DEVELOPMENT OF A DISASTER PREPAREDNESS TOOL KIT FOR NURSING AND MIDWIFERY

Report on a WHO Meeting

Coleraine, United Kingdom
20–21 August 1999
ABSTRACT

As front-line health professionals, nurses and midwives can make an important contribution during and following disasters, but little training material on disaster preparedness is available to them. A WHO meeting discussed possibilities for a WHO initiative to develop a tool kit to fill this gap. Fifteen experts from Albania, Bosnia and Herzegovina, Italy, Slovenia, Sweden, Turkey and the United Kingdom, with a variety of experience in disaster relief nursing, participated in the meeting, along with representatives from the WHO European programmes for emergency preparedness, nuclear emergency response, and nursing and midwifery. A strategic framework was developed that draws on common themes of the three different phases of disasters and considers the perspectives of international, national and local actors in disaster relief. A list of content areas for the tool kit were identified, and the participants agreed to act as an advisory group for its development.

Keywords

DISASTER PLANNING – methods
RELIEF WORK
NURSING
MIDWIFERY
EUROPE

© World Health Organization – 1999
All rights in this document are reserved by the WHO Regional Office for Europe. The document may nevertheless be freely reviewed, abstracted, reproduced or translated into any other language (but not for sale or for use in conjunction with commercial purposes) provided that full acknowledgement is given to the source. For the use of the WHO emblem, permission must be sought from the WHO Regional Office. Any translation should include the words: The translator of this document is responsible for the accuracy of the translation. The Regional Office would appreciate receiving three copies of any translation. Any views expressed by named authors are solely the responsibility of those authors.
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Objectives of the Meeting</td>
<td>1</td>
</tr>
<tr>
<td>Opening session</td>
<td>1</td>
</tr>
<tr>
<td>Context of disasters in Europe, and the nursing and midwifery response</td>
<td>2</td>
</tr>
<tr>
<td>Definition of “disaster”</td>
<td>2</td>
</tr>
<tr>
<td>Overview of disaster preparedness nursing in the European Region</td>
<td>2</td>
</tr>
<tr>
<td>The WHO Humanitarian Assistance Programme response to disasters in Europe</td>
<td>3</td>
</tr>
<tr>
<td>Nuclear emergencies in Europe</td>
<td>4</td>
</tr>
<tr>
<td>Country experiences</td>
<td>4</td>
</tr>
<tr>
<td>Development of the disaster preparedness tool kit</td>
<td>7</td>
</tr>
<tr>
<td>Strategic framework for the tool kit</td>
<td>7</td>
</tr>
<tr>
<td>The content areas for a tool kit</td>
<td>8</td>
</tr>
<tr>
<td>Conclusions</td>
<td>10</td>
</tr>
<tr>
<td>Closure of the meeting</td>
<td>10</td>
</tr>
<tr>
<td>Annex 1 Programme</td>
<td>12</td>
</tr>
<tr>
<td>Annex 2 Case studies of nursing and midwifery interventions in disasters</td>
<td>13</td>
</tr>
<tr>
<td>Annex 3 Participants</td>
<td>15</td>
</tr>
</tbody>
</table>
**Introduction**

Nurses and midwives, as front-line health care professionals widely dispersed throughout the health care system, can make an important contribution during and in the aftermath of natural, technological and complex disasters. However, while training materials for relief personnel have been developed by several nongovernmental organizations and other institutions, few of these are specific to the nursing and midwifery professions.

As part of its humanitarian assistance support to its Member States, the WHO Regional Office for Europe (WHO/EURO) has investigated the possibility of developing a tool kit which sets out the training, guidance and tools necessary for nursing and midwifery competences in the field.

A Meeting to investigate the current tools available to nurses and midwives in disaster situations and to discuss the possibility of taking this initiative further was jointly organized by the WHO/EURO Nursing and Midwifery programme and the University of Ulster Nursing Department, in the light of the latter’s new Master of Science Programme in Disaster Relief Nursing. The Meeting, which was held on 20–21 August 1999 at the University of Ulster, Coleraine, United Kingdom, was attended by 15 participants with varying backgrounds in disaster relief nursing, including direct field work, education and public health coordination. Countries represented at the meeting included Albania, Bosnia and Herzegovina, Italy, Slovenia, Sweden, Turkey and the United Kingdom. Three WHO/EURO technical staff also participated (list of participants in Annex 1).

**Objectives of the Meeting**

The Meeting had three objectives:

- to share knowledge and lessons learned before, during and after emergencies in the countries represented at the Meeting;
- to consider key issues around the roles and responsibilities of nurses and midwives as well as the ethical dimension and public health issues in disaster situations, and the competences needed by these professionals to meet the needs of those affected by disasters to the maximum effect; and
- to achieve consensus on the content of the tool kit for disaster preparedness for nurses and midwives.

The results of the meeting would act as a basis for the development of a plan of action for 1999–2000.

**Opening session**

Professor Jennifer Boore, Head of the Nursing Department, University of Ulster, welcomed participants and Mr Pat Deeny, Director of the Master of Science Programme in Disaster Preparedness at the University of Ulster, expressed his support for the initiative to develop a disaster preparedness tool kit for nursing and midwifery as another new project to take forward action for these professionals in the field.
Ms Ainna Fawcett-Henesy, WHO/EURO Regional Adviser for Nursing and Midwifery, described the interaction which had begun the previous year between the University of Ulster and WHO/EURO to look jointly at the development of the tool kit. Northern Ireland had experience with conflict and the University of Ulster was the first such institution in Europe to have developed a Master of Science Programme in Disaster Preparedness Nursing – thus it was an appropriate venue for the Meeting. On behalf of the WHO Regional Director for Europe, Dr J.E. Asvall, she thanked Dean Allen for hosting the Meeting at his University.

Ms Ainna Fawcett-Henesy was elected Chairperson and Mr Pat Deeny Co-Chairperson. Ms Joyce Smith, Consultant in Disaster Preparedness, was nominated as Rapporteur.

The programme was presented by Ms Fawcett-Henesy and adopted by the participants. This was followed by a general round of introductions by the participants. Apologies had been received from Mr Häkan Sandbladh, Disaster Relief Officer at the International Federation of Red Cross Societies, due to his responsibilities in relation to the earthquake in Turkey.

**Context of disasters in Europe, and the nursing and midwifery response**

**Definition of “disaster”**

For the purpose of clarity, it was proposed that the definition of a disaster which included types and phases be used. This definition was found in the *Guidelines for nurses in disaster preparedness and relief* drawn up by The League of Red Cross and Red Crescent Societies in 1985:

> A disaster is a catastrophic situation in which the day-to-day patterns of life are disrupted and people are plunged into helplessness and suffering and, as a result, need protection, water, food, clothing, shelter, medical and social care, and other necessities of life.

**Overview of disaster preparedness nursing in the European Region**

Ms Fawcett-Henesy said that although the literature related to disaster preparedness in general was plentiful, there was little specific to the roles of nursing and midwifery. The *Guidelines for nurses in disaster preparedness and relief* was one of the few documents on the topic. The International Council of Nurses had attempted to pass a resolution at their Centennial Congress (London, June 1999) on the necessity of disaster preparedness tool kits for nursing, but this resolution had been withdrawn.

The size and diversity of the WHO European Region meant that it is prone to a wide range of disasters, so it was important to define a broad strategic framework from which individual Member States could adapt guidance in accordance with their priority needs. This framework should consider the roles of the professionals before, during and after emergencies, the organization and management of the response, and the sensitization and involvement of national workforces. The conclusions of this Meeting, together with examples of disasters and how the professionals had responded, would act as a vehicle to start discussion across Europe and would be shared with the participants in the Second WHO Conference on Nursing and Midwifery (Munich, 15–17 June 2000).
The WHO Humanitarian Assistance Programme response to disasters in Europe

The WHO European Region has a population of 850 million people. Dr Richard Alderslade, WHO/EURO Regional Adviser for Humanitarian Assistance and Emergency Preparedness, said that it was crucial that humanitarian assistance should be swift, credible and based on a rapid public health assessment. Other guiding principles included the need for (i) coordination between donor agencies, and (ii) laying the foundations for post-emergency reconstruction and reconciliation.

Dr Alderslade categorized disasters as: (a) natural, (b) technological and/or (c) complex (Fig. 1). Characteristics of complex emergencies included social disintegration and collapse, internal conflict and violence, and external conflict.

In 1992, there were no less than eight wars in the European Region. War is a complex disaster which has severe public consequences including increased morbidity and mortality, shortages of health personnel and supplies, destruction of health facilities and infrastructure, food shortages, land mine injuries, torture and sexual assault, post traumatic stress and mass migration. Human rights abuses are common. Vulnerable groups at particularly high risk include children, the frail elderly, the mentally ill, racial and ethnic minorities and families of the dead.

The WHO/EURO Humanitarian Assistance programme participates in:

- rapid assessment of needs based on immediate presence in the field;
- coordination and provision of aid efforts;
collection and dissemination of surveillance and other data to relevant authorities and intergovernmental and nongovernmental agencies;

provision of technical assistance in the rehabilitation phase of an emergency in relation to infrastructure, medical services and disaster preparedness; and

post-disaster evaluation to assist a stricken country to develop/improve its preparedness capacity.

Nurses have a very important role as part of the multidisciplinary team in disasters. They are in a unique position to provide emergency clinical care, undertake preventive activities and give much needed emotional support to victims of all ages and their families as well as to volunteer workers. It is important that this support be culture- and gender-specific, especially in relation to violence and rape. Nurses should be involved in national disaster preparedness planning, training for emergency work and the organization of support structures. Where nurses are involved in international aid, they have a responsibility to emphasize the importance of using national resources to support local capacity-building and sustainability.

A disaster preparedness tool kit which enhances the ability of nursing and midwifery to respond to all phases of an emergency would contribute to greater professionalism and, perhaps, serve as a template for similar initiatives by other professionals involved in disasters.

**Nuclear emergencies in Europe**

Dr Keith Baverstock, WHO Radiation Project Officer, introduced issues related to a major technological disaster such as the nuclear disaster at Chernobyl. Possible causes of nuclear emergencies are accidents at nuclear power plants, satellites re-entering the atmosphere from space, and inadvertent exposure in radiation facilities as well as inhalation or ingestion of radioactive materials which occur in hospitals and laboratories.

There is a 70% probability of a similar accident to Chernobyl recurring as lessons had not yet been learned.

There is a clear distinction between medical and public health responsibilities. Medical services deal with individuals exposed to high doses of radiation who require decontamination and treatment at the site of the accident. Public health services deal with populations exposed to low doses who run an increasing risk of contracting cancer or a hereditary disease. In addition, the psychosocial effects of radiation exposure can lead to illness due to stress and social disintegration.

Among their many tasks during disasters, nurses can play a pivotal role in providing clear information and reassurance to the public during and after this type of emergency. A number of publications exist which provide guidance for public health staff.

**Country experiences**

To place the discussions in a European context, participants from Albania, Bosnia and Herzegovina, Italy, Turkey and the United Kingdom (Northern Ireland) presented their countries’ experience in relation to disasters and their national responses.
Albania

*Ms Enkeleda Karalli, Director of the National Centre for Education and Health Promotion in Tirana, spoke of the consequences for Albania of the war in Kosovo.*

In March 1999, Albania received a mass influx of 200,000 refugees as a consequence of the war in Kosovo. The Albanian Government set up refugee camps and families received some of the refugees directly into their homes. International donor agencies and nongovernmental organizations collaborated with the Albanian Government to provide aid. The immediate problems had included a shortage of blood; this was addressed personally by the Minister of Health and his staff who led a drive for blood donations.

Specific issues addressed by nurses were of a primary care nature, primarily targeting women and children who were in poor physical and psychological condition. The major focus was on maternal and child health, immunization, maintenance of hygiene and sanitation in the refugee camps and follow-up action in relation to communicable diseases.

The majority of refugees have now returned to Kosovo, but a small number still remain in Albania.

Bosnia and Herzegovina

*Sister Anica Katic, Chief Nurse at the Institute of Transfusion Medicine, Sarajevo, described her experience in relation to the Bosnian war.*

The Bosnian war saw hundreds of people die and even more wounded and public services and utilities either severely affected or put out of action. Lack of water and basic items such as soap, and the difficulty in disposing of bodies, created severe public health problems. There was a serious shortage of blood; mobile teams had to pay for donors (1800 donors per month) and agencies such as WHO also donated blood. Storage of the blood also proved difficult due to the lack of electricity, and generators had to be used.

Because of the large number of injured people, 24-hour health care services were organized in Sarajevo mainly to care for them while other patients were cared for by home care teams, comprising one doctor and one nurse initially working out of hospitals. Extended family networks broke down. It was important to get care and support to pregnant women who would deliver at home and elderly people who were incapacitated and living alone. These small home care teams carried food and medicines to their patients and met on a weekly basis to assess and plan health care. Standard emergency kits did not meet the needs of either the health care teams or their patients.

Vulnerable groups such as the elderly experienced great difficulty due to their low pensions and the rising cost of scarce commodities. Increasing numbers of babies were born with anomalies and anaemia due to the under-nourishment of their mothers. Children and adolescents were traumatized. Not least, there was difficulty with employment. Most people received subsistence for survival, and government health workers survived on low salaries. The professional isolation of nurses from the international nursing community was one of the problems they faced.
Italy

Ms Paula Bianco, emergency nurse at the Giovanni Bosco Hospital, Turin, spoke of her personal experience at a refugee camp in Albania.

As a member of an international humanitarian assistance mission to Albania, Ms Bianco was involved in the organization of a camp for Kosovar refugees in Albania. The site of the camp had not been properly reconnoitred before they arrived. The camp was organized in nine sectors, each with a field hospital staffed with personnel trained in emergency care. There was no requirement for sophisticated medical equipment and the staff were predominantly occupied with cases of scabies and head lice and minor ailments among the refugees.

Two lessons were learned from this experience: disaster relief personnel should be both technically and psychologically well prepared before going into a disaster, and appropriate equipment and resources should be made available to them.

Ms Bianco had had similar experiences in Rwanda and Zaire, although the situations in those countries were different. The disaster relief personnel there worked with international agencies which had long experience in humanitarian aid and which undertook to integrate primary health care, medical emergencies and vertical programmes during all phases of the disaster with a view to the long-term development of public health.

Northern Ireland

Mr Robert Sowney, clinical nurse specialist, presented the long experience of Northern Ireland with major incidents.

Northern Ireland has experienced 30 years of major incidents rather than disasters. Although the infrastructure has not been destroyed and there are no requirements for international assistance, the Omagh bombing in 1998 came close to a disaster as it partially affected the infrastructure.

In Ulster, the emergency service providers include hospital accident and emergency departments, the Northern Ireland Ambulance Service, the Fire Service and the Royal Ulster Constabulary. A National Emergency Planning Department coordinates all emergency strategies as well as the equipment required. All four health boards collaborate with the National Emergency Planning Department.

Nurses are represented on all the health boards and are involved in national emergency planning initiatives. Doctors and nurses are trained together for emergency preparedness, but there is still no formal integrated training which includes ambulance personnel, fire-fighters and the police, although major incident exercises are planned by each area health board and include all of these emergency services.

Some lessons learned over the years from which action is currently being taken to improve the response include the following:

- simple mechanisms need to be developed (e.g. organization of emergency services, training of emergency service providers and review of lessons learned);
- communication for alert systems need back-up systems;
• receiving areas should allow for triage, identification and documentation and the dispersal of casualties to a number of hospitals in order to avoid one hospital being swamped;
• action cards need to be developed which can be used to guide and direct staff in emergency situations;
• volunteers should be identified and controlled to prevent opportunism and to safeguard patients;
• contingency planning and training is needed to strengthen performance; and
• the media should be used constructively to relay information.

Turkey

*Mrs Ozden Ulker Koseler, Deputy Director of International Relations at the Ministry of Health gave a history of disasters in her country and the response.*

Turkey is prone to a range of natural disasters including earthquakes, landslides, floods, fires and avalanches. The cost of damage caused by these disasters is equal to approximately 1% of the gross income of the country. It has been estimated that an average of 689.7 persons die annually from the effects of earthquakes in Turkey.

Epidemiological data on disasters are collected by the Ministry of Public Works and Housing which also investigates causes and coordinates assistance.

The response to disasters operates at province level and involves the public health and fire services. These are linked to the municipalities and regional civil defence organizations and the police. At national level, all ministries have legal obligations and responsibilities in times of disaster. Plans for dealing with natural disasters are constantly being reviewed. A coordination Committee has been established in the Prime Minister’s Office and is led by the Ministry of Public Health Services.

Experience to date in Turkey has identified the following problems:

• insufficient technology and equipment for rescue from ruins
• disaster relief staff suffering from emotional trauma
• unclear job descriptions for disaster relief staff, and
• general need for psychological support.

During disasters in Turkey, nurses are responsible for immediate life-saving action, first aid and referrals to hospital. The first graduates of a new system to train high school students as a voluntary support force in emergency first aid are expected in 2000. This project will include 128 schools with 16,974 students.

**Development of the disaster preparedness tool kit**

**Strategic framework for the tool kit**

Group work concentrated on the development of a strategic framework for the tool kit and considered three categories of disaster and their impact on individuals, the community and health systems. Issues to consider when formulating the framework included:
• disaster preparedness is a broad issue;
• the European Region is very large and diverse;
• nurses and midwives are important as they are the largest health care professional workforce and are widely dispersed throughout the health care system.

The content areas for a tool kit

The country presentations and the ensuing discussions highlighted the diverse types of disaster in the Region and their effects, ranging from 30 years of major incidents to complete destruction of a country’s infrastructure and dependence on external aid.

Using the framework outlined in Fig. 2, the groups considered this information in the light of the action required at the three phases of a disaster and in the context of external (international) and internal (national and local) action. To ensure that they took the diversity and size of the Region into account, the groups based their work on the strategic framework as applied to four differing areas within the Region.

Fig. 2. Action at the three stages of a disaster

<table>
<thead>
<tr>
<th>External</th>
<th>Internal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs assessment</td>
<td>Safe environment</td>
</tr>
<tr>
<td>Screening and preparation of personnel</td>
<td>Care facilities</td>
</tr>
<tr>
<td></td>
<td>Risk identification</td>
</tr>
<tr>
<td></td>
<td>Development of simple plans, strategy and tools</td>
</tr>
<tr>
<td></td>
<td>Education and training of nurse</td>
</tr>
<tr>
<td>Coordination of nursing services with governments</td>
<td>Definition of functions and development of technical tools</td>
</tr>
<tr>
<td>Donor</td>
<td>Coordination of human resources and relief efforts</td>
</tr>
<tr>
<td>Support to health services, communities and vulnerable groups, including refugees</td>
<td>Nursing interventions</td>
</tr>
<tr>
<td>Identification and monitoring of local counterparts</td>
<td>Psychological support</td>
</tr>
<tr>
<td>Evaluation of donor aid impact</td>
<td>Safety</td>
</tr>
<tr>
<td>Assessment of future aid requirements</td>
<td>Information for health workers, the community</td>
</tr>
<tr>
<td></td>
<td>Definition of functions and development of technical tools</td>
</tr>
<tr>
<td></td>
<td>Coordination of human resources and relief efforts</td>
</tr>
<tr>
<td></td>
<td>Nursing interventions</td>
</tr>
<tr>
<td></td>
<td>Psychological support</td>
</tr>
<tr>
<td></td>
<td>Safety</td>
</tr>
<tr>
<td></td>
<td>Information for health workers, the community</td>
</tr>
<tr>
<td></td>
<td>Definition of functions and development of technical tools</td>
</tr>
<tr>
<td></td>
<td>Coordination of human resources and relief efforts</td>
</tr>
<tr>
<td></td>
<td>Nursing interventions</td>
</tr>
<tr>
<td></td>
<td>Psychological support</td>
</tr>
<tr>
<td></td>
<td>Safety</td>
</tr>
<tr>
<td></td>
<td>Information for health workers, the community</td>
</tr>
<tr>
<td></td>
<td>Definition of functions and development of technical tools</td>
</tr>
<tr>
<td></td>
<td>Coordination of human resources and relief efforts</td>
</tr>
<tr>
<td></td>
<td>Nursing interventions</td>
</tr>
<tr>
<td></td>
<td>Psychological support</td>
</tr>
<tr>
<td></td>
<td>Safety</td>
</tr>
<tr>
<td></td>
<td>Information for health workers, the community</td>
</tr>
</tbody>
</table>

From the group work it was clear that there were differing requirements for each area. Participants agreed, however, that a common tool would be the development of action cards for each area which could be developed locally, based on the disaster risks identified as relevant to the country.
Other elements agreed as necessary at the three different phases included:

- **pre-disaster phase**
  - risk assessment;
  - facilitation of communication;
  - training (psychosocial support, triage, basic life support, needs assessment, public health including water, sanitation and nutrition);
  - selection of appropriate relief teams (components and positions);
  - clear job descriptions;
  - action cards (by disaster type);
  - good logistical support;
  - identification/adaptation of content of emergency kits;
  - identification of vulnerable groups;

- **disaster phase**
  - logistical control;
  - communication facilitation;
  - distribution of action cards/relief personnel;
  - specialized information on hazards (especially in the case of technological disasters);
  - monitoring mechanisms for system quality control;
  - safety of relief personnel and their families;
  - training of new staff/volunteers;

- **post-disaster phase**
  - information exchange with the primary health care workforce;
  - evaluation (based on monitoring efforts in the previous phase and built into action cards), review of ethical issues, and analysis of missing knowledge and organizational skills;
  - training of volunteer groups/health personnel.

Participants acknowledged that while the elements mentioned above were relevant to both nurses and midwives in disaster situations, midwives could need additional items in the initial acute phase of an emergency situation, including during the setting-up of refugee camps. The United Nations Population Fund (UNFPA) suggests that these would include: supporting safe deliveries, guaranteeing the availability of condoms, preventing and managing sexual and gender-based violence, and planning for the provision of comprehensive reproductive health services. Specific elements might include: (i) ensuring the presence of a coordinator for reproductive health, (ii) the provision of guidelines and training for implementation of selected interventions, and (iii) the provision of different material resources including essential drugs, basic equipment and condoms. The UNFPA's *Reproductive health kit for emergency situations* should be a key resource to support the specific midwifery-oriented aspects of disaster preparedness.
Training to prepare nurses and midwives for disasters should be included in basic and continuing education programmes and should be appropriate to the identified risks of the country in which training is taking place. Two important considerations will be that nurses, especially in disaster situations, learn to function as autonomous professionals with decision-making abilities rather than as assistants, and that they are able to work in multidisciplinary teams. Some degree of integrated training with other emergency services could be useful.

**Conclusions**

Disaster preparedness could prevent potential aggravation. The Meeting agreed that the diversity and size of the European Region would require the use of a strategic framework setting out the common aspects of understanding disasters before, during and after emergencies from the perspective of international, national and local actors and actions.

A list of the content areas of a disaster preparedness tool kit for nursing and midwifery, developed on the basis of this framework, could be applicable across the Region, although Member States might need to adapt the kit according to their assessments of their requirements.

There is an urgent need to include training modules in disaster preparedness in basic and continuing education programmes for nursing and midwifery. Case studies would be a powerful tool to understand disaster situations better. It will also be important to develop action cards for different types of disaster, from which the relief personnel can be guided step by step and can monitor their own actions.

The various groups concerned with disasters and the nursing and midwifery professions will need to reach a consensus on the identified contents for the tool kit. In addition, partners must be found urgently to draw up a plan of action and develop the components of the kit. This will only happen when the existing references and training materials have been identified. Participants agreed to act as a core advisory group to these partners for the further development of the tool kit.

**Closure of the meeting**

Ms Fawcett-Henesy thanked the participants for their hard work and sharing their personal field experiences. She extended special thanks to a small consultative group of experts from Northern Ireland who were able to join in the discussions and share the valuable lessons learned from past times of conflict in the province. Finally, she thanked Professor Boore and Mr Deeny for their hospitality and for the local arrangements, which had certainly added to the success of the meeting.

**Bibliography**


WHO. *Before, during and after radiation emergencies*. Copenhagen, WHO Regional Office for Europe, 1996.


Annex 1

PROGRAMME

Friday, 20 August
08.00–09.00 Registration
09.00–09.30 Opening session
   Welcome addresses:
   Mr Pat Deeny (School of Health Sciences, University of Ulster)
   Ms Ainna Fawcett-Henesy (WHO/EURO Regional Adviser for Nursing and Midwifery)
   Election of Chairperson and Rapporteur
   Adoption of the programme
10.00–10.10 Briefing on background, purpose and expected outcomes of the meeting
   (Ms Ainna Fawcett-Henesy, WHO/EURO)
10.10–10.30 The WHO Europe Humanitarian Assistance Programme and the importance of reinforcing
   the Nursing and Midwifery Workforce (Dr Richard Alderslade, Partnerships in Health and
   Emergency Assistance, WHO/EURO)
10.30–11.00 Coffee break
11.00–12.45 Learning from countries’ experiences:
   Albania (Ms Kristina Kacaj, SQU Central Military Hospital, Tirana)
   Bosnia and Herzegovina (Ms Anica Katic, Institute of Tranfusion Medicine, Sarajevo)
   Turkey (Ms Ozden Ulker Koseler, Ministry of Health, Ankara)
   Northern Ireland (Mr Robert Sowney, Clinical Nurse Specialist, Accident and Emergency)
   Italy (Ms Paola Bianco, Emergency Disaster Nurse)
   Russian Federation (Keith Baverstock, Radiation Project Officer, WHO, Helsinki)
12.45–13.00 Strengths and weaknesses in nursing and midwifery in disaster preparedness
   (Dr Häkan Sandbladh, Head Relief Services, IFRC, Geneva)
13.00–14.00 Lunch break
14.00–15.00 Pulling the pieces together (Open discussion to agree on main issues)
15.00–15.30 Coffee break
15.30–16.30 Group work – defining the contents of the tool kit
16.30–17.00 Feedback from group work

Saturday, 21 August
09.00–09.10 Conclusions of day 1 (Rapporteur’s brief)
09.10–10.30 Agreement on issues and contents of the tool kit
10.30–11.00 Coffee break
11.00–11.30 Identifying partners to develop tool kit areas
11.30–12.00 Identifying potential donor agencies to support the tool kit development
12.00–13.00 Lunch
13.00–14.30 Timetable for the development and testing of the tool kit (including immediate next steps)
14.30–15.00 Conclusions and closure of the meeting
Annex 2

CASE STUDIES OF NURSING AND MIDWIFERY INTERVENTIONS IN DISASTERS

Albania

Giving purpose back to depressed mothers during a disaster

Paola Bianco, an emergency care nurse from Turin, Italy, was sent to Valona, a seaside town in Albania, from April to May 1999 as part of the Italian team to set up a camp for refugees from Kosovo. Paola’s assignment was to establish a nursery for the children who accompanied their mothers to the camp. The age range of these children at this camp was 0–3 years; older children appeared to be sheltered in police stations or other camps.

Drawing therapy started straight away as immediate psychological support to the children. It was interesting to note how their first drawings seemed to reflect the peaceful scenes of home but 2–3 days later the images were replaced by scenes of war. This was the children’s approach to play as well. After a month their drawings shifted to scenes of the refugee camp, a good sign of acceptance, and even later attempts brought the children back to peaceful scenes of home as they had known it.

Apart from continuous diarrhoea as a consequence of donated foods being too rich, the children were also faced with donations of winter clothing even though the hot summer weather was fast approaching.

The main problem faced by Paola and her colleagues, however, was not with the children but with their mothers. The women were anxious about their husbands away fighting as well as about their children in other places. This anxiety soon turned to depression and, as a consequence, the mothers lost interest in caring properly for the children with them in the camp.

Paola and her colleagues assessed that the children were malnourished and realized that the mothers would need to be motivated to ensure the survival of their children. They agreed with the mothers that food would continue to be supplied for the children but that they should prepare it. This exercise in motivation reactivated the women, gave them purpose and independence and helped them to accept the situation. As a consequence, the health status of the refugee children improved dramatically.

Bosnia and Herzegovina

Meeting older people’s basic needs in disaster situations

When the Bosnian war broke out, the first wounded were sent to hospital. This meant that a certain triage had to be carried out of citizens occupying beds in the hospitals used for the war victims. Nurses were forced to send people whose lives were not in immediate danger back to their homes. Anica Katic was one of these nurses. Concerned about the status of those sent home, Anica and her colleagues decided to visit them all. Being surgical and ward nurses, they packed their heavy bags with the instruments they thought they would need during these visits.

Arriving at the house of one old woman, Anica was expecting to measure her blood pressure, take temperature readings and so on. Instead she found a dehydrated, starving and unwashed old woman left abandoned with no water or soap in the house. When she got back to the hospital Anica exchanged stories with her colleagues and found that their experience matched hers. The nurses realized that what was
needed in their heavy bags was not instruments but soup, water, cookies, minerals and vitamins and, not least, soap.

It was a very real lesson that they learned. Technical nursing care may be important, but the life-saving efforts needed at that moment were related to personal care for these people and the security that someone cared enough to come to see them.

Looking back at the situation before the war, Anica now realizes the importance of introducing home care nursing to ensure continuity of care for the people.

**Slovenia**

Thinking like a child helps care for children in disasters

The first refugees from the war in Bosnia (mainly mothers with small children and very old people) walked over the mountains to Slovenia for days at a time to escape the atrocities. The nights were cold and snow had already settled in the early autumn of 1996. Wild animals were also trying to escape and the refugees continually felt them all around and did not dare to sleep at night. On arrival in Slovenia, the people were housed in barracks formerly used by the military. Because they were exhausted, the sedatives distributed to them (including to the children) had no effect in helping them to sleep.

Retired Slovenian nurses, who had been recruited to help care for the war victims, noticed that the children had a problem with sleeping. Thinking about the normal patterns and behaviour of children in relation to sleep, these nurses realized that stuffed toy animals would probably allow an element of normality to return to their lives. The children did not have any toys, so student nurses were asked to look for some old toys for the refugee children. The delivery trucks arriving at the barracks the next day were not carrying medicines or any of the usual materials, but old toys, donated by the students themselves as well as other donors.

Milo, one of the six-year-old refugee boys, was given an old teddy bear with one ear and one eye. He took the bear, pulled it to his chest and hugged it close while he lay down to sleep for 36 hours straight, after not having slept properly in over ten days. A simple solution had been found to a complex situation.

**Northern Ireland**

Development of nursing skills in accident and emergency units

In 1969–1970, as civil unrest intensified, hospital accident and emergency departments were faced with escalating demands for emergency services. Nurses working in these departments were trained general nurses without any extra or specialist training to equip them to work in this field. Skills were developed “on the job”.

By the early 1970s, it was rapidly becoming apparent that the emergency nursing training in the basic nursing curriculum was not enough to prepare nurses for the type and volume of injuries and conditions with which they were now having to deal. As a result, a course for specialist accident and emergency nurses was developed to train nurses to meet identified needs. This course was implemented over the next ten years.

However, once nurses were fully trained in the area of accidents and emergencies, there was no opportunity for them to enhance their skills. In the 1980s, university faculties of nursing identified this gap between nurses’ existing skills and their desire to develop them to a higher level. In response, the University of Ulster has started to develop a training programme to take accident and emergency nursing to practitioner level, i.e. at the level of senior house officers. The first training course is scheduled to begin in February 2000.
Annex 3

PARTICIPANTS

Dr Christina Anderson
Director, The Swedish Red Cross College of Nursing and Health
Crafoords Väg 12
SE-113 24 Stockholm
Sweden

Ms Paola Bianco
Nurse, Giovanni Bosco Hospital
Lungo Dora Savona, 16
10156 Turin
Italy

Professor Jennifer Boore
Head, Academic Affairs in Nursing
School of Health Sciences, University of Ulster
Coleraine, Co. Londonderry BT52 1SA
United Kingdom

Mr Pat Deeny (Co-Chairperson)
Course Director
School of Health Sciences, University of Ulster
Coleraine, Co. Londonderry BT52 1SA
United Kingdom

Ms Lillimor Dikic
The Swedish Red Cross College of Nursing and Health
Crafoords Väg 12
SE-113 24 Stockholm
Sweden

Ms Manuela Gerlin
Emergency nurse, Azienda ospedaliera
CTO-CRF – Maria Adelidde
Turin
Italy

Ms Enkeleda Karalli
Nurse Specialist and Director
National Centre for Education and Health Promotion
Rr. Kavajes, pall 2221, shk 1, ap 4
Tirana
Albania

Ms Anica Katic
Chief Nurse, Institute of Transfusion Medicine
Cekalusa 86
71000 Sarajevo
Bosnia and Herzegovina
Mrs Ozden Ulker Köşeler  
Deputy Director, International Relations  
General Directorate of Curative Services  
Ministry of Health  
Ankara  
Turkey

Mr Vidar Melby  
Lecturer, Trauma Nursing  
School of Health Sciences, University of Ulster  
Coleraine, Co. Londonderry BT52 1SA  
United Kingdom

Ms Majda Slajmer-Japelj  
Professional Adviser, Nursing and Midwifery  
WHO collaborating centre for primary health care nursing  
Zdravstveni Dom Dr Adolfa Drolca Maribor  
Ul. Talcev 9  
62000 Maribor  
Slovenia

Ms Joyce Smith (Rapporteur)  
Nurse consultant, Post-conflict health services re-development  
29 Leyland Grove  
Haslington, Cheshire CW1 5ZE  
United Kingdom

Dr Marion Wright  
Lecturer in Nursing (Nutrition and Public Health)  
School of Health Sciences, University of Ulster  
Coleraine, Co. Londonderry BT52 1SA  
United Kingdom

Mr Robert Sowney  
Northern Ireland emergency care nurse  
Government Adviser, Clinical Nurse Specialist  
7 Lower Parklands  
Dungannon, Co. Tyrone BT71 7JN  
United Kingdom

Mr Garret Martin  
Northern Ireland emergency care nurse  
Craighavon Hospital  
Co. Tyrone BT71 7JN  
United Kingdom

WHO Regional Office for Europe

Dr Richard Alderslade  
Regional Adviser  
Humanitarian Assistance and Emergency Preparedness
Ms Ainna Fawcett-Henesy (Chairperson)  
Regional Adviser  
Nursing and Midwifery  
Tel.: +45 39 17 1355  
Fax: +45 39 17 1865

Ms Sheila Schmidt  
Programme Assistant  
Nursing and Midwifery  
Tel.: +45 39 17 1361  
Fax: +45 39 17 1865

Dr Keith Baverstock  
Radiation Project Officer  
WHO Project Office for Nuclear Emergency Response and Public Health  
P.O. Box 14  
SF 00881 Helsinki  
Finland  
Tel.: +358 9 75988475/552  
Fax: +358 9 75988556  
e-mail: keith.baverstock@stuk.fi