Results: Of the 4,480 cumulative households surveyed from 31 May until 01 December 2002, 57.0% reported a decrease in the amount of food consumed in the two weeks prior to the survey; 67.3% ate less high protein foods (meat, fish); 62.5% ate less fruits/vegetables; 44.3% ate less dairy; and 26.4% ate less basic grains. There were no significant differences in food consumption between WB and GS. The GS households had a greater prevalence of borrowing money and selling assets (57.2% and 25.2%, respectively) than the WB (49.4% and 16.2%, respectively). Lack of money was the primary reason for these activities in the GS (95.8%) and the WB (60.7%), although the imposed curfew was the reason given in 27.8% of the WB households. Markets were functional throughout the collection period.

Conclusion: Food insecurity in the WB and GS is mostly due to a depressed economy and diminished household purchasing power.

Keywords: assets, curfew; economy; food; Gaza Strip; households; insecurity; markets; money; West Bank
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Nutrition Survey in Mauritania

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Background: The Islamic Republic of Mauritania has been affected most by the drought in the Sahel region, as a result of the delayed rains and a low cumulative rainfall. World Vision conducted nutrition surveys in the Assaba and Tagant regions between 12 October 2002 and 02 November 2002, in order to estimate the levels of malnutrition among children age 6 to 59 months.

Methodology: The two regions were divided into four agro-pastoral zones, namely, Aftout, Kankossa, Kiffa/Guérou, and Tagant. Surveys were conducted in each one of the four zones using a two-stage cluster sampling methodology. A total of 3,619 children were measured.

Results:

Zone	Severe Acute Malnutrition		Global Acute Malnutrition	
	(%)	95% CI (%)	(%)	95% CI (%)
Aftout	(2.4)	(1.0–3.8)	(14.1)	(10.9–17.3)
Kankossa	(4.1)	(2.3–5.9)	(13.2)	(10.1–16.3)
Kiffa	(2.2)	(0.9–3.5)	(12.1)	(9.1–15.1)
Tagant	(2.4)	(1.0–3.8)	(10.9)	(8.1–13.7)
Total	(2.8)	(2.0–3.6)	(12.6)	(11.1–14.1)

The crude mortality rate in the survey sample was 0.47 deaths per 10,000 populations per day or 1.40 deaths per 1,000 per month, while the under-five mortality rate was 0.67 per 10,000 per day or 2.02 deaths per 1,000 per month.

Conclusion: The nutrition status of children in Mauritania is a concern, and requires the response of the international community. The current levels of malnutrition demand targeted food aid, in addition to therapeutic and supplementary feeding programs.

Keywords: children; crude mortality rate (CMR); food; Mauritania; nutrition
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Case Study: Bali: Lessons Learnt

Challenges in Victim Handling at the Sanglah Hospital after Bali Bombing

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Objective: To identify the challenges in the handling of victims after the explosions in Bali, and to develop strategies to address these problems.

Methods: Observations and review of experiences, reports, news, and other materials from organizations attending the victims of the bombing were summarized.

Results: First-aid provided at the site of the bombing area was poor, transportation to hospitals was limited, and preparedness for handling of massive numbers of casualties at the hospital was minimal.

Conclusions: The challenges created by the bombing in Bali included the lack of a prehospital disaster plan and intra-hospital disaster organization. Therefore, it is important to develop strategies for improving the prehospital and hospital disaster plan.

The Bali Blast Disaster

Time:	12 October, 2002, 23:15 hours
Location:	Kuta Beach Area, Bali, Indonesia
Type:	Terrorism bombing
Casualties:	138
Deaths:	183
Missings:	46

Keywords: Bali; bombing; disaster; explosion; first aid; hospital; prehospital; plans; victims
Prehosp Disast Med 2002;17(s2):s21.

International SOS Mass Casualty Evacuation - Bali 12 Oct 2002

Erika Nishimoto

Currently, International SOS is the largest medical assistance company worldwide, and has been involved in crisis management during international disasters, both natural and manmade, that have occurred during the last 28 years. International SOS works on behalf of its clients in an effort to ensure that medical care meets appropriate international standards, and that if such care is not available, these persons can be transported safely to the nearest centre of medical excellence, either by charter or commercial means. Dedicated air ambulances are stationed throughout the world, and access to charter aircraft is provided for mass evacuations.

Local medical support is provided on-site in locations such as Bali, to expatriates, tourists and locals, and a detailed knowledge of the local culture and medical capabilities is maintained.

Its role in the Bali disaster was a significant one, and, as the only privately run company involved in mass evacuation of casualties working alongside the Australian military efforts, provided a learning experience in planning and a

valuable experience in crisis management. We were able to compare and visualize these results with those from the next major crisis that occurred two weeks later in Ho Chi Minh City, Vietnam. This presentation will use both Powerpoint and video discussions, and a "walk through" of events as they unfolded from the moment the blast took place to the successful evacuation of casualties.

Keywords: aircraft; Bali; capabilities, Ho Chi Minh, Vietnam; medical; casualties; culture; evacuation; private; standards; transportation
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Secondary Aeromedical Evacuations Post-Bali Bombings

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The Bali Bombings in 2002 resulted in severely injured patients being repatriated to Australia using five Hercules military transport aircraft. These flights transported 65 patients to the Royal Darwin Hospital (RDH) for stabilization and initial surgery. Of these patients, 53 were listed in "serious" or "critical" condition. The Royal Adelaide Hospital (RAH) provided 10 staff to complement the existing resources of the RDH, including a Burns Surgical Team, a Critical Care Medical Team, and Critical Care Retrieval Nurses.

Arriving patients from Bali were retriaged at the Darwin airport by a four-person medical team. Although only three patients on the first two C-130 aircraft were intubated, within a few hours of arriving at RDH, there were many others who required intubation and/or other critical-care support. The RAH staff were involved in ongoing resuscitation, and more than 100 burns surgical procedures. The RAH contribution also was made at the civilian and military liaison level with the benefit of two high-ranking Australian Defence Force (ADF) personnel in the RAH team, who were performing dual military and civilian duties.

As the RDH does not have a burns unit or the capability to provide ongoing management for the majority of patients, decanting from RDH followed. There were 17 Critical Care Aeromedical evacuations from Darwin to capital cities in other Australian states: 14 were transported by civilian critical care teams using business jets; three were transported by ADF C-130 Hercules with specialist reserve staff. The timing and destination of patients was made largely on the basis of patient stability at the time of available critical care transport. Another 34 patients in "serious" conditon were transported from Darwin to other capital cities with the use of a total of four Hercules aircraft.

The use of civilian and military assets to move the critically and seriously ill patients over vast distances across the country was crucial to the success of the medical response.

Keywords: aircraft; Bali; burn injuries; organizing; stabilization; surgery; teams; transfer; transportation; triage
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The Bali Bombing – A State Response to a National Disaster

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Introduction: Survival from burn injury requires a focused, experienced, multi-disciplinary team. To optimize the outcome, treatment must be timely. All intervention from the time of injury to the discharge from the rehabilitation program influences the scar the victim wears for life.

In Australasia, we are living with the increasing threat of fire. In West Australia (WA), statistics demonstrate a 280% increase in the incidence of fires. Coupled with industry and an increase in global terrorist activity, it is vital to understand the capability of a burn unit to treat massive numbers of patients. In Australasia, the focused burn teams are situated in Brisbane, Auckland, Melbourne, Adelaide, Tasmania, and Perth. It is vital to develop a coordinated response in the event that one or other of these regions/countries is overwhelmed.

Results: This presentation outlines the West Australian response to the Bali tragedy. Of the 54 patients treated in Perth, 30 required admission to the extended burn unit facility. All primary surgery was completed by Day 7. Nineteen patients required one surgical procedure. One patient underwent five procedures, but died at nine weeks post surgery. Three patients died.

How the facility was extended and supported is discussed. Specific problems arose due to: time from injury to admission and infection. These issues are discussed with ideas for improvement.

Keywords: Bali; burn injuries; burn unit; coordination; extension; facilities; fire; outcome; support
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Operation Bali Assist: Australian Defence Force Response to the Bali Bombing on 12 October 2002

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Australian Defence Force

Operation Bali Assist was the Australian Defence Force's (ADF) evacuation of injured Australians and other victims after the Bali terrorist bombing. This mission was the largest Australian overseas Aeromedical Evacuation (AME) since the Vietnam War, and was the largest disaster response since the tsunami in PNG in 1998. It relied on military and civilian cooperation to move critically injured patients from Denpasar to Darwin initially, and then onto specialist units around Australia.

This mission involved the triage, stabilisation, and evacuation of 66 critically ill patients from Bali to Darwin over 21 hours using 34 medical staff from the permanent and specialist reserve ADF personnel. The patients were stabilised in Royal Darwin Hospital (RDH), and then, under direction of Emergency Management Australia (EMA), they were transferred to definitive care in various centres around the country. The RAAF transported 35 patients in four separate missions during this second phase (phase one and phase two involved a total of 50 medical staff).

The success of this mission relied on a rapid military