Child Centric DISASTER

Risk Reduction, Priorities, Preparedness and Resilience

Editors
Sigamani Panneer • Santosh Kumar
Kumar Raka • Balu I. • Udhayakumar P.

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Disaster Risk Reduction (DRR): Safety of Vulnerable Groups Through Standardization

Dr Nidhi Yadav[1]

Abstract: *The safety of vulnerable groups specially the children, women, victims of abuse, neglect, natural disasters and inpatients is entrusted upon the law and foresight of the policy makers. The overall system of good governance and development for all rests on the premise of not leaving anyone behind and ensuring that the person standing last of the pedestal also receives care, protections and support in time of need. Disasters are getting bigger in magnitude and impact across the globe, and their ability to disrupt human life is getting intense. The worst affected group of people in the disaster events belong to the vulnerable category due to high level of dependency for fulfilling the basic needs, physical incompetency, social restriction, limited decision-making capacity etc. In order to ensure that the vulnerable population is taken care off and the damages to them is minimized, they must be prioritized for accessibility and availability of services. Due to diverse nature of legal, statutory and voluntary mechanisms for disaster risk reduction and absence of a linear implementation mechanism the penetration of benefits of social, relief and rehabilitative schemes in not equitable. This discrepancy of system can be addressed by standardization of the health delivery system. The first and most immediate need for a disaster affected victim is healthcare. If the healthcare is standardized by implementation of quality management systems the safety of recipient of healthcare and the overall continuity of care by safety of health infrastructure, equipment and manpower can be ensured to a greater extent. This chapter lays thrust on importance of accreditation and standardization of healthcare and schools for ensuring safety of vulnerable groups.*

Keywords: *Disaster, Children, Women*

DISASTER

'A disaster is a sudden, calamitous event that seriously disrupts the functioning of a community or society and causes human, material, and economic or environmental losses that exceed the community's or society's

[1] Associate Professor, IIHMR, New Delhi

ability to cope using its own resources. Though often caused by nature, disasters can have human origins' (1). The amalgamation of hazards with vulnerability and the inability to reduce any potential negative consequences of risk results in disaster. Basically, disasters are a common phenomenon throughout the world whether natural or man-made in nature. They continue to strike, mostly without any warning and it has been perceived that their incidence is on an increase. Disasters are also getting bigger in terms of their frequency of occurrence, magnitude of impact, complexity in nature and economic impact (2).

MAGNITUDE OF DISASTERS – GLOBAL AND NATIONAL

Global

It has been observed that in the second half of the twentieth century, around 200 natural disasters have struck different parts of the world and these disasters have claimed lives of around 1.4 million people. It has been also reported that losses owing to the natural disasters amount to approximately 20 times higher (in terms of the % of GDP) in the developing nations in comparison to the developed ones (2). Asia being the biggest continent, has maximum number of deaths due to natural disasters. The origin of natural disasters could be traced back in history since 430 BC. This was the time when Typhus epidemic broke in Athens and claimed several thousand lives. The ten deadliest and most impactful natural disasters across the world were seen in 1556. During this time one earthquake of magnitude 7 on Richter scale had hit the Shaanxi province of China on 23 January, it is located in China, the earthquake claimed 8,30,000 lives (3). The figure 1 above depicts that around 78.4 per cent of total disaster related events which occurred around the world belonged to hydro meteorological nature. It also indicates that the incidents of Hydro meteorological nature are on a continuous rise and lead to maximum lost loss of life.

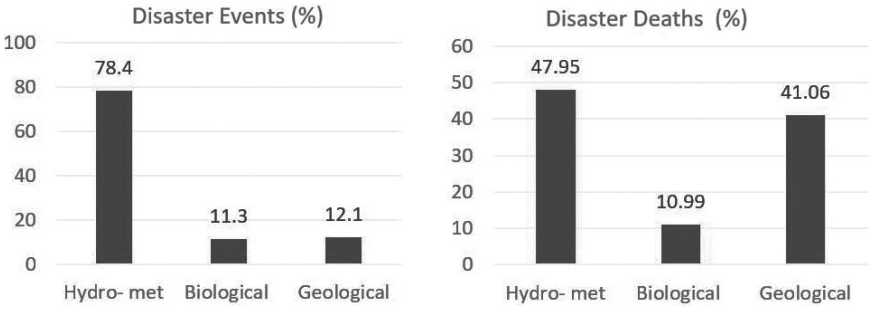

Figure 1: Disaster Events and Deaths (1900–2001) (4)

India

India is vulnerable up to a differential degree, to various disaster of both types i.e. natural disasters as well as man-made disasters. The main reason for this high degree of vulnerability is the unique geo-climatic and socio-economic positioning as compared to rest of the countries. Various disasters to which India is vulnerable include disasters related to earthquakes, floods, cyclones, droughts, landslides, forest fires and avalanches etc. Among the 29 states and 8 union territories of India, 27 states are prone to disaster. Among these 27 states, approximately 58.6 per cent of land is prone to earthquakes of moderate to very high intensity; and approximately 40 million hectares i.e. around 12 per cent of land is prone to either floods or river erosion. India has a coastline of 7,516 km, out of which around 5,700 km is prone to cyclones and tsunamis. At the same time 68 per cent of the cultivable land is prone to extreme drought, whereas the hilly region is prone to risk of disasters like landslides and avalanches (5). India is one among the ten countries in the world which are severely disaster-prone in nature. India is prone to disasters primarily due to several reasons related to the factors that include adverse geo-climatic conditions, environmental degradation, topographic features, urbanization, population growth, un-scientific developmental practices, industrialization, etc. These above-mentioned factors either individually or in combination lead to increase in the magnitude and frequency of disasters.

VULNERABLE POPULATION (PATIENTS AND CHILDREN)

Vulnerability according to the Oxford Dictionary is the quality or state of being exposed to the possibility of being harm either physically or emotionally it is a complex concept with multiple dimensions in different contacts vulnerability as a universities relatable issue relevant also to health and health care law will be a common thread throughout this article (6).

Vulnerable groups are many: like children, women, all people caught in circumstances such as cross border conflicts, natural disasters, irregular and force migration, human trafficking, indigenous groups, PWD, sexual minorities, to name just a few.

Young children and women in particular may not only be subject to abuse but also be deprived of opportunities for social economic freedom person with disabilities and sexual minority groups experience stigma and neglect often feeling to reach the optimum development potential because of externalities such as the existing social cultural religious and political structure the socially disadvantage group in resource poor settings of low and middle income countries such as India a rented mole more vulnerable due to inequalities in social structure

Due to social and economic inequalities, like morality, nutrition, illiteracy, and unemployment, people with social and economic disadvantages are even more vulnerable in places like prisons, homes for homeless youth, refugee camps, orphanages, etc.

Those working with vulnerable groups in public health arena believe that human right education, legal literacy and welfare economics can make for robust health laws as well as better health policies and programs which will benefit the vulnerable groups.

In terms of medical care, a vulnerable patient is the one who is dependent for his activities of daily living (ADL) on others. These patients include sedated, unconscious, mentally challenged, physically handicapped, pregnant females, children below 18 years and elderly above 65 years under medical care, patients with language barrier etc. These categories of patients need special attention all the time and are more vulnerable to injuries and accidents during their course of treatment. In the event of a disaster evacuation and safety of vulnerable patients become more difficult due to ongoing clinical condition which may limit their decision making, mobilization, understanding and higher dependency on other for fulfilling the necessities (7).

GLOBAL AND NATIONAL COMMITMENTS IN TERMS OF SENDAI AND HYOGO FRAME WORK FOR DRR

Global Level Commitments for Medical Preparedness

The Hyogo framework (8): The World Conference on Disaster Reduction was held from 18 to 22 January 2005 in Kobe, Hyogo, Japan, and adopted the 'Framework for Action 2005-2015: Building the Resilience of Nations and Communities to Disasters, this Conference provided a unique opportunity to promote a strategic and systematic approach to reducing vulnerabilities and risks to hazards. It underscored the need for, and identified ways of, building the resilience of nations and communities to disasters.'

The Sendai Framework for Disaster Risk Reduction 2015–30 was adopted in the Third United Nations World Conference on Disaster Risk Reduction, held from 14 to 18 March 2015 in Sendai, Miyagi, Japan (9). The framework aims to achieve remarkable reduction in disaster risk and losses in lives, livelihoods and health. This applies to the economic, physical, social, cultural and environmental assets of the persons, businesses, communities and countries over the next 15 years. The framework was adopted at the Third UN World Conference on Disaster Risk Reduction in Sendai, Japan, on March 18, 2015.

National Level Commitments for Medical Preparedness

In India, disaster management has seen major transformation in terms of its evolution from an activity-based and reactive approach-based set-up to a proactive, institutionalized, self-driving modality. The evolution of its institutional structure can be traced back to the Britishers era in which the country has witnessed numerous disasters for instance the famines of 1900, 1905, 1907 & 1943, and earthquake in 1937 in Bihar-Nepal etc. In India, a permanent and institutionalized set-up in disaster management began in the 1990s with setting up of a cell called as disaster management cell under the Ministry of Agriculture. This was done in the decade 1990 based on a declaration. This was known as the 'International Decade for Natural Disaster Reduction' (IDNDR). After facing numerous natural disasters like Earthquake in Latur in 1993, Landslide in Malpa in 1994, the Super Cyclone in Orissa in 1999 and the Bhuj Earthquake in year 2001, this high-powered Committee was established (10). This committee had the mandate for drawing up a systematic, holistic and comprehensive approach to ensure disasters management in India. This was considered as a paradigm shift in policy from the relief-based approach via financial support to a holistic and inclusive approach for addressing disaster management issues related to early warning systems, forecasting and monitoring setup for various weather-related hazards etc. A structural flow of information, in terms of warnings, alerts and updates regarding the upcoming hazard, also emerged within this framework. The disaster management framework emerged from the recommendations made in the reports of the committee on the issues related to Disaster Management. This report talked about establishing a separate institutional structure in order to address the disasters and enacting suitable law for institutionalization of the disaster management in India. The report also emphasized on having multi-level links between the related ministries for faster and smoother coordination of work. This institutional structure is also in a state of transition these days. This new setup, following the implementation of the Disaster Management Act 2005 (1), is under evolution as on date. The old structure is also simultaneously continuing in India. Hence, both the structures are coexisting in India at present and running on a parallel mode. The National Disaster Management Authority (NDMA) is established at the centre, followed by having a SDMA at state level which in turn will support the NDMA.

DISASTER MANAGEMENT ACT, 2005

The Disaster Management (DM) Act 2005, provisions for setting up of the National Disaster Management Authority (NDMA) under the Prime

Minister (PM), who is the chairperson of this body. As per the act the State Disaster Management Authorities (SDMAs) are established under the Chairmanship of the respective Chief Ministers (CM) and lastly the District Disaster Management Authorities (DDMAs) are provisioned to be established under the leadership of Collectors/District Magistrate/Deputy Commissioners. This Act also asks for constitution of various executive committees. These committees are to be established both at the national and the state levels. It has several other provisions for establishing a research and education body and lead to setting up of the National Institute of Disaster Management (NIDM) for capacity building. In order to ensure quick and effective response to the disaster at the national level it envisioned establishing of the National Disaster Response Force (NDRF).

HOSPITAL SAFETY GUIDELINES AND DRR

The National Disaster Management Policy 2009 (11) and role of Hospital Safety guidelines 2016 (12) in making the hospitals safe from disasters

The National Disaster Management Policy, 2009, envisions to build a safe and disaster resilient India. The policy aims to achieve this by developing a proactive, multi-disaster oriented, holistic and technology driven strategy by developing a culture of prevention, mitigation, preparedness and response. The key objectives of this policy are as follows:

- Promoting a culture of prevention, preparedness and resilience at all levels through knowledge, innovation and education.
- Encouraging mitigation measures based on technology, traditional wisdom and environmental sustainability.
- Mainstreaming disaster management into the developmental planning process.
- Establishing institutional and techno-legal frameworks to create an enabling regulatory environment and a compliance regime.
- Ensuring efficient mechanism for identification, assessment and monitoring of disaster risks.
- Developing contemporary forecasting and early warning systems backed by responsive and fail-safe communication with information technology support.
- Ensuring efficient response and relief with a caring approach towards the needs of the vulnerable sections of the society.
- Undertaking reconstruction as an opportunity to build disaster resilient structures and habitat for ensuring safer living.
- Promoting a productive and proactive partnership with the media for disaster management.

In line with National Disaster Management Policy 2009 (11), the NDMA released its Hospital Safety guidelines in 2016 (12). These guidelines mention the provisions required to be put in place for ensuring that the hospitals or health facilities remain functional in the disaster situations. It is also imperative to consider that the provisions specified in these guidelines are the basic minimum requirements of standards which needs to be complied by the hospitals and healthcare facilities to make themselves disaster resilient. These guidelines are developed with the idea of addressing issues related to both internal and external disasters affecting the hospitals and healthcare facility in the specific region. Implementation of these guidelines for hospitals/healthcare institutions ensures their functionality and continuity of services during as well as immediately after a disaster event. In order to fulfill this objective, the hospitals need to undertake following initiatives:

1. Coordination & Management
2. Planning, Training and Drills
3. Information and Communication
4. Safety and Security
5. Human Resources
6. Logistics, Supply and Finance Management
7. Continuity of Essential Services
8. Triage
9. Surge Capacity for Medical Response
10. Post-disaster Recovery
11. Patient Handling
12. Volunteer Involvement and Management
13. Area Level Networking of Hospitals
14. Coordination and Collaboration with Wider Disaster Preparedness Initiatives

GLOBAL LEVEL COMMITMENTS FOR CHILD SAFETY

The Sendai Framework for Disaster Risk Reduction 2015-2030 (9), the global guidance for building resilience to disasters, captured key issues of gender and social inclusion at policy and practice levels and addressed vulnerabilities as well as capacities. It acknowledged that, 'Overall, women, children and people in vulnerable situations were disproportionately affected from disasters over the decade of 2005-15.' It also said that 'Governments should engage with relevant stakeholders, including women, children and youth, persons with disabilities, poor people, migrants, indigenous peoples, volunteers, the community of practitioners and older persons in the design and implementation of policies, plans and standards.' It recommends that

countries 'invest in and develop people-centred multi-hazard, multisectoral forecasting and early warning systems, disaster risk and emergency communications mechanisms, social technologies and hazard-monitoring telecommunications systems, tailoring them to the needs of users, including social and cultural requirements, in particular gender.' Thus, the Sendai Framework calls for all-of-society engagement, partnership and empowerment, with special attention to people disproportionately affected by disasters, to fulfil its commitments.

The Ha Noi Recommendations for Action on Gender and Disaster Risk Reduction (13) clearly states that that women significantly contribute to disaster preparedness, prevention and risk reduction in the region and play a greater role in risk management and resilience-building than is often acknowledged. It also highlighted that women and girls are particularly vulnerable to disasters due to structural barriers based on gender biases and prejudices and socioeconomic discrimination, and that they often lack access to the resources, skills and information necessary for disaster preparedness and for securing livelihoods that would enhance their resilience

Sustainable Development Goals (2015–30) (14). Risk is increasingly systemic. If we want to reduce risk then we also must be increasingly joined up in our approaches: working cross-sectors, between and within institutions, and ensuring harmony from policy through to activity.

The Sendai Framework was the first of the world's best-known policy agendas. It set out the case for development to be risk-informed in order

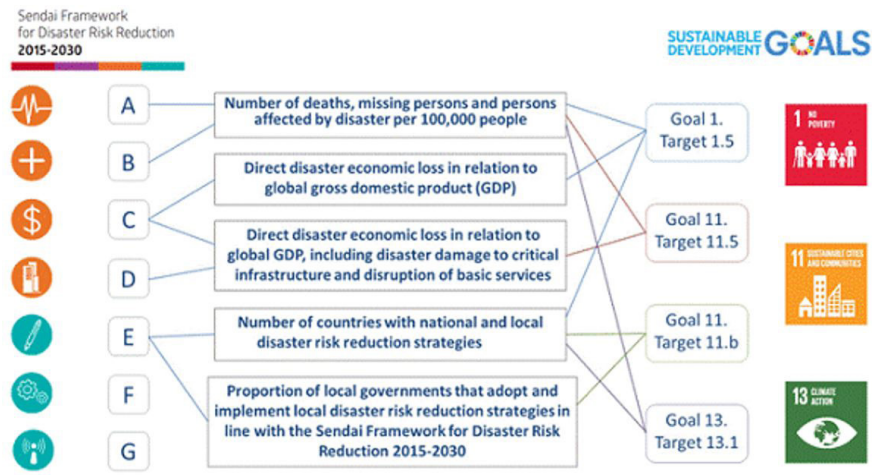

Figure 2: Depiction of Sustainable Development Goals in Relation with Sendai Framework Indicators
Source: UNDRR

to be sustainable. Direct economic losses from disasters have increased by more than 150 per cent over the past 20 years, with losses disproportionately borne by vulnerable developing countries.

Both the Sendai Framework and the Sustainable Development Goals (SDGs) outcomes are a product of interconnected social and economic processes. As such, there is a lot of synergy between the two policy instruments. In fact, Sendai Framework monitoring is intended to complement monitoring of 11 SDG indicators depicted in figure 2 below (corresponding Sendai Framework indicators in brackets):

INDIA LEVEL COMMITMENTS FOR CHILD SAFETY

The Constitution of India (15)

Addressing health of the vulnerable with a human rights approach rides on the common challenge to fundamental freedom granted to every citizen under part 3 of the Constitution of India.

There are other articles linked to Right to Health:

- Article 38 says that state will secure a social order for the promotion of welfare of the people promoting affordable Healthcare is one of the ways to promote welfare
- Article 39e cause the state to make sure that health and strength of workers men and women and the children of tender age are not abused
- Article 41 imposes duty on state to provide public assistance in case of an employment old age sickness disablement and so on
- Article 42 makes provision to protect the health of infants and mother by providing Maternity benefits
- Article 47 makes it duty of the state to improve Public Health for the state's duty includes prohibition of consumption of intoxicating drinks and drugs injurious to health

The Universal Declaration of Human Rights recognized health as an individual civil right meaning that states are bound to provide minimum guarantee to enable individuals enjoy health a right and provide Primary Health Services in an equivalent fair manner.

School Safety Guidelines and Disaster Risk Reduction (DRR)

Disasters are a critical threat to the well-being of children, due to a number of factors, like age, physical ability, gender, health conditions and, dependency on care givers, children are extremely vulnerable during a disaster event. These events may cause serious disruption in their healthy growth and development along with overall well-being. Disasters not only pose challenge to the government machinery and other key stakeholders

involved in providing access to education but also put the lives of children and their teacher at risk while they are engaged in the pursuit of education. It is also well known that the quality of school infrastructure including quality of construction, disaster resilient features and regular maintenance along with existing capacities of the stakeholders have a bearing on a child's vulnerability to disaster risks. School safety attains highest importance due to the fact that children spend majority of their daytime in schools, and bringing back schools to normalcy ensures supply of adequate and safe supplementary nutrition, safe water and sanitation and above all prevention from abuse and exploitation. 'School Safety' is been defined as 'the creation of safe environments for children starting from their homes to their schools and back'it includes all the hazards arising from large-scale 'natural' hazards of geological or climatic nature, man-made risks like riots, violence pandemics, fires, transportation and other related emergencies, and environmental threats that can adversely affect the lives of children.

The NDMA has released National School Safety Policy Guidelines in February 2016 with the aim to ensure that all school children, their teachers, and other stakeholders in the school community are safe from the various kinds risks arising from the natural hazards. These guidelines primarily focus on the urgent need for strengthening risk resilience of schools in both rural as well as urban areas of India. It is envisioned that these guidelines will be helpful in ensuring that all school going children across India remain safe from any kind of disaster risk while they access their right to education. The policy guidelines stressed upon active mainstreaming of disaster risk reduction in all the school education initiatives in India. This can be achieved by seamless collaboration between the state education departments and the state disaster management machinery.

Collaboration would be necessary, especially for capacity development activities such as sensitization of officials, public awareness on disasters, training of students and teachers; pre-positioning equipment's for emergency response, creation of educational material on disasters and, monitoring of risk. A cross sectional study was conducted on the state officers of education and training division on 'Addressing Child Centric Vulnerability, Enhancing Capacity and Promoting Resilience'. A pretested questionnaire having thirty multiple choice questions was used for understanding the response of participants. The questions were designed to capture the knowledge, Attitude and Practice of participants related to Child Centric Disaster Risk reduction. There were 80 participants in the training programme and 65 participated in the study (81 per cent). There were 55.4 per cent males and 44.6 per cent female participants. Maximum number of participants, i.e. 40

per cent were in the age range of 51 to 60 years, followed by 31 per cent in age group of 41 to 50 years and 29 per cent in 30 to 40 years of age.

In terms of knowledge level of the participants, all the participants were aware about the type of natural disaster facing their school and the name of the apex body for disaster management in the country. 94 per cent of the participants had awareness about emergency equipment and 88% could correctly tell about the first aid practices. Approximately 86 per cent of the participants could answer correctly about the type of committee at school level for disaster management. 86 per cent of participants could correctly tell the meaning of disaster and 83% could correctly enumerate the components of school safety disaster management plan.

With respect to the attitudinal components of the study, all the participants believed that planning is the best way to reduce the effect of disasters and mock drills should be conducted regularly to evaluate the effectiveness of disaster plan. They also unanimously believed that school teachers and staff should be trained in emergency response. More than 97 per cent of participants believed that their schools should have disaster management plan along with first aid kit. More than 95 per cent of participants believed that SDMA, DDMA and school authorities should work collaboratively to promote School safety and designated regulatory authorities should monitor safety parameters in all schools on regular basis in order to ensure that children remain safe while they access and enjoy their right to education. Around 85 per cent participants believed that disasters are manageable by human interventions and 77 per cent feel that their school is affected by one or other type of disaster.

With respect to the practice elements, only 23 per cent of participants reported to have disaster management plan at their schools, only 15 per cent schools had a school safety focal point teacher. List of emergency contact numbers was available in only 74 per cent of schools in either principal's office or director's office. Disaster mock drills are conducted in only 45 per cent of the schools. Only 46 per cent of the participants could correctly specify the frequency of conducting mock drills at schools, 32 per cent knew the disaster assembly area, and only 18 per cent reported to have a emergency response team. It was found that safety audits and mock drills were conducted in only 23 per cent of school.

QUALITY MANAGEMENT SYSTEMS IN INDIA AND ITS ALIGNMENT WITH SAFETY OF LIFE: THE QUALITY COUNCIL OF INDIA (QCI)

It was post economic liberalization in 1992 that India felt the need to establish its own accreditation. This body was envisioned to establish such mechanism

so that Indian products and services become internationally acceptable and given based on the conformity assessment results for India. For the medical and testing laboratories, an accreditation body under the Ministry of Science & Technology was already functional. A committee including stakeholders from various ministries and industries was constituted in order to make suitable recommendations on this matter. The committee worked under the supervision of the Department of Industrial Policy and Promotion. Its recommendations and full report were submitted to the Cabinet in the year 1996. The key recommendations of the committee included 'a dire need for establishing a self-sustaining and autonomous organization jointly by the Government and the industry'. Based on the committee recommendations the Quality Council of India (QCI) (16) was established. It came up as an autonomous, not-for-profit body under the Societies Registration Act of 1860. The sole purpose of the QCI was to establish an Indian accreditation structure along with thrust in spearheading the nation-wide quality movement, by undertaking a National Quality Campaign. The Quality Council of India was set up with the mission to make nationwide quality a reality. It was only possible by establishing and operating a National Accreditation structure and process. The accreditation process facilitated trade, by establishing equivalence and global acceptance of certification. They ramped up inspection and Testing in the areas of Quality, Environment, Food Safety, etc. For these two separate boards were established in the QCI. The first one was National Accreditation Board for Certification Bodies (NABL). This board was responsible for testing and calibration laboratories. The second board was The National Accreditation Board for Hospital & Healthcare Providers (NABH). This board was responsible for accreditation of hospitals and healthcare organization. Later on based on the industry acceptance and increase in demand for accreditation QCI also established the National Accreditation Board for Education and training (NABET). QCI closely works with international developmental organization such as FAO of the UN, for spreading the message of quality within and outside the country. QCI also helps the Indian stakeholder to meet international standards by facilitating in national interpretation of private standards and helping in their implementation at ground level.

Definition of Quality

Philips B Crosby defined it as 'Quality is doing the right things right, first time and every time for the right people at the right time' (17). American Society for Quality explains quality as 'A subjective term for which each person or sector has its own definition. In technical usage, quality can have two meanings: the characteristics of a product or service that bear on its ability

to satisfy stated or implied needs; a product or service free of deficiencies'. In the words of Joseph Juran, quality means 'fitness for use'; while as per P. Crosby, it means 'conformance to requirements.' Implementation of quality standards in an organization is considered a demanding task, however in most of the developing countries nations, getting accreditation is frequently used by hospital to assure quality and patient safety.

In the context of healthcare, quality can refer to the medical care quality and the non-medical aspects of service delivery to the consumers of quality, like infection control practices comprises of medical quality while reducing waiting time for patients, staff communication and attitude comprise of non-medical aspects. Both these aspects are based on the foundation of policies and procedures laid down by the management and their implementation in the organisation. The concept of quality management in healthcare can be understood in several ways. 'Quality' can simply be explained as activities undertaken by any that healthcare organization in order to understand and fulfil the needs of its consumers which could be a patient, their attendants, the staff members including the admitting doctor and his team members, the employer, the payer, the vendors or any internal consumers within the organization.

School Safety is not a onetime effort but a continuous process. Safety principles need to be incorporated in the day-to-day functioning of the educational institutions in the country, cutting across the traditional stages of the disaster cycle: preparedness, response and recovery. Thus, institutions involved in providing education in the country need to evolve a methodology and an approach of their own that looks at safety as a continuously monitored indicator of quality.

CONCLUSION

The continuing functionality of the hospital depends on a range of factors, including the safety of its buildings, critical systems and equipment, the availability of supplies, and the emergency and disaster management capacities of the hospital, particularly for response to and recovery from hazards or events which may occur. The accreditation standards laid down by NABH also require hospitals to plan and implement mechanisms for the care of patients during community emergencies, epidemics and other disasters. Risk assessment needs to be carried out to understand the safety and functionality of hospitals, such that life-saving and other health services can be provided in emergencies and disasters. India does not have any indigenous tool specific for hospital risk assessment, therefore it must depend on the scattered tools and checklists as provided by World Health Organisation (WHO) (18) and Pan American Health Care Organisation

(PAHO) (19). There are several benefits of conducting risk assessment by the healthcare organisations. It can help individual hospitals to calculate a cumulative disaster risk percentage and the areas which are at risk according to the hazards facing the hospital. Besides that, the identification and triaging of priority area for planning intervention at organisation level can also done, for instance the areas which get identified into high priority category can be marked in red colour, the areas which will be found moderately prepared can be marked in yellow colour, the areas which showed good level of preparation can be marked in Amber colour and lastly the areas which are most prepared can be marked as green. Triaging the priority areas will help in planning, resource allocation, forecasting and monitoring the progress of interventions. The risk assessment process can also help in development of dash board for the government and decision-making bodies to understand the Knowledge, Attitude and Practices of the hospital staff and keep them motivated in journey towards Safe hospitals. Basis the results of risk assessment cohorting of hospitals and development of a comprehensive system of Hospital Networks may be carried out to enable resource sharing during emergencies. This will also help in moving a step closer to accomplishing the Prime Minister's ten-point agenda on Disaster risk reduction (20). The agenda solicits in 'Investment in mapping disaster risk for all hazards'. It urges the central bodies to undertake a national level disaster risk assessment along with an online platform followed by state level multi-hazard risk assessments in all states. It also urges to develop maps for all major hazards in a standardized format to facilitate disaster risk reduction and ultimately development of standards/guidelines for different types of risk assessments. Therefore, keeping both the requirements parallel to each other and implementing them in letter and spirit will help us achieve the goal of 'safe hospitals' at the end.

In terms of school safety, the accreditation and registration authorities for schools can lay down safe learning environment as a necessary precondition for recognition of schools. They can also insist upon the designation of a school safety focal point teacher in new schools applying for recognition/accreditation. School safety can be introduced as one of the monitor-able indicators for continued recognition of private schools.

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