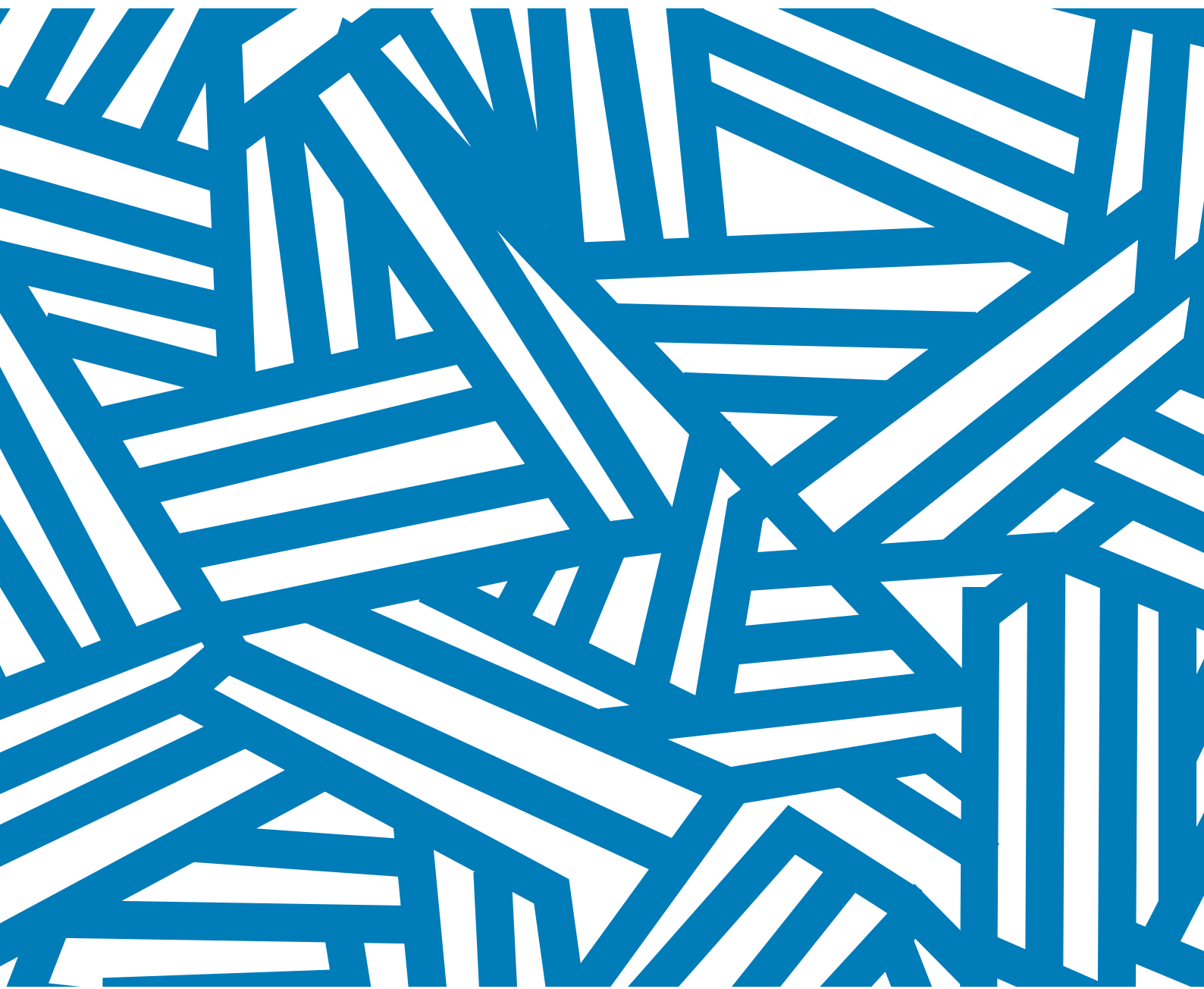# Health and Disaster Risk

A contribution by the United Nations to the consultation leading to the Third UN World Conference on Disaster Risk Reduction

KEY RECOMMENDATIONS FOR ADDRESSING DISASTER RISK IN HEALTH IN THE POST-2015 FRAMEWORK FOR DRR

1. Make people's health and well-being an explicit outcome of the next global framework on DRR.

2. Include health targets and indicators for monitoring and reporting on DRR.

3. Strengthen action and resources to support health and other sectors that are vital for implementing DRR.

4. Establish the Safe Hospitals Initiative as a global priority for action to ensuring that new and existing health facilities remain operational in emergencies and disasters.

Overview/rationale

Protecting people's health from the risk of emergencies and disasters is a social, economic and political necessity. Health should become an essential component for strengthening action in the post-2015 framework for DRR.

The health and lives of millions of people are regularly threatened by hazards. Disasters are considered, first and foremost, in terms of their health consequences. While a focus on reducing deaths and saving lives should remain a high priority of DRR, concerted action is also required to reduce injuries, disease, psychosocial effects, and disabilities from disasters.

Health is a bridge for effective action in DRR as it promotes cooperation across different sectors and disciplines which contribute to health. Health is connected with many aspects of DRR, such as:

- the increasing role of the private sector in health care and health infrastructure;

- protecting critical infrastructure through action on safe hospitals, and safe water and sanitation systems; and

- the vital role of local health workers in building community resilience through community care and as first responders in emergency situations.

Health status is a key factor for the vulnerability and resilience of people and communities to disasters, and is a major determinant of development outcomes associated with DRR, such as:

- livelihoods and economic development, which relies on a healthy, safe and secure workforce in public, private and community sectors,

- community safety and security, and

- early childhood development and school attendance.

- figure (or human loss) of disaster impact and risks for health

People's health is at risk wherever there are hazards across the world:

- More than 110,000 deaths were recorded annually on average due to natural and technological hazards from 2004-2013, while 1.7 billion people have been affected by disasters in the same period.

- More than 1.5 billion people live in countries marked by repeated cycles of political and criminal violence, including conflicts. 172 million were affected by conflict in 2013 alone.

- It is estimated that for every large-scale event, there are hundreds of smaller scale events which cause deaths, injuries, and disabilities.

- A severe influenza pandemic could cost the global economy more than $US3 trillion, through its effects on health, productivity, trade, and travel.

$ figure of scale of global expenditure in health

Global expenditure on health care in 2010 was estimated at $US 6.5 trillion or $US 948 per person.

Expenditure on hospitals may represent up to 70 percent of national health budget.

A review of 94 assessments in Latin America and the Caribbean (from 1972 to 2011) estimated the damage from disasters to health infrastructure at $7.82billion.

Status of mainstreaming disaster risk in health:

Communities and countries are actively strengthening their systems to manage the health risks associated with all types of hazards, emergencies and disasters. Measures implemented by communities and countries include: routine child and emergency immunization programmes, provision of safe drinking water, safe human waste management, safe hospitals, psychosocial support for disasters, trauma care services, first aid training, disease surveillance and early warning systems. These activities are supported by policies, legislation and capacity assessments, evidence-based information on risks and resources, health and intersectoral coordination mechanisms, emergency response planning and exercises, training of health personnel, financial resources and research.

Civil society, local governments, international organizations and the Red Cross/Red Crescent movement are building the capacities of local health workers and community volunteers for their roles in reducing local health risks, disaster preparedness, response and recovery.

- 130 countries have reported to WHO that they have "emergency preparedness and response programmes" in place.

- 77 countries have implemented activities to make hospitals safe and operational in emergencies and disasters- one of the more successful achievements of HFA implementation. This momentum must be built upon in the new framework for DRM for all countries.

- 61 States Parties have reported to WHO that the national core capacity requirements for the International Health Regulations (2005) have been achieved.

In 2008, a global assessment of national health sector emergency preparedness and response in 62 countries found that nearly 70% of countries reported a full-time emergency preparedness and response unit in the Ministry of Health, and 66% reported the presence of health emergency management coordination committee combining the skills and experience of hospitals, health disciplines and other sectors. WHO will conduct another global survey of the status of national emergency and disaster risk management capacities in 2014.

Emerging trends

The health sector is usually well-integrated into national disaster risk management systems in those countries with well-developed capacities. In other countries, there is a greater need to strengthen the limited capacity of the health sector for disaster prevention, preparedness, response and recovery.

WHO and partners are developing a global framework on emergency and disaster risk management for health (EDRM-H) brings together core elements of multisectoral DRM, health systems and the International Health Regulations (2005). This framework aims to identify the capacities which countries should have in place to manage health risks associated with disasters effectively, resulting in better health outcomes. EDRM-H is closely allied with developments in the disaster community towards a more proactive, risk-based and community-centred approach involving all sectors and disciplines.

Drivers for mainstreaming disaster risk into health

Climate variability and climate change

- Major risks to public health are due to extreme weather and climate-related hazards such as extreme temperatures, cyclones and floods, droughts and climate-sensitive diseases such as malaria.

- Actions include safe siting of hospitals, using renewable energy to make hospitals more energy-independent, and climate-informed disease surveillance.

- Health and climate risk have been integrated into the WHO Work Plan on Climate and Health, National Climate Adaptation Plans, IPCC reports and Global Framework for Climate Services.

Private sector involvement
- Greater engagement with the private sector in DRM for health is required as there is an increasing role for the private sector in health care, including in hospitals.

- The private sector relies on a healthy workforce whose safety should be a priority before, during and after disasters.

Increased attention to non-communicable diseases
- Increased attention is needed to the risks of disasters for people who are vulnerable to disasters due to diabetes, hypertension, heart disease, mental health conditions and other non-communicable diseases, and associated dependence on life-saving medications or health services.

Ageing populations
- The increasing proportion of elderly people in many communities around the world requires targeted risk management actions to address their vulnerabilities, including mobility problems and chronic diseases

People with disabilities
- Greater attention is being placed on involving people with disabilities and disabled persons organizations in planning and implementation of disaster risk management measures in health and other sectors.

Women and children
- There needs to be a continuing focus on working with women and children to manage their risks of disasters and to draw upon their capacities for effective community action.

- Health services for women, especially those requiring ante-natal, emergency obstetric and post-natal care, should remain a priority before, during and after emergencies.

Displaced and refugee populations
- More than 50 million internally displaced people and refugees face major health risks from conflict and other hazards, including psychosocial trauma, malnutrition, communicable diseases and injuries. The result is an increasingly high demand on local health systems and the international community which provide services to displaced and refugee populations.

Urbanization
- Increasing unplanned urbanization and industrial not only creates risks for people's health, but also places increasing pressure on improving access to basic and emergency health services in urban areas.

Communicable diseases from animals to humans (zoonotic diseases)
- The transmission of disease-causing agents (pathogens) from wild and domestic animals to humans is influenced by livestock production and food preparation practices, as well as the societal context and the ecosystems within which human-animal interactions take place.
- The movement of people and animals, human behaviour and modifications to natural habitats (associated with other risk factors for disasters such as urban encroachment on wildlife habitat) has a substantial influence on the emergence of diseases.

Recommendations for addressing disaster risk in health in the next global framework for DRR

1. Make people's health and well-being an explicit outcome of the next global framework on DRR:
- Focus must expand beyond the number deaths to include impacts on injuries, disease, disability, and quality of life; and immediate and long-term indicators of health and social outcomes.
- Apply the WHO Disability Assessment Schedule (WHO-DAS) to assess personal, household and community health and social functioning before, during and after disasters.

2. Include health targets and indicators for monitoring and reporting on DRR.

By 2030:

- reduce deaths in emergencies and disasters by 30 percent.
- 100 percent of countries have minimum capacities for managing public health risks
- 100 percent of hospitals and health facilities have emergency response plans to continue health care in disasters
- 100 percent of new hospitals and health facilities built to withstand hazards
- 50 percent of existing hospitals and health care facilities requiring improved safety are retrofitted

A priority is to establish an International Science Advisory mechanism for DRR to strengthen the evidence and science base for developing good practice, and for improved monitoring and reporting, including the measurement of reduction of risks of injury, disease and disability due to hazards.

3. Strengthen action and resources to support health and other sectors that are vital for implementing DRR.

- Address the needs of groups with vulnerabilities (e.g. aged, people with disabilities, children, women, displaced populations)
- Include biological hazards as part of an all-hazards approach to DRR.
- Strengthen DRR in primary care to improve people's health status and resilience (e.g. nutrition, immunization, first aid, emergency preparedness and response)
- Develop health workforce capacity for DRR practice, advocacy and policy development.
- Include community health groups with vital information on community risks and capacities in risk assessments.
- Strengthen the resilience of health systems: integrate DRR with health-related SDGs, improve local and national health emergency response (including international coordination, such as foreign medical teams), safe hospitals, primary care, compliance with the International Health Regulations (2005).

4. Establish the Safe Hospitals Initiative as a global priority for action to ensuring that new and existing health facilities remain operational in emergencies and disasters.

- Recognize that health facilities, especially hospitals, are critical assets for communities before, during and after emergencies and disasters.
- Build on the momentum of 77 countries taking action to make hospitals safe and operational in emergencies and disasters.
- Support the implementation of the Safe Hospitals Initiative, national safe hospital programmes and actions to protect patients and health workers.

Regional/international policy frameworks and initiatives within health to be targeted

(other than the HFA2)

Safe Hospitals Initiative

The Safe Hospitals Initiative should be a global priority for action to ensure that new and existing health facilities remain operational in emergencies and disasters. The Communique of the High Level Dialogue of the Global Platform proposed all stakeholders to rally behind "…a global safe schools and safe health structures campaign in disaster-prone areas with voluntary funding and commitments to be announced at the World Conference for Disaster Risk Reduction for 2015."

Global policies for public health

The World Health Assembly, the governing body of WHO, adopted WHA Resolution (WHA64.10) on "Strengthening national and community health emergency and disaster management capacity and resilience of health systems" in May 2011. WHA 64.10 "urges Member States to strengthen all-hazards health emergency and disaster risk-management programmes (including disaster risk-reduction, emergency preparedness and response) as part of national and subnational health systems, … to improve health outcomes, reduce mortality and morbidity, protect health infrastructure and strengthen the resilience of the health system and society at large …." This Resolution also calls upon the WHO Secretariat to "provide the necessary technical guidance and support to Member States and partners for developing health emergency and disaster risk-management programmes at national, subnational and local levels."

Further resolutions at global and regional levels (AFRO, PAHO/AMRO, EMRO, EURO, SEARO, WPRO) have provided strategic directions for strengthening risk management capacities in health and other sectors, resulting in action by many other actors in international emergency response, disability, non-communicable diseases, mental health, environmental health, climate change, radiation safety, chemical safety etc

International Health Regulations (2005)
The next framework on DRR should be linked with the revised International Health Regulations which were adopted in 2005 to provide an international mechanism for the early detection, assessment and rapid response to public health emergencies with the potential for international spread. The IHR (2005) provide a legal mandate for countries to comply with installing capacities for the management of events which may constitute a public health emergency of international concern.

Measuring disaster risk in health

Disaster databases should record a range of health outcomes, in addition to deaths. Data on injuries, disease and disability are more difficult to collect, however, they reflect the wider health effects of disasters and their risks to other outcomes. The WHO Disability Assessment Schedule is a useful tool for measuring personal and social functioning that has been used in post- disaster assessments in the Philippines after Typhoon Haiyan.

The focus on health in the current HFA is on safe hospitals. There is a need to expand health references in the next framework to take account of the importance of health status as a risk factor for resilience and of effective functioning of health systems and services before, during and after disasters.

Global reporting on the burden of disease should also be improved to include health effects due to emergencies and disasters.

Health Target and Indicator options
By 2030:
- 30 percent fewer annual average deaths in emergencies and disasters
- 100 percent of countries have minimum capacities for managing public health risks of emergencies and disasters
- 100 percent of hospitals and health facilities have emergency response plans to continue health care in disasters
- 100 percent of new hospitals and health facilities built to withstand hazards
- 50 percent of existing hospitals and health care facilities requiring improved safety are retrofitted

List of agencies contributing and very brief description of institutional commitment (input invited)

- The WHO commitment to DRR is prescribed by WHA and Regional Committee Resolutions and in the Emergency Risk and Crisis Management and other programme areas of WHO's Medium-Term Strategic Plan (MTSP) for 2014-2019.
- ADPC, Care, CBM, IOM, IFRC, IFMSA, IMC, IRC, MDM, Save the Children, UNOPS, UNISDR, UNHCR, UNICEF, UNSIC, WADEM; WHO, WMO, academic institutions and other partners collaborate on various programmes in support of Ministries of Health, and other national community actors for DRM. Many partners contribute to the WHO/UNISDR thematic platform for EDRM-H and the Global Health Cluster for humanitarian response.
- The Towards a Safer World Initiative convenes a broad range of multisectoral, multi-regional stakeholders with the goal of more effective whole-of-society preparedness so as to less the economic, social and humanitarian impact of pandemics and comparable high-impact risks.

Key documents/source of additional info (input invited)

- World Health Assembly Resolution 64.10: Strengthening national health emergency and disaster management capacities and resilience of health systems (http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_R10-en.pdf)
- International Health Regulations (2005) (http://www.who.int/ihr/en/)
- Scaling up the community-based health workforce for emergencies (http://www.who.int/hac/techguidance/preparedness/Scaling-up_community_wf.pdf?ua=1)

- Hospital Safety Index (http://safehospitals.info/images/stories/3Resources/techGuides/SafeHosEvaluatorGuideEng.pdf)
- Guidance note on disability and emergency risk management for health (http://www.who.int/hac/techguidance/preparedness/disability/en/)
- Disaster risk management for health - fact sheets (http://www.who.int/hac/techguidance/preparedness/factsheets/en/
- Global assessment of national health sector emergency preparedness and response (http://www.who.int/hac/about/Global_survey_inside.pdf)
- Health Summary: IPCC Special Report - Managing the risks of extreme events and disasters to advance climate change adaptation (SREX) (http://cdkn.org/wp-content/uploads/2012/10/SREX-lessons-for-health-sector.pdf)

About the UN Plan of Action on Disaster Risk Reduction for Resilience: The UN Plan of Action, endorsed by the UN Secreetary-General and the Excutives Heads of UN Specialized Agencies, Funds andProgrammes, includes a commitment for the UN system to work together to ensure disaster risk reduction is a key component of the post-2015 development agenda supported by a post-2015 framework for disaster risk reduction (HFA2). The UN Plan of Action improves system-wide coordinated actions and coherence, as well as increased effectiveness and collaboration in the support to Member States on disaster risk reduction.

UN High Level Programmes Committee Senior Managers Group on Disaster Risk Reduction for Resilience (HLCP/SMG):
Members of the HCLP/SMG that oversees the implementation of the UN plan of Action are FAO, IAEA, IFAD, IFRC, ILO, IMO, IOM, ITU, UNAIDS, UNCCD, UNDP, UNEP, UNESCO, UNFPA, UNHABITAT, UNHCHR, UNICEF, UNISDR, UNOCHA, UNOPS, UNOOSA, UNWOMEN, UNWTO, UPU, WFP, WHO and the World Bank.

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