HEALTH SECTOR SELF-ASSESSMENT TOOL FOR DISASTER RISK REDUCTION

Pan American Health Organization

Regional Office of the
World Health Organization

Health Sector Self Assessment Tool for Disaster Risk Reduction

Pan American Health Organization

Regional Office of the World Health Organization

Barbados, 2010

The Pan American Health Organization welcomes requests for permission to reproduce or translate its publications, in part or in full. Applications and inquiries should be addressed to Editorial Services, Area of Knowledge Management and Communications (KMC), Pan American Health Organization, Washington, D.C., U.S.A., which will be glad to provide the latest information on any changes made to the text, plans for new editions, and reprints and translations already available.

CONTENTS

PREFACE

PREFACE

In 2006 the Pan American Health Organization conducted a regional survey to determine where countries in Latin America and the Caribbean stood in terms of disaster preparedness, mitigation and response. The results of this survey have been used to design and focus activities to reach expected results and meet benchmarks set forth in PAHO's emergency preparedness and disaster relief biennial work plan for 2008-09.

Well-designed and comprehensive surveys, however, are costly and extremely time consuming to carry out. Often, by the time the information is collected and properly analyzed, it is out of date. Therefore, PAHO has looked for ways to help national health authorities assess or re-evaluate on a more frequent basis their progress in this important area.

During working group discussions at the 2008 Caribbean Health Disaster Coordinators meeting, and under the framework of PAHO's Disaster Strategic Plan, participants rallied around the idea of developing a Health Sector Self-Assessment Tool for Disaster Risk Reduction to evaluate key aspects of disaster risk management (notably mitigation and preparedness). The Tool is generally limited to information and data – quantitative and qualitative – available to or generated by the health sector. As an internal tool for use by the health sector, it will aid in determining priorities for a national health sector risk reduction or disaster management program (or set of initiatives) and, if used regularly, as a monitoring tool for measuring changes (or lack thereof) over time. To be effective, it requires objective responses from Health Disaster Coordinators and other relevant health sector stakeholders.

It is important to point out that the Tool was developed with the knowledge of professionals from health and disaster management fields, and with expert input from monitoring and evaluation specialists. Consensus was achieved following intense discussions and pilot application in three countries. By its very nature of application however, the Tool has an element of subjectivity and will likely be adjusted/updated as it is applied and new things are learnt. Even within this limitation, it is recognized as maybe the best system available to rapidly provide a snapshot picture of the status of preparedness and mitigation in the country's health sector.

ACKNOWLE

ACKNOWLEDGEMENTS

INTRO

INTRODUCTION TO THE TOOL

The Health Sector Self-Assessment Tool for Disaster Risk Reduction (the Tool) aims to help health sector managers and health disaster coordinators (HDC) determine the status of key aspects of disaster risk management (DRM) in their country (notably mitigation and preparedness). Its purpose is to assist health disaster coordinators arrive at a comprehensive assessment of disaster mitigation and preparedness of the health sector. Once completed and adjusted to national particularities, it could provide a baseline against which to monitor progress in the implementation of a disaster risk reduction or disaster risk management program, if conducted as part of an annual review process.

The Tool has been developed upon the fundamental premise that countries' limited resources to deliver their national health programmes (or set of initiatives) could be degraded because of disasters, at a time when demand for them is at a peak. Therefore the aim of a health sector disaster risk management program is threefold:

1. Reduce the vulnerability of the health sector to the impact of disasters (Mitigation);

2. Be prepared to support the national response to any disasters in matters relating to health (Preparedness); and,

3. Be prepared to lead the national response to health disaster, e.g. a pandemic (Preparedness).

Another key premise is that in matters of disaster risk management, the health sector does not operate in a vacuum but rather as part of the national disaster risk management system. The health sector both contributes to and is dependent upon the national system.

Tool Development

The Tool was informed by the Pan American Health Organization's (PAHO/WHO) 2008-2012 Strategic Plan, Working Group discussions from the 2008 Health Disaster Coordinators Meeting, deliberations from a small working group comprising health disaster coordinators and other key stakeholders, as well as the PAHO/WHO Disaster Preparedness and Mitigation

in the Health Sector in the Americas 2006 survey instrument. It was further refined taking into account provisions and guidelines included in the following publications:

- Natural Disasters: Protecting the Public Health (PAHO Scientific Publication No. 575, 2000)

- Principles of Disaster Mitigation in Health Facilities (PAHO 2000)

- Guidelines for Assessing Disaster Preparedness in the Health Sector (PAHO, Emergency Preparedness Program 1995)

- Living with Risk: A Global Review of Disaster Reduction Initiatives (UNISDR 2004)

Constructing the Tool

The construct of the Tool is based on first determining the components of mitigation and preparedness from a health sector perspective, their key elements and sub-elements. The sub-elements lead to a selection of both quantitative and qualitative indicators, which provide a reasonably comprehensive description of the state or level of the various aspects of mitigation and preparedness in the health sector. In turn, the data needed for the indicators generated the set of questions, which comprise the Health Sector Self-Assessment Tool for Disaster Risk Reduction.

The components of mitigation and their key elements of relevance to the health sector are:

- Risk Identification: with the key elements of hazard, vulnerability and risk assessments. These assessments are specific to the health sector as a whole and to individual health facilities as opposed to national overall assessments conducted by the National Disaster Offices (NDO). Of course, the health sector assessments rely in great part on information and knowledge generated by the latter.

- Non-structural Mitigation Activities: with land-use planning and building codes as key elements. The sub-elements of each are the national standards and their application within the health sector.

- Structural Mitigation Activities: new and old facilities are the key elements. The sub-elements are the planning processes leading to the construction of new health sector facilities as well as retrofitting activities.

The components of Preparedness and their key elements of relevance to the health sector are:

- Disaster Risk Management Governance: the key elements are the legislative, policy and structural/ systemic frameworks that govern disaster risk management in the health sector.

- Health Sector Disaster Risk Management Planning: the planning framework, health sector national level plans and health sector institution/facility level plans are the key elements.

- Health Sector Disaster Risk Management Resources: this component focuses on resources available to deliver the health sector disaster risk management programme as opposed to the overarching health sector programme. Its key elements are material and human resources.

- Health Sector Disaster Risk Management Public Awareness: Pre-event disaster risk management related health public awareness and post-event disaster risk management related health public information are the two key elements of this component.

Table 1 shows the outline of the Tool

Completing the Tool

During the self-assessment, the health disaster coordinator along with other health sector stakeholders, including private sector representatives and the national disaster coordinator collectively completes the Tool in a working group. To enhance effectiveness, PAHO/WHO recommends involvement of an external facilitator, to orient and coordinate the working group.

The Tool requires objective and frank responses, and is in general limited to information and data – quantitative and qualitative – available to or generated by the health sector. Thus, it is an internal health sector tool that can be used to determine priorities for a national health sector disaster risk reduction or disaster risk management programme (or set of initiatives) and,

if used regularly, as a monitoring tool for measuring changes over time.

The Tool can also be used to conduct an external evaluation by incorporating objective verification in the information/data collection process.

Outline of the Health Sector Self Assessment Tool for DRR

Table 1 shows the outline of the Tool. It presents for each of the areas of preparedness and mitigation, the link with their components, key elements, sub-elements, and related indicators. A mapping of these to the questions in the Tool is also depicted.

TABLE1: OUTLINE OF THE HEALTH SECTOR SELF-ASSESSMENT TOOL FOR DISASTER RISK REDUCTION

1. Mitigation				
Components	**Key Elements**	**Sub-elements**	**Indicators**	**Questions[1]**
1.1 Risk Identification	1.1.1 Hazard Assessment	Hazard Knowledge	• Availability, adequacy and usefulness of hazard information.	• 1
	1.1.2 Vulnerability Assessment	Health Sector National (macro)	• Availability of a national vulnerability assessment.	• 3.a-b
		Health Sector Facilities (micro)	• Evidence that health sector vulnerability assessment is based on and considers priority hazards, and considers all health sector stakeholders, facilities, services, resources and systems.	• 3.c-h
			• Evidence of health sector critical infrastructure catalogued and mapped.	• 3.j
			• Number, types and location of health sector facilities.	• 2 & 4
			• Evidence that health sector vulnerability assessment considers community vulnerability.	• 3.i
	1.1.3 Risk Assessment	Health Sector National (macro)	• Existence of a national risk assessment. • Existence of a health sector-wide risk assessment.	• 5.a-b
		Health Sector Facilities (micro)	• Evidence that a health sector-wide risk assessment is based on and considers priority hazards, and considers all health sector components, facilities, services, resources and systems.	• 5.c-g
			• Evidence of a Hazard Risk Vulnerability Assessment (HRVA) methodology/tool for health sector facilities.	• 6.a
			• #/% of health sector facilities having conducted an HRVA.	• 6.a-c
1.2 Soft Mitigation	1.2.1 Land-use Planning	National Standards	• Level at which land-use planning takes place	• 7.a-b
		Application in Health Sector	• Participation of health sector in land use planning.	• 7.c
			• Evidence of land use regulations enforcement in health sector facility locations.	• 7.d

[1] This column connects each indicator to the relevant question(s) in the Tool.

1. Mitigation				
Components	**Key Elements**	**Sub-elements**	**Indicators**	**Questions[1]**
1.2 Soft Mitigation	1.2.2 Building Codes	National Standards	• Evidence of national building codes and regulations.	• 8.a
		Application in Health Sector	• Evidence of provisions for health sector facilities in the building codes.	• 8.b
			• Participation of health sector in development of the building codes and regulations.	• 8.c
			• Evidence of enforcement of building code regulations.	• 8.d
			• #/% of health sector facilities conforming to building codes.	• 8.e & 9
1.3 Hard Mitigation	1.3.1 New Facilities	Planning Process	• # of planned new health sector facilities and stage of planning.	• 10
			• Evidence that planning process adheres to land use plans, HRVAs, building codes, and includes check consultants.	
	1.3.2 Old Facilities	Retrofitting	• Evidence of a policy, programme and planning process to make older health sector facilities more resilient.	• 13.f
		Safe Hospital Initiative	• Comprehensiveness of resiliency improvement programme.	• 11
			• Level of participation of health sector facilities in the resiliency improvement programme.	• 12.a-b
			• Existence of funding for evaluating structural and non-structural vulnerability of health sector facilities and for retrofitting.	• 13
			• Level of health sector facilities' yearly investment (in %) of replacement.	• 14
			• # and type of facilities identified for safety/ resiliency improvements.	• 12.c & 14
			• Evidence of and level of implementation of Safe Hospital Initiative.	• 13 & 14

[1] This column connects each indicator to the relevant question(s) in the Tool.

2.	Preparedness			
Components	**Key Elements**	**Sub-elements**	**Indicators**	**Questions[1]**
2.1 DRM Governance	2.1.1 Legal Framework	National DRM Legislation Mandating Responsibilities	• Existence of national disaster legislation that has health sector related provisions and mandates the Ministry of Health (MoH) with responsibilities, and establishes a disaster risk management system and committee.	• 15.a-c
		Health Sector Legislation Mandating DRM Responsibilities	• Existence of health legislation that is congruent with disaster legislation, contains disaster risk management provisions, and provides the MoH with sufficient authority/ power to lead the health sector in disaster risk management.	• 16.a-d
	2.1.2 Policy Framework	National DRM Policy	• Existence of national disaster management policy that is congruent with disaster legislation, has health sector related provisions (including their representation on the Disaster Management Committee (DMC)) and provides the Minister of Health with sufficient authority/power to lead the health sector in disaster risk management.	• 17.a-e &18.a-d
		Health Sector DRM Policy		
			• Existence of Health policy with health sector related provisions.	• 19.a
			• Comprehensiveness of disaster risk management areas covered in the health sector policy or by separate policies related to health sector disaster risk management (such as policies on mass casualties, shelter health management, safe hospitals, Business Continuity Plans (BCPs), identification/ handling of bodies, etc).	• 19.a-o
	2.1.3 Structural/ Systemic Framework	Inter-sector Structure/System	• Existence of a national DMC that includes the health sector and where responsibilities are clearly defined.	• 20.a-c & 21.a
		Intra-Sector Structure/System	• Participation in, level of functionality of the DMC and level of frequency of meetings. • Existence of an HDC. • Adequacy of funding provided for HDC. • Existence of a Health Sector Disaster Management Committee (sub-committee of the DMC) with clearly defined responsibilities.	• 20.b & 21.b & 22 • 23.d • 23.f • 23.a-c & f
			• Participation in, level of functionality of the Health Sector DMC and level of frequency of DMC meetings.	• 24
			• Comprehensiveness of functions covered by the Health Sector DMC (including coordination of response).	• 23.b-c & 25

[1] This column connects each indicator to the relevant question(s) in the Tool.

2. *Preparedness*				
Components	**Key Elements**	**Sub-elements**	**Indicators**	**Questions[1]**
2.2 Health Sector DRM Planning	2.2.1 Planning Framework	General Health Sector Planning Regime	• Status of the national health disaster plan • Participation of health sector in development of national health disaster plan • Evidence that national health disaster plan has been coordinated with and endorsed by the NDO and DMC, subject to exercises/ tests/ simulations, and modified based on lessons learned. • Status of the National Influenza/Pandemic Preparedness Plan. • Evidence that National Influenza/Pandemic Preparedness Plan has been coordinated with and endorsed by PAHO/WHO, NDO and DMC, subject to exercises/tests/ simulations, and modified based on lessons learned. • Status of health annexes (or support plans) to other hazard specific national disaster plans. • Status of model health institution disaster plan • Status of model health institution BCP.	• 26.a • 27.a • 27.b-h • 26.b • 28 • 26.c • 26.d • 26.e
	2.2.2 Health Sector National Level Plans	Health Support Plan to the National Disaster Plan	• Evidence that national health disaster plan is based on national hazard and health sector risk assessments, involves all health sector (including private sector/NGOs), addresses foreign medical personnel, treatment of casualties, identification/handling of bodies, disease control, basic sanitation, shelters/ temporary settlements, designates a location and details standard operating procedures (SOPs) for Health DMC and addresses resources for the DMC. • Number and types of exercises/simulations conducted for the national health disaster plan	• 29.a-d • 30.a-b
		Health Disaster Plan (pandemic)	• Evidence that National Pandemic Preparedness Plan (NPPP) is based on WHO guidance, involves all health sector (including private sector/NGOs), addresses foreign medical personnel, treatment of casualties, identification/handling of bodies, disease control, basic sanitation, shelters/ temporary settlements, designates a location and details SOPs for NPPP committee, addresses resources for the NPPP committee and contains a public awareness component. • # and types of exercises/simulations conducted for the National Pandemic Preparedness Plan.	• 31.a-l • 32.a&b

[1] This column connects each indicator to the relevant question(s) in the Tool.

2. Preparedness				
Components	**Key Elements**	**Sub-elements**	**Indicators**	**Questions[1]**
2.2 Health Sector DRM Planning	2.2.3 Health Sector Institution / Facility Level Plans	Health Institution/ Facility Emergency Plans	• Status of model health sector institution/ facility emergency plan. • #/% of health sector facilitates (by type) that have an emergency plan. • #/% that exercised their plan in the last year.	• 33 • 33 • 33
		Health Institution/ Facility Business Continuity Plans	• Status of model health sector institution/ facility BCP. • #/% of health sector facilitates (by type) that have a BCP. • #/% which exercised their plan in the last year.	• 34 • 34 • 34
2.3 Health Sector DRM Resources (The focus is not on resources available to deliver the health sector program. Rather it is on additional specialized resources to deliver the disaster risk management program).	2.3.1 Material Resources	Health Sector Facilities	• #/% of health sector facilities with emergency power and water supplies. • #/% of health sector facilities with patient surge capacity. • #/% of health sector facilities with established pandemic protocols.	• 35.b, d & e • 35.a • 35.c
		Ambulances	• Availability of ambulance surge capacity	• 36.a
		Logistical Resources	• Existence and evidence of central control of medical supplies stockpiles. • Existence of mechanism/system for redistribution of supplies. • Existence of mechanism/system for rapid resource mobilization post-event. • Existence of a resilient communication system and evidence of access to it by health sector stakeholders.	• 36.b-c • 36.d • 36.e • 36.f
	2.3.2 Human Resources	DRM Specialists	• # and type of MoH personnel with capacity and responsibility to manage health sector disaster risk management. • Adequacy of human resources for health sector disaster risk management. • Existence of a MoH HDC and evidence of support and budget to implement health sector disaster risk management program (or equivalent). • Existence of a funded health sector disaster risk management program and level of implementation. • Evidence, size, budget and composition of health sector disaster risk management office/unit.	• 37 & 38 • 37 & 39 • 37.a-c • 37.c • 37.b-c & 38
		DRM Training	• # and type of health sector disaster risk management related courses conducted in the past year. • # and type of persons attending the courses in the past year. • Evidence that disaster risk management is included in the training curricula for health sectors practitioners and in the education curricula for health sector professionals.	• 40.a-i • 40.a-i • 41.a-b

[1] This column connects each indicator to the relevant question(s) in the Tool.

2. Preparedness				
Components	**Key Elements**	**Sub-elements**	**Indicators**	**Questions[1]**
2.4 Health Sector DRM Public Awareness	2.4.1 Pre-event DRM- related Health Public Awareness	Disaster Health Preparedness Information	• Evidence of health disaster risk management information disseminated to the public. • Evidence, # and type of mass media means utilized. • # of materials produced and disseminated. • Evidence that the level of health disaster risk management awareness of the general public is being measured by the MoH. • Accessibility and availability of information to different ethnic/cultural groups in relevant languages. • Evidence that gender and vulnerable groups are adequately addressed in public information materials.	• 42.a • 42.b-e. • 43 • 42.j-k • 42.g • 42.h-i
		Pandemic Advisory/ Information	• Evidence of compliance with current WHO pandemic guidelines.	• 42.f
	2.4.2 Post-event DRM-related Health Public Information	Disaster Health Advisories	• Evidence of protocols for control/coordination of health-related public information. • Evidence of availability of health information for dissemination in shelters. • Accessibility and availability of information to different ethnic/cultural groups in relevant languages. • Evidence that gender and vulnerable groups are adequately addressed in public information materials.	• 44.a • 44.b • 44.c • 44.d-e

[1] This column connects each indicator to the relevant question(s) in the Tool.

FORMS

PLEASE NOTE

This version of the form is for reference or consultation. To complete the assessment and fill out the information, photocopy the forms included in the document, or if you prefer print the file included in the CD-ROM or online.

1. MITIGATION

1.1 RISK IDENTIFICATION

1.1.1 HAZARD ASSESSMENT

1. From the health sector perspective, what is the level of availability and usefulness of hazard information?		
Level	**Benchmarks**	**Response**
Very Low	National priority hazards **not** defined and **little** relevant information useful to planners is available in non-scientific terms.	
Low	National priority hazards **not** defined and **some** relevant information useful to planners is available in non-scientific terms; Hazard information exchange/sharing network does not exist.	
Adequate	National priority hazards and **some** relevant information **somewhat** defined but **not available** from central national repository (in some cases, this could be in the health sector itself); Planners have to search a variety of sources and some information is understandable by non-technical planners; Information useful mainly at the health sector level (macro) but not detailed enough for the health facility level (micro).	
High	National priority hazards **clearly** defined and **all** relevant information **readily available** from central national repository (in some cases, this could be in the health sector itself); Information is provided on request and in a manner understandable by planners; Information useful both at the health sector (macro) and health facility level (micro).	
Very High	National priority hazards **clearly** defined and **all** relevant information **readily available** from central national repository (in some cases, this could be in the health sector itself); Updated information is provided to users' network as available in a manner understandable by planners; Information useful both at the health sector (macro) and health facility level (micro).	
Further comments or explanations:		

2. What numbers of the following health sector-related facilities are situated in areas prone to hazards and what percentage does that represent of the total for each?				
Type	High Hazard (# and %)	Moderate Hazard (# and %)	Low Hazard (# and %)	Don't know (# and %)
a. MoH				
b. Hospitals				
c. Health Centres				
d. Health Posts				
e. Ambulance Services				
f. Water treatment plants				
g. Waste treatment plants				
h. Other:				
i. Other:				
j. Other:				
k. Other:				
l. Other:				
Further comments or explanations:				

1.1.2 VULNERABILITY ASSESSMENT

3. In terms of the health sector **vulnerability assessment**, which of the following statements are valid?				
	Yes	No	Other*	Don't know
a. Conducted as part of a broader national vulnerability assessment.				
b. Conducted separately to supplement the broader national vulnerability assessment.				
c. Is based on the national priority hazards.				
d. Includes consideration of all health sector stakeholders.				
e. Includes consideration of all health sector facilities.				
f. Includes consideration of health sector human resources.				
g. Includes consideration of health sector systems.				
h. Includes consideration of vulnerability of services essential to the health sector.				
i. Includes consideration of vulnerability of communities where health sector facilities are located.				
j. Health sector facilities are catalogued, mapped and included in the national critical infrastructure (CI) list.				
Further comments or explanations:				

* **Other: NR:** Not required; **NA:** Not applicable; **ID:** In development; **PL:** Planned

4. What numbers of the following health sector-related facilities are vulnerable and what percentage does that represent of the total for each?				
Type	High Vulnerability (# and %)	Moderate Vulnerability (# and %)	Low Vulnerability (# and %)	Don't know
a. MoH				
b. Hospitals				
c. Health Centres				
d. Health Posts				
e. Ambulance Services				
f. Water treatment plants				
g. Waste treatment plants				
h. Other:				
i. Other:				
j. Other:				
k. Other:				
l. Other:				
Further comments or explanations:				

1.1.3 RISK ASSESSMENT

5. In terms of the health sector **risk assessment**, which of the following statements are accurate?				
	Yes	No	Other*	Don't know
a. Conducted as part of a broader national risk assessment.				
b. Conducted separately to supplement the broader national risk assessment.				
c. Is based on the national priority hazards.				
d. Includes consideration of all health sector facilities.				
e. Includes consideration of health sector human resources.				
f. Includes consideration of health sector systems.				
g. Includes consideration of vulnerability of services essential to the health sector.				
h. Health sector facilities are catalogued, mapped and included in the national CI list.				
Further comments or explanations:				

* **Other: NR:** Not required; **NA:** Not applicable; **ID:** In development; **PL:** Planned

6. In terms of health sector facilities, which of the following statements are accurate?				
	Yes	No	Other*	Don't know
a. A Hazard, Risk and Vulnerability Assessment (HRVA) methodology/ process for health sector facilities is available.				
b. The HRVA process for health sector facilities feeds into the community HRVA process.				
c. Health sector facilities are required to perform HRVA.				
Further comments or explanations:				

* **Other: NR:** Not required; **NA:** Not applicable; **ID:** In development; **PL:** Planned

OVERALL ASSESSMENT FOR (1) MITIGATION - *COMPONENT 1.1 – RISK IDENTIFICATION*		
Level	**Benchmarks**	**Response**
Risk Identification is Absent	*Absent* generally represents the following: Hazard information generally not available or adequate; National vulnerability or risk assessments are not done; Health sector vulnerability and risk assessments are not done; Health sector CI is not catalogued/mapped; No HRVA is undertaken in the health sector.	
Risk Identification is Poor	*Poor* generally represents the following: Hazard information generally is either not always available or not always adequate; National vulnerability and/or risk assessments are sometimes done; Health sector vulnerability and/or risk assessments are done in some cases; Health sector CI is not fully catalogued/mapped; No HRVA is undertaken in the health sector.	
Risk Identification is Adequate	*Adequate* generally represents the following: Hazard information is generally available and adequate; Both national vulnerability and risk assessments are done; Health sector vulnerability and risk assessments are done in some cases and information from them is available; Health sector CI is catalogued/mapped; An HRVA tool/methodology is available in the health sector; Some health sector facilities conduct HRVA; Either hazard, risk or vulnerability information is sometimes used for planning and decision making.	
Risk Identification is Good	*Good* generally represents the following: Hazard information is available and adequate; Both national vulnerability and risk assessments are done; Both health sector vulnerability and risk assessments are done and information from them is available; Both health sector-wide vulnerability and risk assessments are based on/consider priority hazards and the entire health system; Health sector CI is fully catalogued/mapped; The HRVA tool/methodology is applied across most of the health sector; Hazard, risk and vulnerability information is used for planning and decision making.	
Risk Identification is Excellent	*Excellent* generally represents the following: Hazard information is complete, fully available and adequate; Both national vulnerability and risk assessments are done; Both vulnerability and risk assessments are comprehensively done for the health sector and information from them is fully available; Both health sector-wide vulnerability and risk assessments are fully based on/consider priority hazards and the entire health sector system, and also consider community vulnerability; Health sector CI is completely catalogued/mapped; The HRVA tool/methodology is applied across the entire health sector; Hazard, risk and vulnerability information is always used for planning and decision making.	

Further comments or explanations:

Priorities for the next year (or programming period) for Risk Identification:
  1.
  2.
  3.

1.2 NON-STRUCTURAL MITIGATION

1.2.1 LAND USE PLANNING

7. In terms of the construction location of existing health sector facilities, which of the following statements are accurate?					
	Always	Most times	Sometimes	Rarely	Never
a. Land use planning takes place at the national level.					
b. Land use planning takes place at the local level.					
c. The health sector participates in the development of land use plans where health sector facilities are located.					
d. Land use plans are enforced in areas where health sector facilities are located.					
Further comments or explanations:					

1.2.2 BUILDING CODES

8. In terms of the construction standards of existing health sector facilities, which of the following statements are accurate?				
	Yes	No	Other*	Don't know
a. National building codes and regulations exist.				
b. National building codes and regulations make special provisions for health sector facilities.				
c. The health sector was involved in the development of the codes and regulations.				
d. National building codes and regulations are generally enforced.				
e. National building codes and regulations are applied to the building of new health sector facilities.				
Further comments or explanations:				

* **Other: NR:** Not required; **NA:** Not applicable; **ID:** In development; **PL:** Planned

9. What number and percentage of the following health sector-related facilities are built to code?					
Type	Built to most recent code (# and %)	Built to former code (# and %)	Not built to code (# and %)	Other (# and %)	Don't know (# and %)
a. MoH					
b. Hospitals					
c. Health Centres					
d. Health Posts					
e. Ambulance Services					
f. Water treatment plants					
g. Waste treatment plants					
h. Other:					
i. Other:					
j. Other:					
k. Other:					
l. Other:					
Further comments or explanations:					

OVERALL ASSESSMENT FOR (1) MITIGATION - *COMPONENT 1.2 – NON-STRUCTURAL MITIGATION*		
Level	**Benchmarks**	**Response**
Non-structural Mitigationis Absent	*Absent generally* represents the following: Land use planning does not take place at either the national or the local levels; No evidence of national building codes/regulations or provisions for health sector facilities.	
Non-structural Mitigation is Poor	*Poor* generally represents the following: Land use planning sometimes takes place at national or local levels; There is little health sector participation in land use planning; Land use regulations and/or plans are rarely enforced in areas where health sector facilities are located; There are very few building codes/regulations and/or provisions specific to health sector facilities; There is little health sector participation in development of building codes and/or regulations; There is inadequate enforcement of building code/regulations; Very few facilities are built to either the former or most recent code.	
Non-structural Mitigation is Adequate	*Adequate* generally represents the following: Land use planning sometimes takes place at national and local levels; There is some health sector participation in land use planning; Land use regulations and/or plans are sometimes enforced in areas where health sector facilities are located; There are some building codes/regulations and/or provisions specific to health sector facilities; There is some health sector participation in development of the building codes and/or regulations; Enforcement of such building code/regulations is adequate; Some facilities are built to code (former or most recent).	
Non-Structural Mitigationis Good	*Good* generally represents the following: Land use planning almost always takes place at national and local levels; There is sufficient health sector participation in land use planning; Land use regulations and/or plans are enforced in most cases in areas where health sector facilities are located; There are sufficient building codes/regulations and/or provisions specific to health sector facilities; There is sufficient health sector participation in development of the building codes and/or regulations; Building code/regulations are enforced in most cases; Many facilities are built to either the former or most recent code.	
Non-structural Mitigationis Excellent	*Excellent* generally represents the following: Land use planning always takes place at both national and local levels; There is always sufficient health sector participation in land use planning; Land use regulations and/or plans are always enforced where health sector facilities are located; Building codes/regulations and/or provisions specific to health sector facilities are complete; There is always sufficient health sector participation in development of building codes and/or regulations; Building code/regulations are always enforced; All facilities are built to the most recent code.	
Further comments or explanations		

Priorities for the next year (or programming period) for Non-structural Mitigation
    1.
    2.
    3.		

1.3 STRUCTURAL MITIGATION

1.3.1 NEW HEALTH SECTOR FACILITIES

10. What numbers of the following new health sector facilities are planned for the future and what is their status?					
Type	Contemplated	In Design Stage	In Construction	Other	Don't know
a. Hospitals					
b. Health Centres					
c. Health Posts					
d. Ambulance Services					
e. Water treatment plants					
f. Waste treatment plants					
g. Other:					
h. Other:					
i. Other:					
j. Other:					
k. Other:					
Further comments or explanations:					

11. In terms of the planning process for new health sector facilities, which of the following statements are accurate?	Yes	No	Other*	Don't know
a. The election of the facility location is based on a land use plan.				
b. The design of the facility is based on the results of the local HRVA.				
c. The design meets or exceeds the building code requirements.				
d. Knowledgeable and experienced check consultants are employed at design and construction stages. (*Referring to independent experts with knowledge of mitigation practices, who are aware of local risks/ vulnerabilities, and relevant plans and codes, and are there to ensure integration of mitigatio*n).				
Further comments or explanations:				

* **Other: R**=rarely; **S**=sometimes; **MT**=most times

1.3.2 OLD HEALTH SECTOR FACILITIES

12. In terms of the planning process to make older health sector facilities more resilient, which of the following statements are accurate?	Yes	No	Other	Don't know
a. There is a national policy to make health sector facilities more resilient.				
b. There is a national program to make health sector facilities more resilient.				
c. There is specific financing to evaluate the structural and non-structural vulnerability of health facilities.				
d. Both the national policy and program are **limited** to hospitals.				
e. If the national policy and program are not limited to hospitals, what else do they include/address?	*Policy:*			
	Program:			
Further comments or explanations:				

13. Which of the following statements related to your health sector facility resiliency improvement program are accurate?				
	Yes	No	Other	Don't know
a. Is limited to hospitals.				
b. Is applicable to all health sector facilities.				
c. Is based in part on preventive maintenance.				
d. Facilities invest a minimum of 4% of replacement costs yearly.				
e. Priority health sector facilities identified for additional safety and resiliency improvements.				
f. Funds are earmarked for priority health sector facilities' retrofitting.				
Further comments or explanations:				

14. How would you rate the implementation success of the resiliency improvement program for health sector facilities?		
Level	**Benchmarks**	**Response**
Very Low	Very few health sector facilities participate (mainly some hospitals); Few facilities budget for improvements in their maintenance budget and amounts are below 4% of replacement costs.	
Low	Few health sector facilities participate; Few facilities budget for improvement in their maintenance budget (minimum 4% of replacement cost); Includes mainly non-structural elements; No national retrofitting priority list is being developed.	
Adequate	Most health sector facilities participate; Some facilities budget for improvement in their maintenance budget (minimum 4% of replacement cost); Includes mainly non-structural elements and few structural; National retrofitting priority list is being developed.	
High	All health sector facilities participate; Most facilities budget for improvement in their maintenance budget (minimum 4% of replacement cost); Includes structural and non-structural elements; National retrofitting priority list established but additional funding not yet earmarked.	
Very High	All health sector facilities participate; All facilities budget for improvement in their maintenance budget (minimum 4% of replacement cost); Includes structural and non-structural elements; National retrofitting priority list established and additional funding earmarked.	
Further comments or explanations:		

OVERALL ASSESSMENT FOR (1) MITIGATION - *COMPONENT 1.3 – STRUCTURAL MITIGATION*		
Level	**Benchmarks**	**Response**
Structural Mitigation is Absent	*Absent* generally represents the following: Planning process does not adhere to land use plans, HRVAs, and building codes, and does not include check consultants at design/construction stages; No policy, programme, or planning processes to make older health sector facilities more resilient; No specific financing for evaluating structural/non-structural vulnerability of health sector facilities or retrofitting; No evidence or implementation of the Safe Hospital Initiative.	
Structural Mitigation is Poor	*Poor* generally represents the following: Planning process seldom adheres to land use plans, HRVAs, and building codes, and seldom includes check consultants at the design/construction stages; Some evidence of a policy, programme, or planning processes to make older health sector facilities more resilient; Health sector resiliency improvement programme does not include all priority facilities; Little financing for evaluating structural/non-structural vulnerability of health sector facilities or retrofitting; Few health sector facilities participate in any resiliency improvement programme; Few health sector facilities budget for improvement in their maintenance budget or do not budget sufficiently; No national retrofitting priority list is being developed; Evidence of Safe Hospital Initiative implementation.	
Structural Mitigation is Adequate	*Adequate* generally represents the following: Planning process sometimes adheres to land use plans, HRVAs, and building codes, and sometimes includes check consultants at the design/construction phases; Evidence of either a policy, programme, or planning processes to make older health sector facilities more resilient; Health sector resiliency improvement programme includes most priority facilities; Some financing allotted to evaluating structural/non-structural vulnerability of health sector facilities and retrofitting; Most health sector facilities participate in the resiliency improvement programme; Some health sector facilities budget sufficiently for improvement in their maintenance budget; National retrofitting priority list is being developed but additional funding not yet earmarked; Safe Hospital Initiative being implemented, some hospitals assessed.	
Structural Mitigation is Good	*Good* generally represents the following: Planning process almost always adheres to land use plans, HRVAs, and building codes, and almost always includes check consultants at the design/construction phases; Clear evidence of a policy, program, and planning processes to make older health sector facilities more resilient; Health sector resiliency improvement programme includes almost all priority facilities; Financing is allotted to evaluating structural/non-structural vulnerability of health sector facilities and retrofitting; All health sector facilities participate in the resiliency improvement programme; Most health sector facilities budget sufficiently for improvement in their maintenance budget; National retrofitting priority list established and some additional funding earmarked; Implementation of Safe Hospital Initiative nearly completed and almost all hospitals and health centres/clinics assessed.	

OVERALL ASSESSMENT FOR (1) MITIGATION - *COMPONENT 1.3 – STRUCTURAL MITIGATION*		
Level	**Benchmarks**	**Response**
Structural Mitigation is Excellent	*Excellent* generally represents the following: Planning process always adheres to land use plans, HRVAs, and building codes, and always includes check consultants at the design/construction phases; There is a policy, programme, and planning processes to make older health sector facilities more resilient; Health sector resiliency improvement programme includes all the priority facilities; There is always financing allotted to evaluating structural/non-structural vulnerability of health sector facilities and retrofitting; All health sector facilities participate in the resiliency improvement programme; All health sector facilities budget more than sufficiently for improvement in their maintenance budget; National retrofitting priority list established and additional funding earmarked; Safe Hospital Initiative implemented and all hospitals and health centres/ clinics assessed.	
Further comments or explanations:		

Priorities for the next year (or programming period) for Hard Mitigation:
    1.
    2.
    3.		

2. PREPAREDNESS

2.1 DISASTER RISK MANAGEMENT GOVERNANCE

2.1.1 LEGAL FRAMEWORK

15. With respect to your national disaster legislation, which of the following statements are accurate?	Yes	No	Other*	Don't know
a. A National Disaster Act has been promulgated.				
b. Establishes a national disaster risk management system.				
c. Establishes a Disaster Management Committee (DMC).				
d. Identifies a coordinating agency (i.e. National Disaster Organization (NDO)).				
e. Mandates the Ministry of Health (MoH) (department, Minister, Chief Medical Officer (CMO) or Permanent Secretary (PS)/Chief Executive Officer (CEO) with general disaster risk management responsibilities.				
f. Mandates the MoH (department, Minister, CMO or PS/CEO) with responsibilities specifically for the health sector aspects of national emergencies.				
g. Mandates the MoH (department, Minister, CMO or PS/CEO) with responsibilities specifically for health emergencies/disasters such as pandemics.				
h. Mandates other government departments/agencies associated with the health sector (e.g. water/sewage) with disaster risk management responsibilities.				
Further comments or explanations: (Including if any of the above exist, notwithstanding the absence of national disaster legislation, i.e. if any of the above are found in Executive Orders or Plans)				

* **Other: NR:** Not required; **NA:** Not applicable; **ID:** In development; **PL:** Planned

16. With respect to your national health legislation, which of the following statements are accurate?	Yes	No	Other*	Don't know
a. National health-related legislation has been promulgated.				
b. National health-related legislation contain provisions for disaster risk management (if so, please list the legislations below).				
i.				
ii.				
iii.				
iv.				
v.				
c. Disaster risk management provisions are congruent with provisions in the National Disaster Act (if so, in which? Please list the legislations below).				
i.				
ii.				
iii.				
iv.				
v.				
d. Mandates and empowers the Minister, CMO or PS/CEO to lead the health sector in matters of disaster risk management (if so, in which? Please list the legislations below).				
i.				
ii.				
iii.				
iv.				
v.				
Further comments or explanations:				

* **Other: NR:** Not required; **NA:** Not applicable; **ID:** In development; **PL:** Planned

2.1.2 POLICY FRAMEWORK

17. In terms of national disaster risk management policy, which of the following statements are accurate?				
	Yes	No	Other*	Don't know
a. A national disaster risk management policy (or equivalent) has been promulgated.				
b. The health sector is represented in the DMC.				
c. Disaster risk management provisions are congruent with provisions in the National Disaster Act.				
d. Mandates and empowers the Minister, CMO or PS/CEO to lead the health sector in matters of disaster risk management.				
e. Other relevant policies pertaining to disaster risk management have been promulgated (if so, please list them below).				
i.				
ii.				
iii.				
iv.				
v.				
Further comments or explanations:				

* **Other: NR:** Not required; **NA:** Not applicable; **ID:** In development; **PL:** Planned

18. In terms of Ministerial (MoH) powers, what is your level of agreement with the following statements?						
	Strongly agree	Agree	Disagree	Strongly Disagree	Other	Don't know
a. The **National Disaster Act** provides the Minister, CMO or PS/CEO with sufficient powers to lead the health sector in matters of disaster risk management.						
b. The Health Act (or other relevant health legislation) provides the Minister, CMO or PS/CEO with sufficient powers to lead the health sector in matters of disaster risk management.						
c. The national disaster risk management policy (or equivalent) provides the Minister, CMO or PS/CEO with sufficient powers to lead the health sector in matters of disaster risk management.						
d. The health sector disaster risk management policy (or equivalent) provides the Minister, CMO or PS/CEO with sufficient powers to lead the health sector in matters of disaster risk management.						
Further comments or explanations:						

19. In terms of the health sector-related disaster risk management policies, what is the status of the following?						
	Completed and approved	Completed but not approved	Being developed	To be developed	Other*	Don't know
a. A general health sector disaster risk management policy (or equivalent).						
b. Policy requiring health institutions to have and practice an emergency/ disaster plan.						
c. Policy requiring health institutions to have a Business Continuity Plan (BCP).						
d. Policy on the Safe Hospital Initiative.						
e. Policy on post-disaster employment of foreign medical personnel.						
f. Policy on post-event treatment of casualties (pre-hospital and hospital).						
g. Policy on identification and handling of bodies.						
h. Policy on post-event epidemiological surveillance and disease control.						
i. Policy on basic sanitation and sanitary engineering.						
j. Policy on health management in shelters or temporary settlements.						
k. Policy on training health personnel and the public on health sector disaster risk management.						
l. Policy on medical supply donations.						
m. Other:						
n. Other:						
o. Other:						
Further comments or explanations:						

*Other: **IPLA:** Included in a plan; **IPOL** included in policy

2.1.3 STRUCTURAL/SYSTEMIC FRAMEWORK

20. Which of the following statements relating to the national disaster risk management structure are accurate?				
	Yes	No	Other*	Don't know
a. A DMC has been established.				
b. Involves representation from **all** sectors and key stakeholders.				
c. Responsibilities of members are **clearly** defined.				
d. A Health Sector DMC has been established with clear responsibilities for the health sector dimensions of disaster risk management.				
Further comments or explanations:				

* **Other: NR:** Not required; **NA:** Not applicable; **ID:** In development; **PL:** Planned

21. What is your level of agreement with the following statements?						
	Strongly agree	Agree	Disagree	Strongly Disagree	Other	Don't know
a. The responsibilities of the health sector within the national DMC are clearly defined.						
b. The national DMC meets on a regular basis at least once quarterly and on an *ad-hoc* basis as circumstances dictate.						
Further comments or explanations:						

22. How would you categorize the level of functionality of the DMC?		
Level	**Benchmarks**	**Response**
Very Low	Not established or established, but **does not involve** all key actors; Responsibilities **not clearly** defined**; Rarely** meets.	
Low	Involves **some** key national players; Responsibilities **somewhat** defined; **Rarely** meets; Has a health sector subcommittee.	
Adequate	Involves **most** key national players; Responsibilities **reasonably well** defined; Meets **occasionally on an ad hoc basis** and has a health sector subcommittee.	
High	Involves **all** key national players; Responsibilities are **clearly** defined; Meets **occasionally but consistently**; Has sector subcommittees including a health sector subcommittee.	
Very High	Involves **all** key national players; Responsibilities are **clearly** defined; Meets **regularly and consistently**; Has sector subcommittees including a health sector subcommittee.	
Further comments or explanations:		

23. Which of the following statements relating to the health sector disaster risk management structure are accurate?		Yes	No	Other	Don't know
a.	A health sector DMC has been established as a subcommittee to the national DMC and contains representation of all relevant health sector related stakeholders.				
b.	The health sector DMC performs advisory functions.				
c.	The health sector DMC performs emergency response functions.				
d.	A national health disaster coordinator (HDC) has been appointed.				
e. Within the MoH, the HDC reports to:	CMO				
	PS/CEO				
	Level of Area/Department				
	Level of Unit				
	Other				
f. The HDC has sufficient resources to lead the health sector disaster management program.	Strongly agree				
	Agree				
	Disagree				
	Strongly Disagree				
	Other				
	Don't know				
Further comments or explanations:					

Level	Benchmarks	Response
24. How would you categorize the level of functionality of the Health Sector DMC?		
Very Low	Not established or established but **does not involve** all key actors; responsibilities **not clearly** defined; **Rarely** meets.	
Low	Involves **some** key health sector players; Responsibilities **somewhat** defined; **Rarely** meets; **Rarely** formulates health related advice to the national DMC.	
Adequate	Involves **most** key health sector players; Responsibilities **reasonably well** defined; meets **occasionally on an ad hoc basis;** Formulates health related advice to the national DMC **occasionally;** Reviews **some** of the health sector disaster related plans.	
High	Involves **all** key health sector players; Responsibilities are **clearly** defined; Meets **occasionally but consistently**; **Regularly** formulates health related advice to the national DMC**;** Reviews **most** of the health sector disaster related plans.	
Very High	Involves **all** key health sector players; Responsibilities are **clearly** defined; Meets **regularly and consistently**; **Regularly** formulates health related advice to the national DMC**;** Reviews **all** of the health sector plans.	
Further comments or explanations:		

25. Does the Health Sector DMC structure contain the following elements?				
	Yes	No	Other	Don't know
a. Medical attention including hospitals and ambulatory care.				
b. Environmental health				
c. Epidemiologic surveillance				
d. Nutrition				
e. Temporary settlements/camps/shelters				
f. Supplies				
g. Transportation				
h. Coordination of volunteers				
i. Requests and donations				
j. Public information				
Further comments or explanations:				

	OVERALL ASSESSMENT FOR (2) PREPAREDNESS – *COMPONENT 2.1 – DISASTER RISK MANAGEMENT GOVERNANCE*	
Level	**Benchmarks**	**Response**
DRM Governance is Absent	*Absent* generally represents the following: No disaster legislation exists that has health sector-related provisions; No health legislation exists that is congruent with disaster legislation and contains disaster risk management provisions; No national disaster management policy that is congruent with disaster legislation and has health sector-related provisions exists; Neither the health legislation nor the national disaster management policy provide the Minister of Health/CMO/PS/CEO with sufficient authority/power to lead the health sector in disaster risk management; There is no health policy with disaster risk management-related provisions; Health sector disaster risk management-related policies do not include a comprehensive list of all disaster risk management areas; There is no HDC; The national DMC, if established, does not involve all key actors from all sectors, responsibilities are not clearly defined and the committee rarely meets; The health sector DMC is not established or if established does not involve all key actors, responsibilities are not clearly defined, functions are not comprehensive and it rarely meets.	
DRM Governance is Poor	*Poor* generally represents the following: Disaster legislation has some health sector-related provisions; Health legislation is congruent to some extent with disaster legislation and contains some disaster risk management provisions; National disaster management policy is congruent to some extent with disaster legislation and has some health sector-related provisions; The health legislation or the national disaster management policy provide some definition of the authority/power of the Minister of Health/CMO/PS/CEO to lead the health sector in disaster risk management; Health policy has some health sector disaster risk management-related provisions; Health sector disaster risk management -related policies include some disaster risk management areas; An HDC is planned for but not fully operational and very little funding has been provided; The national DMC involves some key national players, responsibilities are somewhat defined, has a health sector subcommittee (or equivalent), but rarely meets; The health sector DMC involves some key players, responsibilities are somewhat defined, functions are not comprehensive, it rarely meets and does not formulate health-related advice to the national DMC.	
DRM Governance is Adequate	*Adequate* generally represents the following: Disaster legislation has health sector-related provisions, mandates the MoH with disaster risk management responsibilities and establishes a disaster risk management system and committee; Health legislation is congruent with disaster legislation and contains disaster risk management provisions; National disaster management policy is mostly congruent with disaster legislation and has health sector-related provisions; Both health legislation and national disaster management policy provide some authority/power for Minister of Health/CMO/PS/CEO to lead the health sector in disaster risk management; Approved health policy with some health sector disaster risk management-related provisions; Approved health sector disaster risk management -related policies include some key disaster risk management areas; HDC established with some funding; The national DMC involves most key national players, responsibilities reasonably well defined, meets regularly and has a health sector subcommittee; The health sector DMC involves most key players, responsibilities reasonably well defined, meets regularly and formulates some health-related advice to the national DMC occasionally.	

OVERALL ASSESSMENT FOR (2) PREPAREDNESS – *COMPONENT 2.1 – DISASTER RISK MANAGEMENT GOVERNANCE*		
Level	**Benchmarks**	**Response**
DRM Governance is Good	*Good* generally represents the following: Disaster legislation has most health sector-related provisions, mandates the MoH with disaster risk management responsibilities, and establishes a disaster risk management system and committee; Health legislation is congruent with disaster legislation and contains disaster risk management provisions; National disaster risk management policy is largely congruent with disaster legislation and has health sector-related provisions; Both health legislation and the national disaster management policy clearly provide for authority/ power of the Minister of Health/CMO/PS/CEO to lead the health sector in disaster risk management; Approved health policy includes most health sector disaster risk management -related provisions; Approved health sector disaster risk management-related policies cover almost all disaster risk management areas; There is a functional HDC with sufficient funding; The national DMC involves all key national players; responsibilities are clearly defined, meets very regularly, and regularly formulates health related advice to the DMC; Health Sector DMC involves all key players, responsibilities are clearly defined, meets occasionally but consistently, and regularly formulates health-related advice to the national DMC.	
DRM Governance is Excellent	*Excellent* generally represents the following: Disaster legislation has all health sector-related provisions, mandates the MoH with all disaster risk management responsibilities, establishes a complete disaster risk management system and committee; Health legislation is completely congruent with disaster legislation and contains all disaster risk management provisions; National disaster risk management policy is completely congruent with disaster legislation and has all health sector-related provisions; Both health legislation and the national disaster management policy provide completely for authority/ power of the Minister of Health/CMO/PS/CEO to lead the health sector in disaster risk management; Approved health policy includes all health sector disaster risk management -related provisions; Approved health sector disaster risk management-related policies cover all disaster risk management areas; There is a functional HDC with more than sufficient funding and integration into national disaster risk management system; The national DMC involves all key national players; responsibilities are clearly defined, meets very regularly, formulates health related advice to the DMC very often; Health Sector DMC involves all key players, responsibilities are clearly defined, meets very regularly, and formulates health-related advice to the national DMC very often.	

Further comments or explanations

Priorities for the next year (or programming period) for Disaster Risk Management Governance:
1.
2.
3.

2.2 HEALTH SECTOR DISASTER RISK MANAGEMENT PLANNING

2.2.1 PLANNING FRAMEWORK

26. In terms of the health sector-related disaster risk management plans, what is the status of the following?						
	Completed and coordinated with NDO	Completed	Being developed	To be developed	Other	Don't know
a. National health disaster plan.						
b. National Influenza Pandemic Preparedness Plan.						
c. Health annexes to other hazard specific national plans (contingency plans).						
d. Model health institution emergency/disaster plan or planning process.						
e. Model health institution BCP or planning process.						
f. Other:						
g. Other:						
h. Other:						
Further comments or explanations:						

27. In terms of planning process, which of the following are accurate for the national health disaster plan?				
Elements	Yes	No	Other	Don't know
a. Has been developed with the participation of all health sector stakeholders.				
b. Has been developed in coordination with the NDO.				
c. Has been endorsed by the NDO.				
d. Has been subjected to a tabletop exercise involving all key health sector stakeholders.				
e. Has been exercised in a simulation.				
f. Has been modified on the basis of lessons observed.				
g. Has been approved by the Health Sector DMC.				
h. Has been endorsed by the DMC.				
i. Has been activated.				
Further comments or explanations:				

28. In terms of planning process, which of the following are accurate for the National Influenza Pandemic Preparedness Plan?				
Elements	Yes	No	Other	Don't know
a. Has been developed with the participation of all health sector stakeholders.				
b. Has been developed in coordination with the NDO.				
c. Has been endorsed by the NDO.				
d. Has been developed in coordination with PAHO/WHO.				
e. Has been subjected to a tabletop exercise involving all key health sector stakeholders.				
f. Has been exercised in a simulation and evaluated.				
g. Has been modified on the basis of lessons observed.				
h. Has been approved by the Health Sector DMC.				
i. Has been endorsed by the DMC.				
j. Has been activated.				
Further comments or explanations:				

2.2.2 HEALTH SECTOR NATIONAL LEVEL PLANS

29. In terms of plan content, which of the following statements are accurate in respect to the national health disaster plan?	Yes	No	Other	Don't know
a. Is based on a national hazard assessment.				
b. Is based on a health sector risk assessment.				
c. Involves all health sector stakeholders including private sector and NGOs.				
d. Addresses coordination of international humanitarian assistance in the health sector.				
e. Addresses treatment of casualties (pre-hospital & hospital).				
f. Addresses identification and handling of bodies.				
g. Addresses epidemiological surveillance and disease control.				
h. Addresses basic sanitation and sanitary engineering.				
i. Addresses health management in shelters or temporary settlements.				
j. Designates a Health Sector DMC.				
k. Details Terms of Reference (ToRs) for the Health Sector DMC				
l. Considers vulnerable groups.				
m. Is gender-sensitive.				
n. Contains a public awareness and information component.				
Further comments or explanations:				

30a. In terms of exercises related to the national health disaster plan, indicate the number of occurrences of the following activities?					
Activities	In the Past Year	In the past 2 years	In the past 3 years	Other	Don't know
a. National Disaster/Emergency Committee tabletop exercises.					
b. High level command and control tabletop exercises involving the National Emergency Operations Centre (NEOC) and the National Disaster/ Emergency Committee.					
c. General tabletop exercises involving all health sector stakeholders.					
d. National level simulations involving all health stakeholders including health responders.					
Further comments or explanations:					

30b. In terms of exercises related to the national health disaster plan, indicate the level of local level participation?		
Level	Benchmarks	Response
Very Low	Very few exercises have local level participation and communities do not conduct yearly exercises.	
Low	Few exercises have local level participation and most communities do not conduct yearly exercises.	
Adequate	Some exercises have local level participation and some communities conduct yearly exercises.	
High	Most exercises have local level participation and most communities conduct yearly exercises.	
Very High	All exercises have local level participation and most communities conduct yearly exercises.	
Further comments or explanations:		

31. In terms of plan content, which of the following statements are accurate in respect to the National Pandemic Preparedness Plan?				
	Yes	No	Other	Don't know
a. Is based on relevant WHO Guidance Document.				
b. Involves all health sector stakeholders including private sector and NGOs.				
c. Addresses case investigation and treatment.				
d. Addresses maintenance of essential services.				
e. Addresses command and control mechanisms.				
f. Addresses epidemiological surveillance.				
g. Addresses risk assessment.				
h. Addresses legal and ethical issues.				
i. Addresses disease control and prevention in the community.				
j. Addresses research and evaluation.				
k. Addresses coordination of international humanitarian assistance in the health sector.				
a. Designates a National Influenza Pandemic Preparedness Committee.				
b. Details ToRs for the NIPPP Committee.				
l. Contains a public awareness and information component.				
Further comments or explanations:				

32a. In terms of exercises related to the National Pandemic Preparedness Plan indicate the number of occurrences of the following activities?					
Activities	In the Past Year	In the past 2 years	In the past 3 years	Other	Don't know
a. National Disaster/Emergency Committee tabletop exercises.					
b. High level command and control tabletop exercises involving the NEOC and the National Disaster/ Emergency Committee.					
c. General tabletop exercises involving all health sector stakeholders.					
d. National level simulations involving all key stakeholders including health responders.					
Further comments or explanations:					

32b. In terms of exercises related to the National Pandemic Preparedness Plan indicate the number of occurrences of the following activities?		
Level	Benchmarks	Response
Very Low	Very few exercises have local level participation and communities do not conduct yearly exercises.	
Low	Few exercises have local level participation and most communities do not conduct yearly exercises.	
Adequate	Some exercises have local level participation and some communities conduct yearly exercises.	
High	Most exercises have local level participation and most communities conduct yearly exercises.	
Very High	All exercises have local level participation and most communities conduct yearly exercises.	
Further comments or explanations:		

2.2.3 HEALTH SECTOR INSTITUTION/FACILITY LEVEL PLANS

33. With a focus on health sector institutions/facilities' **Disaster or Emergency Management Plans**, please provide the following?			
Type	Number of institutions	# and % with a plan	# and % that exercised plan in the past year
a. MoH (separate health sector-related administrative buildings)			
b. Hospitals			
c. Health Centres			
d. Health Posts			
e. Ambulance Service			
f. Other:			
g. Other:			
Further comments or explanations:			

34. With a focus on health sector institutions/facilities **BCPs,** please provide the following?			
Type	Number of institutions	# and % with BCP plan	# and % that exercised plan in the past year
a. MoH (separate health sector-related administrative buildings)			
b. Hospitals			
c. Health Centres			
d. Health Posts			
e. Ambulance Service			
f. Other:			
g. Other:			
Further comments or explanations:			

OVERALL ASSESSMENT FOR (2) PREPAREDNESS – *COMPONENT 2.2 – HEALTH SECTOR DISASTER RISK MANAGEMENT PLANNING*		
Level	**Benchmarks**	**Response**
Health Sector DRM Planning is Absent	*Absent* generally represents the following: National Health Disaster Plan is not developed; National Pandemic Preparedness Plan is not developed; There are no health annexes (or support plans) to other hazard specific national disaster plans; There is no model health institution emergency/disaster plan and no health sector facility has a specific emergency/disaster plan; There is no model health sector institution/facility BCP and no health sector facility has a BCP.	
Health Sector DRM Planning is Poor	*Poor* generally represents the following: National Health Disaster Plan and/or National Pandemic Preparedness Plan are developed but incomplete and there has been very little health sector participation in their development; Neither plan is based on hazard/risk assessments, and both address only a minority of the following (and only to some extent): foreign medical personnel, treatment of casualties, identification/handling of bodies, disease control, basic sanitation, and shelters/temporary settlements; Neither plan contains a public awareness component; Neither plan has been coordinated with or endorsed by the NDO and national DMC; Both plans have been subject to few exercises/ tests/simulations with little local level participation, and have not been modified based on lessons learned; Health annex(es) (or support plan(s)) to other hazard specific national disaster plans are to be developed as relevant; A model health institution/facility emergency/disaster plan is to be developed, and very few health sector facilities have a specific emergency/disaster plan. A model health sector institution/facility BCP is to be developed and very few health sector facilities have a BCP.	
Health Sector DRM Planning is Adequate	*Adequate* generally represents the following: National Health Disaster Plan and/or National Pandemic Preparedness Plan are developed and there has been some health sector participation in their development; Both plans are based on hazard/ risk assessments to some extent, and both address most of the following: foreign medical personnel, treatment of casualties, identification/handling of bodies, disease control, basic sanitation, and shelters/temporary settlements; Both plans contain some form of a public awareness component; Both plans have been coordinated with and endorsed by NDO and/or national DMC; Both plans have been subject to exercises/tests/simulations with some local level participation, and incorporate some degree of lessons learned; Health annex(es) (or support plan(s)) to other hazard specific national disaster plans have been developed as relevant; A model health institution/facility emergency/disaster plan has been developed, and some health sector facilities have a specific emergency/disaster plan; A model health sector institution/facility BCP has been developed and some health sector facilities have a BCP.	
Health Sector DRM Planning is Good	*Good* generally represents the following: National Health Disaster Plan and National Pandemic Preparedness Plan are developed and there has been sufficient health sector participation in their development; Both plans are based on hazard/risk assessments, and both address all of the following, to some extent: foreign medical personnel, treatment of casualties, identification/handling of bodies, disease control, basic sanitation, and shelters/temporary settlements; Both plans contain a public awareness component; Both plans have been coordinated with and endorsed by the NDO and national DMC; Both plans have been subject to sufficient exercises/ tests/simulations with local level participation, and have been modified based on lessons learned; Health annex(es) (or support plan(s)) to other hazard specific national disaster plans have been developed; A model health institution/facility emergency/disaster plan has been developed, and most health sector facilities have a specific emergency/disaster plan based on the model; A model health sector institution/facility BCP has been developed and most health sector facilities have a BCP based on the model.	

OVERALL ASSESSMENT FOR (2) PREPAREDNESS – *COMPONENT 2.2 –* *HEALTH SECTOR DISASTER RISK MANAGEMENT PLANNING*		
Level	**Benchmarks**	**Response**
Health Sector DRM Planning is Excellent	*Excellent* generally represents the following: National Health Disaster Plan (or support plan) and National Pandemic Preparedness Plan are developed and there has been more than sufficient health sector participation in their development; Both plans are completely based on hazard/risk assessments, and both address all of the following completely: foreign medical personnel, treatment of casualties, identification/handling of bodies, disease control, basic sanitation, and shelters/temporary settlements; Both plans contain a comprehensive public awareness component; Both plans have been fully coordinated with and endorsed by the NDO and national DMC; Both plans have been subject to extensive exercises/tests/simulations with full local level participation, and all have been modified based on lessons learned; Health annex(es) (or support plan(s)) to other hazard specific national disaster plans have been developed; A model health institution/facility emergency/ disaster plan has been developed, and all health sector facilities have a specific emergency/disaster plan based on the model; A model health sector institution/facility BCP has been developed and all health sector facilities have a BCP based on the model.	
Further comments or explanations:		

Priorities for the next year (or programming period) for Health Sector DRM Planning:
    1.
    2.
    3.		

2.3 HEALTH SECTOR DISASTER RISK MANAGEMENT RESOURCES

2.3.1 MATERIAL RESOURCES

35. In terms of health sector facilities potentially available to cope with patient surge following a disaster:				
Categories	#	%	Other	Don't know
a. How many have patient surge capacity (in terms of staff, space and equipment)? What percentage does that represent?				
i. Hospitals				
ii. Health Centres				
ii. Health Posts				
iii. Other:				
iv. Other:				
v. Other:				
vi. Other:				
b. How many have adequate emergency power supply? What percentage does that represent?				
i. Hospitals				
ii. Health Centres				
iii. Health Posts				
iv. Other:				
v. Other:				
vi. Other:				
vii. Other:				
c. How many have established pandemic protocols including isolation capabilities? What percentage does that represent?				
i. Hospitals				
ii. Health Centres				
iii. Health Posts				
iv. Other:				
v. Other:				
vi. Other:				
vii. Other:				

35. In terms of health sector facilities potentially available to cope with patient surge following a disaster:				
Categories	#	%	Other	Don't know
d. How many have an emergency water supply? What percentage does that represent?				
i. Hospitals				
ii. Health Centres				
iii. Health Posts				
iv. Other:				
v. Other:				
vi. Other:				
vii. Other:				
e. How many have **adequate** emergency water supply (based on the PAHO/WHO standard of 3 days of water @ 300L/bed/day)?				
i. Hospitals				
ii. Health Centres				
iii. Health Posts				
iv. Other:				
v. Other:				
vi. Other:				
vii. Other:				
Further comments or explanations:				

36. In terms of logistical resources and support needed for disasters, which of the following statements are accurate?				
Specifics	**Yes**	**No**	**Other**	**Don't know**
a. Ambulance services have a surge capacity for disasters.				
b. Disaster relief supplies are stockpiled and centrally controlled.				
c. A system for maintaining medical supplies is in place.				
d. A system for redistributing medical supplies is in place.				
e. Mechanisms, other than routine normal administrative procedures, allowing for the rapid mobilization of resources after an event occurs.				
f. A health communication system has been established that links all health sector stakeholders and is based on redundancy of means such as telephones, fax, internet and radio, with its nexus located in the MoH.				
Further comments or explanations:				

2.3.2 HUMAN RESOURCES

37. In terms of health sector personnel available specifically for the disaster risk management program, which of the following statements are accurate?				
Specifics	**Yes**	**No**	**Other**	**Don't know**
a. The MoH has a HDC.				
b. The HDC is supported by a disaster risk management office/unit.				
c. There is a budget to implement the health sector disaster risk management program.				
d. The HDC also has other responsibilities.				
Further comments or explanations: *(including any other functions of the HDC)*				

38. Please comment on the number of professional, technical and administrative personnel working in your health sector disaster risk management office/unit:			
Specifics	Available	Minimum Needed	Ideal
a. Full time health professionals.			
b. Full time technical personnel.			
c. Full time administrative personnel.			
d. Part time health professionals.			
e. Part time technical personnel.			
f. Part time administrative personnel.			
g. Other:			
h. Other:			
Further comments or explanations:			

39. Considering the key stakeholders health sector, how would you categorize the overall level of quality (availability and training) of human resources earmarked for health sector disaster risk management?		
Level	**Benchmarks**	**Response**
Very Low	**Few if any** health sector stakeholders have disaster risk management dedicated personnel; **Very few** are trained in disaster risk management and are **not** integrated in the health sector disaster risk management structure/system.	
Low	**Some** health sector stakeholders have disaster risk management dedicated personnel; **Few** are trained in disaster risk management and are **loosely** integrated in the health sector disaster risk management structure/system.	
Adequate	**Most** health sector stakeholders have disaster risk management dedicated personnel; **Some** are trained in disaster risk management and **most** are somewhat integrated in the health sector disaster risk management structure/system.	
High	**All** health sector stakeholders have disaster risk management dedicated personnel; **Most** are trained in disaster risk management and **all** are integrated in the health sector disaster risk management structure/system.	
Very High	**All** health sector stakeholders have disaster risk management dedicated personnel; They are **all** trained in disaster risk management and all are **highly** integrated in the health sector disaster risk management structure/system.	
Further comments or explanations:		

40. In terms of health sector disaster risk management related training, which of the following courses/training are available and how many learners attended them in the past year?			
Courses/training	Yes	No	Learners attending in the last year
a. Mass casualty management			
b. Disaster hospital planning			
c. Epidemiological surveillance			
d. Water and sanitation			
e. Supply management (LSS/SUMA)			
f. Mental health			
g. Management of dead bodies			
h. International assistance coordination			
i. Chemical accidents			
j. Shelter management			
k. Other:			
l. Other:			
Further comments or explanations:			

41. In terms of health sector personnel training, which of the following statements are accurate?				
Specifics	Yes	No	Other	Don't know
a. Disaster risk management is included in the *training* curricula for health sector practitioners.				
b. Disaster risk management is included in the *education* curricula for health sector professionals.				
Further comments or explanations:				

	OVERALL ASSESSMENT FOR (2) PREPAREDNESS – *COMPONENT 2.3 – HEALTH SECTOR DISASTER RISK MANAGEMENT RESOURCES*	
Level	**Benchmarks**	**Response**
Health Sector DRM Resources are Absent	*Absent* generally represents the following: No facilities have emergency power/water supplies, patient surge capacity or established pandemic protocols; Ambulance services do not have surge capacity; No central control of medical supplies stockpiles; Redistribution of supplies and rapid resource mobilization (post-event) mechanism/system not established; No resilient communication system with full health sector stakeholder access; No funded health sector disaster risk management programme, HDC or health sector disaster risk management unit; MoH personnel do not have capacity or responsibility to manage health sector disaster risk management; No health sector stakeholders have disaster risk management dedicated personnel, are trained in disaster risk management, or are integrated in the health sector disaster risk management structure/system; No health sector disaster risk management related courses were conducted in the past year, disaster risk management not included in health sector training or education curricula.	
Health Sector DRM Resources are Poor	*Poor* generally represents the following: Very few facilities have emergency power/water supplies, patient surge capacity or established pandemic protocols; Ambulance services have very limited surge capacity; Some central control of medical supplies stockpiles; Redistribution of supplies and rapid resource mobilization (post-event) mechanism/system are partially established; A communication system with some health sector stakeholder access exists; Health sector disaster risk management program is inadequately funded; HDC not fully operational; Health sector disaster risk management office/unit does not exist; Few MoH personnel have capacity or responsibility to manage health sector disaster risk management; Some health sector stakeholders have disaster risk management dedicated personnel, few are trained in disaster risk management and are inadequately integrated in the health sector disaster risk management structure/system**;** Few health sector disaster risk management related courses were conducted in the past year and few persons attended, disaster risk management is included in training and education curricula to some extent.	
Health Sector DRM Resources are Adequate	*Adequate* generally represents the following: Many facilities have emergency power/water supplies, patient surge capacity or established pandemic protocols; Ambulance services have surge capacity; Central control of medical supplies stockpiles; Redistribution of supplies and rapid resource mobilization (post-event) mechanism/system are established; A generally resilient communication system with health sector stakeholder access exists; Health sector disaster risk management program adequately funded, HDC operational; Health sector disaster risk management office/unit exists but resources inadequate; Sufficient MoH personnel have capacity and responsibility to manage health sector disaster risk management; Sufficient health sector stakeholders have disaster risk management dedicated personnel, many are trained in disaster risk management and are integrated in the health sector disaster risk management structure/system**;** Some health sector disaster risk management related courses were conducted in the past year and were sufficiently attended, disaster risk management is included in training and education curricula.	

OVERALL ASSESSMENT FOR (2) PREPAREDNESS – *COMPONENT 2.3 – HEALTH SECTOR DISASTER RISK MANAGEMENT RESOURCES*		
Level	**Benchmarks**	**Response**
Health Sector DRM Resources are Good	*Good* generally represents the following: Almost all facilities have emergency power/water supplies, patient surge capacity and established pandemic protocols; Ambulance services have sufficient surge capacity; Central control of medical supplies stockpiles; Redistribution of supplies and rapid resource mobilization (post-event) mechanism/system are established and adequate; An almost fully resilient communication system with nearly complete health sector stakeholder access exists; Health sector disaster risk management program adequately funded, HDC operational and sufficiently funded; Health sector disaster risk management office/unit exists with adequate resources; Almost all required MoH personnel have capacity and responsibility to manage health sector disaster risk management; Almost all required health sector stakeholders have disaster risk management dedicated personnel, almost all trained in disaster risk management and are integrated in the health sector disaster risk management structure/ system; Many health sector disaster risk management related courses were conducted in the past year and were sufficiently attended, disaster risk management is almost fully included in training and education curricula.	
Health Sector DRM Resources are Excellent	*Excellent* generally represents the following: All facilities have emergency power/water supplies, patient surge capacity and established pandemic protocols; Ambulance services have completely sufficient surge capacity; Central control of medical supplies stockpiles; Redistribution of supplies and rapid resource mobilization (post-event) mechanism/system are established, adequate and tested; A fully resilient communication system with complete health sector stakeholder access exists; health sector disaster risk management program, operational HDC and health sector disaster risk management office/unit completely funded and with adequate resources; All required MoH personnel have capacity and responsibility to manage health sector disaster risk management; All required health sector stakeholders have disaster risk management dedicated personnel, are all trained in disaster risk management and are completely integrated in the health sector disaster risk management structure/ system; Many health sector disaster risk management related courses were conducted in the past year and were more than sufficiently attended, disaster risk management is fully included in training and education curricula.	

Further comments or explanations

Priorities for the next year (or programming period) for Health Sector Disaster Risk Management Resources:
  1.
  2.
  3.

2.4 HEALTH SECTOR DISASTER RISK MANAGEMENT PUBLIC AWARENESS

2.4.1 PRE-EVENT DISASTER RISK MANAGEMENT RELATED HEALTH PUBLIC AWARENESS

42. Which of the following statements related to pre-event health public information are accurate?	Yes	No	Other	Don't know
a. A program for the development of health disaster risk management material and its dissemination to the general public has been established.				
b. Health disaster risk management information is disseminated through the internet.				
c. Health disaster risk management information is disseminated through radio and television.				
d. Health disaster risk management information is disseminated through the print media (e.g. pamphlets, posters).				
e. Health disaster risk management information is disseminated through other means (please specify). _____				
f. Pandemic public advisories are issued as required by WHO guidelines.				
g. Public information is accessible and available in the relevant language(s) for the different ethnic/cultural groups in the country.				
h. Public information materials developed are gender sensitive in content and in distribution mechanism.				
i. Public information materials developed address vulnerable groups.				
j. The level of public awareness of disaster risk management health issues, including pandemics, is measured regularly through polling.				
k. The quantity and frequency of disaster health information disseminated to the general public is governed by the public awareness polling results.				
Further comments or explanations:				

43. Relating to disaster health public information materials and activities, what was the frequency/quantity of the following in the past year?	
Specifics	**Response**
a. TV messages aired.	
b. New TV messages developed.	
c. Radio messages aired.	
d. New radio messages developed.	
e. Type of pamphlets distributed.	
f. New pamphlets developed.	
g. Health sector public website updated.	
Further comments or explanations:	

2.4.2 POST-EVENT DISASTER RISK MANAGEMENT RELATED HEALTH PUBLIC INFORMATION

44. Which of the following statements related to post-event health public information are accurate?				
	Yes	No	Other	Don't know
a. Protocols exist for all health related public information announcements to be controlled by the health DMC and coordinated through the NEOC.				
b. Public information materials for dissemination in shelters have been prepared in advance of potential events.				
c. Public information is accessible and available in the relevant language(s) for the different ethnic/cultural groups in the country.				
d. Public information materials developed are gender sensitive in content and in distribution mechanism.				
e. Public information materials developed address vulnerable groups.				
Further comments or explanations:				

OVERALL ASSESSMENT FOR (2) PREPAREDNESS – *COMPONENT 2.4 - HEALTH SECTOR DRM PUBLIC AWARENESS*		
Level	**Benchmarks**	**Response**
Health Sector DRM Public Awareness is Absent	*Absent* generally represents the following: No program for the development of health disaster risk management material and no dissemination to the general public; No evidence that the level of health disaster risk management awareness of general public is being measured by the MoH; No pandemic public advisories are issued and there is no evidence of compliance with current WHO pandemic guidelines; No protocols for control and coordination of health-related public information; No available health information for dissemination in shelters.	
Health Sector DRM Public Awareness is Poor	*Poor* generally represents the following: Very little development of health disaster risk management material and incomplete dissemination to the general public; Very few mass media means were utilized; Very few materials have been produced and disseminated; Information is somewhat accessible/available in the relevant language(s) for the different ethnic/cultural groups; Materials are somewhat gender sensitive and are only partially developed to address vulnerable groups; Very little evidence that MoH measuring the level of health disaster risk management awareness of general public; Very few pandemic public advisories are issued and very little evidence of compliance with current WHO pandemic guidelines; Very few protocols for control and coordination of health-related public information; Very little available health information for dissemination in shelters.	
Health Sector DRM Public Awareness is Adequate	*Adequate* generally represents the following: Some development of health disaster risk management material and dissemination to the general public; Some mass media means were utilized; Some materials have been produced and disseminated; Information is generally accessible/available in the relevant language(s) for the different ethnic/cultural groups; Materials are generally gender sensitive and are generally developed to address vulnerable groups; Some evidence that MoH measuring the level of health disaster risk management awareness of general public; Pandemic public advisories are issued and there is some evidence of compliance with current WHO pandemic guidelines; Some protocols for control and coordination of health-related public information; Some available health information for dissemination in shelters.	

OVERALL ASSESSMENT FOR (2) PREPAREDNESS – *COMPONENT 2.4 - HEALTH SECTOR DRM PUBLIC AWARENESS*		
Level	**Benchmarks**	**Response**
Health Sector DRM Public Awareness is Good	*Good* generally represents the following: Sufficient development of health disaster risk management material and dissemination to the general public; Most mass media means were utilized; Many materials have been produced and disseminated; Information is almost fully accessible/available in the relevant language(s) for the different ethnic/cultural groups; Materials are most often gender sensitive and are most often developed to address vulnerable groups; There is clear evidence that the MoH measures the level of health disaster risk management awareness of general public; All required pandemic public advisories are in full compliance with current WHO pandemic guidelines; Almost all needed protocols for control and coordination of health-related public information are completed; Almost all needed health information for dissemination in shelters completed.	
Health Sector DRM Public Awareness is Excellent	*Excellent* generally represents the following: Complete development of health disaster risk management material and dissemination to the general public; All mass media means fully utilized; All needed materials have been produced and disseminated; Information is fully accessible/available in the relevant language(s) for the different ethnic/cultural groups; Materials are always gender sensitive and developed to address vulnerable groups; The MoH measures comprehensively the level of health disaster risk management awareness of general public; All required pandemic public advisories are always in full compliance with current WHO pandemic guidelines; All needed protocols for control and coordination of health-related public information are completed; All needed health information for dissemination in shelters completed.	
Further comments or explanations:		

Priorities for the next year (or programming period) for Health Sector DRM Public Awareness:
    1.
    2.
    3.		

ACRONYMS

ACRONYMS

BCP	Business Continuity Plans
CI	Critical Infrastructure
CMO	Chief Medical Officer
CEO	Chief Executive Officer
DM	Disaster Management
DMC	Disaster Management Committee
DRM	Disaster Risk Management
DRR	Disaster Risk Reduction
EM	Emergency Management
HEC	Health Emergency Committee
HDC	Health Disaster Coordinator
HRVA	Hazard Risk and Vulnerability Assessment
LSS/ SUMA	Logistics Support System/ Humanitarian Supply Management System
MoH	Ministry of Health
NDO	National Disaster Organization
NEOC	National Emergency Operations Centre
NGO	Non-governmental Organization
PAHO	Pan American Health Organization
PS	Permanent Secretary
SOP	Standard Operating Procedure
WHO	World Health Organization

GLOSSARY

GLOSSARY

Business Continuity Planning

An ongoing process supported by senior management and funded to ensure that the necessary steps are taken to identify the impact of potential losses, maintain viable recovery strategies, recovery plans, and continuity of services (3.3.1, Chapter 3 Definitions). In the public sector, this phrase is also known as *continuity of operations or continuity of governance*. Mission, vision, and strategic goals and objectives are used to focus the program, (NFPA 1600, 2007 Edition).

This process often results in the development of a Business Continuity Plan (BCP) for the facility or operation.

Contingency Planning

A management process that analyses specific potential events or emerging situations that might threaten society or the environment and establishes arrangements in advance to enable timely, effective and appropriate responses to such events and situations.

> *Comment: Contingency planning results in organized and coordinated courses of action with clearly-identified institutional roles and resources, information processes, and operational arrangements for specific actors at times of need. Based on scenarios of possible emergency conditions or disaster events, it allows key actors to envision, anticipate and solve problems that can arise during crises. Contingency planning is an important part of overall preparedness. Contingency plans need to be regularly updated and exercised.*

Disaster

A serious disruption of the functioning of a community or a society causing widespread human, material, economic or environmental losses which exceed the ability of the affected community or society to cope using its own resources.

> *Comment: Disasters are often described as a result of the combination of: the exposure to a hazard; the conditions of vulnerability that are present; and insufficient capacity or measures to reduce or cope with the potential negative consequences. Disaster impacts may include loss of life, injury, disease and other negative effects on human physical, mental and social well-being, together with damage to property, destruction of assets, loss of services, social and economic disruption and environmental degradation.*

Disaster Management (See Emergency Management below)

Disaster risk management

The systematic process of using administrative directives, organizations, and operational skills and capacities to implement strategies, policies and improved coping capacities in order to lessen the adverse impacts of hazards and the possibility of disaster.

> *Comment: This term is an extension of the more general term "risk management" to address the specific issue of disaster risks. Disaster risk management aims to avoid, lessen or transfer the adverse effects of hazards through activities and measures for prevention, mitigation and preparedness.*

Disaster Risk Reduction (DRR)

The conceptual framework of elements considered with the possibilities to minimize vulnerabilities and disaster risks throughout a society, to avoid (prevention) or to limit (Mitigation and Preparedness) the adverse impacts of hazards, within the broad context of sustainable development. DRR involves:

- *Risk awareness and assessment including hazard analysis and vulnerability/capacity analysis;*

- *Knowledge development including education, training, research and information;*

- *Public commitment and institutional frameworks, including organizational, policy, legislation and community action;*

- *Application of measures including environmental management, land-use and urban planning, protection of critical facilities, application of science and technology, partnership and networking, and financial instruments;*

- *Early warning systems including forecasting, dissemination of warnings, Preparedness measures and reaction capacities*

(UN/ISDR, 2004)

The concept and practice of reducing disaster risks through systematic efforts to analyse and manage the causal factors of disasters by reducing exposure to hazards, lessening vulnerability of people and property, sustainable management of land and the environment, and improved preparedness for adverse events.

Emergency management

The organization and management of resources and responsibilities for addressing all aspects of emergencies, in particular preparedness, response and initial recovery steps.

Comment: A crisis or emergency is a threatening condition that requires urgent action. Effective emergency action can avoid the escalation of an event into a disaster. Emergency management involves plans and institutional arrangements to engage and guide the efforts of government, non-
government, voluntary and private agencies in comprehensive and coordinated ways to respond to the entire spectrum of emergency needs. The expression "disaster management" is sometimes used instead of emergency management.

Hazard

A dangerous phenomenon, substance, human activity or condition that may cause loss of life, injury or other health impacts, property damage, loss of livelihoods and services, social and economic disruption, or environmental damage.

Hazard, Risk and Vulnerability Assessment (HRVA)

Often referred to as risk assessment. See Risk Assessment below.

Health sector

The health sector encompasses all the entities that produce actions, services, goods, opportunities, and knowledge that in one way or another contribute to the maintenance and improvement of the individual and collective health. This also includes the economic and productive activities of other sectors which impact on health, the political decisions, and their legal-administrative forms of expression, as well as environmental and educational interventions that influence the health determinants, (PAHO/WHO).

HRVA Tool

A tool to assist in conducting a hazard vulnerability and risk assessment. There are a variety of tools available for conducting hazard, vulnerability and risk assessments at various levels (PAHO/WHO).

Mitigation

The lessening or limitation of the adverse impacts of hazards and related disasters.

Comment: The adverse impacts of hazards often cannot be prevented fully, but their scale or severity can be substantially lessened by various strategies and actions. Mitigation measures encompass engineering techniques and hazard-resistant construction as well as improved environmental policies and public awareness. It should be noted

that in climate change policy, "mitigation" is defined differently, being the term used for the reduction of greenhouse gas emissions that are the source of climate change.

Natural hazard

Natural process or phenomenon that may cause loss of life, injury or other health impacts, property damage, loss of livelihoods and services, social and economic disruption, or environmental damage.

Comment: Natural hazards are a sub-set of all hazards. The term is used to describe actual hazard events as well as the latent hazard conditions that may give rise to future events. Natural hazard events can be characterized by their magnitude or intensity, speed of onset, duration, and area of extent. For example, earthquakes have short durations and usually affect a relatively small region, whereas droughts are slow to develop and fade away and often affect large regions. In some cases hazards may be coupled, as in the flood caused by a hurricane or the tsunami that is created by an earthquake.

Preparedness

The knowledge and capacities developed by governments, professional response and recovery organizations, communities and individuals to effectively anticipate, respond to, and recover from, the impacts of likely, imminent or current hazard events or conditions.

Comment: Preparedness action is carried out within the context of disaster risk management and aims to build the capacities needed to efficiently manage all types of emergencies and achieve orderly transitions from response through to sustained recovery. Preparedness is based on a sound analysis of disaster risks and good linkages with early warning systems, and includes such activities as contingency planning, stockpiling of equipment and supplies, the development of arrangements for coordination, evacuation and public information, and associated training and field exercises. These must be supported by formal institutional, legal and budgetary capacities. The related term "readiness" describes the ability to quickly and appropriately respond when required.

Prevention

The outright avoidance of adverse impacts of hazards and related disasters.

Comment: Prevention (i.e. disaster prevention) expresses the concept and intention to completely avoid potential adverse impacts through action taken in advance. Examples include dams or embankments that eliminate flood risks, land-use regulations that do not permit any settlement in high risk zones, and seismic engineering designs that ensure the survival and function of a critical building in any likely earthquake. Very often the complete avoidance of losses is not feasible and the task transforms to that of mitigation. Partly for this reason, the terms prevention and mitigation are sometimes used interchangeably in casual use.

Preventative Maintenance

Linked to the definition above - Planned actions, i.e. care and/or servicing by personnel, undertaken to retain equipment and/or facilities at a specified level of performance by providing repetitive scheduled tasks which prolong system operation and useful life; i.e., inspection, detection, correction of incipient failures, cleaning, lubrication and part replacement.

(IFMA, FM Definitions, http://www.ifma.org/what_is_fm/fm_definitions.cfm)

Recovery

The restoration, and improvement where appropriate, of facilities, livelihoods and living conditions of disaster-affected communities, including efforts to reduce disaster risk factors.

Comment: The recovery task of rehabilitation and reconstruction begins soon after the emergency phase has ended, and should be based on pre-existing strategies and policies that facilitate clear institutional responsibilities for recovery action and enable public participation. Recovery programmes, coupled with the heightened public awareness and engagement after a disaster, afford a valuable opportunity to develop and implement disaster risk reduction measures and to apply the "build back better" principle.

Resilience

The ability of a system, community or society exposed to hazards to resist, absorb, accommodate to and recover from the effects of a hazard in a timely and efficient manner, including through the preservation and restoration of its essential basic structures and functions.

Comment: Resilience means the ability to "resile from" or "spring back from" a shock. The resilience of a community in respect to potential hazard events is determined by the degree to which the community has the necessary resources and is capable of organizing itself both prior to and during times of need.

Response

The provision of emergency services and public assistance during or immediately after a disaster in order to save lives, reduce health impacts, ensure public safety and meet the basic subsistence needs of the people affected.

Comment: Disaster response is predominantly focused on immediate and short-term needs and is sometimes called "disaster relief". The division between this response stage and the subsequent recovery stage is not clear-cut. Some response actions, such as the supply of temporary housing and water supplies, may extend well into the recovery stage.

Retrofitting

Reinforcement or upgrading of existing structures to become more resistant and resilient to the damaging effects of hazards.

Comment: Retrofitting requires consideration of the design and function of the structure, the stresses that the structure may be subject to from particular hazards or hazard scenarios, and the practicality and costs of different retrofitting options. Examples of retrofitting include adding bracing to stiffen walls, reinforcing pillars, adding steel ties between walls and roofs, installing shutters on windows, and improving the protection of important facilities and equipment.

Risk

The probability of harmful consequences, or expected losses (deaths, injuries, property, livelihoods, economic activity disrupted or environment damaged) resulting from interactions between natural or human-induced hazards and vulnerable conditions. Conventionally risk is expressed by the notation: Risk = Hazards x Vulnerability (UN/ISDR, 2004).

The combination of the probability of an event and its negative consequences.

Comment: This definition closely follows the definition of the ISO/IEC Guide 73. The word "risk" has two distinctive connotations: in popular usage it usually placed on the concept of chance or possibility, such as in "the risk of an accident"; whereas in technical settings the emphasis is usually placed on the consequences, in terms of "potential losses" for some particular cause, place and period. It can be noted that people do not necessarily share the same perceptions of the significance and underlying causes of different risks.

Risk assessment

A methodology to determine the nature and extent of risk by analysing potential hazards and evaluating existing conditions of vulnerability that together could potentially harm exposed people, property, services, livelihoods and the environment on which they depend.

Comment: Risk assessments (and associated risk mapping) include: a review of the technical characteristics of hazards such as their location, intensity, frequency and probability; the analysis of exposure and vulnerability including the physical social, health, economic and environmental dimensions; and the evaluation of the effectiveness of prevailing and alternative coping capacities in respect to likely risk scenarios. This series of activities is sometimes known as a risk analysis process.

Also see HRVA above.

All definitions are from UN/ISDR 2009 unless otherwise specified

Risk transfer

The process of formally or informally shifting the financial consequences of particular risks from one party to another whereby a household, community, enterprise or state authority will obtain resources from the other party after a disaster occurs, in exchange for ongoing or compensatory social or financial benefits provided to that other party.

Comment: Insurance is a well-known form of risk transfer, where coverage of a risk is obtained from an insurer in exchange for ongoing premiums paid to the insurer. Risk transfer can occur informally within family and community networks where there are reciprocal expectations of mutual aid by means of gifts or credit, as well as formally where governments, insurers, -lateral banks and other large risk-bearing entities establish mechanisms to help cope with losses in major events. Such mechanisms include insurance and re-insurance contracts, catastrophe bonds, contingent credit facilities and reserve funds, where the costs are covered by premiums, investor contributions, interest rates and past savings, respectively.

Structural and non-structural measures

Structural measures **(Hard Mitigation)**: Any physical construction to reduce or avoid possible impacts of hazards, or application of engineering techniques to achieve hazard- resistance and resilience in structures or systems;

Non-structural measures (**Non-Structural Mitigation)**: Any measure not involving physical construction that uses knowledge, practice or agreement to reduce risks and impacts, in particular through policies and laws, public awareness raising, training and education.

Comment: Common structural measures for disaster risk reduction include dams, flood levies, ocean wave barriers, earthquake-resistant construction, and evacuation shelters. Common non-structural included building codes, land use planning laws and their enforcement, research and assessment, information resources, and public awareness programmes. Note that in civil and structural engineering, the term "structural" is used in a more restricted sense to mean just the load-bearing structure, with other parts such as wall cladding and interior fittings being termed non-structural.

Vulnerability

The characteristics and circumstances of a community, system or asset that make it susceptible to the damaging effects of a hazard.

Comment: There are many aspects of vulnerability, arising from various physical, social, economic, and environmental factors. Examples may include poor design and construction of buildings, inadequate protection of assets, lack of public information and awareness, limited official recognition of risks and preparedness measures, and disregard for wise environmental management. Vulnerability varies significantly within a community and over time. This definition identifies vulnerability as a characteristic of the element of interest (community, system or asset) which is independent of its exposure. However, in common use the word is often used more broadly to include the element's exposure.

BIBLIO

BIBLIOGRAPHY

International Facility Management Association. *Facility Management Definitions*. Available from: http://www.ifma.org/what_is_fm/fm_definitions.cfm. Accessed on: 25 May, 2010.

National Fire Protection Association 1600. *Standard on Disaster/Emergency Management and Business Continuity Programs*. Quincy, MA; 2007. Available from: http://www.nfpa.org/assets/files/pdf/nfpa1600.pdf.

Pan American Health Organization. *Natural Disasters: Protecting the Public Health, Scientific Publication No. 575*. Washington, DC: PAHO; 2000. Available from: http://www.paho.org/english/ped/SP575/SP575_prelim.pdf.

Pan American Health Organization, Emergency Preparedness and Disaster Relief Coordination Program. *Principles of Disaster Mitigation in Health Facilities*. Washington, DC: PAHO; 2000. Available from: http://www.paho.org/English/PED/fundaeng.htm.

Pan American Health Organization, Emergency Preparedness and Disaster Relief Coordination Program. *Guidelines for Assessing Disaster Preparedness in the Health Sector*. Washington, DC: PAHO; 1995. Available from: http://helid.desastres.net/es/d/J060/.

United Nations Inter-Agency Secretariat of the International Strategy for Disaster Reduction. Living with Risk: *A Global Review of Disaster Reduction Initiatives*. Geneva: UN/ISDR; 2004. Available from: http://www.unisdr.org/eng/about_isdr/bd-lwr-2004-eng.htm.

United Nations Inter-Agency Secretariat of the International Strategy for Disaster Reduction. *UNISDR Terminology on Disaster Risk Reduction*. Geneva: UN/ISDR; 2009. Available from: http://www.unisdr.org/eng/library/UNISDR-terminology-2009-eng.pdf.

This document can be accessed on the internet at www.paho.org/disasters

The Health Sector Self Assessment Tool for Disaster Risk Reduction represents a key tool in the quest to achieve a secure and disaster-resilient health sector in the Americas. Thanks to the contributions made by Health Disaster Coordinators in the Caribbean and other specialists throughout the Americas, PAHO/WHO presents this new, rapid and low cost method for assessing the state of disaster risk reduction (DRR) in the health sector.

Though minor adjustment in methodology of use can produce an external evaluation, the Tool was designed primarily for use in a self assessment modality. Applying the Tool enables an overall, approximate appreciation of the status of key aspects of mitigation and preparedness in the health sector. It also serves as a general guide of what best practices performance of DRR in the health sector looks like.

This booklet includes a general introduction to the Tool, the assessment forms required to compile and analyse the information, and a CD-ROM disk with these information in electronic format.

Pan American Health Organization
Regional Office of the
World Health Organization

Area of Emergency Preparedness and Disaster Relief

525 Twenty-third Street, NW
Washington DC 20037, USA
disaster-publications@paho.org

With the financial support of:

Canadian International Development Agency / Agence canadienne de développement international

USAID
FROM THE AMERICAN PEOPLE

9 789275 131428