NEPAL

Assessment of Capacities using SEA Region Benchmarks for Emergency Preparedness and Response

KOFIH
Korea Foundation for International Healthcare
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World Health Organization
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Background and Vulnerability to Disasters

The Government of Nepal has classified Nepal as one of the hotspots of multiple hazards. Nepal has a high frequency and intensity of multiple hazards such as flood, landslide, forest fire, drought, hailstorm, avalanche, conflict, earthquake, etc. Among 200 countries, Nepal ranks 11th and 30th with regard to the vulnerability to earthquake and flood respectively. An inventory of past disasters during 1971–2006 reveals that epidemics take the largest toll of life every year, and that landslides, floods (including flash floods) and urban or rural fires are the principal hazards in terms of their extent and frequency of occurrence, as well as the spread and intensity of physical and socioeconomic impacts. According to the Global Earthquake Safety Initiative, Kathmandu is exposed to the highest earthquake risk per capita among 21 megacities around the world, largely due to building collapse and insufficient preparedness and medical care.

Nepal has also been subjected to armed Maoist insurgency and internal conflict along ethno-caste lines. There are also a large number of internally displaced persons (IDPs) and refugees, mostly from Bhutan. Epidemics account for high morbidity and mortality, further compounded by poor access to health care, especially in remote and conflict-affected areas. Diarrhoeal diseases, acute respiratory infections, Japanese encephalitis, kala-azar and malaria are seasonal threats, and avian and human pathogenic influenza are of increasing concern.

The Ministry of Home Affairs (MoHA) is the national focal ministry for coordination of various aspects of disaster management. 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 the Home Ministry. This has been broadly divided into cross-sectoral and sectoral strategies for disaster risk management.

The sector-specific strategies focus on addressing the identified gaps in particular sectors. The following sectors have been considered: 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.

The national government is ultimately responsible for implementing the strategy, though decentralization of authority as well as responsibilities is planned. Disaster management focal points have also been appointed in key line ministries, including the Ministry of Health and Population (MoHP).

Methodology

A generic tool has been developed by WHO-SEARO to assess the level of emergency preparedness in a country. The preparation process included adapting the tool to the national context, conducting assessment and disseminating the findings. To start with, a high-level steering committee coordinated by Professor Dr Chop Lal Bhusal, Executive Chairman of the Nepal Health Research Council (NHRC), was formed. On the recommendation of the steering committee, the following Thematic Working Groups (TWGs) were formed with members from the government, UN agencies, NGOs and civil society working in the relevant sectors.

- Policy and legislation group
- Community capacity and preparedness group
- Capacity building group
- Health system and surveillance group

A series of meetings of the steering committee and the TWGs were held to discuss the tool and make necessary changes and amendments to fit the Nepalese context. A workshop was held on 18 November 2010 to finalize the tool to be used in the assessment. An emergency preparedness and response (EPR) assessment workshop using the adapted tool was held on 18 January 2011. The assessment was done in groups.

A dissemination workshop was organized on 19 January 2011 with participants from all areas of the health sector. These included the Member of the National Planning Commission (health sector), the Health Secretary and policy-makers of the MoHP, Director-General of the Department of Health Services, Regional Health Directorate Officers, DIG of the Nepal Police, national experts on disasters, academicians, high-level officers of external development partners, MoHA, Nepal Armed Police Force, and national and international NGOs. The assessment of the 12 benchmarks and findings in the form of overall score, achievement, gaps and recommendations for individual benchmarks were presented by the TWG coordinators.

Findings: Achievements and Gaps

Assessment and review of benchmarks relating to legal framework, rules of engagement, national action plan and resources

BENCHMARK 1

Legal framework and functioning coordination mechanisms and an organizational structure in place for health EPR at all levels involving all stakeholders.

Achievements

- A Local Self Governance Act (1999) and early warning system are in place.
- The Nepal Long-term Health Plan (1997–2017) includes EPR, and the *Nepal* Health Sector Programme-Implementation Plan (NHSP-II) (2010-2015) also reflects EPR.
- The Natural Calamity Act (1982) is in place.
- A disaster health working group (at the central level), and regional and district health coordination mechanisms are in place.
- There is a health coordination committee for EPR at the national and subnational levels.
- A coordination mechanism for supporting the health sector has been established at all levels of EPR and is also linked with other clusters, i.e. water, sanitation and hygiene (WASH), nutrition, CCM, education, logistics, etc.
- Multisectoral coordination committees for EPR are in place at the central and subnational levels.
- Roles, responsibilities and lines of authority for EPR are defined in the health sector, and supported by administrative structures.

Gaps

- The National Disaster Management Act is still awaiting endorsement.
- The coordination system is not fully functional.
- The roles and responsibilities of partners are not clearly defined and are not supported by administrative procedures.
- There is little access to emergency funds at the regional and district levels.

BENCHMARK 2

Regularly updated disaster preparedness and emergency management plan for the health sector and SOPs (emergency directory, national coordination focal point) in place.

Achievements

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

Gaps

- The National Health Contingency Plan is not yet developed.
- The roles and responsibilities of NGOs in EPR are not clearly defined.
- The emergency logistics plan does not include all sectors.
- Drills and simulation exercises to test the contingency plans are not conducted regularly.
- Emergency SOPs and TORs for other sectors are under development.

BENCHMARK 3

Emergency financial (including national budget), physical and regular human resource allocation and accountability procedures established.

Achievements

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

Gaps

- There is no emergency budget at the subnational level.
- Analysis of the funding gap for EPR has not been conducted.
- During emergencies, authority is not fully delegated to the subnational level, and not all sectors delegate authority to the subnational level.

BENCHMARK 4

Rules of engagement (including conduct) for external humanitarian agencies based on needs established.

Achievements

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

Gaps

- MoUs with relevant partners have not yet been signed.
- Private–public partnerships during emergencies are still weak.
- A code of conduct for international organizations in emergencies is not included in the national policies for EPR.

Assessment and review of benchmarks relating to community preparedness, participation and response

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.

Achievements

- Community plans for disaster preparedness and response are in place.
- A mechanism for requesting assistance from national authorities in health and other sectors is established.
- A mechanism for coordination and cooperation at the community level is established through the cluster approach.
- Hazard-prone districts have been mapped.
- An emergency contingency plan has been developed in several districts in consultation with various stakeholders.
- An operational District Disability Rehabilitation Centre (DDRC) is in place.

Gaps

- Geographically suitable and need-based tools have yet to be developed.
- The link between communities and the nearest health facility is weak.
- Participation of key stakeholders in cluster meetings is poor.
- Data analysis for early warning and planning is not conducted.
- The disaster budget is allocated on an ad-hoc basis, is inadequate and its release is often delayed.

BENCHMARK 6

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

Achievements

- People at the grass-roots level are reached through female community health volunteers (FCHVs).
- Training for EPR has been conducted in several communities.
- Refresher training on EPR for FCHVs is conducted every six months.

Gaps

- Supervision and monitoring of trained persons is deficient.
- Simulation and mock drills are not conducted for community health workers and the community.
- Basic equipment for responding to disasters by trained volunteers and health workers is inadequate (case-by-case/need-based equipment prepositioned).
- Roles and responsibilities of health workers and the community in disaster situations are not clearly identified.

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

Achievement
- Warehouses are available at strategic locations in regions and districts.

Gaps
- Suppliers and transporters for use during emergencies are not identified, and there is no database of covering them.
- Mapping/prepositioning of essential services and supplies is not adequate.
- Communication equipment and systems for emergency response are lacking.

Assessment and review of benchmarks relating to capacity of the system (advocacy, capacity to identify risks, human resource capacity and health facilities)

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

Achievements
- Awareness and EPR information dissemination is regularly conducted through the media.
- EPR has been included in the school and medical curricula.

Gaps
- The early warning system for disasters is not fully functional.
- Hazard-specific communication is not provided.
- Evaluation of the effective use of media has not been conducted.
- Coordination and information dissemination/ management is weak or lacking at all levels.

BENCHMARK 9
Capacity to identify risks and assess vulnerability at all levels established.

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

Gaps
- Risk and vulnerability assessment has not been conducted at the subnational and community levels.
- Appropriate tools for assessment are not available at the subnational and community levels.

BENCHMARK 10
Human resource capabilities continuously updated and maintained.

Achievements
- Capacity-building programmes for EPR have been conducted for health professionals, including staff from hospitals and district disaster relief committees. These include the following:
- Hospital Preparedness for Emergencies (HOPE)
- Hospital emergency preparedness training
- Triage and mass casualty management
- Contingency planning
- Disaster management orientation

- Hospital preparedness plans have been developed in most key hospitals.

Gaps

- Assessment of training needs has not been done.
- Training institutions need strengthening.
- Standards of training courses have not been established or assessed.
- Evaluation of training courses is not conducted systematically.
- There is no database of available human resources.

BENCHMARK 11
Health facilities built/modified to withstand the forces of expected events.

Achievements

- Building codes have been endorsed.
- Some retrofitting activities have been implemented in health facilities.
- Seismic assessment (structural and non-structural) of health facilities has been conducted.

Gaps

- Implementation of building codes by all sectors is weak, with little rigorous monitoring.
- Structural and non-structural mitigation measures have not been undertaken.

Assessment and review of benchmark: Early warning and surveillance systems for identifying health concerns established

BENCHMARK 12
Early warning and surveillance systems for identifying health concerns established.

Achievements

- A disease surveillance system is in place with regular reporting, but focuses only on communicable diseases.
- Early warning systems are focused on health.
- The health system has the capacity to address surveillance and response for communicable diseases.
- Integration with non-health sectors has begun.
- SOPs have been partially developed.
- Human, financial and logistic resources and support are in place.
- Gaps in terms of resources for communicable diseases have been addressed.
- An information system is in place.

Gaps

- The health system is underdeveloped at the subnational level.
- At the national level, the response mechanism is not timely.
- Participation of the private sector and academic institutions is weak or non-existent.

- Surveillance systems for water quality, food safety and security, sanitation and waste management are not adequately developed and data are not disseminated.
- SOPs are not fully developed.
- Health staff is not trained in risk communication.
- Skills and competencies of health staff have not been developed.
- There is a lack of integration/mainstreaming with other sectors.
- The resources available are insufficient.
- The response time is delayed (due to accessibility issues).

Summary of Results

Benchmark group	No. of indicators	National	
		Cumulative grade of indicator measured	%
Legal	41	44/88	53.6
Community	33	28/64	42.4
Capacity building	33	30/64	45.5
EWARS	12	4/24	16.6

Conclusion and Recommendations

Conclusion

While the health sector has made progress in emergency preparedness, it is critical to take stock and to independently verify whether the course of actions taken is appropriate. There is also 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. This rapid assessment helped to estimate Nepal's emergency preparedness. 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"?

Recommendations

Specific recommendations

- With stakeholders, create workplan 2011–2012 with timelines, outputs and clear indicators to operationalize the recommended actions for each benchmark.
- These rapid assessments constitute a baseline for monitoring and evaluation of the progress made in EPR in Nepal, and should be assessed at an interval of one or two years to evaluate the progress.

Benchmark-wise recommendations

BENCHMARK 1

Legal framework and functioning coordination mechanisms and an organizational structure in place for health EPR at all levels involving all stakeholders.

- The National Disaster Management Act should be endorsed.
- Coordination mechanisms at the central, regional and district levels should be ensured and strengthened.
- Financial, human and logistical resources should be decentralized at the regional and district levels.
- Concrete roles and responsibilities for EPR should be clarified for all sectors and at all levels.

BENCHMARK 2

Regularly updated disaster preparedness and emergency management plan for the health sector and SOPs (emergency directory, national coordination focal point) in place.

- Health contingency plans should be developed at all levels.
- Simulation exercises on the contingency plan should be revisited and conducted at all levels.
- The SOPs for health EPR at the central level should be finalized.
- The logistics system needs to be strengthened and all relevant sectors included.

BENCHMARK 3

Emergency financial (including national budget), physical and regular human resource allocation and accountability procedures established.

- Funding and resource gaps should be identified and analysed at all levels.
- Emergency funds need to be provided at the regional and district levels.
- During emergencies, authority should be delegated to the regional and district levels.

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

- MoUs should be prepared and signed with all stakeholders, including with the private sector and relevant partners.
- The public–private partnership approach must be strengthened for ongoing funding of EPR activities.
- The private sector, academic institutions and others should be involved in EPR activities.
- National health policies should include the code of conduct for international agencies in emergencies.

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.

- Need-based tools should be designed for vulnerability assessment at the community level.
- Regular cluster meetings should be organized and full participation of key stakeholders ensured.
- The disaster budget should be allocated after proper analysis.
- Mechanisms for immediate release of resources should be established.
- Finance and administration officials need to be aware of emergency response procedures.

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

- Mechanisms should be established for tracking trained persons through developing and maintaining a database.
- For enhancing community-level preparedness, training institutions need to be identified.
- Community-based preparedness projects should be piloted with the involvement of key stakeholders.
- Community health workers should be provided with basic equipment.

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

- Warehouses should be regularly and frequently assessed.
- Suppliers and transporters should be identified and long-term agreements signed with them.
- The communication system for emergencies should be strengthened.
- Food security should be ensured and the nutritional status regularly monitored (nutrition early warning).
- Emergency shelters and assembly points should be identified and mapped.
- Emergency supplies must be prepositioned.

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

- Early warning systems should be established, with proper training and orientation at all levels.
- Hazard-specific communication should be prepared and disseminated.
- The effectiveness of the media in delivering relevant information should be evaluated.
- Information management should be coordinated at all levels, and disseminated to all stakeholders.

BENCHMARK 9
Capacity to identify risks and assess vulnerability at all levels established.

- Tools for vulnerability assessment should be created/adapted, and reviewed to assess their adequacy at each level.
- Risk and vulnerability assessments should be expanded to cover all levels.

BENCHMARK 10
Human resource capabilities continuously updated and maintained.

- Appropriate training institutions should be identified.
- Training courses should be accredited.
- A roster of human resources (trained health workers) should be developed and maintained.
- The mechanism for coordination and maintaining a database of human resources should be shared at all levels.

BENCHMARK 11
Health facilities built/modified to withstand the forces of expected events.

- Implementation of building codes by all sectors should be enforced.
- Adequate resources should be ensured for structural and non-structural retrofitting of health facilities.

BENCHMARK 12
Early warning and surveillance systems for identifying health concerns established.

- Early warning and surveillance systems should go beyond the health sector and include other sectors and public–private partnerships.
- The early warning and response system should be strengthened.
- Training curricula should be improved.
- SOPs should be developed for early warning and response systems (EWARS).
- An effective communication system for informing the community about health risks should be developed.

The WHO South-East Asia Region Benchmarks for Emergency Preparedness and Response Framework with its standards and indicators, are used to assess the existing capacities of countries in emergency risk management with a focus in the public health area. Grouped into four categories (legal, community, capacity building, early warning), the benchmarks provide a comprehensive view of emergency risk management in the area of health in the country. This summary report reflects at a glance the status of the country against the standards and indicators under corresponding benchmarks. Assessments are held in the national context with some adaptation and translation of the tools. This assessment in Nepal was led by WHO Country Office with the support of Emergency and Humanitarian Action unit of WHO's Regional Office for South East Asia in partnership with the Nepal Health Research Council (NHRC) and Ministry of Health, with participation of other stakeholders such as UN agencies, national and international NGOs and civil society working in the relevant sectors. The identified gaps in the assessment become the key priority areas for WHO and Ministries of Health and partners to address.

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