Study/Objective: The objectives were to evaluate the progress in achievement of the nine targets, of the 10-year African regional strategy for health disaster risk management.
Background: In November 2012, the 62nd session of the Regional Committee for Africa of the World Health Organization adopted a comprehensive 10-year regional strategy for health Disaster Risk Management (DRM). This was intended to operationalize the World Health Organization's core commitments to health DRM and the Hyogo Framework for Action 2005–2015, in the health sectors of the 47 African member states. This study reported the formative evaluation of the strategy, including evaluation of the progress in achieving nine targets (expected to be achieved incrementally by 2014, 2017, and 2022).
Methods: This study used a mixed methods design. A cross-sectional quantitative survey was conducted along with a review of available reports and information on the implementation of the strategy. A review meeting to discuss and finalize the study findings was also conducted.
Results: In total, 58 % of the countries assessed had established DRM coordination units within their Ministry of Health (MOH). Most had dedicated MOH DRM staff (88 %) and national-level DRM committees (71 %). Only 14 (58 %) of the countries had health DRM subcommittees using a multi-sectoral disaster risk reduction platform. Less than 40 % had conducted surveys such as disaster risk analysis, hospital safety index, and mapping of health resources availability. Key challenges in implementing the strategy were inadequate political will and commitment resulting in poor funding for health DRM, weak health systems, and a dearth of scientific evidence on mainstreaming DRM.
Conclusion: Implementation of the strategy was behind anticipated targets despite some positive outcomes. Health system-based, multi-sectoral, and people-centred approaches are proposed to accelerate implementation of the strategy in the post-Hyogo Framework of Action era.
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Integrating the Sendai Framework into Primary Health Networks: An Australian Experience

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Study/Objective: To explore the feasibility of integrating the Sendai Framework into primary health networks in Australia.
Background: Over the past 20 years, the exposure of the population to weather-related disasters in Australia and across the world has increased faster than vulnerability decreased. This highlights the need to focus disaster risk reduction strategies on the elderly, people with disabilities and those with chronic diseases. To help address this challenge, the Northern Queensland Primary Health Network, Australia, partnered with UNISDR's Global Education and Training Institute (UNISDR-GETI) to explore the feasibility of integrating the Sendai Framework into primary health networks.
Methods: The research was conducted using qualitative and quantitative research methods. Participants included general practitioners, pharmacists and other disaster management stakeholders. The workshop methodology was based on the private sector materials used by UNISDR-GETI (United Nations International Strategy for Disaster Reduction (UNISDR), Global Education and Training Institute (UNISDR-GETI). Qualitative data was collected during the workshops in Cairns, Townsville and Mackay, Queensland, Australia. The quantitative data was collected through a survey of participants after the workshop. A thematic analysis was conducted to analyze the workshop data. Descriptive statistics was used to analyze survey data.
Results: The workshops increased the knowledge of how and why the primary health networks should have an active role in disaster risk reduction activities. Participants indicated that they are now confident they can help integrate primary health into the disaster system by developing and implementing contingency plans. A consistent theme was the need to clearly define the role and function of the primary health network within the Australian disaster system. This should be complemented by access to accredited training.
Conclusion: The workshops identified that the Sendai Framework can be integrated into primary health networks in Australia. This can be sustainably achieved by strengthening partnerships with the academic and government sectors to research roles of primary health professionals, health service providers and the capacity of disaster systems to support local needs.
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The Centrality of Communities and Civil Society in Epidemic and Pandemic Prevention: A Framework for Improved Preparedness and Response

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Study/Objective: Large-scale epidemics and pandemics pose a serious threat, not only to global health security but also to countries, communities and individuals in their efforts to achieve resilience. The threat of emerging infectious diseases, including those of zoonotic origin, and the increasing prevalence of diseases previously controlled by antimicrobials and vaccination efforts, is a cause for concern to the global health community. Communities play an important role in prevention, early detection and early response regarding this threat. Communities can support the containment and control of infectious disease threats, limiting geographic spread, saving lives, and mitigating negative impacts.
Background: Recent outbreaks have demonstrated that without community-driven efforts to prevent, detect and respond to infectious disease threats, government efforts can be delayed and negatively impacted. However, communities cannot

manage risk alone. They form an integral part of a coordinated and collaborative effort between civil society, the private sector and government that works best where there are established structures and systems in place, and partnerships built on trust that have been forged before a crisis strikes.
Methods: Case study.
Results: Communities are central to epidemic and pandemic preparedness.
Conclusion: Global and national public health expertise must recognize this role and work toward how engagement with communities and civil society, can become central to their preparedness and response efforts. Through the presentation of several case studies from the Red Cross and Red Crescent movement, best practice and opportunities for improvement will be showcased. Case studies from a variety of contexts will show how it is possible to include joint planning and implementation, moving beyond risk communication to effective two-way participation, ensuring public health response is understood by, and designed for, the communities they serve in acute and recovery phases.
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The National Health Security Strategy and Implementation Plan: An Overview

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Study/Objective: The purpose of this presentation is to provide an overview of the US Department of Health and Human Services' National Health Security Strategy (NHSS). The NHSS is a congressional mandate to achieve a health-secure and resilient nation by minimizing the health consequences of large-scale emergencies. The NHSS Implementation Plan (IP) which elaborates on activities that stakeholders might undertake to address the priorities of the NHSS will also be discussed.
Background: The 2015-2018 NHSS is a national strategy that envisions a nation that is secure and resilient in the face of diverse incidents with health consequences. The goal of the NHSS is to strengthen and sustain communities' abilities to prevent, protect against, mitigate the effects of, respond to, and recover from incidents with negative health consequences. The IP serves as a framework to help guide the nation and facilitate collaboration and coordination among stakeholders to advance national health security.
Methods: The presentation will provide an overview of the NHSS and the accompanying IP. The five objectives of the NHSS include: (1) build and sustain healthy, resilient communities; (2) enhance the national capability to produce and effectively use both medical countermeasures and non-pharmaceutical interventions; (3) ensure comprehensive health situational awareness to support decision making before incidents and during response and recovery operations; (4) enhance the integration and effectiveness of the public health, health care, and emergency management systems; and (5) strengthen global health security.
Results: Strategic outreach and engagement like this will play a major role in socializing national health security and motivating stakeholders to take actions that address NHSS objectives.
Conclusion: Achieving the goal of preparing for, and responding to, large-scale health consequences will require a willingness to engage a broad array of stakeholders in an ongoing collective ability to recognize, confront, and resolve existing and emerging threats to domestic health.
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Feasibility of the Novel Combination of Influenza Vaccinations and Child Passenger Safety Seat Fittings in the Drive-Thru Clinic Setting

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Study/Objective: We hypothesized that combining influenza vaccinations and child passenger seat fittings (CPSF) in a drive-thru clinic (DTC) format will be both feasible and desired by the community.
Background: Disaster medicine is an ever-evolving area of medicine with the purpose of helping the masses quickly and efficiently. The drive-thru clinic (DTC) model is a disaster tool that allows distribution of supplies or services while participants remain in their automobiles. Influenza vaccination is the most commonly utilized form of the DTC and has been utilized in metropolitan areas successfully as a single service.
Methods: Each automobile's driver was verbally surveyed at each station of the DTC. The survey content involved satisfaction and background health habits.
Results: In our inaugural combined service, five hour-long DTC there were 86 automobiles served that contained 161 children, of which 28 also participated in CPSF. Each CPSF station required one extra worker in comparison to the traditional DTC influenza model. The median total clinic time was 9:00 (IQR 6:00, 14:00) minutes. For those who only received influenza vaccines, the median total clinic time was 7:30 (IQR 6:00, 10:00) minutes. For those who received both services, the median total clinic time was 27:00 (IQR 22:20, 33:30) minutes with an average of 1.75 CPSFs per automobile.
Conclusion: This was a pilot study involving multiple services in the DTC model and is the first of its kind in the literature. Our clinic was successful in executing both services without sacrificing speed, convenience, or patient satisfaction. Additional studies are needed to further evaluate the efficacy of the multiple service DTC.
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Epidemiology of Poisoning Patients Presenting to the Emergency Center of Princess Marina Hospital in Gaborone, Botswana

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