

Attendees were given a pretest before the session and another test after the session. Chi-square test and Wilcoxon rank test were used to compare the results.

**Results:** Total of 105 volunteers participated in the study. Participants were mostly nurses (62.9%) followed by paramedics (23.8%). Overall knowledge level reported to be increased, including knowledge regarding DMAT deployment (29.5% to 93.3%,  $p < 0.001$ ), DMAT personnel (26.7% to 94.3%,  $p < 0.001$ ), DMAT-designated equipment (23.8% to 60.0%,  $p < 0.001$ ), initial response (27.6% to 69.5%,  $p < 0.001$ ) and patient transport priority (74.3% to 94.3%,  $p < 0.001$ ). Questions testing triage and rate of participants answering every question showed improvement with post-test median score of 67% and rate of 1.0% to post-test median score of 100% and rate of 35.2%, respectively (both  $p < 0.001$ ).

**Conclusion:** Educating non-DMAT personnel in emergency departments with a short session showed significant improvement in basic knowledge of disaster response. It may help institutions with limited resources.

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### Remote Teaching in a Rwandan Emergency Medicine Residency: A Viable Option with Limited In-person Staff During a Pandemic

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**Introduction:** Low/middle-income countries (LMIC) in Africa face unique, systemic challenges in medical education. Africa faces a shortage of medical schools; only one school serves 24 countries. 11 countries have no medical school. Residency programs are few. The effect of this shortage is far-reaching. Africa has 3.5% of the world's health workforce and 1.7% of the world's physicians, yet 27% of the global disease burden. COVID-19 created further resource constraints, especially in emergency medicine (EM). Non-clinical physician functions such as student and resident education suffered. In Rwanda, we implemented a pre-recorded, remote teaching model to substitute in-person instruction. This study evaluates whether remote teaching is received positively by EM learners and whether it is a viable alternative during times of limited in-person availability.

**Method:** 28 lectures were recorded by American EM faculty. The recordings were presented to Rwandan EM residents within their standard didactic curriculum. Lecturers were available in real time via Zoom. Topics were chosen by Rwandan faculty based on curricular needs. Program evaluation followed the Kirkpatrick framework. Attendees completed a post-lecture Likert-scale survey assessing the first Kirkpatrick level related to satisfaction, lecture and learning method quality, and suitability. Qualitative and free-response data was also collected.

**Results:** Responses were analyzed with descriptive statistics using means and standard deviations. The mean response range

across questions was 3.6–4.3 (1 = worst, 5 = best); the standard deviation range was 0.4–1.6, indicating an overall positive result. Qualitative feedback, which reached saturation, did not indicate significant dissatisfaction with the quality or suitability. Points for improvement included lecturer accents and rate of speech.

**Conclusion:** When in-person lecturers are unavailable, pre-recorded and remote instructional methods may be a suitable substitute. Future directions may include piloting the project with a multinational cohort or in LMICs with greater technological or resource limitations, and assessing higher Kirkpatrick framework objectives.

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### The WHO Thematic Platform for Health Emergency and Disaster Risk Management Research Network (Health EDRM RN)

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**Introduction:** WHO Thematic Platform for Health Emergency and Disaster Risk Management Research Network (Health EDRM RN) is a global expert network, launched in 2018, aiming to strengthen the scientific evidence for managing health risks associated with all types of emergencies and disasters, and to foster global collaboration among academia, government officials and other stakeholders. The Health EDRM RN's activities are in line with WHO Health EDRM Framework, which support Sendai Framework for Disaster Risk Reduction 2015–2030.

**Method:** Health EDRM RN's strategic direction is discussed and advised by its Core Group that consists of focal points of WHO HQ responsible unit, all six Regional Offices, WHO Center for Health Development (Secretariat), RN co-chairs, and key external stakeholders. Based on the strategic direction, the Secretariat facilitates global, regional, and local collaborative activities with the RN participants and partners. As of 2022, over 250 global experts participate in the network.

**Results:** Following the results of the Core Group Meeting in 2019, 2020 and 2021, multiple activities and results were generated including the identification of five Health EDRM key research areas. WHO Guidance on Research Methods for Health EDRM developed in collaboration with over 150 global experts, initiation of the project to establish WHO Health EDRM Knowledge Hub for developing WHO Health EDRM Research Agenda and aligning with UNDRR research agenda on thematic areas including developing a special supplement on mid-term review of Sendai Framework implementation in health. The 2022 Core Group Meeting, held on October 27, 2022, agreed to promote knowledge dissemination

and implementation research for better outputs for regions and countries.

**Conclusion:** WHO Health EDRM RN will continue its unique function as the platform of global experts and stakeholders to produce, disseminate, and apply knowledge. Participation and engagement by more and broader experts are expected.

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### Using Personal Learning Goals for Participants in Collaborative an International Health Partnership Project: Experiences from the Region Östergötland Model

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**Introduction:** International health partnerships have often been characterized by wealthier countries or organizations pushing resources and money into projects in countries with different needs. This can be new technologies, building facilities, and/or training personnel. Often this has been assessed in the amount of money spent. In recent years more focus has been put on synergy effects in involved organizations. Hence the change from aid to partnerships. A previous study focused on the subjective perception of the workforce regarding clinical skills, management skills, communication & teamwork, etc. (Jones et al., 2013). This paper focuses on defining learning goals and using a model by Patzauer (2022) as a complement to traditional partnership evaluation measures.

**Method:** Seven team members from a health partnership participated in a project for implementing ambulance service treatment guidelines through training of the partner's ambulance personnel and instructors. The training took place during one week in the partnership country. All Swedish participants were nurses actively working as ambulance personnel or had previously worked in ambulances. Before the training week the participants answered a questionnaire with open questions about their personal learning goals and expectations for the training week. At the end of the week, after having trained ambulance personnel, they answered another questionnaire with open questions addressing what they had learned.

**Results:** Analysis of the responses showed that the participants expected to acquire both personal and clinical skills. Afterwards, they had improved language skills, self-efficacy, and becoming better instructors.

**Conclusion:** The model of using learning goals as an integral part of evaluating health care partnerships provides knowledge that is useful both in terms of assessing the project, and also as input to participants' managers showing clinical and

organizational benefits. Including personal learning goals as a part of partnership projects' evaluation, provide useful knowledge about benefits and experiences that improves the organizations.

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### Our Trial of Disaster Victim Identification Training in Chiba, Japan

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**Introduction:** Internationally, Disaster Victim Identification (DVI) activities are conducted under the International Criminal Police Organization system for handling a large number of bodies during disasters. However, the police have taken the initiative and commissioned clinicians and dentists to estimate the cause of death and identify the deceased, under a unique system in Japan. In this presentation, we examine the problems in the current DVI activities in Japan through DVI training.

**Method:** We held DVI training sessions three times in preparation for the occurrence of a large-scale disaster in Chiba Prefecture with Chiba Prefectural Police, Chiba Medical Association, Chiba Dental Association, local government staff in Chiba, and forensic staff in other institutions. We conducted desktop trainings using paper dolls, under a simulation of an aircraft disaster, and a natural disaster such as flooding and landslides caused by typhoon damage in the third session. After the training, participants reflected on their activities through a questionnaire.

**Results:** In accordance with the conventional method, the police officers numbered the bodies, photographed and checked their personal belongings, followed by the estimation of the cause of death with a doctor, the preparation of documents. Subsequently, dentists collected postmortem findings and matched with antemortem data. On the other hand, police officers and local government staff interviewed the bereaved family members under simulations. In the post-survey, participants were generally satisfied with the training, but some said that it was difficult to understand the activities of other professions.

**Conclusion:** In Japan, where there are no DVI teams, this training was a good opportunity for all the job categories involved in DVI activities to meet each other. While the activities conducted by each profession helped to improve skills, the collaboration among professions was poor. We would like to improve the quality of DVI activities by introducing a team system for collaboration among multiple professions.

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