



## **REPORT**

### **ASIA PACIFIC EMERGENCY AND DISASTER NURSING NETWORK MEETING AND CAPACITY BUILDING WORKSHOPS AND EMERGENCIES AND HEALTH IN THE TROPICS CONFERENCE**

**Cairns, Australia  
28 September to 1 October 2009**

**Manila, Philippines  
December 2009**

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ASIA PACIFIC EMERGENCY AND DISASTER NURSING NETWORK MEETING  
AND CAPACITY BUILDING WORKSHOPS  
AND EMERGENCIES AND HEALTH IN THE TROPICS CONFERENCE

Convened by:

WORLD HEALTH ORGANIZATION  
REGIONAL OFFICES FOR THE WESTERN PACIFIC  
AND SOUTH-EAST ASIA

AND JAMES COOK UNIVERSITY

Cairns, Australia  
28 September – 1 October 2009

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## NOTE

The views expressed in this report are those of the participants in the Asia Pacific Emergency and Disaster Nursing Network Meeting and Capacity Building Workshops and Emergencies and Health in the Tropics Conference and do not necessarily reflect the policies of the Organization.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for governments of Member States in the Western Pacific Region and for those who participated in the Asia Pacific Emergency and Disaster Nursing Network Meeting and Capacity Building Workshops and Emergencies and Health in the Tropics Conference which was held in Cairns, Australia, from 28 September to 1 October 2009.

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## 1. INTRODUCTION

Emergencies and disasters are increasing and will continue to multiply in the future. In 2005 alone, more than 157 000 000 persons were affected by these natural events worldwide, many of which occurred in Asia and the Pacific region. Regional and global networks in emergency and disaster response are vital to enhance collaboration, sustainability, capacity-building, experience-sharing, and resource mobilization in the event of a disaster or emergency. The nursing sector is a significant stakeholder in multinational and multi-sector partnerships that will strengthen preparedness for and response to disasters.

Responding to the urgency of coordinated and maximum response, the World Health Organization (WHO) Regional Offices for South-East Asia (SEAR) and the Western Pacific (WPR) Regions, in collaboration with the School of Nursing, James Cook University, organized the 2009 Meeting of the Asia Pacific Emergency and Disaster Nursing Network (APEDNN) to continue to enhance emergency and disaster preparedness in the Asia Pacific Region. As the lead agency in the Global Health Cluster for Emergency Response, the World Health Organization plays a crucial role in bringing partners together to discuss areas of concern and to enhance joint actions at regional and global level.

The *Asia-Pacific Emergency Disaster Nursing Network (APEDNN)* was formed in 2007 at an invited workshop in Thailand, with the aim of providing a network through which emergency and disaster preparedness could be enhanced. Membership is composed of researchers, educators involved in teaching the specific skills required of those working in emergency and disaster situations, curriculum specialists, practitioners, WHO representatives, and invited stakeholders. The network's 2008 meeting was held in Jinan, Shandong, China, from the 16<sup>th</sup> to the 20<sup>th</sup> of October, to strengthen and sustain emergency and disaster nursing network membership, education and research through communication technologies, partnerships and evaluation of progress made.

The 2009 APEDNN meeting, from 28<sup>th</sup> September to 1<sup>st</sup> October, was made possible through the support of the WHO, AusAID and James Cook University.

### 1.1 Participants

The APEDNN meeting was attended by 65 participants from 28 countries. The full list of participants is found in Annex 1.

### 1.2 Objectives

The APEDNN 2009 meeting aim was to support nurses, facilities and communities in effectively preparing for and responding to emergencies and disasters, including maintaining safe hospitals and health facilities, in partnership with other disaster preparedness team and community members. Its four core objectives were to enable participants to:

- Become familiar with community and facility vulnerabilities, risks and hazards associated with disasters and identify assessment tools and health facility preparedness measures for the public health consequences of disasters.

- Review the vision, mission statement and core objectives of the APEDNN and assess progress on implementation of key initiatives;
- Demonstrate an understanding of the core APEDNN course module aims and content, their development and linkages to APEDNN curricular domains, disaster and emergency competencies, the proposed APEDNN research framework to guide research priorities, as well as the monitoring and evaluation of action plans.
- Discuss disaster preparedness and response from the standpoint of tropical and communicable disease outbreaks in the tropics.

The meeting was followed by a one day conference on *Emergencies and Health in the Tropics*, sponsored by WHO and the Faculty of Medicine, Health and Molecular Sciences at James Cook University. The conference focused on some of the key issues facing the region including the threat of H1N1 and its impact on the community. Experts in the area from James Cook University, Australia and across the globe addressed participants.

The meeting agenda is included as Annex 2.

## 2. PROCEEDINGS

### 2.1 Opening session

Opening session chairpersons, Professor Kim Usher and Mrs Kathleen Fritsch introduced Ms Michelle Singleton, who welcomed participants on behalf of aboriginal people to the land of God, Australia. Professor Ian Wronski, Pro-vice-Chancellor, Faculty of Medical Health and Molecular Sciences then welcomed participants to the James Cook University and emphasized the different roles nurses could play in emergency and disaster. Associate Professor David Lindsay, Head of School of Nursing, Midwifery and Nutrition, JCU, acknowledged the vision and efforts of Professor Usher in disaster prevention and management and in bringing this meeting to the school. He referred to the Jinan Call for Action released in 2008 and the realization that there is still a lot of work to do and wished the network success in meeting these challenges. Mr Steve Wattenhall, State Member for Barron River welcomed and invited participants to visit various places in the state. He described the earlier big flood in Queensland which affected more than 60% of lands and stimulated the awareness of policy makers in investment in disaster preparedness. He also recognized the role of volunteers and health personnel in working with communities in disaster preparedness and relief efforts.

Ms Rosemary Bryant, Chief Nurse and Midwifery Officer, Australia and President of the International Council of Nurses (ICN) welcomed nurses and midwives on behalf of Australian and ICN colleagues. She noted the important roles played by nurses in disasters, as well as their need to be properly prepared to work effectively. She highlighted the need for nurses to shift the focus from care to public health and from individuals to family and community and appreciated the aim of the network to enhance information and experience sharing. ON behalf of the Regional Directors of the WHO Western Pacific and Southeast Asian Regions, she welcomed participants and emphasized the role of nurses in keeping individuals, family and communities safe during emergencies.

During his keynote speech, Professor John McBride reviewed what history tells us from disease outbreaks by presenting the epidemiology, history, incidence and lessons learned from five diseases: Dengue, SARS, measles, influenza and Chickungunya, particularly from the perspective of the Queensland experience. He mentioned the importance of effective surveillance and early interventions in the identification of infected persons, including tourists and the increased incidence of communicable diseases in relation globalization and air travel.

## 2.2 Meeting theme, expectations

Dr Prakin Suchaxaya, Regional Adviser, WHO SEAR, gave a brief review of the meeting theme, objectives and expected outcomes and introduced the historical nursing video: *Nurses, Now More Than Ever*, as a tribute to all present in recognition of their public health and primary health care activities. The meeting evaluation form and processes were explained by Dr Kristine Qureshi, University of Hawaii.

## 2.3 Monitoring progress

### 2.3.1 APEDNN outputs

A brief overview of APEDNN progress was given by Kathleen Fritsch subsequent to its formation in 2007 and aim to reduce the impact of emergencies and disaster on the health of communities. Network membership of nurses, partners and stakeholders is increasing. During the second network meeting in Shandong, Jinan, China, which took place after the Sichuan earthquake participants learned first-hand of the network's efforts in strengthening nursing system and capacity building of nurses in China in response to the needs of the those affected by the Sichuan earthquake.

An active working group communicated regularly in preparation for the Cairn's meeting. A stakeholder analysis of the APEDNN website is ongoing and core courses are scheduled for piloting in Cairns. It is expected that by the conclusion of the 2009 meeting, lead institutions will take 2-year terms in serving as the network secretariat; a conceptual research framework to guide the work of the network will be discussed and further action planning will outline sub-regional and country level disaster activities to be implemented over the next year.

The APEDNN website ([www.apednn.org](http://www.apednn.org)) update was given by Dr Amy Zang, Associate Dean, Shandong University. Dr Zang described the work of a team of nurses and students at Shandong University, under her leadership, culminating in the launching of a bilingual tailor-made user-friendly web platform. Most of the web information is for members of the public as well. The web functions include information sharing, video conferencing, online courses, translation and online research and evaluation, etc. Challenges include its dissemination and uptake by users and network members; policy impact; provision of mass education; functional expansion; and resource mobilization and sustainability. Participants asked questions about the network's security and use with existing firewalls; it's use in low-bandwidth areas and where internet accessibility is not available; the aim of attempting to make it free use for everyone; and other communication mechanisms and their cost.

### 2.3.2 ICN disaster nursing competencies

Ms Rosemary Bryant reviewed data and literature from disasters indicating that nurses were inadequately prepared to respond to emergencies and disasters due to curricular deficits and

lack of faculty preparation. In response to these needs, the ICN launched a position paper on nursing and disaster preparedness in 2001 and created a network for disaster nursing in 2007, while commissioning work on the drafting of WHO/ICN competencies in disaster nursing for generalist nurses. The publication<sup>1</sup>, published and launched in 2009, was based on the ICN competencies of generalist nurses. The disaster nursing competencies were grouped into four areas: mitigation/prevention, preparedness, responses and recovery/rehabilitation with ten accompanying competency domains.

### 2.3.3 Competencies and curricular planning

Dr Sheila Bonito and Ms Lisa Conlon presented an overview of disaster nursing curricular work, linked to the disaster nursing competencies development, in response to WHA58.1<sup>2</sup>. Subsequently, in 2007, various curricular and competency documents were reviewed including those developed by the University of Hyogo, the Advanced Practice Registered Nurse (APRN) Emergency Preparedness and All Hazards Response Competencies, as well as competency or curricular materials developed by WHO/Headquarters, Western Pacific, Southeast Asian and Eastern Mediterranean Regions and ICN. Core curricular domains were developed based on the document reviews, needs assessments and planning discussions carried out prior to and during the Bangkok APEDNN 2007 meeting.

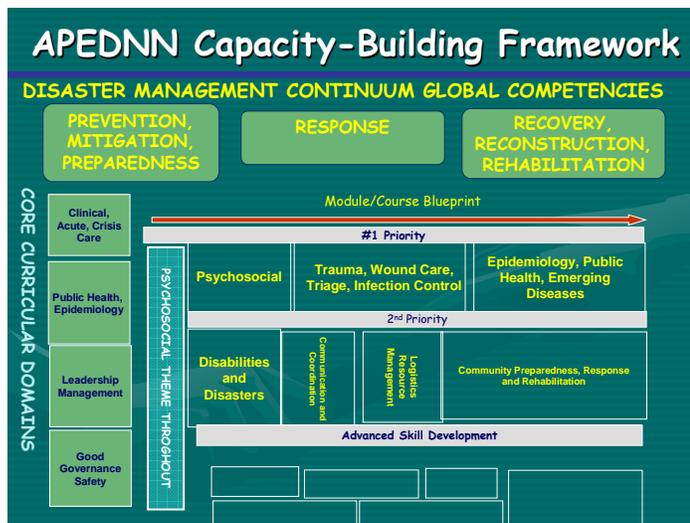
Five courses in the area of response were identified during the 2007 APEDNN meeting, based on the core curriculum and priority capacity-building needs (see Figure 1). Portions of the courses were piloted during the APEDNN 2009 meeting and subsequently in countries, to determine their practicality, usefulness and changes in knowledge and skills. Courses in the areas of preparedness and post-disaster recovery and rehabilitation have not yet been developed.

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<sup>1</sup> World Health Organization and the International Council of Nurses. *ICN Framework of Disaster Nursing Competencies*. Manila, 2009.

<sup>2</sup> World Health Organization. WHA58.1 *Health action in relation to crises and disasters, with particular emphasis on the earthquakes and tsunamis of 26 December 2004*. Geneva, 2005. Available from: [http://apps.who.int/gb/ebwha/pdf\\_files/WHA58/WHA58\\_1-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA58/WHA58_1-en.pdf), accessed 13 April 2010.

Figure 1: APEDNN Capacity-building framework, core courses



The overall guiding APEDNN curricular blueprint, linked to competencies and curricular domains, was developed across three phases of emergency and disaster management: preparedness (prevention and mitigation), response and recovery/rehabilitation (see Table 1). The curricular content includes, among other concepts, the role and functions of nurses in disasters; acute phase, public health interventions; psychosocial needs in disasters; coordination and communication, logistics and social mobilization.

**Table 1. Matrix of Competencies, Content Domains and Topics on Emergency Preparedness, Response, Recovery and Rehabilitation (EPRRR)**

Preparedness	Response	Recovery and Rehabilitation
Professional competencies		
A. Assist in the assessment of communities to determine pre-existing health issues and health care resources in a given community B. Contribute to the planning of health care needs of individuals and communities in an emergency/disaster C. Mobilize/ support community for health and intersectoral plan on health emergency management D. Collaborate with other health care professionals to develop measures to	A. Perform situation and needs assessment and prioritize care and management in the field and health facility during emergencies B. Provide initial relief and care during emergencies C. Provide nursing care of individuals, especially the vulnerable groups D. Support and implement public health interventions E. Provide safety and security of patients and personnel F. Provide psychosocial support to patients and staff G. Facilitate coordination and communication H. Supervise/support management of logistics and supplies	A. Provide long-term care to individuals and families (including psychosocial and mental health support to patients and staff) B. Support recovery-reconstruction efforts in the hospital and community C. Evaluate the impacts of nursing intervention and utilize these results to develop evidence-based decisions

Preparedness	Response	Recovery and Rehabilitation
<p>reduce vulnerability of populations</p> <p>E. Support health policy and organizational preparation for emergencies</p> <p>F. Develop health education and advocacy materials and provide training on health emergency management</p> <p>G. Demonstrate application of professional, ethical, legal, cultural and gender considerations</p> <p>H. Demonstrate leadership and management skills in health emergency management</p>		
Content domains and topics		
<p>A. Roles of nurses and midwives in health emergency management</p> <p>B. Elements and planning process of health emergency management</p> <ol style="list-style-type: none"> <li>1. Types of emergencies and disasters</li> <li>2. Risk management framework (including risk assessment and hazard mapping)</li> <li>3. Capacity assessment and development</li> </ol> <p>C. Policy advocacy and health promotion (including risk communication)</p> <p>D. Professional, ethical, legal (scope of practice) frameworks and cultural and gender considerations</p> <p>E. Leadership and management skills in emergency and disaster preparedness and</p>	<p>A. Initial relief and care</p> <ol style="list-style-type: none"> <li>1. Triage</li> <li>2. Trauma and initial stabilisation</li> <li>3. Wound care/</li> <li>4. Initial surgical intervention</li> <li>5. Movement/ Transport of casualties</li> <li>6. Infection control</li> </ol> <p>B. Nursing care of individuals</p> <ol style="list-style-type: none"> <li>1. Patient assessment and intervention</li> <li>2. Psychosocial and mental health support (e.g. psychological first aid, counselling skills)</li> <li>3. Infection control measures/ interventions</li> <li>4. Vulnerable groups (e.g. pregnant women, child-rearing mothers, children, patients with chronic disease, patients with physical or psychological disabilities, older persons)</li> </ol> <p>C. Public health interventions</p> <ol style="list-style-type: none"> <li>1. Early recognition and surveillance of disease outbreak, emerging diseases and morbidity trends</li> <li>2. Disease control focusing on communicable and infectious diseases</li> <li>3. Basic needs (nutrition, water and sanitation, shelter/temporary housing</li> </ol>	<p>A. Long term care needs</p> <ol style="list-style-type: none"> <li>1. Post-surgical interventions</li> <li>2. Supportive care</li> <li>3. Physiological rehabilitation</li> <li>4. Psychosocial and mental health support</li> </ol> <p>B. Structural and economic rehabilitation (e.g. safe hospitals and health facilities)</p> <p>C. Monitoring and evaluation in emergency and disaster</p>

Preparedness	Response	Recovery and Rehabilitation
response.	<ul style="list-style-type: none"> <li>4. Mass casualty management</li> <li>D. Safety and Security (of both patient and personnel)                             <ul style="list-style-type: none"> <li>1. Universal precautions</li> <li>2. Personal Protective Equipment (PPE)</li> <li>3. Exposures to Chemical, Biological, Radionuclear, Explosives (CBRNE)</li> <li>4. Scene evaluation</li> </ul> </li> <li>E. Coordination and communication                             <ul style="list-style-type: none"> <li>1. Incident command system (ICS)</li> <li>2. Documentation and reporting</li> </ul> </li> <li>F. Management of logistics &amp; supplies                             <ul style="list-style-type: none"> <li>1. Principles in managing supplies</li> <li>2. Issues in logistics and operations management</li> </ul> </li> </ul>	

#### 2.3.4 Guiding conceptual framework

Dr Beth Marks introduced a draft ecological approach to an APEDNN conceptual framework and described its intended use to guide and articulate APEDNN goals and ensure that network members work towards a common shared goal. The draft conceptual framework includes inputs of a multiplicity of inter-personal, intra-personal and community factors influencing behavior change. These included the community, nursing and country factors such as community empowerment, collaboration, building collective self-efficacy and interim outcomes and impacts which are in line with APEDNN's vision and objectives, aimed at reducing the impact of disaster on health.

The conceptual framework provides a structure, context and direction for the work of the network, in a manner consistent with the network's vision, mission and goals. It is meant to be organized in a manner that can be easily communicated to others; can promote or sensitize researchers and clinicians as to what data to look for, collect and analyze. It represents a travel guide or road map to enable all travelers on different paths or working in different ways, to reach the same place or aim. Continual evaluation of progress, outcomes and impact is supported by such a conceptual framework. An invigorating discussion followed the presentation during which time participants contributed their thoughts and ideas to further refine and improve the conceptual framework.

#### 2.4 Keeping hospitals, families and communities safe during disasters

The afternoon sessions began with selected country presentations of recent disasters, realities on the ground and lessons learned.

##### 2.4.1 Republic of the Marshall Islands

Ms Rensely Phillip Alik presented disaster risks in the Republic of the Marshall Islands, a country of low-lying coral atolls and islands and thus vulnerable to natural disasters. Country contextual vulnerabilities of increasing significance include poverty, unemployment and a weak governmental system. Floods occurring in 2008 illustrated the resulting negative impacts of

disasters on the economic development of the country as well as the need for efforts to improve disaster risk reduction and management. Public health nurses are very much involved in teaching and addressing hygiene skills, water and sanitation, and necessary vaccinations during outbreaks and disasters and gradually, the nursing profession overall is becoming more involved with other administrators working in the areas of disaster management as well as affected persons. The nurses participating in the meeting recognized the importance of RMI nurses in the APEDNN network, to strengthen in-country disaster preparedness and response capacities.

#### 2.4.2 Fiji

The history of Fiji's share of emergencies and disasters was presented by Ms. Silina Waza Ledua. Such disasters included Hurricane Bibi in 1970; severe floods in the Northern Division in 2003; bush fires in 2008 and flash floods in 2008 and 2009. Nurses have been actively involved in responding to emergencies and disasters in-country. Ms Waqa described a nurse who was killed while trying to save people in an isolated island at the height of Hurricane Bibi was posthumously awarded a Medal of Bravery. She also noted the important roles played by nurses in a peri-urban district hospital in dealing with the 2008 bush fire.

The Fiji National Health Emergencies and Disaster Management Plan (HEADMaP) addresses the important roles played by nurses in the different phases of emergency response. During the preparedness phase nurses organize training and supervision of staff and awareness campaigns on emergency preparedness. In the response phase, they provide public health services, serve as sources of information, staff evacuation centers and provide clinical services. During recovery and rehabilitation, nurses are part of the multisectoral and multidisciplinary Rehabilitation Response Committee (RRC) for decision making; coordination of immunizations, maternal child health and school health; and as members of various teams, including disease surveillance, post-disaster evaluation, counseling and support, environmental health and food coordination teams. They also play important roles in the national women's response group and the national women's plan of action.

Fiji nurses recognize a number of important needs including: (1) development of competencies and standards to strengthen nursing response to emergencies and disasters; (2) development of continuing nursing education courses; and (3) proper debriefing processes; and (4) the importance of good coordination, a clear line of authority and quality team work.

#### 2.4.3 Samoa

With memories of the Spanish flu epidemic in Samoa in 1918 when 25% of the island population was killed, Ms Pelenatete Stowers and Ms June Scanlan Lui described how Samoa acted promptly to set up border controls in the advent of Influenza A H1N1 outbreaks. During the recent 2009 outbreak, nurses were involved in issuing health cards, taking temperatures of persons entering the country and placing in quarantine those with temperatures above 37 degrees Centigrade. Nurses led the conducting of laboratory testing for H1N1 and monitoring of the population for 4 weeks to detect any trend in increased numbers of cases. Nurses were also part of the decision-making processes to close schools for 2 weeks at the height of the H1N1 outbreak. Nurses activated community centers and women organizations to help in monitoring the outbreak and in community and home care of those affected. Among the lessons learned was the importance of a multisectoral approach to planning and acting in the event of emergencies such as H1N1 outbreaks.

#### 2.4.4 Cook Islands

During the recent H1N1 pandemic, Ms Iokopeta Ngari described how nurses in the Cook Islands screened patients for signs and symptoms related to influenza H1N1. Nurses also opened flu clinics in the community where suspected patients could consult and be assessed as hospitals were closed to patients with the flu. During national Independence Day celebrations and accompanying sports tournaments involving people from the outer islands, nurses were also involved in the screening and opening of clinics for suspected cases of H1N1

#### 2.4.5 Tonga

Ms Ofa Takulua presented the H1N1 situation in Tonga, in which two confirmed cases of H1N1 died: a pregnant woman and a traveler from New Zealand. Similar to the efforts of other island countries, Tonga started working on border controls and screening for arriving persons who might be infected with H1N1. Nurses with potential signs or symptoms of H1N1 case exposures were asked not to go to work.

#### 2.4.6 Australia

Dr Margaret Grigg reported on the recent six week bushfires in Australia, resulting in 170 reported deaths and thousands of displaced persons. She highlighted the critical importance of governments to having policy guidelines in place, adapted from international standards, to guide actions at national and community levels. Lessons learned highlighted the importance of having advocacy materials and information accessible to communities. Though it is impossible to plan for what one cannot foresee, such planning is still needed, including the consideration of the complexities and breadth of needs of entire communities when preparing for emergencies or disasters. During the response phase, Australian officials noted the failure to transition from acute care to primary health care. A continuing challenge is how to address sustainability issues in recovery and rehabilitation.

#### 2.4.7 Keeping hospitals and communities safe during disasters and emergencies

During this session, Ms Kathleen Fritsch discussed community vulnerability and readiness, including that of health facilities, in regard to disaster preparedness and response. Measures to take in preparing communities and facilities for emergencies and disasters were presented, from a primary health care and health systems perspective, utilizing available supportive tools and guidelines.

Dr Sheila Bonito described the Safe Hospitals Assessment Tool, showing the indicators for the structural, non-structural and functional elements of safe hospitals. Some questions raised about the tool were how it differs from the WHO AMRO/PAHO Hospital Safety Index, and legal implications on how to address safety issues in hospitals after they were assessed. The consensus was that it is better for health workers and communities to be informed whether health facilities are safe or not so that necessary actions can be taken. Nurses are seen as participating team members in the assessment of hospitals and other health facilities.

### 2.5 Working together to keep families and communities safe

#### 2.5.1 Post-Sichuan Earthquake interventions

Ms Sunshine Chan, on behalf of the China team, presented the experiences after the Sichuan earthquake which highlighted the need for multidisciplinary national and international teams providing people manpower, materials, and technical support. WHO and various members of the APEDNN provided immediate grant writing, technical deployment and support. Collaborative efforts of various parties, including the government, army, civilians and health care professionals across boundaries and countries resulted in a massive response effort. Hong Kong Polytechnic University conducted several training on psychosocial support and infection control in Sichuan province. Home visits and health education sessions were also conducted in the affected communities and in temporary shelters.

#### 2.5.2 Disaster lessons for secondary schools Nurses

Disaster mitigation education for Junior High School students in the community was presented by Dr Hatsumi Kanzaki, as part of an integrated learning course aimed at increasing community awareness of disaster preparedness and supporting other people. Thirty eight students participating were divided into six groups of 6 or 7 members to engage in group learning activities. Core course lessons included the use of a disaster readiness scale to assess disaster preparedness and assess learning outcomes; the use of animation videos and lectures to share lessons learned from past disasters; the needs of elderly and other vulnerable community members; evacuation centre simulated experiences and community hazard identification and mapping. Students, community members and parents responded positively to the disaster education programme.

#### 2.5.3 Disaster competency building for emergency room nurses

Dr Orapan Thosingha presented the outcomes of a May 2009 two-day disaster nursing workshop for emergency department nurse administrators, attended by 150 tertiary care hospital nurses from every region of Thailand. The workshop included a plenary lecture by the secretary of the Institute of Thai National Emergency Management System; panel discussions; the development of a disaster preparedness framework and identification of the competencies needed by emergency room nurses and nurse managers for emergency and disaster preparedness and response.

A five-year plan on capacity building in disaster preparedness for Thai emergency room nurses was developed and included:

1. Disaster preparedness and emergency management during disasters.
2. Clinical assessment, triage, injury management and special wound care.
3. Mitigation, rehabilitation, psychosocial management and care for the special groups; people with chronic illnesses, elderly people, children, disability groups and marginal groups.
4. Safety and security of health care personnel during disaster management.
5. Stress management for health care personnel.

Action planning included the establishment of a Thai Nursing Association on emergency Care and the implementation of disaster nursing workshops and training programmes.

## 2.6 Research and evaluation

Following a recap of day 1 by Dr Kim Usher, an overview of research and evaluation pertinent to the network was provided.

### 2.6.1 Research and evaluation for emergency and disaster nursing

Dr Kristine Qureshi's applied quantitative and qualitative research concepts and processes to the activities of the APEDNN. She used the phrase 'simple is eloquent' in guiding prospective researchers of the need to ensure that all research endeavors are clearly articulated to facilitate the likelihood of success. A discussion followed focused on ensuring that nursing continues to meet its ethical obligation to communities and continual improvement in practice. Research tips were offered:

- If this is not what you do every day, start simple.
- Work to your strengths.
- Pacific Island nations, having a strong oral tradition, may want to start with a qualitative study.
- If your country has a large database, or great infrastructure for collecting data, start with a quantitative study.
- It is more important to be successful at something small, and learn from the experience.
- Partner with others, communities and academia.

The presentation highlighted a growing trend in using community based participatory action research methodologies, consistent with the conceptual framework principles described by Dr Beth Marks. This approach shifts the dynamic – the question is developed from the population and the research is the facilitator rather than the driver of the research. Dr Qureshi concluded with a review of the ethics of research and the need to ensure that research maintains its beneficence and non-maleficence requirement to communities.

## 2.7 Concurrent capacity-building sessions

Participants divided into smaller groups to take part concurrent capacity-building sessions on day two:

- Capacity building A: Psychosocial Health and Disasters – Dr M. Grigg;
- Capacity building B: Epidemiology, Disasters and Emerging Diseases – Dr K Qureshi and Dr S. Bonito;
- Capacity building C: Trauma, Triage and Wound Care – Ms Lisa Conlon; Ms Sunshine Chan, Dr Sijian Li, Col Heidi Warrington;
- Capacity Building D: Reproductive Health and Disasters – Carina Hickling;

- Capacity Building E: Disabilities and Disasters – Dr Beth Marks and Dr Amy Zang;

Summary highlights of the individual capacity-building sessions were presented in the concluding plenary session.

#### 2.7.1 Psychosocial health and disasters

The objectives of the psychosocial health and disasters session were to:

- Have an increased understanding of the psychosocial consequences of disasters;
- Be able to use some evidence based public health interventions to promote psychosocial health;
- Identify some of the mental health implications for individuals and communities; and
- Be able to recognize one's own psychosocial needs and the needs of other nurses

Participants discussed their own learning aims prior to a mini-lecture, overview of stress and the varied physical, emotional, cognitive and behavioural responses of individuals and groups to disasters. Working in pairs, participants related prior experiences with or exposures to disasters and their impact.

The sequence or typical timing of reactions to disasters was presented as well as common reactions of different age groups. Discussions enabled participants to differentiate the concept of empathy from that of sympathy and how to engage with another person in an empathic manner. Means of supporting the functioning and recovery of those affected were discussed by all participants, within the context of both individual and community support, recognizing that most people recover with no intervention.

#### 2.7.2 Epidemiology, disasters and emerging diseases

The objectives of the epidemiology, disasters and emerging diseases session were to:

- Discuss the use and applications of epidemiology in disasters;
- Demonstrate the use of epidemiologic tools and processes in emergencies
  - Rapid health assessment
  - Public health surveillance
- Describe the role of nurses and midwives in epidemiology in disasters

Group work focused on the application and use of data collection tools and methods in rapidly taking stock of the situation, emergency or disaster. Accompanying discussions enabled participants to reflect on nursing and midwifery roles and responsibilities in planning, implementation and evaluation of rapid assessments. Group members reviewed public health

surveillance, the systematic collection, analysis, reporting and taking action in relation to diseases and trends and discussed issues facing nurses in regard to public health surveillance.

Epidemics and corresponding effective public health responses of facility-based and public health, community providers were discussed, in relation to necessary interfaces between hospitals, public health and communities, in epidemic preparedness and response. Case investigation skills were applied to a simulated case of a person presenting with respiratory symptoms. Interactive group work and use of evidence-based tools took place throughout the session.

### 2.7.3 Reproductive health and disasters

The session commenced with the underlying rationale for providing Reproductive Health in complex emergencies and the expectations of participants. The facilitator began the session, accompanied to the beat of a drum, by describing the story and vulnerabilities, during times of emergencies, of a traditional birth attendant (TBA) in Uganda. A key message throughout the session was that reproductive health means not only women's health but also the need for engagement of men.

Reproductive health concerns in emergencies were discussed in small groups. The needs differing from those during normal times were identified as:

- Risk of sexual violence may increase during social instability;
- STI/HIV transmission may increase in areas of high population density;
- Lack of family planning availability increases risk of pregnancy and associated complications;
- Malnutrition and epidemics increase risks of pregnancy complications;
- Childbirth occurs on the wayside during population movements;
- Needs increase while access to services decreases; a breakdown in social networks and becomes the norm, with increased vulnerability to sexual violence.

The essential reasons identified for addressing reproductive health (RH) needs during times of crisis were:

- The magnitude and make-up of a crisis affects populations.
- RH is a serious public health issue and significant cause of morbidity and mortality.
- RH is a human right and the provision of RH services in emergencies is a global standard.
- Approximately 75 % of the 65 million refugees and internally displaced persons worldwide are women and children.

The Minimum Initial Service Package (MISP) has been introduced to reduce mortality morbidity and disability among populations affected by crises, particularly women and girls. MISP is a multi-sectoral package of activities for implementation by humanitarian workers operating in crisis situations, such as during times of natural disasters, emergencies and conflicts. The MISP also forms the starting point of all RH programming – it is not just for the acute crisis phase. Services included are: safe motherhood (delivery) and post-abortion care; gender-based violence; STI/HIV management; but not family planning. Despite being an internationally accepted standard, MISP has not been well implemented to date and has not been fully implemented anywhere in the world.

MISP United Nations Interagency RH kits have been discussed as part of the AusAID SPRINT initiative, aiming to improve the coordination of the MISP in times of emergencies and disasters in Pacific Island and Asian communities. Given the current weaknesses of RH services within many countries within the region, the group supported a recommendation that MISP be included in disaster response plans within countries, and placed within the context of overall strengthening of RH services.

Actions discussed to reduce the risk of sexual violence included:

- Appropriate design and location of settlements for displaced populations;
- Appropriate, safe location of latrines and water points;
- Providing latches to latrines and washing facilities;
- Providing adequate lighting;
- Providing community based security patrols including women;
- Identifying individuals or groups that may be at higher risk of sexual violence; and
- Ensuring the use of confidential reporting systems.

Appropriate responses to rape survivors were identified and discussed:

- Ensuring a standard medical response (ie.STI treatment, post-exposure prophylaxis (PEP), tetanus vaccination);
- Ensuring privacy and confidentiality of the survivor;
- Ensuring the presence of same sex, same language health worker or chaperone;
- Ensuring the physical safety of the survivor;
- Ensuring population awareness of services; and
- Applying standard guiding principles in the medical management of rape survivors, from a standpoint of:
- Safety

- Cultural appropriateness
- Confidentiality
- Respectful care
- Non-discrimination

Methods of preventing excess maternal and neonatal morbidity and mortality of paramount importance are:

- Functioning referral systems including communication and transport 24/7;
- Clean birth kits for pregnant women) and midwife delivery kits, produced locally if possible; and
- Implementation of strategies to mitigate against the “three delays” – ensuring access to services; utilization of female health care providers; and, advocacy with male leaders.

Field lessons learned which are applicable to a variety of emergencies and disasters include supplying of dignity kits (sanitary napkins, underwear), as a key strategy in assisting displaced female populations. Such kits can be procured or assembled locally so ensure their cultural appropriateness.

#### 2.7.4 Trauma, triage and wound care

The trauma, triage and wound care session was focused on the following objectives:

- Introducing the history and concepts of trauma care;
- Applying the principles of triage in emergency and disaster situations; and
- Understanding the different types of wounds; management principles and care in special circumstances—chest injuries; abdominal injuries; impaled objects and amputations.

Lectures, group work, case studies and active learning exercises were used in the session to highlight the trauma nursing functions; various types of wounds, their assessment and management; primary and secondary assessments or surveys; and, triage principles and systems applied to casualty situations.

#### 2.7.5 Disasters and disabilities

Objectives of the disasters and disabilities session were to:

- Discuss the experiences of disaster among persons with disabilities;
- Identify strategies for including people with disabilities in disaster planning;

- Formulate plans for working with your disability community;
- Implement a plan integrating universal design addressing social vulnerabilities; and
- Create social networks with available tools and resources.

Session participants discussed values surrounding the disaster planning and management principles of being inclusive of all—nobody is left behind, with in the context of the unique and varied abilities and needs of persons with disabilities. Surveys and lessons learned have revealed that people with disabilities are left out of preparedness and planning activities and response systems, including shelters, are designed for people without disabilities as there are many access barriers.

Steps towards establishing collaborative dialogue among leaders and experts within disability communities, relief organizations, media professionals and government officials were outlined, in terms of identifying key issues; developing effective strategies for resolving the issues; and, building relationships and responsibilities among the groups. Seven principles for dialogue were highlighted;

- Accessible disaster facilities and services;
- Accessible communications and assistance;
- Accessible and reliable rescue communications;
- Partnerships with the media;
- Disaster preparation; education and training; and
- Universal design and implementation strategies.

The over-riding importance of accessible communications and reliable assistance technologies was emphasized as communications technology is essential for persons with disabilities for disaster preparedness—to warn the people most likely to be affected; during a disaster and for those incurring a disability resulting from a disaster. In terms of universal design principles to meet the needs of persons with disabilities, such design interventions, before and after disasters, will positively benefit many people, including very young as well as older persons without disabilities.

Suggestions for opening and promoting communication and respectful interactions with persons with disabilities put forth were:

- Ask if assistance is wanted;
- Arrange for a quiet, well-lit environment;
- Look directly at an individual;
- Treat people as people;

- Do not assume that a person with a disability is more fragile or make assumptions about what they can or cannot do;
- Identify yourself and anyone else with you;
- Consider the need for extra time
- Try to be seated to facilitate eye contact when interacting with persons in wheelchairs or of short stature;
- Use universal communication strategies and/or communication support devices--- if you do not understand, do not pretend that you did.

## 2.8 Infection control

Along with organizational and country experiences in acute respiratory infection control, prevention and management, the three major components of the regional infection control toolkit were highlighted.

### 2.8.1 Infection control toolkit

Dr Danny Tong reviewed the toolkit's development, necessary requirements and aims; within the context of how multiple Hong Kong infection control (IC) experts contributed their knowledge and skills to the endeavour following the 2003 SARS outbreak. The toolkit is user-friendly; practical, as well as a standardized, evidence-based set of guidelines and tools, containing core technical information, materials and illustrations, inclusive of information, education and communication (IEC) materials. The toolkit emphasizes clinical IC requirements as well as preparedness for and response to emerging infectious disease outbreaks.

Toolkit components enable the implementation and analysis of an systematic infection control national, sub-national or institutional assessment, using a guiding assessment tool and reporting template. The toolkit and accompanying tools, targeted toward lesser-resourced countries and settings, are adaptable to varying cultures and socioeconomic settings. Evidence-based practices are promoted, with recognition of resource limitations. Content areas include clinical management; general infection control practices; waste management; supplies and personal protective equipment (PPE); accessibility and surveillance and issues requiring urgent short-term rapid actions necessary for immediate patient safety and protection of the public.

### 2.8.2 Infection control curriculum

Patricia Ching described the ongoing work of the WHO Infection Control Collaborating Centre in Hong Kong as well as experiences gained through regular infection control courses offered by the Hong Kong Polytechnic University, in collaboration with Queen Mary Hospital. The training course is targeted at 'Infection Control Link Nurses,' whose functions include:

1. Serving as on-duty resource person;
2. Trainer of others on infection control issues;
3. Monitor of infection control guidelines;

4. Liaison between ward staff and the Infection Control Nurse and/or relevant facility infection control officer;
5. Facilitator of response and management of outbreaks, for patients and staff; and
6. Monitoring and facilitating reporting of notifiable diseases.

The infection control curriculum, targeted particularly toward nurses and other health professionals working in lesser-resourced settings, aims to serve as an evidence based infection control course curriculum, applicable in low resource countries. Course objectives are to:

1. Enhance awareness and update infection control knowledge and skills for ward/link nurses, others with similar responsibilities;
2. Improve patient care practices; and
4. Prevent nosocomial infections

Curricular content includes but is not limited to the following components, based on a preceding needs assessment, carried out through interviews, supported by electronic responses to a structured questionnaire to prioritize core content:

- Overview of microbiology and infection control, impacts;
- Isolation precautions and use of personal protective equipment (PPE);
- The importance and skills of hand hygiene;
- Disinfection and sterilization;
- Patient care practices for the prevention of catheter-associated urinary tract infections, blood infections, surgical site infections and pneumonia;
- Specimen collection;
- Hospital laundry and waste management;
- Participation in outbreak investigation and management;
- Healthcare worker immunization program and management of occupational exposures; and
- Roles and responsibilities of infection control link person/manager.

The use of pre- and post-assessment measures to measure learning outcomes was emphasized during the subsequent discussion.

### 2.8.3 Training in acute respiratory disease (ARDS) in community settings

Dr Il Young Yoo described the development of training on infection control of ARDS in community settings, including the background, rationales, overall objectives, progress and key points deserving attention. Given past pandemics, including SARS and others, transmitted by respiratory aerosols, we recognize that hospitals alone have insufficient resources to deal with the disease burden, in the context of frequently mutating viruses and the time required for necessary vaccine, medication research and use.

Thus WHO Headquarters, in 2008, invited WHO Collaborating Centre (CC) representatives from Bahrain, China, Egypt, Jordan, Thailand, and Korea to develop standardized training packages on infection control of ARDS, utilizing WHO evidence-based ARDS prevention and management guidelines. In October 2008, the initial training of trainers (TOT) was implemented during the APEDNN meeting in Jinan, China.

The TOT training package addresses infection control of pandemic/epidemic prone ARDS in communities, within and outside facilities, including in homes. Each CC has its own terms of reference regarding training packages being implemented in their own country, subsequent to relevant language translation. The Yonsei University College of Nursing's WHO Collaborating Centre for Research and Training for Nursing Development in Primary Health Care serves as the project focal centre, collecting and posting multi-site country information and progress on a webpage presently under development. An ARDS project evaluation meeting is scheduled in November 2009 in Bangkok. The ARDS CC network offers many opportunities for utilization for other communicable diseases.

#### 2.8.4 ARDs, Samoa

Ms June Scanlan Lui described what has been done in Samoa to strengthen the nursing workforce in infection control practices, during the recent H1N1 outbreak, when screening sites were handling more persons than could realistically be handled. In the face of the ARDs outbreak, clinics in the hospitals and community were closed; operating rooms were opened only for emergency surgeries so that nurses could be available for ARDS prevention, management and control. In order to reduce the risk of cross infection, ARDs patients were not placed in the same wards as other patients. Community training efforts by local nurses were greatly intensified, using the key points and concepts in the ARDs training toolkit, such as hand washing, application and removal of PPE, and basic infection control practices. Village members expressed gratitude for the training and information regarding home care of persons with ARDs.

#### 2.8.5 Tuberculosis transmission and control

Dr Peter Van Maaren gave a detailed account on how TB could be transmitted, how it can be controlled, and highlighted the new WHO Policy on the control of TB to be released later this year. Emphasis was placed on the long-term treatment needs for TB---ranging from 6 months, to 24 months for drug resistant TB. Transmission of the mycobacterium bacilli was reviewed in-depth, highlighting methods of transmission:

- Person-to-person through the air by a person with TB disease of the lungs;
- Less frequently transmitted by ingestion of mycobacterium bovis found in unpasteurized milkp; and/or
- Laboratory accidents.

Transmission is affected by the degree of infectiousness of the patient; environmental conditions and the duration of exposure, all inter-related to the patient, recipient, bacterial and institutional factors. Prevention therefore needs to target the patient, the workers, and visitors to the patient and facilities.

Patient factors influencing transmission include:

- Infectiousness: sputum smear positive or negative; cavitation; force and frequency of cough, noting that the number of infectious bacilli in room air is influenced by the patient's immune status;
- Understanding of TB, cough etiquette, and adherence to IC practices;
- Treatment (time since start of correct treatment and adherence to treatment);
- Cough-inducing procedures; and
- General health status (immune status, nutritional status, comorbidities, e.g. diabetes, HIV etc)

Recipient factors affecting transmission are:

- Contact closeness, duration and frequency of contact—all of which influence the dose of inhaled bacilli;
- Risk of TB infection (prior treatment, age, homelessness, contact of known case, etc)
- Adherence to IC practices; and
- Susceptibility—either intrinsic or acquired (i.e. immune status, general health, other diseases, nutrition, age)

The risk of health care associated transmission of *M. tuberculosis* varies, based on:

- TB prevalence in health-care setting
- TB prevalence in community
- Patient population served
- Health-care worker occupational group
- Effectiveness of infection control measures

Known higher-risk procedures generating aerosols include:

- Endotracheal intubation, suctioning and bronchoscopy;
- Open abscess irrigation;

- Autopsy;
- Sputum induction; and
- Aerosol treatments

Bacterial factors were reviewed, noting that the intrinsic virulence of M(X)DR-TB bacilli may not be greater than drug susceptible bacilli. However, patients with multiple drug-resistant tuberculosis (M(X)DR-TB) may infect more people due to the prolonged period of infectiousness; the chronic nature of cases; defaulters, treatment failures, or re-treatment cases.

Institutional physical environmental factors facilitating transmission are:

- Exposure in small, enclosed spaces;
- Lack of adequate ventilation; and
- Re-circulation of contaminated air.

Two transmission pathways are of vital importance in TB transmission:

Path of the patient:

- In-patient
- Out-patient
- High risk procedures

Path of the specimen:

- Collection location and procedures
- Transportation
- Processing procedures
- Disposal procedures

When assessing transmission pathways, always broaden your thinking to cover common areas visited by TB patients:

- Home/referral clinics; TB departments; TB wards;
- Reception and outpatient department areas; voluntary counseling and testing centres; radiology; laboratory; pharmacy and other departments; as well as
- General wards and maternity wards.

TB infection control policy and practice standard measures include the need for available resources; regulation of patient movement and housing; and taking into account the time lag between detection of drug resistance and proper treatment. Infection control programmes for TB should include these essential components:

- Performance of a TB risk assessment in all settings;
- Development of a TB IC programme as part of an overall IC programme;
- Basic IC program on risk assessment; as well as
- Determination of details of the IC program by considering the likelihood that persons with TB will be encountered in that setting or transferred to another setting.

The recently updated and released WHO TB infection control policy promotes a combination of integrated IC controls:

- Addressing health facilities, congregate settings, and households;
- An essential managerial component at national level;
- Minimizing time spent in health facilities;
- Emphasizing community involvement in raising awareness, promoting behavior change and reducing stigma; and
- Promoting integrated TB infection control with other infection control activities.

Audience member suggestions included the routine use of a TB assessment checklist, including those which may be in the IC toolkit and/or available from the United States CDC. Dr J. Tuazon suggested that nurses should assume everyone has TB until proven otherwise so that precautions are always followed. Ms Jemmabeth Simbilo of Guam Memorial Hospital concurred that precautions be taken for all staff, as Guam, for example, has experienced an upsurge of TB cases. The hospital is also considering reduction in the contact time of relatives with the bodies of deceased relatives, to reduce the risk of TB transmission.

## 2.9 Partnerships, resource sharing and generation

### 2.9.1 Red Cross

Ms Lyndal Scobell described the Australian Red Cross (ARC) efforts in capacity building at the national level in collaboration with the regional office for the Red Cross and with other Pacific Islands; as well as the challenges faced. For example, natural disasters now displace more people than armed conflict; those who live in the Pacific are among the most vulnerable in the world to natural disasters as they live in the most geologically active region on earth. The Australian Red Cross (ARC) works closely with local partners to encourage a broad understanding of disaster management and disaster risk reduction, so that when disaster strikes it doesn't strike twice. The ARC is helping 11 countries throughout the Pacific to preposition relief supplies and keep them well stocked; and working with staff and volunteers to ensure that they are familiar with the appropriate emergency response, as well as able to work with communities to reduce potential risks and devise ways of adapting to climate change. They also strive to build relationships with communities during times of normalcy to enable appropriate responses being made available during times of disasters.

Ms Pelenatete Stowers talked about their experiences in working with the Red Cross in Apia, while Ms Mary Roroi of Papua New Guinea shared highlights of the Nursing Leadership Meeting in Switzerland where the importance of nurses' response in times of disasters was recognized. Strong working relationships between the Red Cross and the nursing work force are seen as important. Ofa Takulua of Tonga commented that one of the representatives from Red Cross was active in helping in doing resuscitation training and in funding the establishment of a blood bank. Margaret Grigg highly praised the resources, assistance, and the willingness to work with others offered by the Red Cross. It was clear that there are a number of opportunities to build further working relationships between nurses and the Red Cross. For example, Heidi Warrington commented that the Red Cross has an excellent template to plan for and guide mass relocation, evacuation, and resource allocation, all of which are important during times of mass casualties and disasters.

### 2.9.2 Military partnerships

Michelle Walker discussed how the Australian military works during times of disasters and the constraints they face. As the Australian Air Force is part of the Federal Government, formal Government requests have to be made through the established communication channels, in order to involve the military in disaster situations. Academic institutions and the military find their collaborative undertakings to be mutually beneficial. For example, a five-day short course on health aspects of disasters was organized by the Australian Centre for International Tropical Health (ACITH), School of Population Health, University of Queensland; the Centre for Military and Veterans Health, University of Queensland; the University of Adelaide, and Charles Darwin University) in a Center of Excellence in Canberra. The military work with various groups in different disaster situations.

An overview of the work done by the American Military in relation to disasters was given by Colonel Heidi Warrington. Colonel Warrington described three military disaster components in the United States of America—the Active Army, which is part of the federal government; the National Reserve, with congressional oversight; and the National Guard, which is called upon in cases of disaster when the Government mandates their services. Some military staff work in different parts of the country in collaboration with local agencies. The US military acts as part of a national think tank and carries out strong practical frontline disaster work, especially in areas such as public health.

Dr Eric Chan described the response of the Chinese Army to Sichuan immediately after the earthquake. Nurses working in the Army actually formed the backbone of the rescue work. It was felt to be important to strengthen that important work force collaboration, and also to revisit basic nursing/midwifery curricula in terms of disaster preparedness and response. Heidi Warrington confirmed that military nurses are prepared to work in harsh conditions and unfavorable environments.

Ms Carina Hickling discussed the sexual and reproductive technical work of the International Planned Parenthood Federation (IPPF) and the Sprint initiative, in emergency situations in South East Asia in emergency situations.

Professor Paul Arbon, of Flinders University, presented the experiences of the World Association for Disaster and Emergency Medicine (WADEM), including developing the evidence-based for for disasters; publishing in their peer-refereed journal, the *Pre-Hospital and Emergency Medicine Journal*; a nursing section furthering nursing interests in the field; a web-based journal, *Nursing Insight*, available in three languages; and, the production of a textbook, *International Disaster Nursing*, released in 2010. WADEM also maintains a research sub-group.

Professor Lydia Mayner, also of Finders University, discussed recent successes in the development in the research research and development of the International Classification of Nursing Practice (ICNP), pertinent to nursing and disasters. The ICNP coding concepts are used for diagnoses, interventions and evaluation documentation and research. In 2008, the International Council of Nurses (ICN) recognized the ICNP as a member of the WHO Family of International Classifications. The ICNP version 2, launched in Durban in 2009, is based on a 7-Axis model—*Focus, Judgment, Client, Action, Means, Location, and Means* and provides a subset of concepts, standardized nomenclature and terms relevant to disaster nursing.

### 3. CONCLUSIONS

Participants discussed the value of continued capacity-building sessions as well as the importance of further developing and utilizing APEDNN core courses for continuous capacity-development and evaluation of such processes and outcomes. Updates on partnerships, work of network members, lessons learned from disasters; research and ongoing information-sharing and capacity-building were found to be valuable.

#### 3.1 Action planning

Standardized templates (Annex 3) were used by sub-groups of regions to plan priority activities for the next year. Northern Pacific Island nurses worked with Dr Maria Salomon of the University of Guam in planning methods of shared capacity-building across jurisdictions, while the South Pacific nurses worked together as members of the South Pacific Chief Nursing and Midwifery Officers Alliance (SPCNMOA). Mekong countries worked together in planning in infection control training of trainers (IC TOT) course, linked to the IC toolkit and South-east Asian region participants developed a collaborative research plan as well as a training programme on disaster and emergency nursing.

#### 3.2 The way forward

Participants of the APEDNN 2009 meeting emphasized continuing to strengthen and address capacity-building, information sharing and research, within a monitoring and evaluation framework. Additionally, they advocated for the inclusion of the Reproductive Health (RH) Minimum Initial Service Package (MISP) in country Emergency and Disaster plans. Participants recommended that general RH services within countries be given priority, to facilitate provision of the MISP during times of emergencies and disasters.



## ASIA PACIFIC EMERGENCY & DISASTER NURSING NETWORK

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## MEETING AGENDA

**APEDNN 2009 MEETING and CAPACITY-BUILDING WORKSHOPS, CAIRNS, AUSTRALIA 28-30<sup>TH</sup> SEPTEMBER with EMERGENCIES AND HEALTH IN THE TROPICS CONFERENCE, 1 OCTOBER 2009. JAMES COOK UNIVERSITY, CAIRNS.**

**Jointly hosted and supported by WHO Western Pacific Region Office, James Cook University and AusAID ISSS.**

**Theme**

*Disaster preparedness: family, community and health facility*

**Aim**

Enable nurses, facilities and communities to effectively prepare for and respond to emergencies and disasters, including maintaining safe hospitals and health facilities, in partnership with other disaster preparedness team and community members.

**Objectives**

- To become familiar with community and facility vulnerabilities, risks and hazards associated with disasters and identify assessment tools and health facility preparedness measures for the public health consequences of disasters.
- To review the vision, mission statement and core objectives of the APEDNN and assess progress on implementation of key initiatives;
- To demonstrate an understanding of the core APEDNN course module aims and content, their development and linkages to APEDNN curricular domains, disaster and emergency competencies, the proposed APEDNN research framework to guide research priorities, as well as the monitoring and evaluation of action plans.
- To discuss disaster preparedness and response from the standpoint of tropical and communicable disease outbreaks in the tropics.

**Expected Outcomes**

By the end of the meeting and capacity-building workshops, participants will have:

- Demonstrated knowledge and skills in selected aspects of participatory learning approaches and technical content of at least one of the following emergency/disaster courses, i.e. Psychosocial health and disasters; Epidemiology, Disasters and Emerging Diseases; and Trauma, Triage and Wound Care; Reproductive Health and Disasters; Infection Control.
- Formulated sub-regional annual action plans for policy and planning, monitoring and evaluation, research, capacity-building, and/or other work, utilizing tools for action planning and policy-making and evaluation.

**DAY 1 – MONDAY SEPTEMBER 28**  
**Family, Community & Health Facility Disaster Preparedness**

TIME	SESSION INFORMATION
0730-0830	Registration in building A1
0830-1000	<p><b>Session 1: Opening/Welcome Remarks</b></p> <ul style="list-style-type: none"> <li>• Chaired by Dr. Kim Usher, James Cook University and Kathleen Fritsch, Regional Nurse Adviser, WHO Western Pacific Region</li> <li>• Welcome to Country</li> <li>• Prof Ian Wronski, Pro-Vice-Chancellor, Faculty of Medicine Health &amp; Molecular Sciences, JCU</li> <li>• Assoc Prof David Lindsay, Head of School of Nursing, Midwifery &amp; Nutrition, JCU</li> <li>• Mr Steve Wettenhall, State Member for Barron River</li> <li>• Ms Rosemary Bryant, Chief Nurse and Midwifery Officer, Australia; President, ICN</li> <li>• Dr Arturo Pesigan WHO WPR/SEAR – Thematic Overview</li> <li>• Keynote Speaker – Prof John McBride. Disease Outbreaks: What History Tells Us</li> <li>• Open Forum for Questions, Responses</li> </ul>
1000-1030	Group photo and morning tea
1030-1045	<p><b>Session 2: Introductions and Expectations</b></p> <ul style="list-style-type: none"> <li>• Introductions to the theme, expected outcomes, ground rules</li> </ul>
1045-1230	<p><b>Session 3: Setting the Scene and Monitoring Progress—Where we were, where we are and how we've gotten there</b></p> <ul style="list-style-type: none"> <li>• Brief overview of APEDNN, progress: Kathleen Fritsch, Prakin 'Suchaxaya</li> <li>• APEDNN Website – Amy Zang, Associate Dean, Shandong University</li> <li>• ICN Competencies – Rosemary Bryant</li> <li>• Competencies and curricular planning – Sheila Bonito and Lisa Conlon</li> <li>• Introduction to proposed research framework guiding the work of APEDNN – Beth Marks</li> <li>• Facilitated Q and A session and discussion</li> </ul>
1230-1330	Lunch
1330-1500	<p><b>Session 4: Keeping Hospitals, Families and Communities Safe During Disasters: Realities on the Ground</b></p> <ul style="list-style-type: none"> <li>• Country presentations: Realities on the ground: Marshall Islands; Fiji, Silena Waqa Ledua; Australia (Mr Adrian Miller: H1N1 – developing Indigenous community protocols; Dr Margaret Grigg: Psychosocial Response to Bushfire)</li> <li>• Dr. A. Pesigan, WHO/WPR Emergency and Humanitarian Affairs – Keeping Hospitals and Communities Safe During Disasters and Emergencies: Practical Guidelines</li> <li>• Q and A, summary, conclusion</li> </ul>
1500-1515	Afternoon tea
1515-1630	<p><b>Session 5: Working Together to Keep Families and Communities Safe During Times of Disasters</b></p> <ul style="list-style-type: none"> <li>• Panel presentation: China Post-Sichuan Earthquake Interventions: HKPT; Eric Chan</li> <li>• Panel Presentation: Hyogo University. International Society of Disaster Nursing – Dr. Kanzaki – Disaster Lessons for Secondary School Nurses</li> <li>• Dr Orapan Thosingha (Thailand)</li> <li>• Facilitated Discussion, including links to conceptual framework, action planning</li> </ul>
1630-1700	<p><b>Day 1: Summary, Highlights, Reflections</b>  <b>Orientation to Day 2 – Concurrent Capacity-Building Workshops</b></p>
1700-1800	<b>JCU Welcome function – Student Refectory</b>

**DAY 2 – TUESDAY SEPTEMBER 29**  
**Collaborative Research & Capacity-Building**

TIME	SESSION INFORMATION
0800-0900	<p><b>Capacity-Building and Empowerment: Research and Evaluation Foundations</b></p> <ul style="list-style-type: none"> <li>• Brief Recap of Day 1</li> <li>• Keynote Speakers – Kim Usher, Kristine Qureshi: Generating and Applying Evidence to Chart the Way Forward</li> </ul>
0900-1500 (Includes Morning tea from 1015-1030; Lunch from 1230-1330)	<p><b>Concurrent Capacity-Building Sessions (A-E)</b></p> <ul style="list-style-type: none"> <li>• <b>Capacity building A:</b> Psychosocial Health and Disasters – Dr. M. Grigg</li> <li>• <b>Capacity building B:</b> Epidemiology, Disasters and Emerging Diseases – Dr. K Qureshi and Dr. S. Bonito</li> <li>• <b>Capacity building C:</b> Trauma, Triage and Wound Care – Lisa Conlon; Sunshine Chan, Sijian Li , Col Heidi Warrington</li> <li>• <b>Capacity Building D:</b> Reproductive Health and Disasters – Carina Hickling</li> <li>• <b>Capacity Building E:</b> Disabilities and Disasters – Dr. Beth Marks, Dr. Amy Zang; Ms. Jasmina Sisirak,</li> </ul>
1500-1600	<p><b>Plenary Session: Infection Control Toolkit: Respiratory Infection Control</b>  Facilitators: Eric Chan (and team), Pieter Van Maaren, Il Young Yoo.</p>
1600-1615	Afternoon tea
1615-1730	<p><b>Plenary feedback from each of the concurrent capacity building sessions</b></p> <ul style="list-style-type: none"> <li>• Capacity building session highlights</li> <li>• Course Prioritization: Options Appraisal using prepared template</li> <li>• Preparations for Day 3</li> <li>• Reflections, Closure</li> </ul>

**DAY 3 – WEDNESDAY SEPTEMBER 30**  
**Moving Forward: Partnerships, Resource Generation & Strategic Action Planning**

TIME	SESSION INFORMATION
0800-0900	<p><b>Moving Forward—Resource Generation, Partnerships, Action Planning and Evaluation</b></p> <ul style="list-style-type: none"> <li>• Brief recap of day 2</li> <li>• Panel presentation: Resource Generation and Partnerships: Military/APEDNN partnerships; IFRC, Red Cross and APEDNN Partnerships [Dr. Jeya, IFRC Rep; Lyndal Scobell Australian Red Cross]; IPPF – Carina Hickling; Col. Heidi Warrington; Ms Lisa Conlon; Krsitine Qureshi; Beth Marks]</li> </ul>
0900-1045	<p><b>Infection Control Panel Discussion</b></p> <ul style="list-style-type: none"> <li>• Bi-Regional Infection Control Toolkit – Dr Eric Chan &amp; team. Introduction and Use in Relation to Disaster Preparedness and Response, including Respiratory Disease Outbreaks</li> <li>• Bi-regional ARDS Training – Dr. Il Young Yoo, Yonsei University</li> <li>• TB and related infection control, overall preventative measures in lesser-resourced settings – P Van Maaren</li> </ul>
1045-1100	Morning tea
1100-1230	<p><b>Introduction to Action Planning at Regional, Sub-Regional and National Levels</b></p> <ul style="list-style-type: none"> <li>• Facilitated Q and A; discussion, using guided template</li> <li>• Action plan: sub-regional and where indicated, national groups</li> </ul> <p><b>Group plenary feedback</b></p>
1230-1315	Lunch
1315-1415	<p><b>Plenary feedback of action plans (continued)</b></p> <ul style="list-style-type: none"> <li>• Revisiting the APEDNN Conceptual Research Framework, including monitoring and evaluation indicators – Upcoming Collaborative Work</li> </ul>
1415-1445	<ul style="list-style-type: none"> <li>• Feedback, evaluations; compilation of action plans, documents</li> <li>• Informal Closure</li> </ul>
1445-1500	Afternoon tea
1500	<p>Cairns Base Hospital Tour – Maximum of 40 people on tour</p> <p>Afternoon/evening visit to Cairns city and Esplanade</p> <p>Return by bus to Student Lodge Accommodation by 1830</p>

## APEDNN ACTION PLANNING—Overview and Working Template 2009

### INTRODUCTION

The APEDNN action plans are meant to be core activities, based on the network objectives, aimed at strengthening nursing ability to reduce the impact of emergencies and disasters on the health of communities. Cross-cutting themes across all areas of work include, but are not limited to:

- Self-efficacy; empowerment, including collective self-efficacy (of a group)
- Partnerships, teamwork
- Capacity-building
- Evidence-base for practice
- Equity, gender, human rights, ethical standards of practice
- Persons with unique needs, vulnerabilities, disabilities
- Service access, quality, including safety
- Health outcomes
- Measurement of short-term and longer outputs, impact....is what we are doing making a difference? If so, how?

Interventions are expected to be harmonized with existing sub-regional action plans and national emergency and disaster policies and plans. The plans will build on preceding work, already developed materials, modules, programmes, where applicable and enable flexibility, so that sub-regions and countries each have opportunities to prioritize interventions, targeting selected priority groups and adapting to local needs and cultural contexts. At the same time, some common evaluation indicators and methods or tools will enable more efficient ongoing measurement of progress and impact....particularly linked to the populations and communities served.

#### Priority areas of work:

- Resource generation
- Curricular change and evaluation of such change
- Education/training
- Collaborative research
- Communication, web-site, information sharing

Of course, we also plan for upcoming APEDNN meetings, ongoing work and reporting on such work between meetings. Finally, maintaining sustainability and reporting on

effectiveness, interventions and changes; as well as impact require that each of the above areas of work follow a strategic planning process, involving key steps such as those of any strategic planning cycle or QI cycle.

Strategic planning, QI planning, policy-making processes:

- Identifying the problem, including problem analysis
- Stating desired outcomes
- Stakeholder analysis and coalition building
- Understanding the contextual environment
- Understanding and working within the political, policy and decision-making processes
- Communication and the change process
- Implementing change
- Monitoring and evaluation.....reviewing, reassessing, re-planning

## PROGRAMME OR ACTIVITY NEEDED

Title

Description

### 1. BACKGROUND (DATA, EVIDENCE, RESOLUTIONS; RATIONALE FOR IMPORTANCE)

**2. OBJECTIVE(S):**

**3. EXPECTED OUTPUTS:**

The programme will:

**4. METHODS—HOW IT WILL BE PLANNED, IMPLEMENTED**

**5. PRINCIPLES AND CROSS-CUTTING THEMES**

The programme will address the following themes or principles:

APEDNN priority(ies) the activity would address:

Intended Target Group, Participants



## RESOURCE ESTIMATES AND FUNDING

The total required amount is

Activity phase	Funds	Available or Potential Funding Sources
<b>TOTAL</b>		