World Health Organization

REGIONAL OFFICE FOR **Africa**

REGIONAL COMMITTEE FOR AFRICA　　　　　　　　　　　　**ORIGINAL: ENGLISH**

Sixty-second session
Luanda, Republic of Angola, 19–23 November 2012

Agenda item 10

DISASTER RISK MANAGEMENT: A STRATEGY FOR THE HEALTH SECTOR IN THE AFRICAN REGION

Report of the Secretariat

EXECUTIVE SUMMARY

1.　　The WHO African Region continues to be challenged by frequent natural and man-made emergencies causing injury, death, population displacement, destruction of health facilities and disruption of services, often leading to disasters.

2.　　The frequency and magnitude of emergencies and disasters have increased since the adoption, in 1997, of the Regional Strategy on Emergency Preparedness and Response. In addition, several global initiatives, developed since 2005, including the World Health Assembly resolution WHA64.10 adopted in 2011, have focused on Disaster Risk Management (DRM) as the approach to containing and minimizing the impact of emergencies.

3.　　WHO has recognized the need for Member States to formulate policies and legislation, and develop capacities in order to institutionalize DRM in the health sector. An assessment conducted in 2011 revealed that most countries in the Region lack these policies, capacities and legislation.

4.　　This regional strategy proposes that Member States strengthen disaster risk management by developing appropriate laws and policies; building adequate capacities in the MOH; assessing and mapping the risks from a health sector perspective; assessing the level of safety of, and applying standards to, hospitals and other health facilities; building community resilience; strengthening preparedness; developing national standards for response; and strengthening evidence and knowledge management, including cross-border sharing of vital intelligence and alerts. This will ensure that the health system has been prepared and will be able to provide adequate health sector response to emergencies and reduce their likelihood of becoming disasters.

5.　　The Regional Committee examined and adopted this strategy.

CONTENTS

INTRODUCTION

1.   In 2011, thirty-five countries[1] in the African Region reported emergencies, defined as "threatening conditions that require urgent action".[2] An emergency often escalates into a disaster, which is "serious disruption of the functioning of a community or a society, causing widespread human, material, economic or environmental losses exceeding the ability of the affected community or society to cope using its own resources".[3] Recent disasters in the Region include the 2007/2008 post-election violence in Kenya which displaced over 300 000 people; the large cholera outbreak in Zimbabwe in 2008 with more than 11 000 cases and high mortality; the 2009 Horn of Africa drought that affected about 23 million people; the November 2010 post-election violence in Côte d'Ivoire that displaced over 900 000 persons; the 2010/2011 floods in nine countries of Southern Africa that affected about 150 000 persons and destroyed farmlands, housing and social infrastructure including health facilities; and the current crisis in the Sahel sub-Region affecting over 15 million persons in nine countries.

2.   Recognizing the importance of emergencies, the Forty-seventh session of the WHO Regional Committee for Africa, in 1997, adopted Resolution AFR/RC47/R1, on the Regional Strategy for Emergency and Humanitarian Action. The five-year strategy focused mainly on emergency preparedness and response. However, recent major disasters, including the tsunami in the Indian Ocean in 2004 and the Pakistan and Haiti earthquakes, have increasingly emphasized the importance of addressing disaster risk, as defined in the Hyogo Framework for Action 2005–2015.[4] Lessons learnt from the 2011 Horn of Africa crisis show that the scale of deaths and suffering, and the financial costs, could have been reduced had a risk management approach been applied. It was recommended, therefore, that all actors *'manage the risks, not the crisis'*.[5] This approach was reinforced in 2011 by the Sixty-fourth World Health Assembly in its resolution WHA64.10, urging Member States to strengthen health emergency and disaster risk management programmes. The Declarations of Libreville (2008) and Luanda (2010) also reiterate the fact that environmental factors, including climate change, constitute major risks for emergencies and disasters.

3.   Disaster Risk Management (DRM) encompasses both Preparedness "the knowledge and capacities developed by health system and communities to effectively anticipate, respond to, and recover from, the impacts of likely, imminent or current hazard events or conditions" and Response "the provision of emergency services and public health 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". These two are covered by the 1997 strategy. In addition to these however, DRM encompasses an element of prevention by enhancing the ability of the health system, community or society exposed to hazard to resist or absorb the effects of a hazards through interventions based on risk analysis.

4.   Disaster Risk Management is defined as the systematic process of using administrative and organizational directives, operational skills and capacities to implement strategies, policies and improved coping capacities in order to lessen the adverse impact of hazards (phenomena or substances that have the potential to cause disruption or damage to humans and their environment) and the

---

[1]   Algeria, Angola, Benin, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of Congo, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Mali, Malawi, Mauritania, Mozambique, Namibia, Niger, Nigeria, Senegal, Togo, Uganda, Zambia and Zimbabwe.

[2]   Health Sector Self Assessment Tool for Disaster Risk Reduction, Barbados, Pan American Health Organization; 2010. Available at http://www.disasterpublications.info/english last accessed: 13 April 2012.

[3]   Ibid.

[4]   Hyogo Framework for Action 2005–2015: Building the Resilience of Nations and Communities to Disasters. World Conference on Disaster Reduction, International Strategy for Disaster Reduction, Kobe, Hyogo, Japan; 2005.

[5]   A Dangerous Delay: The cost of late response to early warnings in the 2011 drought in the Horn of Africa. Joint Agency Briefing Paper. London, Save the Children and Oxfam; January, 2012.

possibility of disaster.[6] In order to implement DRM, countries will require an enabling environment (policy and legislation; information and communication; training; research and funding). Certain capacities also need to be built, namely capacities for: coordination in the health and other sectors; risk assessment; making health facilities safer; minimizing the event impact (preparedness and response); post-disaster rebuilding of the health system (recovery); and strengthening local resilience (community support). The foregoing underscores the need to develop a regional strategy that comprehensively addresses DRM.

SITUATION ANALYSIS AND JUSTIFICATION

5.   The African Region is struck, year after year, by natural and man-made disasters, with direct and indirect impact on mortality, the disease burden and health care delivery, needless to mention the adverse implications for economic growth and attainment of most national development goals. In 2010 the African continent experienced 69 disasters affecting 9.9 million people.[7] In 2011, the Horn of Africa experienced a disaster that affected more than 13 million people and claimed an estimated 50 000–100 000 lives.[8] Between 2007 and 2011, the African Region required an average of over US$ 3.2 billion annually to respond to disasters and, of that amount, an average of US$ 288 million was for health sector response.[9]

6.   Emergencies and disasters exert negative economic impact on countries. According to the World Bank, natural disasters resulted in damages constituting between 2% to 15% of an exposed country's annual GDP; and that the cost of natural disasters could have been reduced by US$ 280 billion if US$ 40 billion had been invested in preventative measures.[10] The discounted total economic loss resulting from disaster-related deaths in the region in 2007 was US$ 117.2 million.

7.   Despite the prevalence of emergencies and disasters, and their negative health and economic impact, baseline assessment of an enabling environment and the capacity for DRM, conducted in 32 countries in the Region in 2011 showed that the health sector in the assessed countries lacks relevant policies and capacities for DRM. The health sector roles outlined in multisectoral National Disaster Acts and policies have not been adequately translated into health-specific policies and practice. National Health Acts and National Health Policies cover DRM issues in only seven[11] and ten[12] of the assessed countries respectively. Clear gaps in the health sector's capacity to perform intrasectoral and intersectoral coordination have also been identified. Only 14 of the 32 surveyed countries have a unit in the Ministry of Health (MOH) with responsibilities for DRM. There is a national multisectoral disaster management committee in 25 countries, but the health sector subcommittee exists in only 13 of them.[13]

8.   All countries have yet to establish health facility resilience building programmes based on assessment results, using the hospital safety index.[14] Community-based activities related to DRM, often implemented through NGOs, are not coordinated and structured according to community-specific risk assessment. Health sector disaster response plans do not consider all potential hazards in the countries, and are based on risk assessments in only four countries.[15] In only six countries do these response plans

[6]   Health Sector Self Assessment Tool for Disaster Risk Reduction, Barbados, Pan American Health Organization; 2010. Available at http://www.disasterpublications.info/english last accessed: 13 April 2012.
[7]   Guha-Sapir D, et al. Annual Disaster Statistical Review 2010: The Numbers and Trends. Brussels, CRED: 2011.
[8]   A Dangerous Delay: The cost of late response to early warnings in the 2011 drought in the Horn of Africa. Joint Agency Briefing Paper. London, Save the Children and Oxfam; January, 2012.
[9]   Financial Tracking Service of the Office for the Coordination of Humanitarian Assistance (OCHA).
[10] http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:20169861~pagePK:64257043~piPK: 437376~theSitePK:4607,00.html accessed 9 July, 2012.
[11] Burkina Faso, Comoros, Ethiopia, Gabon, Liberia, South Africa and Uganda.
[12] Angola, Burkina Faso, Comoros, Ethiopia, Ghana, Mali, Senegal, South Africa, Togo and Uganda.
[13] Burkina Faso, Cameroon, Côte d'Ivoire, Democratic Republic of Congo, Ethiopia, Lesotho, Liberia, Madagascar, Mauritania, Senegal, South Africa, Togo and Uganda.
[14] Hospital Safety Index –Evaluation Forms for Safe Hospitals. Pan American Health Organization, Washington DC; 2008.
[15] Burkina Faso, Democratic Republic of Congo, Tanzania and Togo.

undergo the recommended processes of table top exercises, simulations and periodic review based on lessons learnt.[16] None of the surveyed countries has established all the four key elements of optimal emergency and disaster response and operations readiness (Business Continuity Plan, Standard Operating Procedures, Triage System and Evacuation Procedure).[17]

9.   The capacity to enforce national standards during response to an emergency or disaster remains inadequate. There are several humanitarian actors operating in the field, each employing different strategies and technical guidelines that, in many cases, are not in line with national standards.[18] Member States' allocation of resources for emergencies remains inadequate, and most countries rely mainly on donor funding which is largely focused on acute response. Disaster prevention and preparedness, and post-disaster health system recovery remain under-funded.

10.   The existing regional strategy, adopted in 1997, focused mainly on emergency preparedness and response. However, recent developments within and outside WHO, at the global level, following recurrent major disasters, have created a paradigm shift towards disaster risk management. This is articulated in World Health Assembly resolution WHA64.10 urging Member States to strengthen health emergency and disaster risk management programmes. This new regional strategy therefore has to focus not only on response to emergencies and disasters, and mitigation of their consequences, but also on preventing them through strengthening risk management in accordance with the above resolution. The interventions of DRM for the health sector are targeted at the components of the health system including leadership and governance, building resilience of health facilities as well as preparedness in line with the six components. A strengthened health system will not only be able to provide an adequate health sector response during emergencies, but will also have beneficial effects outside emergency periods.

THE REGIONAL STRATEGY

Aim, Objective and Targets

11.   The aim of the strategy is to contribute to human security and development through improving the health sector's management of disaster risks, including providing a comprehensive health response to emergencies and disasters.

12.   The specific objectives are:

   (a) to ensure the availability of relevant policies, strategies and capacities to guide health sector interventions in DRM;
   (b) to reduce the occurrence and the number of emergencies turning into disasters, by managing risks and improving preparedness and response;
   (c) to strengthen the use of evidence for emergency and disaster early warning, preparedness and response.

Targets

13.   By the end of 2014 all Member States in the African Region would have:

   (a) identified, assigned responsibility to and equipped a unit in the MOH to coordinate the implementation of DRM interventions for the health sector;

---

[16]   Burkina Faso, Democratic Republic of Congo, Ghana, Liberia, Madagascar and Togo.
[17]   Health Sector Self Assessment Tool for Disaster Risk Reduction, Barbados, Pan American Health Organization; 2010. Available at http://www.disasterpublications.info/english last accessed: 13 April 2012.
[18]   In addition to WHO guidelines, there are several others developed or in process of development by the UN Inter-Agency Standing Committee (IASC), International Committee of the Red Cross and Red Crescent (ICRC), *Médecins Sans Frontières* (MSF), etc.

    (b)   established functional health sector subcommittees in national multisectoral coordination committees on DRM;

    (c)   incorporated DRM into their national health legislation, national health policies and health sector strategic plans;

    (d)   conducted health disaster risk analysis and mapping in a multisectoral approach;

14.   By the end of 2017, at least 90% of Member States in the African Region would have:

    (a)   instituted a preparedness planning and management process that includes plan development, pre-positioning of essential supplies, resource allocation, simulations, evaluations and annual updating based on all risks prevalent in the country;

    (b)   incorporated emergency and disaster early warning, preparedness, response and recovery indicators into the national surveillance and health information systems;

    (c)   instituted health facility and community resilience building, and preventive interventions based on disaster risk analysis and mapping;

    (d)   established emergency and disaster response and recovery operations, based on national standard operating procedures, and capable of supporting cross-border interventions.

15.   By the end of 2022 all Member States in the African Region will be fully implementing all the interventions of the Regional Strategy.

Guiding Principles

16.   The guiding principles of this strategy are:

    (a)   **Gender and human rights** principles that ensure incorporation of gender equity and human rights perspectives into policies and programmes as well as neutrality and impartiality in humanitarian response.

    (b)   **Equity** in access to services, with special focus on highly vulnerable population groups including migrant populations[19] and people living in Small Island Developing States.[20]

    (c)   **Country Ownership,** with governments coordinating and ensuring that all interventions by partners are in line with relevant national guidelines.

    (d)   **Participation,** with the involvement of communities, civil society and the private sector.

    (e)   **Strengthening partnerships** within the health sector, using the humanitarian reform principles.

    (f)   Fostering sustainable **intersectoral collaboration** at local and regional levels.

Priority Interventions

17.   The interventions proposed below are the minimum required by each country in order to establish the necessary enabling environment and capacities to manage disaster risks. The strategic approach is to consider all potential hazards and all potential contributing factors that may affect health, including health determinants; climate change adaptation interventions; and action involving all MoH departments. The strategy may not require the development of new documents and structures, but an updating and strengthening of what exists. The following are the proposed interventions, the prioritization of which would depend on country context and specificities.

---

[19]   These include nomads, economic migrants, seasonal farmers that migrate to water sources, migrant fishermen.
[20]   Cape Verde Declaration by Ministers of Health of Small Island Developing States of the African Region: Praia, 19 March 2009.

18. **Develop appropriate policies, strategies and regulations to facilitate risk management:** This would involve updating the existing health legislation, national health policies and health sector strategic plans to incorporate provisions on prevention, preparedness and readiness, as well as response to the health impact of all potential hazards in the country. The revisions should be congruent with national multisectoral legislation, policies and plans on DRM.

19. **Provide adequate capacity for risk management in the health sector:** The MoH should be given responsibility and adequate authority, capacity and resources to coordinate all health actions before, during and after emergencies and disasters. The health sector should participate in all decisions and actions of the national multisectoral committee on DRM, through a functional health sector subcommittee. Resources should be allocated "from the national budget to fund DRM activities in the health sector." Education and training programmes at undergraduate and graduate levels as well as continuing professional education and research on DRM should be developed and funded. The training should be aligned with the regional standard package on emergency training. Development of networks and communities of practice on DRM should be encouraged, at national and subregional levels.

20. **Conduct assessments and map risks**. Vulnerabilities and capacities of the health sector should be assessed in conjunction with other sectors in order to measure and map the risks to health and health care delivery. The structural and functional capacity of existing health facilities to withstand and respond to the impact of hazards should be assessed, using the health facility safety index.[21] Risk assessment and mapping should be updated regularly, based on changes in hazard and vulnerability profiles.

21. **Implement resilience building interventions in health facilities and at community level**. This will imply designing the structural, non-structural and functional requirements of new health facilities to enable them to withstand the impact of hazards, and be functional in emergencies. Existing health facilities should be retro-fitted to increase their resilience, based on the results of risk assessments. Health facility disaster plans should be developed and tested. Community leaders and health workers at the community level should be engaged in risk assessment, planning and preparedness to build on local knowledge, experience and capacity that would have been strengthened through adequate community education and empowerment. Community members should also play decisive roles in the execution, monitoring and evaluation of DRM intervention at community level.

22. **Prepare and provide timely and adequate response to emergencies.** Preparedness should be strengthened by developing, evaluating and revising response plans based on comprehensive risk analysis, taking into account all prevalent hazards. The plans should involve identifying rapid response teams at local and national levels including sources of surge support; pre-positioning medical supplies and other logistics; designating isolation units and safe areas; and organizing mass casualty management services. Procedures should be regularly tested through desk-top exercises and simulations. Standard Operating Procedures (SOPs) for health response and recovery operations should be developed to determine what needs to be done, by whom and how, before, during and after emergencies and disasters, in order to minimize related casualties. Post-disaster needs assessment should be conducted to foster continuity of service, and rebuild public health services, as part of updated national health strategic plans.

23. **Generate and disseminate evidence:** Information on the projected and actual health consequences of natural and man-made disasters including event-based surveillance should be generated and monitored, using appropriate indicators, through the national surveillance system. This will provide early warning and guide preparedness and health response. Information management including use of feedback should be strengthened. Operational research should be conducted on changing risk patterns for various communities, including highly vulnerable groups like migrant populations and persons

---

[21] Hospital Safety Index –Evaluation Forms for Safe Hospitals. Pan American Health Organization, Washington DC: 2008.

living in Small Island Developing States. Operational aspects of response and recovery, e.g. the quality and impact of response, should be assessed through regular monitoring and research to inform adaptation of strategies and actions.

Roles and responsibilities

Member States

24.   Member States should:

(a)   provide leadership and mobilize partners for the development of national road maps for implementation of the key interventions outlined in this regional strategy;

(b)   mobilize and allocate the necessary human, material and financial resources for the implementation of interventions, including contributing to the African Public Health Emergency Fund which caters for response, prevention and preparedness to save lives, and soliciting funds from the private sector;

(c)   identify the responsibilities of the various agencies and levels of government, and set the criteria for decision making, using an accountability framework;

(d)   establish mechanisms for networking and cross-border collaboration under the aegis of regional and subregional bodies, and for sharing information on DRM as stipulated in the IHR (2005) document;

(e)   adapt or develop guidelines and norms for the implementation of interventions, including monitoring and evaluation.

WHO and Partners

25.   Based on the proposed priority interventions, WHO and partners should:

(a)   develop and make available updated tools, standards and guidelines for implementation of interventions, including updating national health policies and plans;

(b)   provide the necessary technical guidance and support on DRM to Member States at national, subnational and local levels;

(c)   strengthen collaboration with, and ensure coherence and complementarity of actions among, the relevant entities including those in the public, private, nongovernmental and academic sectors as part of support to countries;

(d)   strengthen the evidence base for disaster risk management, through operational research and impact assessments, and disseminate information collected to all Member States;

(e)   support capacity building at national and subnational levels;

(f)   establish a functional emergency database and build a roster of experts in the Region;

(g)   advocate for resource allocation to DRM in the African Region, and rapidly operationalize the APHEF;

(h)   support the creation of regional and sub-regional networks on DRM;

(i)   develop tools for estimating the cost of the interventions.

Resource Implications

26.   Literature and experience regarding the cost of establishing DRM are scarce, considering that the approach is relatively new. The resources required for the implementation of the new strategy will depend on the context and specificities of individual countries, in terms of size, prevalence of hazards and existing capacities to manage disaster risks.

27.   Some of the proposed interventions in this strategy, including updating the legal, policy and strategic documents, could be covered by routine administrative costs, and may not require large capital investments. According to the Financial Tracking Service of the Office for the Coordination of Humanitarian Assistance (OCHA), the countries in the Region required an average of over US$ 3.2 billion annually from 2007 to 2011 to respond to emergencies and disasters, about 9% (US$ 288 million) of which was for the health sector response. At least 10% of this should be used for risk management, preparedness and recovery, in line with the African position and high level commitment to the global platform for disaster risk reduction. Introducing hazard-resistant design measures in constructing new health facilities, and retro-fitting old facilities, are some of the main resource-intensive components and should be incorporated into the health sector capital development budget. This would increase construction costs by 5%–24% which, compared to the cost of reconstruction or damage repair after a disaster, is significantly lower.

MONITORING AND EVALUATION

28.   Progress towards the attainment of the targets set in this strategy will be evaluated in 2014, 2017 and in 2022. Data will be collected through surveys to monitor progress and identify constraints that hamper achievement of set targets.

29.   Countries will be monitoring key indicators for disaster risk management interventions at national and district levels, by using data from health information and surveillance systems, satellite forecasts, rapid health assessments and surveys. Disaggregation of data to capture age, sex, social status and geographical differences will be emphasised. Pre-disaster monitoring will include general risk trends, health risks trends and event early warning. The monitoring before disaster will capture details on the accessibility, quality, readiness, and safety of health services. During response and recovery there is need to monitor health outcomes focusing on the coverage of essential health services and interventions to mitigate diseases and behaviours that lead to poor health, such as antenatal care coverage. Other indicators to be monitored are severity of disaster, epidemic onset and evolution, and nutrition indicators.

CONCLUSION

30.   Countries in the African Region continue to be affected by emergencies, resulting in disasters with avoidable loss of life and significant socioeconomic costs. The African Strategy on Emergency Preparedness and Response, adopted in 1997, focused on emergency preparedness and response. However, World Health Assembly resolution WHA64.10, adopted in 2011, re-affirmed the current global focus on strengthening disaster risk management.

31.   This regional strategy therefore proposes that Member States strengthen disaster risk management by developing appropriate laws and policies; building adequate capacities in the MoH; assessing and mapping risks from a health sector perspective; assessing safety and applying standards to building of hospitals and other health facilities; building community resilience; strengthening preparedness; developing national standards for response; and strengthening evidence and knowledge management. This would ensure a prepared health system capable of providing adequate health sector response, and decrease the likelihood of emergencies turning into disasters.

32.   The Regional Committee examined and adopted this 10-year strategy.