

Keywords: abuse; children; displaced; elderly; missing; Sri Lanka; survival; tsunami

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Implementation of an Emergency Measles Campaign—Aceh Province, Indonesia, January–March 2005

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Introduction: Following the tsunami, there were concerns about the potential for a large measles outbreak in Aceh province, Indonesia. Reasons for the concern were low routine measles vaccine coverage (estimated at 50%), population movement, and overcrowding in camps for displaced persons. There also were concerns about access to good case management for the complications of measles.

Methods: The Indonesian Ministry of Health, assisted by the United Nations and non-governmental organization partners, targeted all children in Aceh province aged six months to 15 years to receive a measles vaccine, along with a supplementary dose of Vitamin A. Adjustments were made for missing, dead, and displaced persons when estimating the target population.

Results: The campaign targeted the entire Aceh province. However, priority was given to its capital, Banda Aceh, and three other highly-affected districts: (1) Aceh Besar; (2) Aceh Baret; and (3) Aceh Jaya. The campaign was completed in the first two locations with coverage of 70% and 94% in Banda Aceh and Aceh Besar, respectively. The campaign still is in process in the other two districts where heavily damaged infrastructure, loss of local health personnel, and lack of security continue to affect campaign progress.

Keywords: Aceh province; children; campaign; Indonesia; measles; Ministry of Health; vaccination

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Post-Tsunami Health Interventions—Support Available from the Cochrane Collaboration and Priorities for Further Systematic Reviews in the Disaster Setting

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Theme 13: Disaster Planning

Chair: Mauricio Lynn

Comparison of the Disaster Management Frameworks of the US and the UK: Similarities and Differences

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The geopolitical status of the world today intensifies the likelihood that disasters will increase in terms of numbers, type, and complexity. To this end, both the United States (US) and the United Kingdom (UK) have developed disaster management frameworks for the purpose of achieving command, control, and coordination. In the US, it is referred to as the Incident Command System, while in the

UK it is referred to as the Combined Response (or sometimes the Gold, Silver, and Bronze System). Since many disaster events involve response from more than one nation, it is likely that there will be many instances where the US and the UK response teams will work side by side.

The purpose of this presentation is to compare and contrast the two disaster management frameworks, illustrating how they are similar and how they differ. Understanding how partner nations organize response operations is likely to facilitate international coordination and cooperation, and perhaps ultimately assist with the development of a universal standard.

Keywords: Combined Response; disaster management; frameworks; incident command system; preparedness; United Kingdom; United States

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Assessment Report on the Amendment of Disaster Medical Services in Japan—What Has Been Changed during the Last 10 Years after the Great Hanshin-Awaji Earthquake?

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Through the lessons learned from the 1995 Great Hanshin-Awaji Earthquake (GHAE), which struck and destroyed parts of the modernized city of Kobe, The Ministry of Health and Welfare of Japan and the Government of Hyogo Prefecture developed several plans to improve the disaster medical services system. These plans included: (1) development of a widespread emergency and disaster medical information network; (2) designation of core hospitals for use during disasters; (3) education and training of medical personnel on disaster medicine; and (4) collaboration between the fire department and medical experts.

On the 10th anniversary of the GHAE, the Hyogo Prefecture Government organized a committee for the assessment of the countermeasures taken following the earthquake. This presentation deals with the assessment report that was surveyed by the author in 2004 in Hyogo Prefecture. As to the area-wide emergency and disaster medical information system, almost all of the hospitals have been equipped with laptop computers that will be used exclusively for this system. However, most of the hospitals could not use this information system during multi-casualty incidents and the earthquake in Niigata in October 2004. Reasons for the low usage rate were investigated.

About 500 hospitals in Japan and 15 in Hyogo Prefecture are designated as disaster core hospitals. They are expected to play leading role in accepting patients in the disaster-affected area, and, if necessary, transfer those patients to the hospitals in the non-affected areas. The preparedness for disasters and capabilities of each of these hospitals were investigated and it revealed that there are many differences between the disaster core hospitals.

Training and education on disaster medicine was minimal before the GHAE, and, if any was provided, it was

quite superficial. However, after GHAE, one-week training courses on disaster medicine are held regularly at the National Hospital Tokyo Disaster Medical Center, and realistic disaster drills are adopted and performed mainly in disaster core hospitals.

The establishment of Disaster Medical Assistant Teams (DMATs), composed by emergency physicians, nurses, and emergency medical technicians, has been a long-time dream in Japan. In August 2004, thanks to the efforts of the people concerned, DMATs were organized in Tokyo. This new effort is expected to expand into other areas in the near future. Several other improved areas and their problems are discussed in the presentation.

Keywords: anniversary; assessment; core hospitals; disaster medical assistance teams (DMATs); disaster medicine; education; exercises; Great Hanshin-Awaji Earthquake (GHAE); Hyogo Prefecture; Japan

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Hospital Preparedness for Disasters

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The Pan-American Health Organization (PAHO) and the Mexican Federal Government signed an agreement to establish the voluntary and temporary certification at the institutional, national, and international levels of health installations prepared to face disaster situations.

The Mexican Social Security Institute was interested in this initiative, taking into account the number of hospitals that form its infrastructure: 254 hospitals of medium and high complexity, of which 131 (52%) are situated in high-risk areas, 67 (26%) in medium-risk areas, and only 56 (22%) in low-risk areas.

Because of the aforementioned statistics, a model was designed to certify the hospitals in order to establish a permanent and priority program entitled “Hospitals Prepared to Face Disaster Situations” in agreement with the PAHO recommendations. The Institute, through the Institutional Committee for Disaster Cases, created rules for the creation of the “Hospital Plan for Disaster Cases”, which includes structural and non-structural aspects of the organization and specified the governing body for each organization.

Each hospital unit is responsible for designing its own plan, which should designate the actions to be followed in an internal or external disaster in the stages before, during, and after the event, including identifying the risk factors, vulnerability, human resources, and materials at their disposal (“made to measure”).

For the certification stage, the Committee designed an “instrument” for quantitative evaluation, which permits the qualification of the medical units to select the hospitals classified as high-resolution level and situated in high-risk areas.

Later assessment visits were programmed and the evaluation procedure was applied. Forty hospitals have achieved this Certification, and others currently are in the process.

At the present time, the Institute is involved in the national level certification stage. This certification will

ensure the security of users and installations, and will facilitate a decrease in insurance premiums, which will be reinvested in strengthening hospital security.

Keywords: certification; coordination; disaster; evaluation; hospital; Mexico; preparedness

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Australian Mass-Casualty, Burn, Disaster Plan

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Australia has a series of dedicated burn units. Emergency medical services in capital cities respond to the emergency needs of the population of 20 million. The significant distance involved in transporting patients necessitates a two-phase response to a mass-casualty event: (1) The surge phase is the initial phase of rapid expansion of urgent services provided by core health services of the given state or territories; and (2) The redistribution phase is the protracted period of ongoing needs for medical care that challenges the capacity of the given state or territory due to the prolonged healing and rehabilitation needs of burn survivors.

We intend to develop a coordinated national response for events involving multiple burn casualties. The plan will be based on the international literature in context of local resources and conditions. The plan will interface with the disaster plan of the states and territories in addition to the overseas mass-casualty plans of the Australian Government. The development of the two-phase, kinetic, mass-disaster model is an original concept that provides a template for any mass-casualty event in Australia or overseas. This plan will be discussed.

Keywords: burns; coordination; disaster; mass casualties; phases; planning; response

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Shipping Disasters in the English Channel: A Need for International, Multidisciplinary Rescue

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On 06 March 1987, the Herald of Free Enterprise (HOFE), a car ferry transporting 543 passengers and crew, 42 trucks, and 84 cars, capsized one mile away from Zeebrugge harbor. A large rescue operation began at three operational levels. Rudimentary means of rescue were attempted on-board the wreck. Helicopters transported victims from the wreck to a nearby military harbor, and boats were directed towards an empty pontoon. At the pontoon, emergency care was provided and further transport was organized to surrounding hospitals. The available resources made it possible to start advanced life support (ALS) at the triage station, where 21 medical teams received >250 victims within hours after the event. The majority of casualties were due to immersion, while most of the injuries were minor orthopedic trauma, bruises, and cuts, which could be treated easily. A few victims with cardiac arrest and hypothermia were referred to a hospital for