aid workers. This paper reviews two frameworks in the international literature to propose a model for cultural competency education in the humanitarian workforce.

Methods: The framework for disaster health, developed by the World Association for Disaster and Emergency Medicine (WADEM) Education Committee, and the Australian National Health and Medical Research Council's (NHMCR) "Cultural Competency in Health: A Guide for Policy, Partnership and Preparation" (2006) were used as frameworks for this review. A meta-review of the literature was conducted to identify cultural considerations in disaster management.

Results: A definition of cultural competence was adopted from a range of theoretical models. Both the WADEM model, which includes the "Socio political, cultural context", and the NHMRC model, which describes four dimensions for actions (systemic, organizational, professional, and the individual), identify key principles. Using these principles informed by the literature review, a model is proposed to foster culturally competent behavior incorporating all four dimensions.

Conclusions: The model argues that "everyone" is responsible for culturally appropriate and responsive management. This review makes explicit the importance of cultural competency skills in the humanitarian workforce and provides a model, underpinned by contemporary frameworks, to address this challenge.

Keywords: cultural competency; disaster health; disasters; education; humanitarian workforce; training
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(M26) Model for Emergency Preparedness and Disaster Health

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Introduction: The conceptual framework for disaster medicine is weak and unstructured. There is a need to reinforce disaster medicine education and research with appropriate conceptual models. This paper outlines the development and structure of one such model—a "work-in-progress".

Methods: A literature review of contemporary education programs in disaster medicine was performed and used to enhance the outcomes of the evolving framework of the World Association for Disaster and Emergency Medicine (WADEM) Education Committee.

Results: The literature review identified some consistent themes representing "new" thinking on conceptualizing the field of disaster medicine.

Four domains were constructed to develop a new framework for conceptualizing disaster medicine, namely: an expanded disaster health framework developed by the WADEM Education committee, which includes the primary disciplines of public health (the collective), emergency and risk management (the organizational), the clinical and psychosocial (the individual), secondary disciplines, the community, and, the socio-political-cultural context; a contemporary view of the disaster cycle; the disaster epidemiology of the region; and the generic personal attributes expected of the humanitarian professional.

The consequent model demonstrates the relationships between these domains.

Conclusions: As a "work-in-progress", this model has been used to successfully guide the development of undergraduate and graduate programs in emergency preparedness and disaster health. The model provides a framework for common communication and subsequent modification in the light of further research and discussion.

Keywords: disaster medicine; education; framework; research
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Oral Presentations—Coordination and Clusters

Formation of the World Association for Disaster and Emergency Medicine Oceania Chapter: Process, Lessons Learned, and the Future

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Introduction: The World Association for Disater and Emergency Medicine (WADEM) Oceania Regional Chapter is the first WADEM Chapter to be formed. This paper describes the journey experienced in the formation of this Chapter.

Methods: This is a descriptive, historical review.

Results: The Chapter had its origins in WADEM's 13th World Congress in Melbourne (2003). In Edinburgh (2005), the WADEM General Assembly approved the establishment of Chapters to promote both the discipline and WADEM activities. WADEM Vice President, Professor Frederick (Skip) Burkle Jr, led the development of guidelines for establishing WADEM Chapters, which were considered by the WADEM Board in Amsterdam (2007) and subsequently approved by the WADEM Officers in August 2007.

Three "Chapter co-sponsors", later expanded to a steering group of five to include members from Australia, New Zealand, and the Pacific Island Nations, led the process. Three constituting meetings were conducted by teleconference, the general geography of the Oceania region defined, and draft Chapter Charter and Chapter bylaws were distributed for input from WADEM members in the region. The Chapter was launched in November 2008.

Nominations for the inaugural Chapter Council have been called in advance of an election to be finalized in February 2009. The first Chapter Council will meet before the WADEM World Congress in Victoria, Canada (May, 2009). The Council has a list of activities proposed in the constituting meetings, upon which to base an initial strategy plan for the young Chapter.

The WADEM Chapter guidelines have been most useful and the concept of Chapter co-sponsors has proved essential. Enthusiasm in the region has been promoted by the formation of the Chapter and membership in WADEM increased.

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Conclusions: The model and process experienced in the Oceania region may prove useful for other potential WADEM Chapters. Experience to date would suggest that WADEM Chapters are viable, achievable, and useful in promoting WADEM and its members.

Keywords: chapters; disaster medicine; Oceania; partnership; World Association for Disaster and Emergency Medicine
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Lessons Learned from the Health Cluster Approach in Africa

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Introduction: A review of humanitarian interventions suggested a reform based on three pillars: appointment of a Humanitarian Coordinator; an emergency fund; and the cluster approach for more predictability, efficiency, and accountability in a specific sector with an appointed leader. The cluster approach started late 2005 with some pilot countries in Africa, was followed by other countries. So far, Africa has been the wider cluster experience area. This paper will present different case studies and to highlight lessons learned.
Methods: Seven cases from African countries were studied. Cases were analyzed based on a developed framework that took different factors into account. Data were collected from field visits and from exiting documents.
Results: The cluster approach was adopted using different models based on existing coordination structures, government structures and implications, and the presence of a Health Coordinator or an existing emergency body.

The cluster approach has improved sectoral programming in humanitarian responses in the field. It provided stronger and more predictable leadership across sectors, improved preparedness and surge capacities. However, it lacked clear guidance in implementation as well as resources for effective coordination in the field, which are successes. There was a lack of understanding of the concept which made non-governmental organizations reluctant to adhere to a cluster approach.
Conclusions: The success of implementation of the cluster approach required flexibility for an appropriate model in order to be adopted. A participatory approach and transparency are required to bring all partners on board.

Keywords: Africa; cluster; coordination; humanitarian; partnership
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A Tale of Two Cities

A Tale of Two Cities: New Orleans and Dresden—Cutting-Edge Issues in Public Health Preparedness

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From hurricanes and flooding, to bridge collapses and earthquakes, to large-scale blackouts and military conflict, the latter part of the past decade and the early part of this decade has confronted the world with a diverse group of disasters. After each event, local governments, businesses, and public heath organizations prepare after-action and improvement reports that describe the incidents and make recommendations for improvement. The science of disaster medicine is in its infancy and disaster metrics are urgently needed to measure what works and whether changes truly decrease morbidity and mortality. Millions of dollars have been infused into the improvement of public health preparedness, but where is the evidence that this new money has improved patient outcomes and the ability for the healthcare system to quickly restore baseline operations? Using relevant recent case studies to illustrate key findings, this panel will explore cutting edge issues in public health preparedness requiring additional research and education.

After introductory remarks by the Dr. Koenig as moderator, Dr. Bey will describe major issues that surfaced during the 2002 Dresden floods in Germany. Dr. Klein will then discuss policy and operational issues evolving from Hurricane Katrina—the first full-scale activation of the patient transport portion of the National Disaster Medical System in US history. Her presentation will include "black tag" triage decision analysis, state-of-the-art decision making for the allocation of scarce resources, evacuation issues, and scientific evidence to support or refute commonly held beliefs like the prevalence of panic during disasters and the potential for dead bodies to spread disease. Finally, Dr. Schultz will summarize key public health preparedness areas that would benefit from scientific inquiry and describe the most recent approaches to measuring the effectiveness of disaster management. This will be followed by a moderator led discussion with audience participation.

At the completion of his session, participants will be able to describe the challenges to measuring preparedness and the opportunities for future research and education in public health preparedness.

Keywords: benchmark; Dresden flood; flood; Hurricane Katrina; metrics; preparedness; public health; public health preparedness;
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Oral Presentations—Psychosocial Issues

"In Gauze We Trust": Lessons Learned from a Gendered Profession during Severe Acute Respiratory Syndrome

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In 2003, 44 people (including two nurses and one physician) in Canada lost their lives in the Severe Acute Respiratory Syndrome (SARS) outbreak, 30,000 people were quarantined, and several hundred people fell seriously ill with the SARS Corona virus. The World Health Organization placed an international travel advisory on Toronto as the city struggled to understand and contain the disease. SARS resulted in a "wake-up" call for the Canadian healthcare system. Five years after SARS, the lessons learned have resulted in significant nation-wide invest-

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