

Understanding Local Disaster Risk Reduction Management for Health Planning Process in Select Eastern Samar Municipalities*

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This policy brief aims to describe and examine the current organizational structures, planning process, and capacity development of local government units (LGUs), as well as the support mechanism of the central and Region 8 offices of the Department of Health-Health Emergency Management Bureau as they relate to the development of the Disaster Risk Reduction and Management in Health (DRRM-H) plans and mechanisms. It is a step toward framing a direction and mapping specific strategies to harmonize the planning process related to DRRM-H at the local level. This paper summarizes the findings and the policy indications presented in the commissioned policy research report on resilient local health systems¹ and results of discussions during the dialogue on resilient health systems².

The LGUs are, based on the Local Government Code (Republic Act 7160) and Philippine Disaster Reduction and Management Act (RA 10121), at the forefront when it comes to addressing health services and disaster preparedness. In strengthening responsiveness of local health systems to address disaster-related health impact, this brief proposes interventions to address policy and challenges related to operational and strategic planning and implementation of local DRRM-H interventions:

- The local DRRM plan should be comprehensive and detailed to include health concerns. Thus, there is a need to develop a comprehensive DRRM-H training agenda and standardized training modules for municipal and barangay stakeholders based on development training and needs assessments and information from a national health human resource database given the disproportionate number of health workforce to the demand for health providers especially with the complexity brought about by disasters.
- Monitoring and evaluation at the LGU level should be strengthened as a mechanism to ensure quality services in four thematic areas namely: ⁽¹⁾ disaster prevention and mitigation; ⁽²⁾ disaster preparedness; ⁽³⁾ disaster response; and ⁽⁴⁾ disaster rehabilitation and recovery. Effective feedback mechanism should be in place so the results of this regular monitoring of Department of Health regional office can be used for enhanced information dissemination at the local level.

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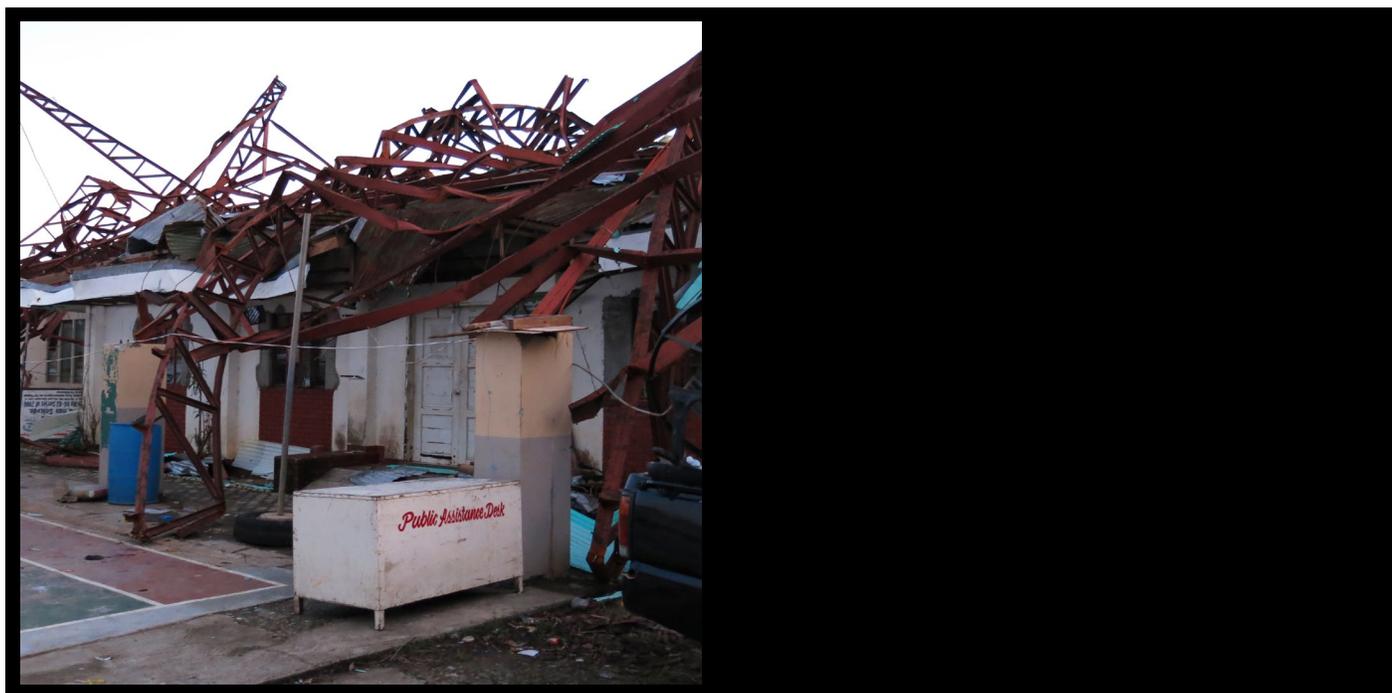
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¹ Canila, C., et.al. (2017) Policy Research on Disaster Risk Reduction and Management for Resilient Local Health Systems in Selected LGUs, Eastern Samar

² ZFF Dialogue on Resilient Local Health Systems held in November 20 2017 in Pasig City

Background

Super typhoon Haiyan (local name: Yolanda) brought heavy rains, powerful winds, and destructive storm surges to coastal towns and cities in the Philippines when it made landfall in November 2013. According to the official 2014 report of the National Disaster Risk Reduction and Management Council (NDRRMC), Haiyan displaced more than 890,895 families, or more than 4 million individuals, with estimate damage to infrastructure and agriculture amounting to more than P90 billion. After the calamity, the Department of Health (DOH) identified policy and implementation gaps, and developed an integrated policy for disaster risk reduction and management in the health sector. The integrated policy shall ensure effective translation of policy to action (DOH-HEMB, 2017).



Side by side photos show the damage and what was left of the rural health unit in Salcedo, a municipality in Eastern Samar province, after super typhoon Yolanda hit in November 2013. The massive number of casualties and damages to infrastructure due to the disaster brought to the fore the need for an integrated policy for disaster risk reduction and management, which includes plans for health. (Photos by Zuellig Family Foundation)

The efforts of the DOH toward resilient local health systems are through the training initiatives of the Health Emergency Management Bureau (HEMB), specifically on the management of health emergencies by provincial and municipal health service providers. Results of the post-Haiyan stock-taking workshops conducted by the United Nations Children's Fund (UNICEF) showed that resiliency factors and sectoral coordination mechanisms were not considered during the Health Emergency Preparedness, Response and Recovery Planning (HEPRP). Given the significant and long-lasting individual- and population- level effects on physical, mental, and social wellbeing brought by disaster, successful post-disaster rebuilding of healthier, more sustainable and resilient communities requires the coordinated efforts of a multidisciplinary group of stakeholders from health and non-health sectors (Institute of Medicine, 2015). Local leaders should develop and support programs designed to strengthen social networks and deepen trust among community members before and after disasters, thereby increasing resilience. Strategies for enhancing and preserving social networks should be specifically included in community health improvement and disaster recovery plans (Institute of Medicine, 2015).

These findings guided the design of UNICEF's 15-month (October 2014 to December 2015) initiative, "Roll-out of Evidence-Based Action Planning for Resilient Health Systems." The project aimed to help Haiyan-affected municipalities develop their three-year HEPRRPs, which will guide the LGUs in strengthening their health systems before, during, and after disasters. For the Zuellig Family Foundation (ZFF), this was in complement to the Health Leadership and Governance Program (HLGP) of the DOH which was rolled out in some of the Yolanda-affected municipalities as part of its efforts to assist municipalities in the recovery and rehabilitation of their health systems.

As an implementing partner, ZFF together with the DOH -HEMB RO 8, and the provincial health offices of Samar and Eastern Samar provinces, facilitated the training and coaching of the municipal disaster risk reduction teams of the 12 LGUs to develop their HEPRRPs or DRRM-H Plans. Other than the leadership and governance training for the mayors and municipal health officers of the 12 LGUs³, they were also provided training in three areas deemed necessary to enable them to craft their MDRRM-HPs. These were on psychosocial processing, basic health emergency management system and evidence-based planning processes for HEPRRP. These training inputs were then complemented with coaching and write-shops by ZFF with the DOH partners to assist the LGUs in completing their HEPRRPs. When the project was completed in December 2015, the HEPRRP teams of the 12 Yolanda cohort LGUs presented their HEPRRPs duly endorsed by their respective local health boards and approved by the Municipal Council⁴.

The findings, policy implications and recommendations presented in this paper were culled from the policy research report, "Disaster Risk Reduction and Management for Resilient Local Health Systems in Selected LGUs Eastern Samar," done by the team of Carmelita Canila, M.D., MPA (principal investigator), Ma. Esmeralda Silva, PhD (co-investigator), and Verdad Agulto, MSc (co-investigator), completed in November 2017.

The policy research aimed to:

- (1) Describe the current mechanism and plans of DOH-HEMB central and Region 8 offices to provide support (e.g., policy development, harmonization) to LGUs in the development, implementation, monitoring of DRRM-H, and its harmonization with related DRRM plans required by other agencies;
- (2) Identify best practices in health resiliency planning, implementation, and monitoring among the four⁵ identified municipalities that can be mainstreamed or adopted by other government agencies and local governments; and
- (3) Describe planning, implementation, and monitoring processes aligned with the DRRM-H in selected barangays (villages) of the four municipalities.

The four municipalities were part of the 12 Yolanda cohort municipalities that participated in the leadership and governance training and subsequently drafted their HEPRRPs. These municipalities rolled out the Barangay Health Emergency Management training in selected barangays.

The study used qualitative methods. A records review was conducted. Policies in relation to DRRM-H issued by the municipal governments and barangay councils were collected, scanned and uploaded on Google Drive. In gathering primary data, key informant interviews with the mayors and representatives of regional and national HEMB and focus group discussions (FGDs) with municipal and barangay DRRMC members were undertaken, aided by a semi-structured guide developed specifically for this study.

³ A critical feature of the HEPRRP teams of the LGUs is its composition as it illustrates the inclusive participation of both health and non-health LGU officials. The teams were composed of both health (municipal health officer and nurses) and non-health LGU officials including the municipal officers for planning and development, DRRM, and local government operations. ZFF also engaged Manila Observatory, a scientific research institution with research work in the fields of atmospheric and earth science, to map the vulnerabilities and trust networks of the 12 municipalities.

⁴ The 15-month UNICEF initiative involved, other than the 12 Samar Island LGU partners of ZFF, 38 other municipalities in Leyte, Cebu, Iloilo and Capiz that were likewise severely affected by Yolanda. These areas were covered by two other UNICEF implementing partners namely University of the Philippines (UP) Visayas in Iloilo and UP School of Health Sciences in Palo.

⁵ Salcedo, Guiuan, Balangiga and Mercedes

Major Findings of the Study

A. Current mechanism and plans of HEMB of DOH central and Region 8 offices

The overall mandated objective of DRRM-H is three-pronged: 1) prevent unnecessary morbidity and mortality; 2) provide continuous service; and 3) avert outbreak of preventable diseases, secondary to disaster (DOH-HEMB, 2017). In ensuring these objectives are realized, the leadership and policymaking on DRRM-H reside with the LGU. The policies issued by the DOH central and regional offices were seen as support in capacitating health emergency management system (HEMS) on the ground. Based on the Philippine Disaster Reduction and Management Act (RA 10121), the DOH is a regular member of NDRRMC to ensure health is mainstreamed and integrated in the whole disaster management process. Below are the health-related policy objectives as indicated in RA 10121:

Declaration of Policy

1. Mainstream disaster risk reduction and climate change adaptation and mitigation in development processes such as policy formulation, socioeconomic development planning, budgeting, and governance, particularly in the areas of environment, agriculture, water, energy, health, education, poverty reduction, land-use and urban planning, and public infrastructure and housing , among others; (g)

2. Enhance and implement a program where humanitarian aid workers, communities, health professionals, government aid agencies, donors, and the media are educated and trained on how they can actively support breastfeeding before and during a disaster and/ or an emergency; (o)

Source: Declaration of Policy of Philippine Disaster Reduction and Management Act (RA 10121)

The DOH central office is an enabler, therefore, is responsible for developing policies and systems, as well as helping build the capacities of regional offices through training, technical assistance and funding. The DOH regional offices facilitate the development of LGUs as managers and orchestrate organization and operationalization of DRRM-H. The LGUs are the managers localizing and leading the implementation of DRRM-H on the ground in which families and communities are the eventual end-users.

The National Disaster Coordinating Council (NDCC) Memorandum Circular No. 5 of May 10, 2007 called for the institutionalization of the Cluster Approach in the Philippine Disaster Management System. With the introduction of the Cluster Approach by the United Nations-Office for Coordination of Humanitarian Affairs, 11 clusters were organized. The nutrition, water, sanitation and hygiene (WaSH), and health clusters are led by the DOH through the HEMB.

In July 2016, HEMB launched in Region 8 its Six-Year Strategic Plan (2017-2022) with the vision of achieving communities' disaster resilience for health, or in Pilipino Kaligtasang pangKalusugan sa Kalamidad sa Kamay ng Komunidad (5K). To achieve its 5K vision, one of the critical strategies of HEMB is establishing

the 5K Kadre, a team of trained Regional DRRM-H experts and serves as the main mechanism for the institutionalization of the DRRM-H in the cities, municipalities and communities. It likewise serves as the key resource for the prevention, mitigation, preparedness, response, recovery and rehabilitation strategies of the DRRM-H Plan. The organizing and training of the 5K Kadre was then piloted in Region 8 involving provincial and city HEMS coordinators, as well as other regional, provincial and even hospital DOH personnel. Overall, the DOH follows the Manual of Operations of the Health Emergency Management System. In terms of monitoring initiatives, the DOH has not yet set up an integrated monitoring system for DRRM-H in the study sites. But, the desire of municipal governments to be recognized under the Seal of Good Local Governance (SGLG) provided the impetus for monitoring.

B. DOH support to LGUs on harmonization with DRRM plans required by other agencies

Based on interviews and FGDs, municipal-level respondents were well aware of the need to integrate DRRM-H into the wider LGU DRRM (LDRRM) plan and to ensure budgetary support via the LGU annual investment plan. They also understood LDRRM plans that embody the needs of the communities provide good leverage for external funding and technical support by partners (both local and international non-government organizations and government agencies).

However, the challenge for most LGUs was the lack of check-and-balance mechanisms to facilitate the use of the critical avenues where DRRM-H is integrated and harmonized with the larger LDRRM plan or LGU investment plans. These check-and-balance mechanisms ensure that the LDRRM plans (including the DRRM-H) and activities are:

- consistent or in line with standards set forth in the NDRRM framework and plan; and
- responsive, integrated and comprehensive, as well as result in resiliency.

C. Health emergency and resilience policies at local levels

To determine policy support by the LGUs, an inventory of policies was done per municipality and barangay.

1. Health emergency or resilience policies created and implemented at the municipal level

All four municipalities have HEPRRP developed and adopted in 2015. All have the HEMS organizational structure, with MHOs as designated municipal HEM coordinator (see Table 1). All DRRM plans, including HEPRRP, formulated by municipal and barangay LGUs in the study sites were based on risk assessment. Based on the documents reviewed, there were similar process, information used and outputs generated in risk assessment, vulnerability and resource mapping for DRRM and DRRM-H planning—resulting in redundancy.

Table 1. Key DRRM-H components

<i>Components</i>	<i>Salcedo</i>	<i>Guiuan</i>	<i>Mercedes</i>	<i>Balangiga</i>
Municipal HEMS structure	Organized and functional	Organized and functional	Organized	Organized and functional
Basis of the plans	Risk assessment	Risk assessment	Risk assessment	Risk assessment
Objectives of the policy and plans	Be prepared against any form of calamities. Prioritize the needs of the vulnerable groups.	Minimize the effects of the hazards, especially on health. Address the needs of the vulnerable population groups.	Minimize the effects of the hazards, especially on health, and strengthen preparedness.	Ensure responsiveness to health, prevention and mitigation.
Level of implementation	More than 50% of the HEPRRP plan has been implemented.	More than 50% of the DRRM plan has been implemented largely because these are existing programs already.	No exact figure given but some activities were already implemented.	More than 50% of the HEPRRP plan has been implemented.
Funding source/s	Internal and external funding used to support the DRRM activities (e.g., gender, DRRM, development fund and some from maintenance and other operating expenses)	5% DRRM fund, gender and development fund and funds through the LHB or health funds	5% DRRM fund	5% DRMM fund, 20% development fund, as well as external sources

It has been noted that the LGU HEPRRP team is composed of both health and non-health municipal officials, with MHO as the focal person. Supported by the local chief executive, the team worked to draw-up LGU HEPRRP. When asked about the components or elements of the policy, respondents identified the movement from institutional preparedness to family preparedness. One respondent shared that the BDRRM plan included the Barangay Health Emergency Management System (BHEMS), as well as the strengthening of the WaSH coverage at the barangay level.

In implementing DRRM plans of the municipalities, common issues were identified by the respondents. These include low absorptive capacity of the LGU in implementing projects, largely driven by the lack of skilled personnel who manage and monitor projects, which resulted in delays. Funding was also a challenge, with most municipalities reporting low utilization rate (less than 5 percent) of DRRM fund for the past two years, driven by priority to externally-funded projects. DRRM plans were funded using the mandated 5 percent of the LGU regular income including the annual internal revenue allotment. Donor-organizations or NGOs would shoulder the expenses of programs, projects or activities that were within their mandate. One pressing issue related to vulnerability has been the lack of access to health services in the relocation sites. Based on interviews, people in those sites depended highly on the health services provided in the nearby barangay health station or rural health units (RHUs).

All respondents were knowledgeable about the DRRM's primary financial source and for what purpose it must be used for—70 percent for preparedness and 30 percent for response operation. However, there was no clarity on where to source funding allocation for HEPRRP implementation since they could not always rely on the DRRM funds. As a result, health managers of LGUs learned to be creative in fund sourcing and mobilization. They used multiple sources within the LGU such as the gender and development (GAD) fund for training and emergency use for mothers; health budget used for sanitation, waste segregation, medicines for preparedness; and 20 percent development fund, among others. Further, MDRRM funds were used as counterpart to externally-sourced support for health.

2. Partnerships and monitoring mechanism related to health emergency and recovery at municipal level

DRRM-H was integrated into the LGU planning processes. While LGUs interviewed revealed DRRM-H plans were formulated and implemented, monitoring and evaluation of the DRRM plans did not appear to be harmonized (see Table 2).

Table 2. Participatory planning, partnership, and monitoring process related to DRRM-H

<i>Components</i>	<i>Salcedo</i>	<i>Guiuan</i>	<i>Mercedes</i>	<i>Balangiga</i>
Approaches to participatory planning	<p>One-week workshop was done.</p> <p>Consultation with all sectors was done.</p>	<p>DRRM plan started with a situational analysis at the community level. A series of workshops was conducted. This was followed by planning and assessment activities. These activities were consultative and participative in nature. At the barangay level, DepEd officials, affected individuals, people’s organizations, organized health teams participated in these activities.</p>	<p>Discussed among health staff</p>	<p>Planning process was led by the MHO.</p>
Partnerships developed	<p>With local and international NGOs and government agencies</p>			
Monitoring mechanism	<p>Plans are monitored by health staff and discussed in the LHB meeting.</p> <p>Resilient local health systems roadmap is used.</p>	<p>Monitoring of plans are done by RHU.</p> <p>“Non-negotiables” are monitored through resilient local health systems roadmap.</p>	<p>Updating done by health staff</p>	<p>Updating done by health staff</p>

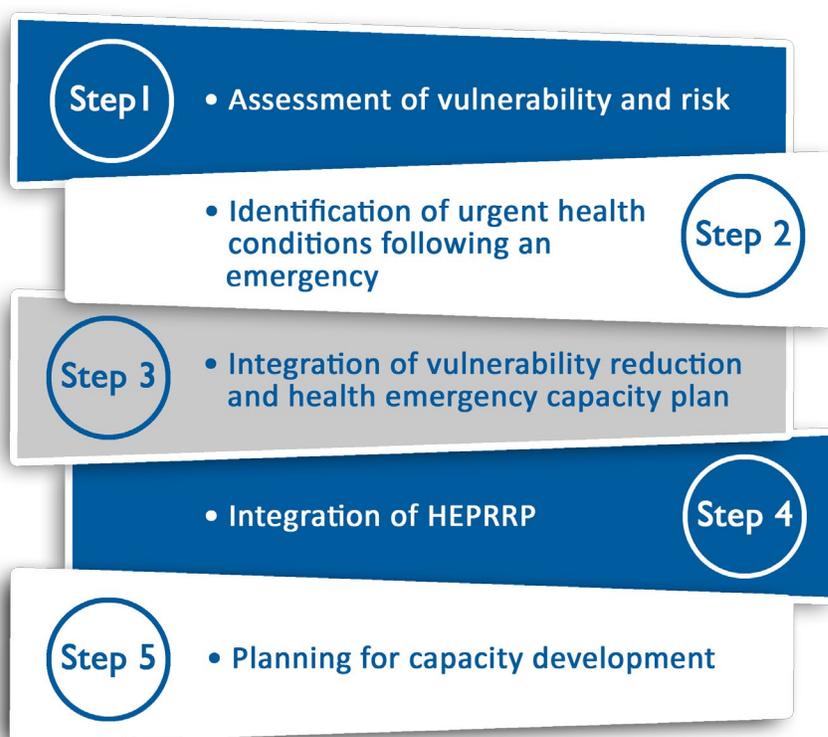
Partnerships with local and international NGOs were developed to address needs of municipalities and barangays. Plans of LGUs were matched with INGOs' priority thrusts. Presence of recovery, relocation, and rehabilitation plans paved the way for determining the type of assistance to be provided. The mayor's role to facilitate trust building became highly necessary. SGLG track record, LGU's readiness to provide counterparts, as well as conduct of regular meetings among local department heads, contributed to the successful implementation of programs and projects.

D. Common practices related to health resiliency planning among the four identified municipalities that can be mainstreamed or adopted by other government agencies and local governments

All municipalities have practiced evidence-based and participatory planning based on risk, vulnerability and capability assessment, as well as hazard and resource mapping. Members of the planning team led by the barangay captain include: rural health midwife or kagawad on health, barangay health worker, barangay nutrition scholar or focal person for nutrition, barangay sanitary inspector or focal person for WaSH, sectoral representative from local organization, parent leader, Day Care teacher, committee member on finance and appropriations, and school DRRM Council representative or school principal.

It may be overwhelming for a barangay to have multiple plans, but these, coupled with participation in the planning process, represented dynamic governance at the barangay level. This also meant this is something doable, with the technical and financial assistance of the DOH, ZFF and other development partners. The presence of organizational structures (BDRRMC, expanded barangay health board, WaSH committee, etc.), even if composed of the same people, is a testament to a working governance structure with the communities.

The planning process followed a methodological manner. Reading through the municipal HEPRRP, the following planning process and results were observed in the LGUs:



Step 1. Assessment of vulnerability and risk

The DRRM planning process started with a situational analysis at the community level. Risk assessment preceded planning process, be it for DRRM or HEPRRP done at the municipal or barangay level, as narrated by the respondents in all study sites. Health risk assessment was also included in the DRRM planning. These activities were consultative and participative in nature which included Department of Education officials, affected individuals, people's organizations, and organized community health teams at the barangay level.

Typhoons were commonly used as disaster scenario. Communities vulnerable to typhoons were profiled and the expected impact on these populations was visualized. Impact level of different hazards to vulnerable communities was shown in an analysis. This was a pragmatic risk assessment, done by the DRRM Council and committees, as well as LGU officials, but technically assisted by different partners.

Since the risk assessment for the DRRM planning was done ahead of the HEPRRP, it was highly probable the steps taken in risk assessment were the same, or HEPRRP benefited from the initial situational analysis done at the DRRM planning. However, one emerging need is to streamline the tool to identify hazards, particularly the technical definition of health hazards that can be easily understood and measured by local stakeholders.

Step 2. Identification of urgent health conditions following an emergency

To facilitate the development of preparedness and response plans, urgent conditions were classified by chronological order (first 24 hours, after two to three days, after one week, after one month). Furthermore, services required to address these conditions were identified and tabulated. The required services, under the disaster health response were organized along four main clusters (medical services, WaSH, nutrition, and mental health and psychosocial services). This step resulted in a more strategic intervention to address priority health needs considering the limited resources of the LGUs. Respondents identified the zero casualty related to health consequences of the typhoon, such as diarrhea and pneumonia during Typhoon Ruby, as a sign of increased resiliency among the people in the four municipalities.

Step 3. Integration of vulnerability reduction and health emergency capacity plan

The World Health Organization Health Systems Framework is used to identify possible barriers to health service provision after a disaster. Existing capacity, or the strength and available resources, was assessed. The disaster's possible impact on existing capacity was scrutinized. Gaps and opportunities in delivering the required services were identified and prioritized, including lack of human resources and overlapping activities related to disaster response. Strategies to address these identified gaps were recommended to harmonize the efforts of the LGUs and partners and establish a more resilient health system. These strategies were further discussed to become the Health Emergency Preparedness Plan, or the LGU's strategies in building local capacity to respond to emergencies.

As a result, households developed an increased awareness of what needs to be done. Examples given include assigning meet up points if they get separated during disasters as well as preparation of "go bags." Respondents shared houses were built better. Anticipatory meetings at the community level

were being conducted. The barangays started infrastructure audit complemented by MOAs with homeowners with resilient houses as possible evacuation sites during disasters. Critical investments in WaSH have been identified at the municipal and barangay levels.

Step 4. Integration of HEPRRP

The Response Plan contains the strategies and activities for effective and efficient response during emergencies. The Recovery and Rehabilitation Plan contains the strategies and activities to build the locality after the emergency and return to or even prosper than its original status.

In Guiuan, there is Level 3 network (individual household connection) for potable water to ensure access. Disaster preparedness is now part of the curriculum, even among Day Care centers. The health facilities also serve as evacuation centers in line with the municipality's push to ensure government facilities are more resilient (ie., able to withstand 300+ kph winds). As an example, the new RHU in the poblacion —also an evacuation center—was built through pooled KALAHI funds of the different barangays in its catchment area. Other programs in Guiuan include the creation of mangrove plantations, push for smart agriculture (organic farming and the planting of disaster resilient crops), and creation of economic resiliency through a savings program where approximately three groups for livelihood projects in marine protected areas were created in which members were encouraged to have a group savings account (*pahulugan* program).

Step 5. Planning for capacity development

The strategies detailed under HEPRRP become the basis for developing a Capacity Development Plan with timeframe, required resources (funding, human, technology, technical, etc.), strategy implementation lead, and a monitoring and evaluation system.

This plan, when implemented, should enable the local health system respond to different challenges and increasing demand during, after, and recovery from the disaster.

Revisiting Local DRRM-H Process, Policy Implications and Recommendations

The results of the policy research underscore the importance of local capacity in making health systems resilient. LGUs able to implement DRMM-H plans have strong support from their local executives. Implementation challenges were apparent due to weak leadership and policy support and lack of funding sources. Political capital facilitated the development of structures and institutional arrangements in the LGUs for the implementation of DRRM-H programs.

Leadership and local governance are imperative in shaping minds of the people, community, and the entire local health system to be resilient and responsive to any form of disaster. Capacity building among local leaders is needed to steer local health system to become responsive to the health needs of the people during and after disaster. This formation is needed to develop a sense of accountability and responsibility to the health conditions of the vulnerable groups and the entire community.

The lack of integrated process in terms of policy and financial support, and technical competence among health workers and local officials were encountered at the local levels. Evidence and experience suggest local governments may benefit through the following policy and program recommendations:

Policy and program recommendations for DOH, DILG and institutional partners

- Enhance dissemination of national policies in appropriate discussion venues, clearly explaining the basis and specific implementation points of policies.
- Disseminate and implement DRRM-H-related policies and plans in collaboration with the Department of the Interior and Local Government, maximizing this agency's influence over LGUs, to increase compliance to policy and strengthen governance in DRRM-H.
- Streamline tool to identify hazards, particularly technical definition of health hazards that can be easily understood and measured by local stakeholders. Specifically, there is a need to categorize the level of health hazards to ascertain the urgency and level of prioritization of LGUs considering their limited resources.
- The LDRRM plan should be comprehensive and detailed to include health concerns. Thus, there is a need to develop a comprehensive DRRM-H training agenda and standardized training modules for municipal and barangay stakeholders based on development training and needs assessments and information from a national health human resource database.
- Strengthen the role of the local health workforce in health emergency management system to provide health services, through enhanced planning, training, and access to other resources.
- Empower local authorities, through regulatory and financial means, to work and coordinate with civil society, communities and indigenous peoples and migrants in disaster risk management at the local level.
- Strengthen coordinating and monitoring mechanisms among government and NGOs to avoid overlapping processes related to disaster management. The DOH may develop guidelines to harmonize all efforts related to health resiliency. This encourages all the government and NGOs working directly with the LGUs to review their programs and streamline planning, implementation and evaluation processes at all levels. A regional intersectoral committee can be organized to oversee processes related to health resiliency. The committee may be composed of DOH, DILG, the Department of Social Welfare and Development, Office of Civil Defense and other government, non-government and private sector representatives who will monitor health resiliency activities and performance of LGUs as mandated by the law. Part of their work is to develop the annual report with recommendations for the NDRRMC necessary to strengthen health resiliency efforts.

Policy and program recommendations for LGUs

- Adopt national policies at the local level (LGU executives to pass local counterpart policies).
- Strengthen monitoring and evaluation at the LGU level to ensure quality services in all phases of prevention and mitigation, preparedness, response and rehabilitation. Feedback mechanism should be in place so the results of this regular monitoring of DOH regional office can be used for enhanced information dissemination at the local level.

Policy and program recommendations for DOH and LGUs

- Ensure the institutionalization of the 5K Kadre to: 1) enable the DOH regional office to guide the LGUs in providing technical assistance to the cities, municipalities, and barangays in developing and implementing their DRRM-H Plans, and 2) improve regional capacity to provide training and capability building for LGUs and monitoring based on DRRM-H.
- Improve regional capacity (i.e., having more skilled personnel) to provide training and capability building for LGUs and monitoring based on DRRM-H than emergency response alone.
- People with life-threatening and chronic disease and special needs (e.g., pregnant, elderly and PWDs), due to their specific needs, should be included in the design of policies and plans to manage their risks before, during and after disasters. These include access to life-saving services, livelihood support as part of recovery, and rehabilitation plan.
- For safe health facilities: 1) ensure compliance of existing and new hospitals with the DOH Safe Hospitals Protocol, and 2) develop, promote and ensure compliance with Safe Health Facilities Protocol (RHUs and BHS). This will entail the assessment of existing health facilities according to the protocols and remedial action is taken.
- Map out health facilities (both public and private) and establish a mechanism or arrangement for referrals. This can be integrated as one package intervention with Service Delivery Network and inter-LGU collaboration to strengthen capacity for DRRM-H.

Acronyms

BHEMS	Barangay Health Emergency Management System
BDRRMC	Barangay Disaster Risk Reduction and Management Council
DILG	Department of the Interior and Local Government
DOH	Department of Health
DRRMC	Disaster Risk Reduction and Management Council
DRRM-H	Disaster Risk Reduction and Management for Health
DSWD	Department of Social Welfare and Development
GAD	Gender and development
HEMB	Health Emergency Management Bureau
HEMS	Health Emergency Management System
HEPRRP	Health Emergency Preparedness, Response, and Recovery Plan
IRA	Internal revenue allotment
LDRRM	Local Disaster Risk Reduction and Management Plan
MDRRM-HP	Municipal Disaster Risk Reduction and Management Plans in Health
NDCC	National Disaster Coordination Council
NDRMMC	National Disaster Risk Reduction and Management Council
NGO	Non-government organization
RA	Republic Act
RHU	Rural health unit
SGLG	Seal of Good Local Governance
WaSH	Water, sanitation and hygiene
WHO	World Health Organization

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