



OCEANIA NEWSLETTER October 2014

WELCOME!!!

Two matters dominate this newsletter; one is the world wide concerns regarding outbreaks of Ebola and its rapid spread. Information has been gathered from reliable sources and referenced for readers. This information is from the likes of CDC, Yale New Haven Health and experts on the subject. It is not intended as a knee-jerk panic reaction, it is included to enable us all to keep appraised of the situation and to consider and plan a response.

I have also heard of health workers wanting to help in the fight against this virus, the last thing that is wanted is for untrained and under equipped workers going into the field. Experienced, trained and properly equipped workers as part of teams from recognised organisations are required.

The second dominating material is a decision on an Oceania bid for hosting a future WCDEM. Input from Oceania members is required to enable your Committee to make an informed decision. Please contact any committee member with your views.

Cheers

Graeme

WADEM Oceania Chapter Newsletter Aims

The aims of the WADEM Oceania Chapter news letter are to:

- *provide communication for regional members*
- *encourage a collegiate relationship amongst regional members*
- *update members on news and events such as health issues in the region*
- *provide a forum for discussion on emergency medicine/health issues*
- *give encouragement and support for research papers*
- *allow publication of basic case studies*
- *support exchange of information and work programmes*
- *publicise coming events*
- *support the aims and activities of WADEM within the region*

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OPINION PIECE

A paper by Rebecca Zukowski in the August 2014 Pre-Hospital and Disaster Medicine Journal grabbed my attention; this was a study of the relationship, if it exists, between the development of adaptive capacity and disaster response and recovery outcomes.¹ While this research was a survey based on descriptive returns, it fits with the 'actual' observations of the Christchurch post-earthquake experiences.

Two sentences in the paper were of particular interested me, these were;

*'Conceptually, the building of community resilience to improve outcomes related to disaster response and recovery has wide support.'*²

and

*'Resilience begins with pre-disaster preparedness and planning, and ends with the ability of a community to recover effectively following a disaster.'*³

Starting with the latter. All emergency planners/managers should be in total agreement with the need for resilience preparedness and planning in that pre event situation. How can a community be made stronger by such activities? Mostly this is achieved by identifying and remedying risks, strengthening infrastructure, housing design (and location), and the like.

Such activities have been subject to the confined or restricted thinking of so many involved in emergency management. This could be because of what is perhaps an existing narrow definition of 'resilience'. Definitions traditionally have been focussed on 'material things' or situations. For example⁴

1. *The power or ability to return to the original form, position, etc., after being, bent compressed, or stretched; elasticity.*
2. *The ability to recover readily from illness, depression, adversity, or the like; buoyancy.'*

That tradition is being broken or advanced by more thought given about the people involved/victims of disasters. It was interesting to find a definition that gave more consideration to these people.⁵

'Resilience *is that ineffable quality that allows some people to be knocked down by life and come back stronger than ever. Rather than letting failure overcome.'*

However, what is not covered is the always ongoing need for resilience in all forms both pre and post disaster. In a previous edition of this newsletter and a later paper, I outlined how I believe that people experienced a 'pause' between response and the road to recovery. This developed into a model to outline the process.⁶ To that model I have added 'resilience' as I have observed that is an over-arching necessity to assist people on the way to recovery.

¹ Zukowski RS. The impact of adaptive capacity of disaster response and recovery: evidence supporting core community capabilities. Prehosp Disaster Med 2014;29(4): 380-387

² ibid p 381

³ ibid p 381

⁴ <http://dictionary.reference.com/> : accessed 14-10-1014

⁵ www.psychologytoday.com/basics/resilience : accessed 14-10-2014

⁶ McColl G., Burkle FM. Jr., The new normal- twelve months of resilience and recovery in Christchurch: Disaster Medicine and Public Health Preparedness AMA 2012 Vol 6 No 1 P 40.

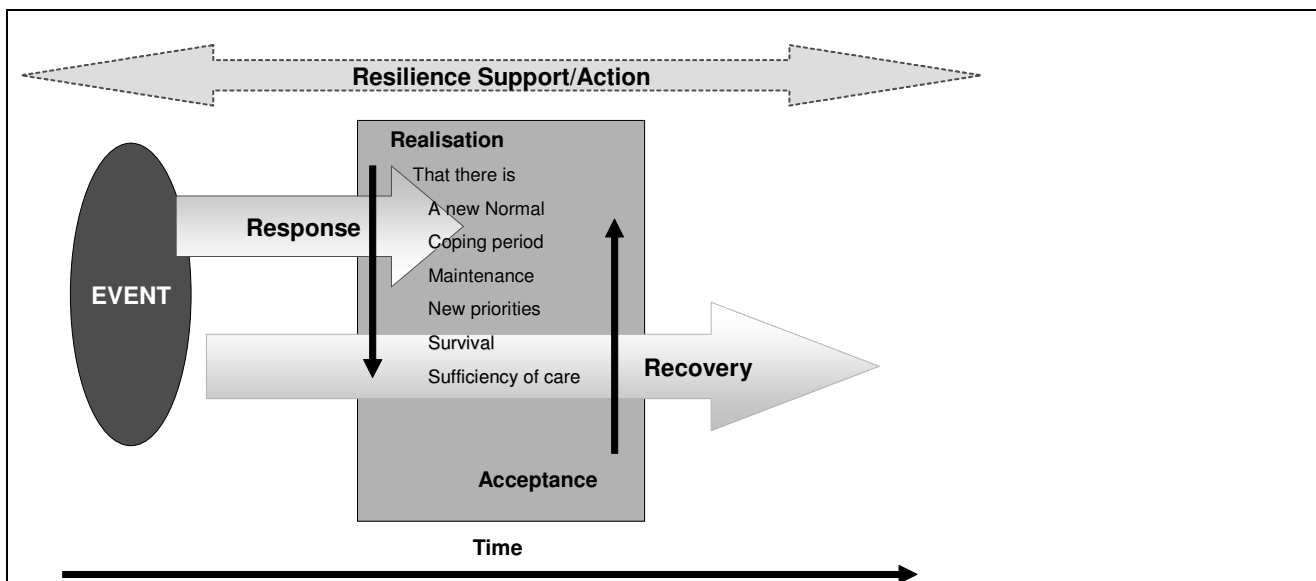


Figure 1: The relationship between response, realisation/acceptance of the situation and move to recovery

Health organisations and providers must come to terms with the wider terms and requirements of resilience, and be prepared (along with others) to deliver services that support people for long periods post-disaster, to enable them to have or develop the resilience to cope not only towards but also in the period when it is thought recovery has been reached.

However, these organisations and providers can't deliver all the services that may be required even if they can identify requirements and those in need. Eyes and feet on the ground are needed to provide local input formally, and even more importantly informally, and involving 'community'.

Defining 'Community' gives direction to working on and even achieving resilience that gets people coping and functioning post disaster.⁷

Community

1. a group of people living in the same place or having a particular characteristic in common.
2. the condition of sharing or having certain attitudes and interests in common

The second of these meanings highlights requirements to develop resilience in communities, key words are: 'sharing', 'attitudes', 'interests in common'. The development of these facets can mistakenly thought to be driven and achieved by national policies, the 'top down' approach.

The traditional 'top down' approach to managing major crises has dominated thinking and research for decades. This includes normal emergency management hierarchy at the city,

⁷ <http://dictionary.reference.com/> : accessed 16-10-1014

⁸ Reaves EJ, Termini M, Burkle FM Jr. Reshaping US Navy Pacific response in mitigating disaster risk in South Pacific Island nations: adopting community-based disaster cycle management. Prehosp Disaster Med. 2014;29(1):P5.

⁹ Ibid P6

¹⁰ Available online at www.wadem.org Publications Oceania Newsletter

¹¹ Ozanne L. Research finds Lyttelton time bank a builder and mobiliser of resources. Reported in the Akaroa Mail 27 September 2013. For full report http://www.lyttelton.net.nz/images/timebank/timebank_eq_report_email_pdf

state, and national levels and is the foundation of strategic and tactical operations that influence military decisions. Both the 2003 SARS pandemic and the 2009 swine flu epidemic challenged this approach. In studies from five continents, both strategic- and tactical-level plans functioned well, but major flaws occurred in local community-level operational capacity.⁸

This is perceived as in the “national interest”, while individual communities live with risks that are specific to, and only capable of management within, those communities. In every community crisis/disaster events are “discreet and unique”. Letting the community anticipate and assess individual, local characteristics and risks has revealed that considerable information was not known through the traditional top down assessments, which tended to be generic in content, and lacked necessary specificity. These issues can only be addressed properly within the communities themselves.⁹

Clearly, resilience and recovery cannot be forced from above or subject to handouts in the hope that they provide solutions. Communities must be involved and take ownership. Communities are aware of their ‘local characteristics and risks’. I became aware of a simple example when recently talking to a Red Cross field manager in Fiji. He had been discussing tsunami risks with local villages and how they would handle this. The village elders led him to a series of caves in the hillside above the village, the caves were surrounded by gardens and for years had been accepted as the place for the villagers to gather when faced with risk from cyclone or tsunami. Simple local solution and planning!

For me a closer-to-home example of community sharing of interests and resources post-disaster is the work of the Lyttelton (Christchurch) time bank. I first reported on this in the WADDEM Oceania Chapter Newsletter of November 2013.¹⁰ A study of the time bank’s work reported;

Marketing lecturer, Dr Lucie Ozanne, says her research found a surprising partner in emergency management - the local community time bank. ‘We saw a strong role for the Lyttelton time bank promoting community resilience following the earthquakes’ she said.¹¹

As a recent member of this time bank I am aware of the work carried out of checking on residents, delivering food, providing community events, lobbying for further support, etc. These examples of community involvement and ownership show the necessity of understanding and involvement with communities in their planning for, resilience to, and recovery from disasters.

If all the definitions and the need, community involvement and ownership were combined, we would at least be meeting with what Zukowski, I’m sure, intends when she talks of a ‘community’ in relation to resilience. Linked to this is ‘recovery’, and hopefully, a new and enhanced state of normals.

This brings me to the first sentence quoted. This sentence is led by the word ‘conceptually’. While Zukowski’s study indicated that ‘conceptually’ those surveyed believed the building of community resilience to improve outcomes related to disaster response and recovery was supported, how many were actually implementing, assisting or being allowed to implement and assist such action, and was there sufficient or any funding for the purpose?

Such questions on actual action and funding we should all be considering.

Comment to Graeme.mccoll@ilsogno.info

OCEANIA NEWS

The Oceania Committee met recently to review Chapter activities and discuss future opportunities. Much progress has been made towards the Chapter Objectives; activities discussed by the committee in furthering these efforts includes:

- Development of an Oceania WCDEM bid (See below)
- Increased engagement in mentoring and research within the Oceania region
- Promotion of regional conferences
- Development of an operational plan to guide activities supporting the Chapter Objectives.

With plans for another meeting prior to WCDEM 2015, the current committee will continue to track and communicate our performance.

The WADEM Oceania committee requests input from members for a bid for a future WCDEM to be held in this region.

The Committee at this stage favours a bid for 2021, with Brisbane the leading contender, based on ease of travel with direct international flights; active WADEM membership; suitable venue and accommodation; convention centre support, and leisure and partners' activities.

Other venues considered; Sydney, Melbourne (Previous host), Adelaide (Less international flights), Christchurch (Additional flights for international visitors), Cairns (Ditto and no WADEM Members).

It is intended to work with various colleges to be involved with hosting.

EVENTS/PROJECTS / PROGRAMMES / RESEARCH / COURSES REPORTS

Cyclone Ian, Tonga

Cyclone Ian hit Tonga on 11 January, 2014 and caused extensive damage to the Island groups of Ha'apai and Vavau'u.

I have been interested in the impact of this cyclone on the Island of Ha'apai as I was the medic on a NZ Army aid project there back in the early 1980s when this causeway was constructed between the islands of Lifuka and Foa.



pacific.scoop.co.nz

The island is low and narrow and was relatively undeveloped, at least to Western eyes, when I was there. It would have offered little resistance to a category 5 cyclone.

We saw photos, like these, of the damage, but we have heard little since of the recovery.



eliefweb.int



.nzkanivapacific.co.nz

I recently found one report from the Global Facility for Disaster Reduction and Recovery who were active in Tonga's response.

It lists some of their achievements and three lessons:

Achievements:

- For the first time, with the World Bank's support, a Housing Recovery and Reconstruction policy was developed, clearly outlining the government's strategy for housing reconstruction and self-recovery.
- The damage assessment helped to leverage \$12 million in World Bank grants and low-interest credits, and a \$2 million grant from the ACP-EU NDRR Program.
- Cyclone-proof housing design was completed and reconstruction contracts awarded within 6 months after the disaster.
- The housing assessment and field surveys have helped to forge a coalition between the government, local communities, and civil society organizations, including the Tongan Red Cross, and other stakeholders.

Lessons:

- Investing in prevention saves lives and mitigates the scale of disaster impact.
- Innovative tools can support recovery planning and reconstruction.
- Integration of 'building back better' principles into recovery is important for building long-term resilience.

The 2 page report is available here:

https://www.gfdr.org/sites/gfdr/files/publication/GFDRR_Stories%20of%20Impact%20Tonga%20Final%20ACP-EU.pdf

Do any of our members or readers have any more information?

John Coleman

Note: *Alas some of the links that follow may not connect for everyone. Graeme*

From Yale New Haven Health Bulletin. Reprinted with permission.

Communicating with Family and Friends During a Disaster

A focus of Preparedness Month (September) was how to reconnect with your loved ones after a disaster. At times, we focus on the preparedness kit and forget to establish a communications plan with family. FEMA provides tips for establishing a plan to communicate with loved ones in the wake of a disaster. Tips include:

- Completing a contact card for each member of your family and have them placed in purses, wallets and book bags;
- Having a contact that does not live in your area that each family member can notify when they are safe if unable to contact family in the affected area. An out-of-area contact may be in a better position to communicate among separated family members;
- Using text messaging when telephone calls are not possible because of network disruptions; and
- Using social media outlets such as Facebook and Twitter to alert family members that you are safe. You can also use the American Red Cross's Safe and Well program.

Enterovirus D68 Confirmed in 43 States

As of October 6, 2014, forty three states and the District of Columbia have confirmed nearly five hundred cases of Enterovirus D68 (EV- D68). The CDC believes that the number of states reporting cases, and that of patients who are infected with EV D68 will rise in the upcoming weeks. The virus causes mild to severe symptoms. Mild symptoms often include runny nose, sneezing, coughing, body and muscle aches and fever. Severe symptoms may include polio-like paralysis, difficulty breathing (especially in those with asthma) and wheezing. "EV-D68 likely spreads from person to person when an infected person coughs, sneezes, or touches contaminated surfaces" (CDC, 2014). For more information about EV D68, please visit the CDC's list of frequently asked questions by [clicking here](#).

EBOLA UPDATE

For information refer to the following references

Ebola Virus Disease: Essential Public Health Principles for Clinicians

<http://escholarship.org/uc/item/1bh1352j#page-1>

Paolo Costa
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World Health Organization
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Ebola in US.

The first case of the Ebola virus has been confirmed in the United States. According to the New York Times (September 30, 2014), "A man who took a commercial flight from Liberia that landed in Dallas on Sept. 20 has been found to have the Ebola virus, the Centers for Disease Control and Prevention reported on Tuesday. He is the first traveler to have brought the virus to the United States on a passenger plane and the first in whom Ebola has been diagnosed outside of Africa in the current outbreak." The CDC has taken several precautions in an effort to prevent the spread of West Africa's Ebola epidemic to the United States. CDC officials assume that it is only a matter of time before someone infected with the virus presents to a hospital or other healthcare facility. For

this reason, the CDC has issued comprehensive checklists for Ebola preparedness for hospitals and for other healthcare providers. The checklists provide information to assist healthcare personnel to rapidly assess whether individuals are infected. Included in the checklist are steps to help healthcare workers treat infected patients and protect themselves against transmission, as well as online resources to help hospitals and other healthcare facilities prepare. Click here for the [Health Care Provider Checklist](#) and here for the [Health Care Facility Checklist](#). For general information on the outbreak and to monitor updates from the CDC, [click here](#).

CDC Provides Stricter Guidance on PPE

On October 20, 2014, the CDC issued updated guidance to healthcare workers on the personal protective equipment (PPE) to use when caring for patients with possible Ebola. This guidance also provides information on proper donning and doffing of PPE. The recommended equipment now includes the use of PAPRs or N95 masks. The CDC also specifies that a trained observer should be used to help with removal of the primary provider's PPE. You can find the updated guidance by [clicking here](#). You also see a video on PPE by [clicking here](#).



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CDC Ebola Hospital Preparedness Checklist - Electronic Version

The Yale New Haven Health System - Center for Emergency Preparedness and Disaster Response - has replicated the CDC's Detailed Hospital Checklist for Ebola Preparedness into an electronic format. The electronic checklist, built in Microsoft Excel™, will provide the user with a percentage of tasks that are completed, in progress, or not started. It will help to illustrate where the facility stands on their Ebola preparedness. This form is available at no cost from YNHHS-CEPDR and can be retrieved by [clicking here](#) and completing the survey. Once complete, you will be redirected to the tool.



Finally on this subject (*These links do work. Graeme*)
From Kristi Koenig

1. <http://escholarship.org/uc/item/1bh1352j>
2. The 2014 Ebola Virus Outbreak and Other Emerging Infectious Diseases - Oct. 21, 2014
This is a draft chapter from KOENIG AND SCHULTZ'S DISASTER MEDICINE: COMPREHENSIVE PRINCIPLES AND PRACTICE, 2ND EDITION, which is coming soon.

Refer to <http://www.acep.org/ebola/>

EDUCATION AND TRAINING OPPORTUNITIES & PROJECTS

Online Research Repository

WADEM has developed an online Research Repository for members to access information about current disaster health research projects. Members are able to provide information about projects they are presently working on, as well as connect with other researchers around the world who are conducting similar types of research.

The Research Repository can be accessed by clicking on the following link –
<http://research.wadem.org>

The Nursing Section of WADEM is currently undertaking a review in partnership with the International Council of Nurses of the use of the ICN Disaster Nursing Competencies. The competencies were released in 2009 and this work will consider how the listed competencies are being utilised across nursing associations and organisations internationally.

RESEARCH ASSISTANCE REQUIRED

Consider becoming part of the WADEM Mentoring Ship programme. You can provide mentoring guidance and advice from your training and experiences or for those studying or working to gain knowledge they can become a 'mentee' and seek help from a mentor.

Contact gmccoll@wadem.org for initial advice. (He is a mentor)

MEMBER NEWS

Paul Arbon, WADEM President, will be inducted as an International Fellow of the American Academy of Nursing.

An honour deserved and congratulations Paul

Our Chapter Founding Father, **Frank Archer** has been appointed to the Board of the Asia Pacific Conference on Disaster and Emergency Medicine Board.

WADEM COMMUNITIES of INTEREST

The following WADEM Sections provide contacts and information for members interested in the specific area/skills. More such areas of interest are likely to be established in the future.

Nursing Section

Contact: alison.hutton@flinders.edu.au

Osteopathic Physician Section

Contact: William Bograkos irisbo@comcast.net

Psychosocial Section

Contact: Tracey O'Sullivan tosulliv@uottawa.ca

Mass Gathering Section

Chair is Paul Arbon.

Contact paul.arbon@flinders.edu.au

Emergency Medical Response Section

Contact; jocuthbertson@hotmail.com

Proposed Section: Disaster Metrics

Contact frank.archer@monash.edu

CALENDAR OF EVENTS

<p>2015 10-12 February</p>	<p>International Disaster Conference & Expo., New Orleans http://internationaldisasterconference.com/about-idce/schedule-at-a-glance/</p>
<p>21-14 April</p>	<p>Save the Date. WCDEM Cape Town, South Africa</p>
<p>2016 24-26 February</p>	<p>People in Disasters, Response, Resilience and Recovery. Christchurch, New Zealand. For expressions of interest and further information. www.peopleindisasters.org.nz</p>
<p>18-21 April</p>	<p>16th International Conference Emergency Medicine. (ICEM), Cape Town, South Africa. www.icem2016.org</p>

A COFFEE WITH

In this section members are invited to introduce themselves to other members in an informal manner.

This issue: Beverley Raphael

Q. Nickname?

A. Bev

Q. Where are you working?

A. Australian National University where I am head of the Academic Unit of Psychiatry and Addiction Medicine and am involved in a range of research and education, including children and trauma.

Q. What three words best describe you?

A. Future oriented, innovative, committed to the human response

Q. What is your best disaster experience?

A. The best moments I have experienced in disaster are when you see the recovery and strength with which people handle shocking experiences, and the courage with which they keep going forward and support others to do the same.

Q. What is your worst disaster experience?

A. The Szechuan earthquake in China for its extensive and terrible impact, and the large number of children impacted. The Granville train disaster for the sense of helplessness in the face of mass death. You can support and assist people but you know what is ahead for people with loss of a loved one and how final it is.

Q. Which 3 people would you most like to share your ration pack, cold pizza and instant coffee with?

A. Family, Penny Burns, and Lars Weisaeth (Professor of Psychiatry University of Oslo, Norway)

And **Peter Kara**

Q. Nickname?

A. “ GI Joe” (my adult children have called me this for some years)

Q. Where are you working?

A. Nelson Marlborough District Health Board - Emergency Manager

Q. What three words best describe you?

A. Decisive, committed, pragmatic

Q. What is your best disaster experience?

A. Working in Christchurch in 2011 – putting to use knowledge and experience in a large scale incident and learning more in the process

Q. What is your worst disaster experience?

A. Being detained in Iraq (*Peter is a former UN Chemical weapons inspector*)

Q. Which 3 people would you most like to share your ration pack, cold pizza and instant coffee with?

A. Richard Branson – great innovator, from few resources to a global entity, a survivor and adventurer, pushing the boundaries. Sir Graham Henry – great motivator, but also a pragmatist, strong stalwart of respect and dignity. My Wife, the one person who will definitely tell me how it is!

Volunteers wanted to introduce themselves in ‘Coffee with’.

Disaster Myths

A section for sayings, lessons and humour. **Contributions invited.**

Not a myth! Lawyers are doing well following the Christchurch earthquake, with a large number of cases heard and many more still to be heard. Cases are mainly around insurance payments or non-payments, house zoning and the like.

ASK AUNTIE

This section is an advice column where readers can submit their questions and ‘Auntie’ will draw on many years of experience to provide reasoned advice and counselling.

Dear Aunty,

My wife and I are shortly to take a holiday and visit South Africa. As well as the lovely city of Cape Town we will also be visiting a game park and attending a rugby match in Johannesburg.

We are greatly concerned with what the health situation is in Africa.

Your wise advice on our situation and whether we should cancel our trip and stay home in Brisbane where we have wonderful health care would be greatly appreciated

Sincerely,

Malcolm

My dear Malcolm,

Aunty has done one of those wonderful risk assessment thingys on your proposed travel. They just make things and decisions so much clearer. Accordingly, I have rated the dangers from your travels in order of risk to you and your wife.

Attending rugby at Ellis Park in Johannesburg and not supporting the home team.
Standing in the middle of a buffalo herd in Kruger Park.
Swimming with sharks in the sea near Durban.
Walking alone back to your hotel after midnight after having partaken of fine South African wine.
(This is no different to the situation in downtown Brisbane and probably better than sinful Sydney)

I assure you that there are great health facilities in South Africa, not all their Doctors have migrated to Australia and New Zealand, you know.

My dear nephew Graeme has visited South Africa twice and loves it and has never felt threatened, he has also visited Groote Schur Hospital and was very impressed with the facilities and staff. He travelled on public buses, trains and taxis and also walked around the city in Cape Town and Johannesburg.

Finally Malcolm, if you are still concerned and want to cancel your travel, Aunty and her new friend Robert would gladly accept the gift of your tickets. After all Aunty is always willing to help.

In Kindness

Aunty

CALL FOR MATERIAL

Material is required for any of the sections listed, or under a new category, if that is appropriate. Personal experiences, case and research reports are especially welcome and we ask that these are limited to no more than 1,000 words. The subject matter can be aspects of a disaster or response that is unusual because of its type, location or effects. Material is welcome from WADEM members and even non-members internationally.

Any suggestions regarding material for content, or suggestions to improve this Newsletter are welcome.

Please forward contributions to Graeme McColl at gmccoll@wadem.org

DISCLAIMER

The comments, opinions and material in this newsletter are those of the respective authors and not necessarily those of WADEM or the WADEM Oceania Chapter.