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REGIONAL INITIATIVE ON SAFE HOSPITALS

Background and General Concept

1. The 45th Directing Council of the Pan American Health Organization approved Resolution CD45.R8[1] urging Member States to adopt "Hospitals Safe from Disasters" as a national risk reduction policy in 2004. This resolution established the goal for the Region that all new hospitals must be built with a level of protection that guarantees that they remaining functional in disaster situations. It also calls on governments to ensure that the reinforcement and refurbishing of existing health facilities, particularly those providing primary and emergency care, includes the appropriate mitigation measures.

2. In January 2005, 168 countries adopted the same "Hospitals Safe from Disasters" goal at the World Conference on Disaster Reduction,[2] as one of the priority actions to be implemented by 2015.

3. The first step in implementing this new initiative in the Region is to identify, together with experts of Member States, a working definition of the term "safe hospital." As a result, a **"**safe hospital**"** is defined as: "a health facility whose services remain accessible and functioning at its maximum capacity, and in the same infrastructure, during and immediately following the impact of a natural hazard."

Challenges

4. According to data provided by PAHO/WHO Member States, 67% of their health facilities are located in disaster risk areas.[3] In the last decade, nearly 24 million people in

[1] Resolution CD45.R8 Disaster Preparedness and Response. www.paho.org/english/gov/cd/CD45.r8-e.pdf
[2] Hyogo Framework for Action 2005-2015: Building the Resilience of Nations and Communities to Disasters. www.unisdr.org/eng/hfa/hfa.htm

the Americas lost health care for months, and sometimes years, due to the damage directly related to disasters. On average, a hospital out of service in the Region leaves approximately 200,000 people without health care and the loss of emergency services during disasters sharply reduces the chance to save lives.

5. A report prepared by the UN Economic Commission for Latin America and the Caribbean estimates that the Region lost more than US$ 3.12 billion in 15 years due to damage to health infrastructure.[4] Indirect losses are estimated to be significantly higher when measuring the increases in health care costs for the millions that have been left without health services for a prolonged period of time.

6. Functional collapse is the main cause of hospitals being out of service after a disaster; only a small proportion of them are out of service due to structural damage. Although the measures necessary to prevent a functional collapse require a significantly smaller financial investment, they remain nonetheless a major challenge for the technical, managerial and political levels.

7. Natural disasters are not singularly responsible for the collapse of hospitals. The major reason for the collapse of health infrastructure and corresponding deaths are due to the fact that hospitals are constructed without taking into account natural hazards, and that systems progressively deteriorate due to lack of maintenance over time. The good news, though, is that this increasing trend of vulnerability of health facilities can be reversed, as demonstrated in several pilot cases, through sustained political support.

More than Infrastructure

8. The goal of safe hospitals is much more than protecting only infrastructure and equipment; it is to ensure that health services remain functional, as part of a network, and can protect patients' safety. This also entails that workers be able to continue to perform their duties and that other essential functions remain operational, such as sanitation, water supply, disease control, and laboratories, laundry facilities and kitchens. The presence of effective health systems has been identified as the backbone for achieving the health-related Millennium Development Goals.

9. Building codes for health facilities, therefore, should not only ensure the survival of staff and patients, but also be stringent enough to ensure that facilities continue to function after disasters.

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[3] CD47/INF/4 Progress Report on National and Regional Health Disaster Preparedness and Response. www.paho.org/english/gov/cd/CD47-inf4-e.pdf

[4] "Economic Impact of Natural Disasters in Health Infrastructure". UN/ECLAC. LC/MEX/L.291. This report was presented at the International Conference on Vulnerability Reduction in Health Facilities. Mexico, DF, 1996

10. Mechanisms should be put in place to ensure that at least hospital infrastructure and operations are checked through an independent process to inform health facility owners about the safety of the health facility.

11. Patient safety and the health of workers is the foremost concern. This has been too frequently overlooked, which explains why hospitals that could have reopened quickly have taken several weeks or months to recover properly.

12. Health workers are the main players and promoters for ensuring the continuous operation of health services in complex facilities but, more importantly, they are fundamental for primary health care. Together with teachers and other local leaders, health workers at the local or community levels should assist in identifying the main health risks and promote the implementation of affordable and cost-beneficial risk reduction measures. The "prevention is better than cure" approach must be adapted to natural hazards.

13. Healthcare workers face physical, chemical, biological, and psychosocial occupational hazards. The creation of a healthy hospital environment is directly dependent on the protection of the health and safety of healthcare workers. Occupational safety and the health of the healthcare sector must remain a priority in the Safe Hospitals initiative.

14. Health disaster programs within each Ministry of Health should be equipped with a risk reduction branch. Other key programs within the Ministries of Health, such as health services, health infrastructure, human resources and training centers, planning, water and sanitation, communicable diseases, laboratory, and chemical and radiological specialities, also have critical roles to play in improving safety. A failure in any of one the basic functions of the health facility can be responsible for the collapse of the entire system.

A Collective Responsibility

15. Access to health services is a critical need in saving lives, especially during emergencies, and is part of the essential public health functions. Hospitals are among the most complex infrastructures in our societies and are heavily dependent on basic services. Hospitals will be safe when other sectors also routinely recognize that health facilities save lives and consequently must remain functional following disasters.

16. The Safe Hospitals initiative is also an essential aspect of healthy communities that requires expertise from all health services and water supply, electricity, transportation, and communication systems, as well as the local community, in order for hospitals to remain functional.

17. Actors outside the health sector, such as planning, national and international financial institutions, universities, scientific and research centers, and local authorities, should also be fully involved in the process, as they are key contributors towards reducing risk.

Countries' Efforts and Opportunities

18. Twenty-one countries in the Americas report undertaking specific actions to reduce disaster vulnerability in the health sector, and 11 countries report having a national policy on safe hospitals. The countries that show major advances towards safer hospitals are those in which the national multisectoral disaster coordination institution supports these efforts.[5]

19. Member States use a variety of strategies towards this aim, such as the development of national and international agreements, the adoption of appropriate and regular updates of norms and standards, and the monitoring of their national safe hospitals program.

20. The Safe Hospitals initiative contributes to reducing inequality, as it also facilitates access to health services for vulnerable populations and promotes the safety of the entire network of health services, including health centers, outpatient centers, and other medical care facilities. The hospital accreditation process should include risk reduction as a category, in order that it be addressed systematically. In the long run, there is need to establish an appropriate institutional policy that links accreditation with quality assurance and improvement programs.

21. One of the most important advances in 2006 was the development of a Hospital Safety Index, thanks to the contribution of the PAHO/WHO Disaster Mitigation Advisory Group (DiMAG) [6] and the contributions of a number of national experts. This tool takes into consideration multiple aspects, such as the geographic location and structure of the building, the nonstructural components; and the hospital organization. The calculated index provides an idea of the likelihood that a health facility will remain functional after a disaster, and can be used as a qualitative scoring system to prioritize interventions on selected health facilities. It does not replace an indepth vulnerability assessment. Authorities can appreciate, at a glance, areas where it would be the most efficient to intervene, to improve safety in health facilities. Safety is no longer a black-and-white situation; it can be improved gradually.

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[5] Report on Reducing the Impact of Disasters on Health Facilities. www.paho.org/english/gov/cd/CD45-27-e.pdf

[6] The Disaster Mitigation in Advisory Group is composed of volunteers from public and private institutions of Latin America and the Caribbean that are available through the PAHO/WHO collaborating center for hospital mitigation based in Chile.

22. Mexico, and to a more limited degree, Costa Rica, Cuba, Dominica, Peru, and Saint Vincent and the Grenadines, have conducted pilot surveys to test the Hospital Safety Index. The present Hospital Safety Index will have to be updated regularly as technology and assessment methodology evolve.

World Disaster Reduction Campaign 2008-2009

23. The UN International Strategy for Disaster Reduction (ISDR) decided to organize for 2008-2009, the global Safe Hospitals campaign, as an example of a complex entity that requires collaboration from all sectors in order to make hospitals resilient to disasters. WHO is the technical entity responsible for the campaign.

24. The success of the campaign depends on, among other things, sufficient national information systems that allow countries to decide strategically on how to improve the safety of new designs and existing facilities.

25. Policymakers' awareness of the social, economic, and political benefits of hospitals and health facilities that remain functional in a disaster is considered a critical factor towards making progress in this campaign and for the public to see real results. The campaign will provide an excellent chance to engage the public and decisionmakers from all sectors as stakeholders in the safety of their country's hospitals.

Conclusion

26. Over the last year, significant progress has been made towards making hospitals safer, especially in addressing the technical issues. What is most needed now is to have a national risk reduction program in the Ministry of Health that includes the Safe Hospital initiative.

27. The complexity of reducing risk resides in that fact that multiple specialties and sectors are involved. The failure of any of the components will make the hospital unsafe. The goal can only be reached by 2015 if there is direct involvement of key health departments, such as health services organizations, networks and systems; patients' and health workers' safety; laboratories; medications; and supplies and sanitation. In addition, the effort must involve entities beyond the health sector, such as financial institutions, water and power supply companies, telecommunications, and foreign affairs.

28. The global campaign proposed by ISDR and WHO provides an excellent multisectoral platform that can benefit the health sector of Member States by allowing them to share their best practices as well as practical and significant progress on Safe Hospitals at the country level.

29. PAHO has included the objectives contained in the safe hospitals initiative into the Strategic Plan 2008-2012, as well as into the Program Budget 2007-2008, under Strategic Objective 5.1. It will monitor and report on the implementation of this initiative and provide technical cooperation to assist countries in documenting and improving their national Hospital Safety Index.

Action by the Executive Committee

30. The Executive Committee is requested to review the information provided on progress to date and to make suggestions on efforts that can be pursued at the country level and by PAHO to reach the goal of Hospitals Safe from Disaster by 2015.

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