

With the FDA advising consumers not to eat fresh spinach from any source until further notice, the outbreak could ruin California's whole spinach industry. The state grows about three-quarters of the American crop. In recent years the market for fresh spinach has benefited hugely from what one producers' spokesman calls "a great health profile". In 2005, per capita consumption in America was forecast at 2.2 pounds (one kilogram), up from just 0.6 pounds ten years ago. That total isn't likely to increase again for a while.

E *coli* outbreaks did not stop with spinach. Again in California, a general recall of all unpasteurised milk from Organic Pastures was ordered after it was found to contain E coli. Organic Pastures have been banned from supplying milk until the source of the contamination has been identified. **#**

Chikungunya reaches England

Public Health authorities in England report that so far this year nearly 100 cases of chikungunya fever have been reported – up from an average of about 6 cases annually. Chikungunya, on which we have reported in the past, causes a high fever, headache, nausea, vomiting and muscle and joint pain. Mosquito borne chikungunya virus is endemic in the Indian Ocean and now in many states in India.

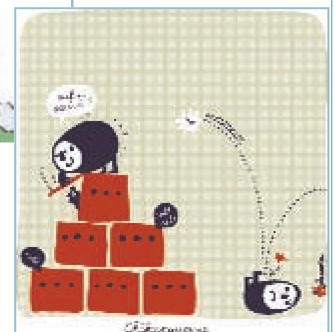
The incubation period for the illness can be 2-12 days. Acute fever can last a couple of weeks and some patients report debilitating joint pain, which can continue for weeks or months. Treatment consists of rest, drinking fluids and taking painkillers.

Researchers at the Institut Pasteur in France report that the unique molecular features of the analysed Indian Ocean isolates of chikungunya virus demonstrate their high evolutionary potential and show links to an evolving east African strain. This offers possible clues for understanding the atypical magnitude and virulence of this outbreak and—while the researchers do not suggest so—more virulent strains in the future.

The cases in England are in people who have been bitten by the vector Aedes albopictus while in the Indian sub continent or islands in the Indian Ocean. One must assume that New Zealanders travelling in the area are just as susceptible to mosquito attacks so we can well expect to see cases in this country.

This is yet another example of rapid, long-distance transport of infected people to countries where a particular pathogenic virus, in this case chikungunya, is absent. Fortunately, the virus is unlikely to become established in New Zealand because the usual mosquito vectors are currently absent.

French Health Minister Xavier Bertrand has announced that a drug to fight the disease, which was first identified in Tanzania in 1952, could be ready by the end of 2006. Bertrand added that French and American authorities have agreed to work on a vaccine that protects against the virus. **#**



Cartoonists were quick to pick up on the need to stay on guard against mosquitoes as well as bird flu.

Research Suggests H5N1 Virus Replicates More Strongly Than Common Flu

The H5N1 bird flu virus replicates far more aggressively in people than common human flu viruses, a study of patients in Viet Nam has found, offering further insight as to why the virus is so deadly. The study, is reported in a paper, *Fatal outcome of human influenza A (H5N1) is associated with high viral load and hypercytokinemia* published ahead of print in Nature Medicine on line. The authors, Menno D de Jong and 17 others at the Oxford University Clinical Research Unit, Ho Chi Minh City, Viet Nam also found that the virus had got into the blood stream of many of the human victims it killed, which means the virus could have spread to other parts of the body.

Menno de Jong, a key researcher in the study, explained that the unusually high viral loads triggered intense "cytokine" responses; an immune system overreaction that can be fatal. Cytokines are proteins in the immune system that fight off intruders such as bacteria and viruses. "During H5N1 virus infection, the (cytokine) response seems to be very, very intense. Cytokines want to get rid of this intruder, but if you have very high levels of cytokines, it can also damage the body ... it can be directed against your own cells and organs," de Jong told Reuters in an interview.

The study involved 18 people infected with H5N1 and 8 with human flu in 2004 and 2005 in Viet Nam. Scientists found far higher viral loads in the nose and throats of those infected with bird flu than human flu. Thirteen of those infected with H5N1 died, and the virus was found in the blood of at least 9 of them, implying it could have been transported out of the respiratory tract. The virus was also found in the rectums of most of those with H5N1, suggesting it could have spread through the blood stream into the gastrointestinal tract. Those with common flu had no virus in their blood or rectum. No one died in that group.

"The fatal outcome of H5N1 infections seems to be associated with high levels of replication of the virus and also the detection of the virus in the blood," de Jong said.

The team was able to draw a connection between those who were most ill and the level of cytokines found in them. "We found that levels of cytokines were much higher in H5N1 patients than in the human flu cases. Again, the highest levels of cytokines were found in those who died of H5N1," he said. " The high levels of the virus triggered an overwhelming inflammatory response that contributed to lung dysfunction and eventual death."

De Jong highlighted the need to stop the virus replicating. "What's important is to stop the replication as soon as possible, so you prevent damage to the lungs and prevent the inflammatory response to the virus," he said. But he conceded that early diagnosis was a challenge, especially in remote places where health services were not readily available.

To what extent, however, their observations are specific for H5N1 influenza is debatable. Their 2 groups of patients were not precisely comparable. The seasonal influenza patients being hospitalized at an earlier stage in the disease process and possibly from urban rather than rural communities. Of greater relevance may be the genetic constitution of their patients, since most humans are vulnerable to seasonal influenza, whereas few contract avian influenza. Furthermore, detrimental chemokine and cytokine cascades can be an accompaniment of other respiratory virus infections, such as severe respiratory syncytial virus (RSV) infections in infancy. #

The Washington Post's Mensa Invitational once again asked readers to take any word from the dictionary, alter it by adding, subtracting, or changing of one letter, and supply a new definition. Here are the 2005 winners:

1. Cashtration (n.): The act of buying a house, which renders the subject financially impotent for an indefinite period.

2. Intaxication: Euphoria at getting a tax refund, which lasts until you realize it was your money to start with.

3 Foreploy: Any misrepresentation about yourself for the purpose of getting laid.

4. Giraffiti: Vandalism spray-painted very, very high.

5. Sarchasm: The gulf between the author of sarcastic wit and the Person who doesn't get it.

6. Inoculatte: To take coffee intravenously when you are running late.

7. Hipatitis: Terminal coolness.

8. Osteopornosis: A degenerate disease. (This one got extra credit.)

9. Glibido: All talk and no action.

10. Arachnoleptic fit (n.): The frantic dance performed just after you've accidentally walked through a spider web.

11. Caterpallor (n.): The color you turn after finding half a worm in the fruit you're eating.

During a visit to the psychiatric ward, a visitor asked the Team Leader what the criterion was to define whether or not a patient should be institutionalized.

Well," said the Team Leader, "We fill up a bathtub, then we offer a teaspoon, a teacup and a bucket to the patient and ask him or her to empty the bathtub."

"Oh, I understand," said the visitor. "A normal person would use the bucket because it's bigger than the spoon or the teacup."

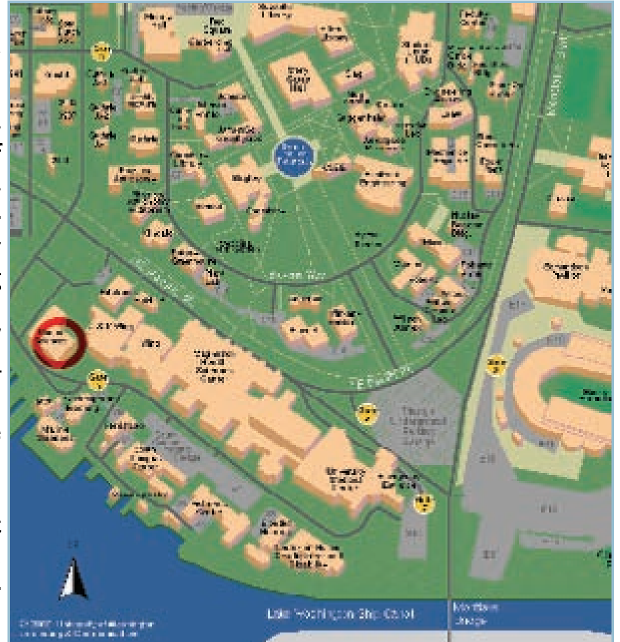
"No." said the Team Leader, "A normal person would pull the plug. Do you want a bed near the window?"

Fitting special needs population into your emergency plans.

On any given day over 60,000 people are present on the University of Washington Seattle campus – more than can be found in many New Zealand towns. Among this small city of students, faculty, staff and visitors are people who require more individualised assistance in the case of an emergency. Often called special needs (SN) populations, the term vulnerable populations or specific needs are also used. These vulnerable populations include minors under the age of 18; physically, psychologically, cognitively, and sensory impaired persons; hospitalised patients and others with medical conditions; the frail elderly; and non English speaking persons. Companion, service (and for the University), research animals are also considered to be special needs groups.

In 2004 the University was awarded a US$300,000 grant from FEMA, which was matched locally, to develop and implement seven projects, including a special needs study, aimed at mitigating the effects of natural disasters. A report on the Emergency Preparedness for Special Needs Populations has now been published and is a useful tool for those planning for their special needs populations in the community and in their workplace.

The report is an analysis of the special needs populations, stakeholders emergency responsibilities, and recommendations to strengthen emergency preparedness for special needs groups.



The University campus is extensive so keeping track of special needs people can be difficult

The university campus has a diverse group of special needs populations with unique requirements for emergency preparedness including up to 1,700 children, 3,000 with disabilities/ medical needs, and 400 – 800 with limited command of English. These numbers, while significant, are lower than what one would expect in a community setting. Only the 200,000 research animals on campus create a special problem.

The recommendations in the report include:

- Assembling an inventory of special needs populations linked to campus location and a voluntary real time location programme. This includes investigating voluntary communication systems with special needs individuals such as global positioning chips, text messaging, pagers and two way radios.
- Raising the awareness of special needs emergency preparedness resources for students, faculty and staff by using the existing infrastructure of available materials. Such as the Access Guide and course syllabi and targeting special needs related audiences.
- Updating current evacuation and emergency operations plans around the university based on emergency knowledge related to special needs populations by incorporating emergency guidelines on disability accommodation for emergencies and lessons from recent disasters.
- Including special needs individuals and university experts in policy planning and practice drills.
- Expanding emergency communication methods for non English speaking individuals
- Strengthening emergency preparedness for the special needs groups on campus was seen as not only serving those populations, but also helping the University in general being overall more prepared for the next disaster.

Yes this is the university — not a hotel and he is a student

In your planning have you allowed for the special needs populations on your sites? #

Low key 2006 Hurricane season, so far

After the excesses of 2005, with 28 tropical storms, of which 15 became hurricanes, the 2006 the six-month Atlantic storm season that began on June 1 has been thus far relatively quiet. Helene, became the fourth hurricane of the Atlantic season with sustained winds of 120 kilometres an hour but did not threaten land. Well at least not American land. Helene veered off to the north east and as an intense hurricane is now forecast to strike Ireland as a tropical storm at about 18:00 GMT on 28 September. Data supplied by the US National Hurricane Center suggest Helene is expected to bring 1-minute maximum sustained winds to the region of around 64 km/h (40 mph). Wind gusts in the area may be considerably higher.

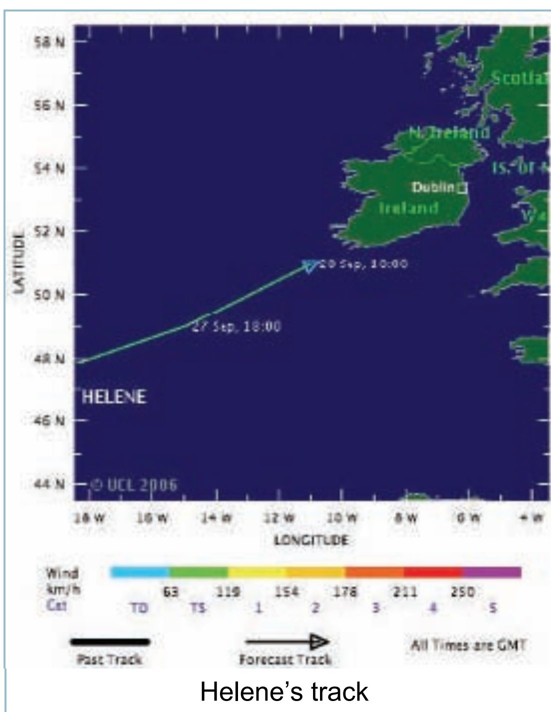
But the U.S. has nor escaped unscathed. Severe storms crossing the southern U.S. Midwest this past weekend producing heavy rains, hail and flooding and caused at least 10 deaths. The storms dumped more than 10 inches (25 cm) of rain in southeast Missouri and stretched into north eastern Kentucky, the National Weather Service said.

The National Weather Service said there were 37 preliminary tornado reports around the region and one confirmed tornado in Phelps County, Missouri. In northeast Arkansas, several people caught in fast-rising flood waters survived by clinging to trees along the Spring River near Hardy. "The water just rose so fast, there were several individuals rescued from trees in that area," Sharp County emergency dispatcher Tamara Roberts said.

In northwest Arkansas, a 51-year-old woman was struck and killed by lightning while in a fishing boat on a small lake. Nine people died in Kentucky, including two women who fell into a drainage ditch in Lexington, emergency officials said. Another woman was killed in Kentucky, when her pickup truck was swept off a road and overturned in a creek, county officials said.

Hurricane forecasters had originally predicted that this Atlantic storm season would be busier than usual. But the development of El Nino weather conditions in the Pacific, and other factors such as high quantities of West African dust in the atmosphere over the Atlantic, have led weather experts to reduce their expectations.

The El Nino phenomenon, an unusual warming of waters in the eastern Pacific, causes high wind shear over the Atlantic. Wind shear, the difference in velocity or direction of winds at different altitudes, tears cyclones apart.



Helene's track

Elsewhere on our planet

Meanwhile, half way round the globe, storms that battered Bangladesh and eastern India have killed more than 170 people and left many missing, according to navy and coastguard officials. A new cyclone alert has also been issued for early Sunday in the Kutch region in the Indian state Gujarat located on the western coast, and two ports -- one in Mundra and one in Kandla -- have been shut down.

Strong winds and heavy rain triggered by a storm last week have left around 375,000 people homeless in India and Bangladesh over the past four days. Life across Bangladesh, especially in the capital Dhaka, remained largely paralysed with roads knee-deep high with water, witnesses said.

Most of the victims in the eastern coast of India and Bangladesh were fishermen caught in the storm while fishing in the Bay of Bengal, government officials said. They said more than a dozen navy vessels, other boats and helicopters launched a massive search and rescue operation off the Bangladesh coast on Saturday, as hopes of finding the missing alive faded fast. "The sea is still very rough, hampering rescue efforts," a coastguard official said.

"So far nearly 100 bodies have been retrieved from the sea at half a dozen spots," said an official in the badly hit Bangladeshi coastal district of Barguna. Authorities say that while many boats have managed to return to shore, the navy and coastguard are still looking for hundreds of fishermen who remain unaccounted for. Also they were looking for a naval officer missing in the bay after his patrol boat ran aground on an island during Tuesday's storm. Other crews of the grounded boat had been recovered by helicopter.

Surviving fishermen said they were caught off guard as weather authorities had failed to warn them of the impending storm. Dhaka's weather office denied this, saying an alert was issued well in advance. In the eastern Indian state of West Bengal, constant rain and flooding have killed around 30 people, and forced 350,000 living mainly in coastal areas from their homes.

"People have been killed mostly from houses collapsing, lightning, trees landing on them," said Mriganka Biswas from the state's relief department. Victims are now living under tarpaulin sheets provided by the government," he said, adding that around 70,000 homes had been destroyed in the state.

In West Bengal's capital, Kolkata, police used boats to rescue hundreds of families stranded in low-lying slums. The storms also killed more than 40 people and left nearly 15,000 homeless in Andhra Pradesh state on India's east coast. #

Reassessing Psychosocial Interventions

Now as our Psychosocial Recovery Guidelines are being issued for general consumption it is opportune to review psychosocial and mental health interventions for disaster victims internationally.

A recent conference at the Institute of Psychiatry at King's College London with a focus on displaced persons heard case studies of vulnerable groups ranging from housewives in Kashmir to trafficked women in London and the chronically mentally ill in tsunami-affected areas of Aceh in Indonesia.

According to International Medical Corps (IMC), a U.S.-based NGO that specialises in mental health interventions, some 450 million people suffer from mental and behavioural disorders worldwide. Yet governments and local authorities often virtually ignore the issue, even more so in areas of armed conflict, and it is often one of the last factors to be considered in humanitarian health programming.

Media reports routinely refer to the "mental scars" that long outlive the physical damage of conflict, natural disaster or displacement, and coverage of so-called "psychosocial" interventions is drawing increasing amounts of donor funding into mental health programmes, especially post-disaster trauma counselling.

A debate is gathering pace in what has come to be known as International Mental Health over how to identify and treat these scars, if indeed they are scars. Are people as traumatised as we think they are, and if they are, are we truly going to help them by applying Western diagnostics of mental illness?

"PTSD is an anachronism, the discussion is fake," said Dr Joop de Jong, professor of mental health and culture at the Vrije Universiteit in Amsterdam. "There are certain core symptoms, so parts of PTSD can form a valid diagnosis, but it cannot be uniform." As far as de Jong and many of his colleagues attending the London conference are now concerned, trauma per se is a blunt diagnostic tool, which tells us little about the social and cultural context within which people may experience distress. More importantly, they say it turns human beings into victims by transforming their quite ordinary and understandable distress into a pathological condition.

"There is often an assumption that experience of conflict will automatically traumatise a person," said Janaka Jayawickrama, a research associate at the Disaster and Development Centre at Britain's Northumbria University. "Yet we often don't take into consideration the capacities and skills of affected populations."

According to Jayawickrama, a Sri Lankan who has worked extensively with communities in Sudan's Darfur region, Western practitioners often make the mistake of treating trauma in developing countries as a personal, individual experience when it is in reality viewed primarily as a collective challenge. It is help with this collective challenge, he says, that beneficiary communities are looking for on both practical and social levels. Isolating individuals for a therapeutic intervention is the last thing they need.

One delegate at the conference, who asked not to identified, ridiculed the belief that Western counsellors could possibly understand, measure and treat the distress suffered by residents of far-off humanitarian emergencies according to psychiatric guidelines. (The Harvard Trauma Questionnaire, a checklist of emotional symptoms associated with traumatic stress, is still widely used.) "Standalone trauma-based interventions are very attractive because the donors like them," he said. "It's really quite comical."

Aside from base ineffectiveness, others are warning of more damaging consequences, namely that those exposed to trauma counselling will begin to believe they are seriously unwell when traditional - and effective - coping mechanisms are freely available to them.

When it comes to the genuine needs of disrupted communities and displaced populations, conference delegates drew clear distinctions between the long-term needs of those who already suffered chronic mental illness and so-called beneficiaries who may or may not be suffering emotionally from post-disaster trauma

> Afghan refugees call it "mualagh". Roughly translated, it means a feeling of floating in sad uncertainty, like a leaf held aloft only by gusts of wind. Villagers driven from their homes in Darfur talk about "mondahesh", a sense of shocked surprise.
>
> And when the displaced in East Timor complain of "hanoin barak", they are telling you quite simply that they are thinking too much.
>
> Consider then the Western equivalents. People are burdened with stress, they suffer from depression, and if things get really bad, there is the wide embrace of the mother of all 21st century mental diagnoses, Post Traumatic Stress Disorder (PTSD).
>
> Tempting as it has been to transfer these concepts neatly from Western clinical settings into humanitarian emergency contexts, questions are increasingly being asked of their validity.
>
> In short, are we all feeling the same thing? Is it valid to apply Western psychological concepts to humanitarian contexts worldwide? An increasing number of experts say no.

"So many people are getting involved in short-term trauma interventions, but given the cultural support that exists, many of those symptoms of distress will dissipate over time," said Dr Andrew Mohanraj, a Malaysian psychiatrist working with International Medical Corps (IMC) in Aceh. "You've got to look at long-term intervention in pre-existing structures to see sustainable development."

As Mohanraj pointed out, patients suffering from conditions such as schizophrenia and epilepsy were found either caged or chained to trees following the tsunami, such was the lack of local investment in formal psychiatric care. "Mental health services must be improved at the community level," he said. "There is a lack of proper distribution of resources."

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HEMNZ Bulletin

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

Editor's soapbox

The influenza pandemic threat, what 'we' are doing about it and the difficulties 'we' face is a common theme repeated in many countries. Note this report carried widely by the print media in England this week.

English doctors have expressed concerns about their government's plans for a flu pandemic. In a poll of 1,061 GPs and hospital doctors for Hospital Doctor magazine, more than a third said the government was badly prepared. Over half said they had not received any information although the government insisted GPs should have received advice packs.

In the poll, carried out in conjunction with Doctor magazine ahead of a conference on pandemic preparedness, doctors said there needed to be better communication and investment in vaccine research. Speaking at the conference in London, Shadow Health Secretary Andrew Lansley raised concerns about the availability of critical care beds, face masks and plans for ordering a vaccine.

Professor John Oxford, a virologist at Queen Mary's School of Medicine in London, said the UK Government was among the best prepared. But he admitted there was a danger of people becoming weary about repeated warnings about the risk of a flu pandemic. "It is difficult stuff to plan for. I do feel myself this is a huge threat, but I am not sure everyone is convinced."

Professor Lindsey Davies, a flu expert from the Department of Health, said it was "challenging to fight a foe" that had not been encountered yet. But she said plans were being updated continuously. And she added: "We have an opportunity to really get ahead of this. "If we think carefully and act sensibly, we may be able to do things to mitigate the impact."

Is there anything there you can not relate to? There are large chunks of our healthcare workforce who will say they have not been told (enough) about what we are doing and what is expected of them and the job of all opposition politicians is to attack whatever the government is doing.

Telling our stakeholders what we (and they) are going to do is not enough. The real challenge we face is having them tell us that the message has been received and understood and they are ready to respond. And that ladies and gentlemen is a real challenge.

Bruce Parkes

Up coming Events

11—13 October 2006
Understanding and Managing Landslide Hazards
Avalon, Lower Hutt
Cost: $600 + GST and $100 + GST for optional field trip
More information from;
d.barton@gns.cri.nz

18—19 October 2006
Decision Making in Uncertain Times
3rd National Conference on Risk Management
Sky City Conference Centre, Auckland
Cost: from $760 + GST for early bird
More information from;
www.risksociety.org.nz

20—22 November 2006
8th Asia Pacific Conference on Disaster Medicine
Tokyo Conference Centre, Shinagawa
Cost: Doctors ¥30,000; Others ¥10,000
More information from;
www2.convention.co.jp/8apcdm/

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According to Atalay Alem, an Ethiopian doctor at the conference, an additional flaw in international interventions was their tendency to poach staff from local mental health structures, who flock to work for trauma NGOs at five times the salary, thus abandoning what little is left of domestic institutions.

For all the mistakes that have been made, mental health is slowly moving into the mainstream of humanitarian aid. The U.N. formed an inter-agency taskforce on mental health and psychosocial support last year, which has drafted a comprehensive set of guidelines and minimum standards on these kinds of operations. These include the absolute necessity of integrating responses with local social and spiritual practices.

Agencies such Medecins Sans Frontieres now incorporate mental health considerations into all health planning for humanitarian operations. "We culturally validate our programmes by placing far greater emphasis now on the role of national staff in programme design," said MSF's mental health advisor, Kaz de Jong. As far the wider aid debate is concerned, experts say it is only to be welcomed that beneficiaries are no longer viewed as anonymous recipients of food, shelter and medical care. International aid organizations have at least cottoned on to one small truth: They have feelings too. #