REPORT ON RAPID ASSESSMENT OF EMERGENCY PREPAREDNESS RESPONSE IN NEPAL

Supported by
World Health Organization

Conducted by
Nepal Health Research Council
Ramshah Path, Kathmandu

January 2011

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SUBMITTED TO
WORLD HEALTH ORGANIZATION (WHO)
COUNTRY OFFICE NEPAL

SUBMITTED BY
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JANUARY 2011

Acknowledgement

The report has incorporated the process of adoption of tools in Nepalese context, rapid assessment of emergency preparedness and response of health sector using adopted tools and proceeding of dissemination workshop. The report has contributed to analyze the emergency preparedness and response capacity of Nepal and the development of action plan to address the disaster emergency in Nepal.

I extend my sincere thanks to all members of steering committee for their extensive input to finalize the tools in Nepalese context, assessing the status and developing final presentation for dissemination. My special thanks go to Mr. Meghnath Dhimal, Chief Research Officer of NHRC who coordinated this program and prepared this report.

I am thankful to the World Health Organization (WHO) Country Office Nepal for the financial and technical support to complete this report. My sincere thanks goes to Ms. Hyo-Jeong Kim, Technical Officer, Mr. Damodar Adhikari, National Professional Officer and Mr. Prahlad Dahal, EHA assistant of WHO for their continuous technical and administrative support to make the program success.

The great thanks go to Dr. Praveen Mishra, Health Secretary, Ministry of Health and Population for accepting our request as chief guest for inaugurating the dissemination workshop and putting his remarks and emphasizing need of emergency preparedness and response in Nepalese context and commitment to translate policy into action.

I heartily appreciate the presence of Dr. Chet Raj Pant, Honorable member of National Planning Commission, by accepting our request as special guest in dissemination workshop and his commitment and emphasis on emergency preparedness and response on policy and planning in Nepal.

I would like to thank Dr. Yashovardhan Pradhan, Director General, Department of Health Services for accepting our invitation as guest and giving valuable remarks in dissemination workshop with the commitment of translating developed action plan in practice.

Similarly immense thanks go to all the thematic working group members' especially from Nepal Red Cross Society, WHO, GTZ, USAID, CARE Nepal, Institute of Medicine Maharajgung, and participants from Regional Health Offices and others NGO/INGOs for their great effort in assessment of tools and making this report to happen.

At last but not least, my sincere thanks goes to all supporting staffs of NHRC who directly or indirectly supported this program especially Mr. Nirbhaya Kumar Sharma, Mr. Subodh Kumar Karna, Mr. Bijay Kumar Jha, Mr. Bikram Dhimal, Mr. Hari Datt Joshi and Mr. ~~Pooka~~ Puka Lal Ghising for their administrative and technical support.

Thanking you.

With regards,
Prof. Dr. Chop Lal Bhusal
Executive Chairman
Nepal Health Research Council

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CHAPTER 1: INTRODUCTION

1.1Background

The Government of Nepal has classified Nepal as one of the hotspots of multi hazards. The country faces high frequency and intensity of a multiple hazards including floods, landslides, forest fire, drought, hailstorms, avalanche, conflict, earthquake etc. Among 200 countries, Nepal ranks 11th and 30th, respectively, with regard to relative vulnerability to earthquake and flood (UNDP/BCPR, 2004). An inventory of past disastrous events during 1971-2006 reveals that epidemics takes the largest toll of life every year, and that landslide, flood (including the flash floods) and urban or rural fire are the principle hazards in terms of their extent and frequency of occurrence as well as the spread and intensity of physical and socio-economic impacts(NSDRM 2008). According to the Global Earthquake Safety Initiative, Kathmandu is exposed to the greatest earthquake risk per capita among 21 megacities around the world, largely due to building collapse and insufficient preparedness and medical care (GHI/UNCRD, 2001). If an earthquake of the 1934 magnitude is repeated at this point of time, an estimated 40 000 deaths, 90,000 injured and 600 000–900 000 homeless can be expected (GHI/NSET, 1999). Such numbers pose a tremendous challenge to the health system of the country, which is highly vulnerable to any seismic event. Nepal's health system is highly vulnerable to natural and man-made disasters. As such, it is imperative that the health sector focus its work on improving and strengthening the health system of Nepal against possible disasters that may occur.

Efforts have been ongoing since early 2000 to enhance the level of emergency preparedness in Nepal in all sectors. The Ministry of Home Affairs (MOHA) is the national focal Ministry for coordination of various aspects of disaster management in Nepal. The focus of disaster management in Nepal is changing from reactive (relief and response) to proactive (preparedness) risk reduction, as seen in the "National Strategy for Disaster Risk Management 2009" prepared by Home Ministry. This strategy has been broadly divided into the Cross-sectoral and Sectoral strategies for Disaster Risk Management.

Comment [M1]: Sequence and repitition

The sector-specific strategies are focused on addressing the identified gaps in particular sectors. They are divided into the five Priorities for Action. The following sectors have been considered (MOHA, 2009):

- Agriculture and Food security
- Health
- Education
- Shelter, Infrastructure and Physical Planning
- Livelihood Protection
- Water and Sanitation
- Information, Communication, Coordination and Logistics
- Search and Rescue, and Damage and Needs Assessment

Implementation and follow-up of the Strategy is the most important tasks. While the National Government is the ultimate responsible agency for implementing the Strategy, the latter envisages decentralization of authority as well as responsibilities. Disaster Management focal points have also been appointed in key line Ministries including Ministry of Health and Population. Health sector is a main area where numerous partners have implemented various programs with the same goal of enhancing health sector preparedness for emergencies. The programs have focused on enhancing the overall readiness of the health sector through training of its personnel, development of guidelines and implementing simulation exercises at national, regional and district levels.

The World Disaster Report 2006 highlighted the discouraging fact that around 58% of the total number of people killed in natural disasters during the decade 1996-2005 was from SEAR countries. In 2005, three countries (Bangladesh, India and Indonesia) were among the top ten countries most affected by natural disasters. The benchmark framework is a response to the collective experience of five SEAR countries during the earthquake and Tsunami of 26 December 2004, the recurring emergencies in all SEAR member countries and the global call for improved emergency preparedness actions across the countries. All the countries in SEA Region are committed to it. The benchmarks would help to set standards and can be applied to specific situations in the member countries. The application of benchmarks approach would facilitate planning, monitoring and evaluation and allow adoption of country specific approaches.

Comment [M2]:

The Emergency and Humanitarian Action (EHA) Program of WHO SEARO and its partners have applied the process of setting benchmarks as a tool to assess the quality and improve performance in emergency preparedness and response. The benchmarks are an expression of the consensus and commitment of the countries. Benchmarking is a strategic process often used by businesses to evaluate and measure performance in relation to the best practices of their sector. The SEARO Benchmark Framework consists of 12 benchmarks which were developed through a participatory process that involved the member countries in the Region. The benchmarks are the product of a regional consultation in Bangkok in November 2005. Each benchmark has a corresponding set of standards, and indicators which were developed following a regional consultation in Bali 2006. Each benchmark has one or more standards. The standards denote the technical reference level of quality or attainment of the benchmark. The standards are qualitative and universal in nature and are applicable in any operative environment as they specify the minimum level to be attained. The standards were derived from each benchmark. In order to measure the progress or achievement of each standard there are several indicators identified. These indicators relate to health sector and all the partners within the sector including the government at different levels, private sector (for profit and not for profit) and academic institutions. Similarly there are indicators for other key sectors outside the health sector that impact the overall preparedness and response. Some examples of these key sectors include water and sanitation, food security and food safety, sanitation and waste management etc. For each of the indicator there is questions/checklist that helps to assess the indicator. The assessment of indicators can be done by qualitative and quantitative means. The assessment of indicators would contribute to establishment of the baseline and to assess progress.

These benchmarks integrate multi sectoral concerns at community, sub national and national levels. This means that if all benchmarks are achieved, the level of preparedness of the country will be high and intersectoral linkages and wide participation by all stakeholders will be achieved. This would help to mitigate the impact of disasters.

While the health sector has made progress in emergency preparedness, it is critical to take a stock of action and also to independently verify whether the course of actions taken is appropriate. Further there is a need to verify whether the emergency response capacity of MoHP

Nepal is adequate to respond to the health challenges that may arise in a severe disaster. In order to assess the preparedness of MOHP for emergency response at the time of Disaster, this rapid assessment is done. .

1.2 Justification for using the tool in Nepal

Nepal has had numerous programs in emergency preparedness which have been running for a number of years. The programs include: District and regional level contingency planning; Standard Operating Procedures for disaster response for the health sector; hospital preparedness in emergencies; mass casualty management and many others related activities. Despite the number of programs, no comprehensive assessment has been done of the health sector to fully understand its level of readiness and the impact of the different programs. The frequent changes within the health sector have also raised the question on the sustainability of the various programs. The ultimate question to be answered is "will the health sector be able to respond effectively and efficiently and be able to reduce avoidable mortality and morbidity during emergency or disaster". This tool will allow the health sector to take a critical review of its readiness and structure, and allow it to identify the gaps and use this analysis to better plan for future activities.

1.3 Objectives

The overall objective of this rapid assessment is to identify the level of preparedness of the health sector of Nepal in responding to disasters.

The specific objectives would be:

a. to describe the level of preparedness of the health sector to emergencies by
    i. identifying capacities in place in key areas
    ii. identifying gaps in key areas
b. to relate the findings of the assessment to the existing programs being implemented on emergency preparedness in the health sector
c. to identify key areas where gaps exist
d. to advocate on bridging the gaps that are identified by the survey

CHAPTER 2: METHODOLOGY

2. 0 Methodology

A generic tool has been already developed by WHO SEARO to assess the level of emergency preparedness in ~~a country~~a ~~of~~country of SEAR Member States. The preparation process included adapting the tools to the national context, conduction of the assessment and dissemination of the findings. The details are given below:

2.1 Formation of High Level Steering Committee

A high level steering committee coordinated by Prof. Dr. Chop Lal Bhusal, Executive Chairman of NHRC consisting of following members was formed.

Prof. Dr. Chop Lal Bhusal, Executive Chairman, NHRC- Coordinator

Prof. Dr. Pradeep Baidya, Disaster Coordinator, Institute of Medicine- Member

Dr. Laxmi Raj Pathak, Chief, PPICD, MOHP- Member

Dr. Senendra Raj Uprety, Chief, Curative Division, MOHP-Member

Dr. Garib Das Thakur, Director, EDCD, DOHS-Member

Dr, Baburam Marashini, Chief, Health Sector Reform Section, MOHP- Member

Dr. Shanker Pratap Singh, Member-Secretary, NHRC-Member

Dr. Gajananda Prakash Bhandari, Senior Epidemiologist, NHRC-Member

Dr, Rajendra Kumar B.C., Research Advisor, NHRC- Member

Ms. Hyo-Jeong Kim, Technical Officer, EHA, WHO- Nepal -Member

Mr. Damodar Adhikari, National Professional Officer, WHO-Nepal- Member

Mr. Meghnath Dhimal, Chief Research Officer, NHRC-Member cum secretary

2.2 Formation of Thematic Working Group (TWG)

On the recommendation of steering committee meeting, following Thematic Working Groups were formed with members from the government, UN agencies, NGOs and civil societies working in the relevant sectors.

Policy and Legislation Group

Dr. B. R. Marashini, Chief, HSRU, MOHP- Coordinator

Dr. L. R. Pathak, Chief, PPICD, MOHP – Member

Ms. Hyo-Jeong Kim, Technical Officer, WHO- Member

Mr. George Murray, Disaster Readiness and Response Advisor, OCHA Kathmandu, Nepal- Member

Mr. Markus Behrend, Program Manager, HSSP, GTZ, Teku- Member

Community Capacity and Preparedness Group

Mr. Meghnath Dhimal, Chief research Officer, NHRC- Coordinator

Dr. Senendra Raj Uprety, Chief Curative Division, MOHP- Member

Dr. Rajendra Kumar BC, Research Advisor, MOHP- Member

Mr. Umesh Dhakal, Executive Director, Nepal Redcross Society- Member

Ms. Nirmala Sharma, Health Coordinator, CARE Nepal- Member

Capacity Building Group

Prof. Dr. Pradeep Vaidya, IOM- Coordinator

Prof. Dr. Chop Lal Bhusal, Executive Chairman, NHRC-Member

Mr. Damodar Adhikari, National Professional Officer, WHO-Member

Mr. Maxime Piasecki, Country Director, MERLIN Nepal- Member

Ms. Linda Kentro, Health Development Specialist, USAID Nepal –Member

Health System and Surveillance Group

Dr. G. P. Bhandari, Senior Epidemiologist, NHRC- Coordinator

Dr. G. D. Thakur, Director, EDCD, DOHS- Member

Dr. Shanker P. Singh, Member-secretary, NHRC-Member

Dr. Jerge Caravotta , Maternal and Child Health Specialist, UNICEF- Member

Dr. Nihal Singh, Medical Officer, WHO- Member

2.3 Periodic Meetings

Series of meeting of steering committee and the TWG were held to discuss the tools and make necessary change and amendments to the tools to fit the Nepalese context. A workshop was held on 18 November 2010 to finalize the tool to be used in the assessment.

The list of participants of tools finalization workshop is attached in Annex II

2.4 Assessment Workshop

An emergency preparedness and response assessment workshop using the adopted tools was held at Hotel Park Village, Budhanilkanth on 18 January 2011. The assessment was done in groups. For each indicator one or more questions were identified. There were more than one question for some indicator, in such situation, an overall assessment was made. The assessment of achievement/status was made based on the response to all the questions that were listed for the indicator. The assessment was done in the form of a score for each indicator. This was categorized as 2 when all or most of the criteria covered by the questions. A score of 1 was given if considerable progress has been made (i.e. 50% of desired level has been achieved). A score of 0 was given if little or no progress had been made with respect to all or most of the questions. For the team responsible for the assessment of benchmark, guidelines were included in the matrix to help reach the decision on scoring of each item. These scores were based on a collective decision made by the team responsible for assessment of the benchmarks. When there was more than one question for the indicator then the assessment was done for each question and an overall conclusion drawn whether the score assigned was to be 2, 1 or 0. The list of participants of assessment workshop is given in Annex III.

2.5 Dissemination Workshop

The dissemination workshop was organized on 19 January 2011 with participants from all areas of the health sector. The Honorable member of National Planning Commission (Health Sector), Health Secretary of the Ministry of Health and Population, Director General of Department of Health Services, Policy makers of Ministry of Health and Population, Regional health Directorate Officers, DIG of Nepal Police, National Experts on Disasters, Academician, high level officers of External Development Partner (EDP), Ministry of Home Affairs, Nepal Armed Police Force, I/NGOs etc were present. The assessment of 12 bench marks and findings in the form of overall score, achievement, gaps and recommendation in individual benchmark was presented by TWG coordinators. The feedbacks from the workshop are incorporated in the report. The list of participants of dissemination workshop is given in Annex IV. Similarly, the work schedule of dissemination workshop is given in Annex V.

CHAPTER 3: RESULT

The results of the assessment workshop are given below. The full assessment result can be found in Annex VI.

Benchmark 1: Legal framework coordination mechanism and organizational structure

The benchmark received 16 score out of 24 which is about 67%. This shows that Nepal is quite ahead in policy and legislation.

Standard 1: A legal framework for preparedness and responses is in place with sector specific policies / provisions

Standard 2: Coordination mechanisms involving government, UN, civil society and private stakeholders are in place and functioning at national, provincial/ regional and district level

Standard 3: Organizational structure that includes defined roles for preparing for and responding to health effects of natural, biological, technological and man-made disasters is in place

Achievements:

- Local Self Governance Act (1999) and Early Warning System are in place.
- Nepal Long term Health Plan (1997-2017) includes emergency preparedness response (EPR) and NHSP-II (2010-2015) also reflects EPR.
- Natural Calamity Act (1982) is in place.
- National Disaster Management Act is waiting for endorsement since 2008.
- Disaster health working group (at the center level), regional health coordination mechanism and district health coordination mechanism in place.
- Health co ordination committee for EPR at national and sub national levels are in place.
- Coordination mechanism is in place at all levels.
- Multi-sectoral coordination committees for EPR are in place at the central level as well as at sub national levels.
- Roles are defined.
- Roles, responsibilities and lines of authority for EPR are defined in health sector, and supported by its administrative structures.

Gaps:

- National Disaster Management Act is still waiting for endorsement

- Coordination system is not fully functional
- Roles and regulations of partners are not clearly defined and are not supported by administrative procedures
- There is little access to emergency funds at regional and district level

Recommendations:

- Endorse National Disaster Management Act
- Ensure and strengthen the coordination mechanisms at central, regional and district levels
- Decentralize financial, human and logistical resources at regional and district levels
- Clarify concrete roles and responsibilities for EPR in all sectors at all levels

Benchmark 2: Regularly updated action plan and SOPs for disaster preparedness and response

Standard 1: All countries have a completed and up-to- date national disaster preparedness and response plan for the health sector

Standard 2: Health Sector Disaster preparedness and response plans must be practiced and critiqued at all levels and at regular intervals

Standard 3: Standard Operating Procedures are in place outlining roles and responsibilities, coordination mechanisms, TOR of focal points and other key positions

Achievements:

- National Health Sector Emergency Preparedness and Disaster Response plan (2003) is developed and adopted
- District level health contingency plans are based on risk, hazard and vulnerability analysis specific to the district

Gaps:

- National health contingency plan is not yet developed
- Roles and responsibilities for NGOs in EPR is not clearly defined
- Emergency logistics plan does not include all sectors
- Drills or simulation exercises to test the contingency plans are not in place
- The emergency SOPs and TORs for other sectors are under development

Recommendation:

- Develop health contingency plans at all levels
- Revisit and conduct simulation exercise on the contingency plan at all levels
- Finalize the SOPs for health EPR at the central level
- Strengthen the logistic system ensuring inclusion of all relevant sectors

Benchmark 3: Emergency financial, physical and regular human resource allocation and accountability procedures established

Standard 1: National budgets include provisions for implementation of laws, regulations and plans for emergency preparedness and response

Standard 2: National focal points or emergency units have been appointed to deal with emergencies and are provided with adequate resources to respond as required.

Standard 3: Clearly defined roles for emergency units and focal points for EPR and legal framework provisions are in place at all levels that specifies accountability procedures

Achievements:

- EPR focal point and a unit for EPR are established by the MoHP.
- MoHP has established EPR focal points at district and regional levels
- Other sectors have also appointed focal persons for EPR and established EPR units at the national level.

Gaps:

- Sub-national level does not have emergency budget
- Funding gap analysis for EPR has not been conducted
- Delegation of authority is not fully given to sub-national level in emergencies
- Not all sectors have delegation of authority to sub-national level

Recommendations:

- Conduct funding and resource gap analysis at all levels
- Provide emergency fund at regional and district level
- Ensure delegation of authority in emergencies to regional and district levels

Benchmark 4: Rules of engagement (including conduct) for external humanitarian agencies based on needs established

Standard 1- National guidelines include rules of engagement for external humanitarian agencies to be based on needs and following the direction of national authorities

Achievements:

- National EPR plans relating to collaboration reflect the contributions expected from each partner
- Arrangements with international humanitarian organizations responsible for health care are in place and health cluster approach is well understood and used

Gaps:

- MoUs with relevant partners are not yet signed
- Private-Public partnership in emergencies is still weak
- Code of conduct for international organizations in emergencies are not included in the national policies for EPR

Recommendations:

- Prepare and sign MoUs with all stakeholders in emergency including with private sectors and relevant partners.
- Strengthen Public Private Partnership approach for ongoing funding for EPR
- Involve private sectors, academic institutions and others for EPR
- Ensure the inclusion of code of conduct of international agencies in emergencies in the national health policies

Benchmark 5: Community plan for mitigation, preparedness and response developed, based on risk identification and participatory vulnerability assessment and backed by a higher level of capacity

Standard 1- Capacity to identify risks and assess vulnerability has been established in communities

Standard 2- Community plans for disaster preparedness and response are in place in communities based on vulnerability assessments and risk mapping.

Standard 3- Community plans outline the process for requesting and receiving the needed resources and plans interlink with national and sub-national plans

Standard 4- Financial and human resources to implement these plans at community level are identified

Achievements:

- Community plans are in place
- Mechanism for requesting for assistance from national authorities in health and other sectors is established.
- Mechanism for coordination and cooperation at community levels is established through the cluster approach.
- Hazard prone districts are mapped
- Emergency Contingency Plan has been developed in numerous districts in consultation with various stakeholders.
- Operational DDRC is in place

Gaps:

- Geographically suitable and need based tools need to be developed
- Community emergency preparedness plans are not developed and not envisioned
- Weak link between communities and nearest health facility
- Feeble participation from key stakeholders in cluster meetings
- Data analysis for early warning and planning is not practiced
- Disaster budget allocation is on an ad hoc basis
- Disaster budget is inadequate and release is often delayed

Recommendations:

- Design need based tools for vulnerability assessment at community level.
- Organize regular cluster meetings and ensure full participation of key stakeholders
- Allocate disaster budget after proper analysis
- Establish mechanism for immediate release of resources

- Enhance awareness among finance and administration officials on emergency response procedures

Benchmark 6: Community-based response and preparedness capacity developed, supported with training and regular simulation/ mock drills

Standard 1: Community capacity for emergency preparedness and response is developed

Standard 2: Community level emergency preparedness and response plan and capacity is improved through mock drills and simulations annually

Achievements:

- Grass root level is reached through FCHVs
- Trainings for emergency preparedness and response conducted at several communities
- Refresher training for FCHVs conducted every 6 months on EPR

Gaps:

- Supervision and monitoring of trained persons is deficient
- Simulation and mock drill are not conducted for community health workers and community peoples
- Basic equipments for trained volunteers and health workers in disaster response is inadequate (Case by Case/need base equipment prepositioned)
- Role and responsibility of health workers and community people should be clearly identified in disaster situation

Recommendations:

- Establish mechanism for tracking of trained person through developing and maintaining a database of trained persons (supportive supervision)
- Identify training institutions for enhancing community level preparedness
- Pilot community based preparedness projects with involvement of key stakeholders
- Provide basic equipments for community health workers

Benchmark 7: Local capacity for emergency provision of essential services and supplies (shelters, safe drinking water, food, communication) developed

Standard 1: The minimum need for essential health services and supplies at the local level has been determined.

Standard 2: Local capacity for emergency provision of essential health services and supplies (e.g. shelters, safe drinking water, food, communication) is in place

Achievements:

- Warehouses exist at strategic locations in regions and districts

Gaps:

- Suppliers and transporters are not identified for emergency
- A database of suppliers and transporters that can be used in emergencies does not exist
- Mapping/ Pre positioning of essential services and supplies are not adequate
- Communication equipment and system for emergency response are lacking

Recommendations:

- Conduct regular and frequent assessments of warehouses
- Identify suppliers and transporter and sign long term agreements with them.
- Strengthen communication system for emergencies.
- Ensure food security and conduct regular monitoring of the nutritional status (Nutrition Early Warning)
- Identify and map emergency shelters assembly points
- Preposition emergency supplies

Benchmark 8: Advocacy and awareness developed through education, information management and communication (pre-, during and post-event)

Standard 1: Advocacy for improved awareness of emergency preparedness measures and life-saving behavior during emergencies is carried out through regular education/media channels and through targeted communication

Standard 2: Information is managed in a way that it is available to all stakeholders

Achievements:

- Awareness and EPR information dissemination through media regularly conducted
- Inclusion of EPR in school and medical curricula in service

Gaps:

- Disaster early warning system not fully functional
- Hazard specific communication lacking
- Evaluation of effective use of media not conducted
- Coordination and information dissemination/management at all levels lacking
- Weak information management

Recommendations:

- Establish early warning system with proper training and orientation at all levels
- Prepare and conduct hazard specific communication
- Conduct evaluation of media effectiveness
- Introduce coordination of information management at all levels
- Ensure information (ICT) management and dissemination to all stakeholders

Benchmark 9: Capacity to identify risks and assess vulnerability at all levels established

Standard 1: Capacity to assess vulnerability and identify risks is developed at community, sub-national (regional/provincial/district) and national level

Standard 2: Methods and tools for assessments are appropriate for various levels; participatory; and practical

Achievements:

- Risk and vulnerability assessment has been conducted at national and regional levels

Gaps:

- Risk and vulnerability assessment at sub-national and community level missing
- Appropriate tools for assessment are not available for sub-national and community level

Recommendations:

- Create/adapt/review tools for vulnerability assessment adequate for each level
- Expand risk and vulnerability assessment to all levels

Benchmark 10: Human resource capabilities continuously updated and maintained

Standard 1: Essential human resources capabilities for responding to public health needs in emergencies and trained and maintained continuously.

Standard 2: Trained experts are identified and on-call to provide immediate back-up in case of a disaster

Achievements:

- Capacity building programs for EPR:
- Hospital Preparedness for Emergencies (HOPE)
- Triage and mass casualty management
- Contingency planning
- Disaster management orientation
- Hospital preparedness plans developed in most key hospitals

Gaps:

- Training need assessment lacking
- Training institutions need strengthening
- Standards of training courses not established and assessed
- Evaluation of training courses not conducted systematically
- Human resources data base missing
- Coordination and cooperation between stakeholders needs strengthening

Recommendations:

- Identify appropriate training institutions
- Conduct accreditation of training courses

- Establish human resources (trained health workers) roster
- Share mechanism for coordination and human resources data base at all levels

Benchmark 11: Health facilities built/modified to withstand the forces of expected events

Standard 1: New health facilities are built to withstand expected risks and will be able to continue to provide the required medical care at all times

Standard 2: Existing health facilities have undergone risk mitigation and reduction to improve their security and ensure functionality during emergencies

Achievements:

- Building codes endorsed
- Some retrofitting activities of health facilities implemented
- Seismic assessment of health facilities conducted
    - Structural
    - Non-structural

Gaps:

- Implementation of building codes by all sectors weak with little rigorous monitoring
- Structural and non-structural mitigation measures lacking

Recommendations:

- Re-enforce implementation of building codes by all sectors
- Provide adequate resources for structural and non-structural retrofitting of health facilities

Benchmark 12: Early warning and surveillance systems for identifying health concerns established

Standard 1: Early warning and surveillance systems for identifying public health concerns are established

Standard 2: Ability is installed to launch adequate surveillance and early warning systems to

respond to a new public health hazard or threats to health in an emergency

Achievements:

- Disease surveillance is in place with regular reporting but only focusing on communicable diseases.
- Early warning is focused on health.
- Health system has capacity to address surveillance and response for communicable disease.
- Integration with non-health sector has been started.
- SOPs partially developed
- Human, financial and logistic resources and support in place.
- Gaps are addressed in terms of resources in communicable disease.
- Information system is in place.

Gaps:

- Health system is under-developed at sub national level
- Timely Response mechanism deficient at national levels
- Participation of the private sector and academic institutions weak or not existing
- Surveillance system for water quality, food safety and security, sanitation and waste management is not developed/strengthen and lack of data dissemination
- SOPs are not fully developed
- Health staff are not trained in risk communication
- Development of skills and competencies are lacking
- Lack of integration/mainstreaming with other sectors
- Resources available but insufficient
- Response time delayed (due to accessibility issues)

Recommendations:

- Early warning and surveillance system should go beyond the health (other sectors) and public system (PPP etc)
- Strengthen the early warning and response system.
- Strengthen the training curricula
- Develop SOPs for EWARS.
- Develop an effective communication system for informing the community about health risks

CHAPTER 4: CONCLUSION and RECOMMENDATION

The rapid assessment of emergency preparedness and response of the health sector of Nepal showed that Nepal still needs to do a lot to strengthen its capacity and capability to prepare and response to disaster situation. There is an urgent need to endorse the National Disaster Management Act, need to strengthen multi-sectoral coordination at central and district level, train more health workforce on emergency preparedness and response with close supervision, allocate adequate budget to regional, district and local level based on evidence, ensure clear roles, responsibilities and regulations to external agencies working on health sector emergency preparedness and response and finally massive awareness raising at the community level. There should be national health contingency plan, emergency logistics plan and drills and simulation exercises to test the contingency plans. The Public Private Partnership must be strengthened for ongoing funding for EPR and higher involvement of private sectors, academic institutions and others for EPR in Nepal. Surveillance system for water quality, food safety and security, sanitation and waste management should be ensured and strengthened. While developing the action plan, it is recommended to do so in connection with priority actions identified by National Strategy for Disaster Risk Management in Nepal 2009.

The specific recommendations are as follows

- With stakeholders CREATE an ACTION WORPLAN 2011-2012 with TIMELINE, OUTPUTS and clear INDICATORS to OPERATIONALIZE the recommended actions of each BENCHMARK
- These Rapid assessments EXERCISE constitute a BASELINE for monitoring and evaluation of PROGRESS made on EPR in Nepal and need periodic assessment at the interval of one or two years to evaluate the progress.

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ANNEXES

ANNEX I: Proceeding of Dissemination Workshop

The dissemination workshop started with a Welcome Speech by Prof. Dr. Chop Lal Bhusal, Executive Chairman of Nepal Health Research Council. In his welcome address, he heartily welcomed all distinguished guests and participants. He said that Nepal is vulnerable to many disasters among which flood, landslides, fire and earthquake are some of the more common hazards and risk of Nepal. He expressed that during the past years various big and small scale of earthquakes have been felt in the country. In a mountainous country like Nepal the danger of disasters cannot be neglected due to its fragile, geographic variation in its structure and seismically activities, he further added. He said Himalayan ranges are still unconsolidated and young and this increases the risk of disaster in Nepal. He stressed that water pollution, malnutrition, unhygienic shelter, low level of public awareness and low level of response mechanism has increased the risk of epidemic disaster in Nepal.

He was worried about the fact that the happenings of disaster may have a huge impact to a small and developing country like Nepal. In order to address this, he pointed out that there is a need of emergency and immediate response mechanisms to deal with the possible hazards that may arise in the coming days. He added that we have to broaden the concept of emergency preparedness in addressing the issues of disaster including the measures of response, preparedness, rehabilitation and reconstruction and disaster mitigation.

Prof. Dr. Bhusal said that the World Disaster Report 2006 highlighted the discouraging fact that around 58% of the total number of people killed in natural disasters during the decade 1996-2005 was from South East Asia countries. He added that benchmark framework is a response to the collective experience of five SEAR countries during the earthquake and Tsunami of 26 December 2004, the recurring emergencies in all SEAR member countries and the global call for improved emergency preparedness actions across the countries.

He remembered past events and expressed that during the period from 1980-2008 the total number events of natural disasters recorded in Nepal was sixty-nine in which 10,444 deaths occurred and more than 44,14105 people were affected by it. He gave the evidences of the latest diarrhoeal outbreak in the Mid and Far West regions of Nepal in 2008 which killed more than 500 people.

Prof. Dr. Bhusal said the tool that has been developed in response to the disaster in our country is noteworthy and valuable. The benchmark, standard and indicators developed in these tools are well arranged and constructed. These benchmarks integrate multi sectoral concerns at community, sub national and national levels. This means that if all benchmarks are achieved, the level of preparedness of the country will be high and intersectoral linkages and wide participation by all stakeholders will be achieved. He expected that this would help to mitigate the impact of disasters. He expressed his confidence that the application of benchmarks approach would facilitate planning monitoring and evaluation by knowing the baseline situation in our context. At the end, he wishes the success of the program and requested to enjoy in very pleasant atmosphere of Buddhanilkanth.

Mr. Meghnath Dhimal, Chief Research Officer of Nepal Health Research Council gave an overview of the program. He briefly highlighted the situation of emergency preparedness and response scenario in South East Asia Region (SEAR), initiative taken by member countries and commitment of Nepal Government on emergency response. He expressed that the benchmarks are the product of a regional consultation in Bangkok in November 2005. While developing benchmarks 11 SEAR member countries were represented at the consultation which consists of Ministry of health, Ministry of Home Affairs, Foreign Affairs and Education as well as UN agencies, International Federation of Red Cross, International Non-Governmental Organization (INGO), donors and universities. He further said, following a regional consultation in Bali in June 2006, the Benchmarks Framework was further refined to include standards and indicators to make planning, monitoring and evaluation more accurate. He said that the present assessment is done using 12 benchmarks, their indicators, standards, questions and checklist. He also highlighted the process perused for adopting tools in Nepalese context and methodology of rapid

assessment of emergency preparedness and response in Nepal. Then, he requested each coordinator of thematic working group: Policy and Legislation, Community Capacity and Preparedness, Capacity Building and Health Surveillance and Early Warning for presenting the findings of dissemination.

Dr. Baburam Marasaini, coordinator of Policy and Legislation group presented the findings of this group. This group has 4 benchmarks. He presented the standards of each benchmark, score obtained and findings in the form of achievement, gaps and recommendation. The findings of community capacity and preparedness group were presented by Dr. Abisek Rimal of Nepal Red Cross. This group had also four benchmarks. He also presented the findings in the form of score obtained in each benchmark, achievement, gaps and recommendation. On behalf of capacity building group, Prof. Dr. Pradeep Baidya presented the findings on benchmark 9, 10 and 11 in the form of score obtained, achievement, gaps and recommendations on each benchmark. Finally, Health Surveillance and Early Warning group coordinator Dr. Gajananda Prakash Bhandari presented the findings on benchmark 12 in the form of score obtained, achievement, gaps and recommendation.

After the presentation, there was brief introduction among the participants, resource persons and guests followed by floor discussion. In discussion session, queries were raised about the assessment process, difference in scoring of different benchmark, action plan, funding commitment, institutional memory, provision of emergency preparedness and response on policy and plan of Nepal Government, implementation of previous studies findings into action etc. The raised queries were satisfactorily answered by assessment team members, representative of external development partners and high level officers of Ministry of Health and Population.

The guest Dr. Yashovardhan Pradhan, Director General of Department of Health Services, Ministry of Health and Population thanked the Organizer of the workshop Nepal Health Research Council and World Health Organization. He said that he is impressed by the findings of the study and stressed that there is no need to manipulate the findings of the study obtained by using the tools developed by all member countries and commitment by Nepal Government too. However, he felt that caution should be taken for implementation the finding of this study

because this is the rapid assessment and disaggregated data is needed at national, regional and district level. He expressed that we have to be prepared for the disaster and the consequences of the health related disasters need to be address by the Ministry of Health and Population. He said that MoHP is learning by doing and gave the example of latest dengue fever outbreak which killed only five people and others affected by the disease were rescued from the epidemic. He further added that health system is well prepared to tackle the epidemic. Dr. Pradhan expressed that immediate commitment is dangerous and is quite impossible to achieve so need clear action plan, sharing among all stakeholders including external development partners prior to implementing the findings of study. He also felt the need that some responsibility should be handed to concerned NGOs/INGOs to address the specific hazards that arise due to the disaster. Finally, he concluded that there is the need of multisectoral and multidimensional approach to address the problem resulting from disasters and emergency.

The Guest Mr. Bhisma Prasai, Deputy Inspector General of Nepal Police expressed that Nepal Police is the first defender body to respond emergency with any disaster that occurs in the country. He said that emergency needs to be shared by many agencies because single agency can not deal with disaster and emergency. Mr. Prasai said that many donor agencies are working in the field of emergency response but still there is long way to go. He quoted the Koshi Flood of 2008 that largely devastated the lives and property of people some years back was a trial and example for the Nepal Police to deal with it though all agencies worked in good coordination. He said the success of Nepal police in rescue and help made to all the victims and the people who were affected from it.

The Chief Guest Dr. Praveen Mishra, Health Secretary, Ministry of Health and Population said that health is a cross cutting issue so Ministry of Health and Population do not only have the responsibility to address the problems of disaster. Dr. Mishra expressed that there should be multidimensional and multisectoral collaboration to mitigate and adapt the emergency. He said, we have seen the gap in addressing the problems of disaster in Nepal so to fulfill the gap well coordination, identification of the stakeholders and comprehensive approach should be developed. He further added, not only this but there is also the need to know what has been done before and the needs of future to deal with all the problem of emergency in Nepal. Appreciating

the findings, he said benchmark that we all are dealing with is the guidelines but the site specific problem must be identified. Dr. Mishra expressed multiple problems can be correlated according to the cost effective analysis. There is no scarcity of resources allocation but only the problem is the availability of manpower to act on time is quite difficult. He recommended that urgently let us countdown to precede the development policy to make way forward otherwise another workshop has to be conducted on delay. At the last, he demanded the practicable action plan.

The Special Guest Dr. Chet Raj Pant, Honorable Member of National Planning Commission expressed that the program is very timely and relevant and benefitted him a lot. He said that we are dealing with health related disaster and thanked for developing such benchmark so that we can incorporate in our National planning. How effectively and quickly we respond the disaster? Police are the immediate response team though we have to make local community as the first response team to disaster management and rescue the people from the hazard of disasters but the question is who will make them capable to cope with such disaster happening in their life ?Delay of response lead to death of many people . Institution, VDCs, school, Red Cross needed to be alert and equipped to have immediate response. Timely release of fund is important to have the grass root people access. He expressed that unfortunately, the fund is always freezed and not utilized at the time of emergency because of lengthy and complex fund transfer mechanism. At the last, he expressed that these Benchmarks are learning point for us so we must learn and the research should go side by side as a development agenda.

At the end of the session, Prof. Dr. Chop Lal Bhusal, Executive Chairman of Nepal Health Research Council delivered his vote of thanks individually to the chief guest, special guest, guests, members of steering committee, members of thematic working groups, external development partners, WHO and collectively to all the participants and media personnel. And last but not least, he thanked to all supporting staffs and management team of Park Village Resort, Buddhanilkanth.

ANNEX II: List of Participants on Tools Finalization Workshop

S.N	Name	Organization
1	Mr. Damodar Adhikari	WHO
2.	Mr. Darinji Sherpa	CARE Nepal
3..	Dr. Baburam Marashini	MoHP
4.	Dr. Bandana Pradhan	IOM
5.	Prof. Dr. C.L. Bhusal	NHRC
6..	Dr. G.D Thakur	EDCD
7..	Dr. Gajananda Prakash Bhandari	NHRC
8..	Dr. Nihal Singh	WHO
9..	Dr. Pradeep Vaidya	IOM,TUTH
10.	Dr. Rajendra B.C	NHRC
11.	Dr. Rohit Pokharel	TUTH
12.	Dr. S.P Singh	NHRC
13.	Dr. Senendra Upreti	MoHP
14.	Mr. Hari Datt Joshi	NHRC
15.	Ms. Hyo-Jeong Kim	WHO
16.	Dr. Jerge Caravotta	UNICEF
17.	Mr. Khakindra Bhandari	Merlin Nepal
18.	Mr. Man Dhwaj Tamang	NHRC
19.	Mr. Markus Behrend	GTZ
20.	Mr. Meghnath Dhimal	NHRC
21.	Mr. N.K. Sharma	NHRC
22.	Mr. Puka Lal Ghising	NHRC
23.	Mr. Subodh Kumar Karna	NHRC
24.	Mr. Umesh Prasad Dhakal	NRCS
25.	Mr. Bijay Kumar Jha	NHRC
26.	Mr. Bikram Dhimal	NHRC
27.	Mr. Bir Bahadur Ghising	NHRC

ANNEX III: List of the Participants in Assessment Workshop

S.N	Name	Organization
1	Mr. Damodar Ahdikari	WHO
2.	Dr. Abhishek Rimal	NRCS
3..	Dr. Anju Karki	WRHD
4.	Dr. Baburam Marassini	MoHP
5.	Dr. Bandana Pradhan	IOM, TUTH
6..	Dr. C.L. Bhusal	NHRC
7..	Dr. Gajananda Prakash Bhandari	NHRC
8..	Dr. Jerge Caravotta	UNICEF
9..	Dr. Pradeep Vaidya	IOM, TUTH
10.	Dr. Rajendra Kumar B.C.	NHRC
11.	Dr. Rohit Pokharel	IOM,TUTH
12.	Dr. Senendra Raj Upreti	MoHP
13.	Ms. Femila Sapkota	NHRC
14.	Ms. Hyo-Jeong Kim	WHO
15.	Mr. Meghnath Dhimal	NHRC
16.	Mr. Prahlad Dahal	WHO
17.	Mr. Shree Krishna Bhatta	FWRHD, Dipayal
18.	Ms. Sushhama Neupane	NHRC
19.	Ms. Ambika Shrestha	NHRC
20.	Mr. Bal Krishna Bhusal	RHD, Surkhet
21.	Mr. Bijay Kumar Jha	NHRC
22.	Mr. Bikram Dhimal	NHRC

ANNEX IV: List of the Participants in Dissemination Workshop

S.N	Name	Organization
1	Mr. Bal Krishna Bhusal	RHD, Surkhet
2.	Mr. Bhishma Prasai	Nepal Police
3.	Mr. Bimal Baral	HECAF- Nepal
4.	Ms. Christine Smerdon	HANDICAP INT'L
5.	Mr. Damodar Adhikari	WHO
6..	Mr.David Mahat	National News
7.	Mr. Deepak Pd. Neupane	MoHA
8.	Dr. Abhishek Rimal	NCRS
9.	Dr. Anju Karki	WRHD
10.	Dr. Bandana Pradhan	IOM,TUTH
11.	Dr. Basu Dev Pandey	Teku Hospital, Teku
12.	Dr. Chop Lal Bhusal	NHRC
13.	Dr. Gajananda Prakash Bhandari	NHRC
14.	Dr. Nishita Pathak	Armed Police Force
15.	Dr. Pradeep Vaidya	IOM,TUTH
16.	Dr. Praveen Mishra	MOHP
17.	Dr. Rajendra B.C	NHRC
18.	Dr. Rohit Pokharel	IOM,TUTH
19.	Dr. S.P. Singh	NHRC
20.	Dr. Senendra Raj Upreti	MoHP
21.	Dr. Y.B. Pradhan	DOHS
22.	Ms. Femila Sapkota	NHRC
23.	Mr. Gopal Dahal	LWF Nepal
24.	Ms. Hyo-Jeong Kim	WHO
25.	Dr. Linda Kentro	USAID
26.	Mr. Meghnath Dhimal	NHRC
27.	Mr. Bijay Kumar Jha	NHRC
28.	Mr. Bikram Dhimal	NHRC

29.	Mr. Rakesh Thakur	EDCD, DoHS
30.	Mr. Shree Krishna Bhatta	FWRHD, Dipayal
31.	Ms. Sudha Shakya	HDM-France
32.	Ms. Susanne Stain	HDM-France
33.	Mr. P. L. Ghising	NHRC
34.	Ms. Sushhama Neupane	NHRC
35.	Ms. Ambika Shrestha	NHRC

ANNEX V: Work Schedule of Dissemination Workshop

Dissemination Workshop
On
Rapid Assessment of Emergency Preparedness Response in Nepal

Organized by

Nepal Health Research Council, Ramshah Path, Kathmandu, Nepal

Supported by

WHO Country Office, Nepal

Venue: Park Village Resort, Buddhanilkantha

19 January 2011 (Wednesday)

09:30 – 10:00	**Registration/ Tea Coffee**
10:00 – 10:45	**Opening Session**
	Welcome Address
	Prof. Dr. Chop Lal Bhusal, Executive Chairman, Nepal Health Research Council
10:45- 11:00	Highlighting Overview of Program and Assessment Tools
	Mr. Meghnath Dhimal, Chief Research Officer, NHRC
11:00- 12:00	Presentation of findings of assessment study
	TWG Coordinators
12:00-12:30	Discussion
12:30-01:30	**Remarks**
	Dr. Yasobardhan Pradhan, Director General, DOHS, MoHP
	Mr. Bhisma Prasai, Deputy Inspector General of Nepal Police, Kathmandu
	Dr. Praveen Mishra, Health Secretary, Ministry of Health and Population
	Dr. Chet. Raj Panta, Hon'ble Member, National Planning Commission
13:00 – 13:30	**Vote of Thanks**
	Dr. Chop Lal Bhusal, Executive Chairman, Nepal Health Research Council
13:30 – 14:30	**Lunch**
	End

ANNEX VI: Assessment Score Table of Each Benchmark

Table 1: Benchmark 1-Legal framework, coordination mechanism and organizational structure

Standard	**Indicator**	**Score (2,1 or 0)**
1.	1	1
1.	2	2
1.	3	1
1.	4	0
2.	1	2
2.	2	2
2	3	1
2.	4	2
2.	5	1
3.	1	1
3.	2	2
3.	3	1
Total		**16**

Table 2: Benchmark 2-Regularly updated action plan and SOPs for disaster preparedness and response

Standard	Indicator	Score (2,1 or 0)
1.	1	1
1.	2	2
1.	3	2
1.	4	2
1.	5	1
1.	6	1
1.	7	1
1.	8	0
1.	9	0
1.	10	1
2.	1	0
2.	2	0
2.	3	0
3.	1	0
3.	2	1

3.	3	0
Total		**12**

Table 3: Benchmark 3- Emergency financial, physical and regular human resource allocation and accountability procedures established

Standard	Indicator	Score (2,1 or 0)
1.	1	1
1.	2	0
1.	3	2
2.	1	2
2.	2	2
3.	1	1
3.	2	1
Total		**9**

Table 4: Benchmark 4-Rules of engagement (including conduct) for external humanitarian agencies based on needs established

Standard	Indicator	Score (2,1 or 0)
1.	1	1
1.	2	2
1.	3	2
1.	4	1
1.	5	1
1.	6	0
Total		**7**

Table 5: Benchmark 5-Community plan for mitigation, preparedness and response developed, based on risk identification and participatory vulnerability assessment and backed by a higher level of capacity;

Standard	Indicator	Score (2,1 or 0)
1.	1	1
1.	2	1

2.	1	1
2.	2	1
2.	3	1
2.	4	1
3	1	1
3.	2	1
3.	3	1
3.	4	1
3.	5	2
4.	1	1
4.	2	1
Total		**14**

Table 6: Benchmark 6- Community-based response and preparedness capacity developed, supported with training and regular simulation/ mock drills

Standard	Indicator	Score (2,1 or 0)
1.	1	1
1.	2	0
1.	3	2
1.	4	0
1.	5	0
1.	6	1
1.	7	0
2.	1	1
2.	2	1
Total		**6**

Table 7: Benchmark 7-Local capacity for emergency provision of essential services and supplies (shelters, safe drinking water, food, communication) developed

Standard	Indicator	Score (2,1 or 0)
1.	1	1
1.	2	1
2.	1	1
2..	2	1
2	3	2
2.	4	1
2.	5	1
2.	6	0
2	7	0
2	8	0
2.	9	0
Total		**8**

Table 8: Benchmark 8- Advocacy and awareness developed through education, information management and communication (pre-, during and post-event)

Standard	Indicator	Score (2,1,0)
1	1	1
1.	2	1
1.	3	1
1.	4	1
1.	5	2
2	1	1
2.	2	0
Total		**7**

Table 9: Benchmark 9-Capacity to identify risks and assess vulnerability at all levels established

Standard	Indicator	Score (2,10)
1.	1	2
1.	2	1
1.	3	0
1.	4	1
1.	5	1
2	1	1
2.	2	1
2.	3	1
2.	4	1
Total		**9**

Table 10: Benchmark 10-Human resource capabilities continuously updated and maintained

Standard	Indicator	Score (2,1,0)
1.	1	1
1.	2	1
1.	3	0
1.	4	1
1.	5	0
1.	6	1
2.	1	0
2.	2	0
Total		**4**

Table 11: Benchmark 11-Health facilities built/modified to withstand the forces of expected events

Standard	Indicator	Score (2, 1, 0)
1.	1	2
1.	2	1
1.	3	2
2	1	1
2.	2	0
2.	3	1
2.	4	1
2.	5	1
2.	6	1
Total		**10**

Table 12: Benchmark 12-Early warning and surveillance systems for identifying health concerns established.

Standard	**Indicator**	**Score (2,1 or 0)**
1.	1	1
1.	2	1
1.	3	0
1.	4	1
1.	5	0
2.	1	0
2	2	0
2.	3	0
2	4	0
2	5	0
2	6	0
2	7	1
Total		**4**