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An Offering to Stimulate Further Thought
for the
Hyogo Framework #2 Symposium
Break-out Group on Development of evidence-based technical guidance and education programs for the advancement of health and disaster risk management capabilities

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"Dictionary" or Terms of Reference not defined in this document:

1. Member states: This phrase means the individual countries or states who are members of the UN
2. DRR: Disaster Risk Reduction
3. Disaster Cycle: For simplicity this is comprised of 4 phases—Response, Recovery, Mitigation, and Preparedness

Assumptions or Pre-conditions:

1. State Authorized and Supported: UN member states support the adoption of national laws, programs, and strategies that include the health sector (inclusive of clinical care and public health systems) into national DRR (Disaster Risk Reduction) priorities.
2. Whole-of-Cycle: At the member state level, DRR is inclusive across the span of the Disaster Cycle, e.g., it includes Response, Recovery, Mitigation, and Preparedness Phases
3. Scaling from Local/Community DRR: Member state DRR recognizes the importance of all levels of society and government in DRR
    a. Initial response is at the local or community level, local response is supported by higher levels of member state government up to the national level—thus resilience (synonymous with risk reduction) becomes integrally connected to the baseline strengths and weaknesses of local or community clinical and public health systems.
    b. Regional support between member states is actively pursued and encouraged by national policies and leadership
    c. Member state policies, programs, and plans, to the extent feasible, align with UN and WHO recommendations, programs, and guidance. Note: May also want to align with other broad international initiatives such as the Sphere Project, etc.
4. From Capabilities to Competencies: Member states should consider DRR holistically by addressing the concept of capabilities:

a. Capabilities are defined as the means to accomplish a mission, function, or objective based on the performance of related tasks, under specified conditions, to target levels of performance[1].
b. Reasoning: This broadens the perspective of DRR in the medical and public health sector of disasters by including people (specifically health professionals) as a key element of a capability. So, while engineering fixes are important to such things as mitigation (ex., Safe Hospitals) and supplies are important to preparedness, response, and recovery, then a focus on the "human capital development" aspects of capabilities ensures the centrality of competence, education, and training.
c. Human capability is the constant for all phases of DRR.
d. From an education and training perspective, human capability is probably more appropriately called competence
e. Competence is composed of knowledge, skills, and attitudes at the individual level of learning.
f. In the disaster setting, it should be noted that teams, organizations, and systems can also exhibit aggregate competence which is derived from their personnel (or human capital).

5. Disaster related considerations:
   a. Proficiency Issues: All health professionals in a member state do NOT need to be educated and trained to the highest levels of competence.
      i. Levels of needed competence within a team, organization, and health system can vary based upon the individual's role or roles during the various disaster phases.
      ii. Many areas of competence for disaster health only require lower levels of proficiency. This can be described as "awareness" knowledge (examples might include knowing which ministry of the member state government is responsible for debris removal or the handling of mass fatalities—no need for deeper knowledge beyond who, no need for detailed engineering or mortuary knowledge).
   b. All-Hazards Approach: The scope of events included in disasters must be broad and inclusive, meaning a typology that includes natural and human-generated (technological + terrorist + conflict-associated events of short, medium, and long durations). This can be referred to as an all-hazards approach.
   c. Goal: The overall goal of DRR for the health sector (clinical + public health) is the reduction of death and suffering from all types of disasters.
   d. Volunteer Management: Member states should address how they will incorporate (or not) local, national, and international volunteers and volunteer teams in DRR.

[1] From US Federal Emergency Management Agency, "National Preparedness System", November 2011, p. 1, http://www.fema.gov/pdf/prepared/nps_description.pdf, accessed 06 March 2014.

Potential Themes:

1. Addresses All 4 Phases: Member states health professions workforce directly contributes to the effectiveness of and the impact on all phases of DRR, the focus should not be on competence in only the Preparedness or Response Phases.
2. Career Long Focus: Initial (undergraduate), advanced (graduate), and lifelong (certification, maintenance of certification, and licensure) education and training of a member state's health professions workforce should include, support, and encourage aspects and content pertinent to DRR across all 4 disaster cycle phases.
3. Competency-based and Outcome-focused: The development of a member state's disaster health workforce should be competency-based and outcome-focused rather than just focusing on the accumulation of course completion certificates. The key is in being able to apply or demonstrate the competency rather than just demonstrating factual knowledge.
4. Quality Improvement Considerations: The quality of personal and collective competence:
    a. Can be most effectively and efficiently tested via well designed exercises rather than inspections.
    b. Can also be improved through these exercises with a focus on continuous learning and performance improvement through rigorous individual and collective performance testing rather than just factual knowledge testing.
    c. After action reports are only valuable when they are evaluated against existing policies and procedures and for the changes (improvements) they foster. Unless they generate actions for the greater good, they are hollow documents and largely a waste of time.
5. Foster Local Health Collaborations/Coalitions: Since effective DRR requires competence at the local and community level, member states should encourage and, when feasible, support the development of local collaborations and coalitions that seek to link the local elements of the member state's clinical and public health system to themselves at the local level and to higher levels of government. Such local collaborations and coalitions introduce the key local health sector stakeholders to each other before a disaster which increases the efficiency, effectiveness, and timeliness of response and recovery.
6. Inter-professional Scope: Competency-focused education and training for the disaster health workforce should emphasize attributes that address cross-sector collaboration, communication, and support that enhances DRR. It should be interprofessional (trans-disciplinary) in nature, bringing together a broad span of health professions such as but not restricted to physicians, nurses, emergency medical services, public health, health care administrators, veterinarians, dentists, allied health professionals (psychologists, laboratory technicians, etc.).
7. Implementation Options/Examples:

a. Member states may consider the addition of individual, team, organization, and systems disaster health competencies to all levels of health professions education, training, and licensure via national policies and laws.
b. Alternatively, member states may seek to motivate a focus on DRR competency through various economic/financial incentives that may be based on national systems of payment (ex. Health insurance) or budgeting for clinical and public health care.

8. Core Competencies[2]: A member state's long term goal might seek to develop DRR competence in the following areas for all health sector (clinical + public health) staff. Individual core competencies may include but are not limited to the following broad topics:
    a. Preparedness at individual, family, professional(practice), and health systems levels
    b. Communication both within and external to the setting in which the individual or entity is functioning
    c. Establishing and maintaining appropriate situational awareness.
    d. Safety—personal and collective to include personal protective measures and equipment
    e. Medical surge—addressing health system access in the face of catastrophic demands
    f. Triage systems and approaches appropriate to one's role in the DRR context
    g. Clinical and public health principles and practice for the DRR context with linkages and differences from daily routine health system operations
    h. Ethical and legal principles for the DRR context
    i. Recovery phase considerations
9. Role Focused: Within the competency building process, the health professional's role in all phases of disasters and how the member state plans to respond to disasters in all 4 phases of the disaster cycle (response, recovery, mitigation, and preparedness) should be clarified.
10. "Command and Control": At some point, it is important for the member state to ensure clarity on the structure and function of local and national authority or "command and control" structures for disasters. Ex) The National Incident Management System (NIMS) or the Incident Command System (ICS) in the U.S. These communication structures must also be applied and utilized within the health sector and should not just be used by military, police, and public safety (fire and emergency medical services) to the exclusion of the health sector. Without such inclusion, it is impossible to maintain situational awareness and coordination among all involved sectors.

[2] Adapted from the published article available at: http://ncdmph.usuhs.edu/Documents/Core-Competencies.pdf