INTRODUCTION

Yearly there are hundreds of natural and man-made disasters worldwide that all impact upon the health of populations. We seldom think about healthcare as an entire system, let alone a global system, but when talking about disaster nursing and disaster care, it is important to understand the system as a whole.

UNDERSTANDING HEALTH SYSTEMS

The definition of a health system actors used by the World Health Organization (WHO, 2000) is: all [those] who see their primary purpose, their main purpose, as contributing to health, whether it is to improve, maintain, or restore health. Education is of course very important for health, but the primary purpose is not health. Housing is very important. Other things are very important for good health, as for example, agriculture, but its primary purpose is not health. For nurses, the primary purpose is health.

The goal of all health systems is health outcomes: health for people, wherever they are, whoever they are.

A more detailed explanation is provided by the WHO health system framework (Fig. 1), which shows the component functions (stewardship, human resources, information management, financing, service provision) and goals (responsiveness, coverage, quality and safety, efficiency, financial protection) of the ideal health system, resulting in health outcomes for the patients.

Components of a health system

Stewardship is the leadership of any system. It involves provision of direction; defining roles and allocating resources, both human and material; managing competing demands and assuring the quality and safety of services and procedures.

Stewardship for emergency contingencies requires more detailed guidelines of all of the above to ensure an effective response.

Human resources is the major expenditure of any healthcare system and effective management requires a sufficient, trained and productive workforce: the right people with the right skills in the right place at the right time. Repeated and regular training for different disaster scenarios is essential so that everyone knows who does what, when and where. This is not something to decide at the last minute after a disaster has happened. Every person’s role must be clear.

Information management is ensuring the generation, availability and use of information through effective utilization of technology and the media, including clear guidelines on who disseminates information during emergencies when normal lines of communication may be disrupted or absent.

Fair and sustainable financing of health systems is essential, with additional financial protection in the time of emergencies and disasters, including recovery funds.

Service provision is linked to stewardship and human resources, but includes adequate infrastructure of hospitals and clinics, and coverage, which is getting the right help to those who need it, wherever they are and can be particularly problematic in an emergency when utilities and transport systems are also affected.

The efficiency of health systems (i.e. ensuring that resources are used “wisely” and that interventions are relevant) is tested during a disaster. In “normal times” all health systems must aim at the best health outcomes for
all. Any nurse or doctor will attend to the sickest patient first, but in a time of disaster, the very sick may have to be ignored, which is not easy, and when do you ignore and how do you ignore (i.e., triage) becomes a terrible ethical dilemma.

Finally, responsiveness. This encompasses treating all people with dignity, respecting “who they are” (culture, religion, etc.). It is ensuring confidentiality and in a disaster situation, ensuring that the dead are also treated with dignity and that families can eventually be notified.

**SOCIAL DETERMINANTS OF HEALTH**

The social determinants of health are the conditions in which people live and work that affect their opportunities to lead healthy lives (e.g., education, housing, safe water, safe waste disposal, safe work, food safety, etc.). Good medical care is vital, but unless the root social causes that undermine people’s health are addressed, the opportunity for well-being will not be achieved.

Disasters are terrible in any well-established society, such as Japan, but poor social determinants lead to more disasters and worse outcomes. In low-income countries, the percentage of non-communicable diseases under the age of 60 (diabetes, mental illness, high blood pressure, stroke, Parkinson disease, etc.) is even higher than in high-income countries (Fig. 2), so they have a double burden of disease, chronic disease and also acute disease. Children are always more vulnerable, so are the elderly.

**CHALLENGES FOR GLOBAL NURSING LEADERS**

Many disasters are man-made natural disasters. The floods, earthquakes, landslides and fires are often also caused by human interference. War and refugees are totally man-made disasters. So a Global Nursing Leader has to know what is happening in the world, has to be politically aware, and advocate for change, and skilled at
Creating alliances and using the media.

**Becoming politically aware**
- Realize that we live in “one world”
- Keep abreast of international affairs: broadcast media, government, official organizations (e.g., WHO)
- Use electronic media (e.g., Facebook, Twitter) to establish links across nations (e.g., “alert group”)

**Becoming political advocates**
All man-made and many “natural” disasters can be avoided! A Global Nursing Leader is an advocate for:
- Poverty alleviation and closing of gaps
- Saving the environment
- Peaceful international solutions

**Creating alliances**
To achieve change, or simply to have an influence, we must create and build alliances. In some cases, this can be best achieved through political parties, which is sometimes anathema for nurses. We can work “top down” with:
- Community and “like-minded” organizations
- Nursing and other health professional organizations
- Political parties
- All levels of government
- International individuals and organizations (e.g., ICN, WHO, UNICEF, UNHCR, OCHA...).
We must also work “bottom up” with students, volunteers, patients’ organizations and religious groups. There are many people willing and interested to work together, but they have to feel respected and cared about. You can make a difference if you have these links.

**Understanding the media**
A big difficulty for most nurses is understanding and effectively using the media, because if the media are not there, you can have 10 years of war, as in the Congo, and nothing is ever known about it; millions of dead and nothing is done.
As well as understanding the role of the media, it is essential for a Global Nursing Leader to learn how to effectively use the different media (e.g., electronic, TV, radio, written) and to critically evaluate media reports.

**BECOMING “DISASTER EXPERTS”**
The UN Office for the Co-ordination of Humanitarian Affairs (OCHA) is doing very important work, also creating awareness of the phases of emergency manage-

![Figure 3 Phases of emergency management.](image)

ment (Fig. 3). The WHO has defined its principles of (i) an all-hazard approach, rather than specific preparations, (ii) a multidisciplinary (intrasectoral) approach, (iii) a multisectoral approach (i.e. making hospitals safe), and (iv) a comprehensive approach.

**The all-hazard approach**
Different crises invariably result in similar problems and responses requiring similar systems and types of capacity. It is essential that information and resource management systems maintain effective communication, and that vertical planning mechanisms are discouraged.

**The multisectoral approach**
Health sector plans must be linked to and interface with national disaster preparedness plans to avoid confusion, prevent duplication of effort and make best use of resources. This is important not only during a crisis, but also for prevention, reduction and mitigation strategies. However, such an approach remains a challenge in many countries because governmental departments often develop their own plans in isolation of other key players.

One crucial component are hospitals.
Six essential actions to make hospitals safe.
1. Adopt national policies and programs for safe hospitals
2. Design and build resilient hospitals
3. Assess the safety of individual hospitals
4. Plan for emergency response
5. Protect and train health personnel for emergencies
6. Protect equipment, medicine and supplies

**LEARNING FOR SPECIFIC DISASTERS**
Preparation for specific disasters draws on the broad expertise of the Global Nursing Leader must focus upon the following.
• Specific nature of an emergency: expected trajectory
  ◦ Sudden, catastrophic and localized (e.g., earthquakes, floods, wildfires; man-made: terrorism)
  ◦ Sudden with slowly developing consequences (e.g., global financial crisis, unemployment, homelessness)
  ◦ Regional or global threat (e.g., nuclear radiation, epidemics, oil spills)
  ◦ Slow and “creeping” disaster (e.g., disease, global warming, desertification, refugees, hunger)
• Specific context of an emergency: country/local background such as geography, epidemiology, demography, political system, health system characteristics, culture, languages, available and sympathetic media
• Identify structural barriers
• Ethical sensitivity to dilemmas and ability to analyze and collaboratively seek ‘least bad’ solutions
• Critical awareness of how personal dynamics can interfere according to sociocultural-political contexts, understandings and misunderstandings; the importance of self reflection and stress management (i.e., human beings need sleep!)
• Cultural competence. Easier said than done, cultural competence takes time to develop. Even if we respect and like a person a lot, one has to be very careful, despite that respect, not to make big mistakes because we come from different ways of thinking and talking. In summary, the culturally competent leader has the following attributes:
  ◦ Ability to interact effectively with persons from different cultures
  ◦ Positive attitude to different cultures: shared respect, shared meaning and shared knowledge—learning together by genuinely listening
• Knowledge of different cultural practices and world views
• Awareness of Cultural Safety; Cultural competence includes being aware of cultural safety issues. In countries where there are minority groups, that country’s cultural safety is a major issue. There should be no challenge to, or denial of the identity of, those who need and those who provide care In New Zealand, the Maori nurses have done very interesting work on cultural safety, on what does it mean to be safe as who you are (Richardson 2010; Woods, 2010).

WHAT UNDERLIES OUR CARE-GIVING?

“Any one story consists of layered subjective narratives evolving from within contexts of identity, culture and social setting. They are shaped by the position and perception of the story teller and co-created in relationship to other persons” (Richardson, 2010, p.17). Our goal as nurse leaders is not to show that we have an important contribution to make or to show whatever political rivalries we have; the main goal, as the French say, the “raison d’etre,” the meaning of our being, is better health outcomes. Underpinning this is a global ethic of knowledge, of what it means to be human beings, despite cultural, religious, ethnic, political, gender and economic differences. Health for all is the star by which we sail.

REFERENCES