Regional Framework on Operational Partnerships for Emergency Response
(South-East Asia Region)

November 2017

World Health Organization
Regional Office for South-East Asia
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<td>USAID</td>
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<td>4Ws</td>
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</tbody>
</table>
**GLOSSARY**

**Benchmark** Reference point or standard against which performance or achievements can be assessed. [WHO Definitions: Emergencies]

**Capacity** The combination of all strengths, attributes and resources available within an organization, community or society to manage and reduce disaster risks and strengthen resilience. [UNISDR] Capacity may include infrastructure, institutions, human knowledge and skills, and collective attributes such as social relationships, leadership and management.

**Cluster** A group of agencies, organizations and/or institutions working together towards common objectives to address needs in a particular sector such as health. [WHO Definitions: Emergencies]

**Cluster Lead** An agency/organization that formally commits to take on a leadership role within the international humanitarian community in a particular sector/area of activity, to ensure adequate response, and high standards of predictability, accountability, partnership, and to serve as provider of last resort when necessary. [IASC]

**Coordination** In the context of humanitarian response, the aim is to have all participating organizations/operational partners to harmonize efforts and use available resources efficiently within the framework of agreed objectives, priorities and strategies, for the benefit of the affected population(s). [IASC]

**Contingency Planning** The process of establishing programme objectives, approaches and procedures to respond to situations or events that are likely to occur, including identifying those events and developing likely scenarios and appropriate plans to prepare and response to them in an effective manner. [Inter-Agency Contingency Planning Guidelines for Humanitarian Assistance 2001].

**Effectiveness** A measure of the extent to which an intervention’s intended outcome (its specific objectives) have been achieved.

**Efficiency** A measure of the relationship between outputs (the products produced or services provided by an intervention) and inputs (the resources it uses).

**Disaster** A serious disruption of the functioning of a community or a society at any scale due to hazardous events interacting with conditions of exposure, vulnerability and capacity, leading to one or more of the following: human, material, economic and environmental losses and impacts. [UNISDR]

**Emergency** It is a term describing a state. It is a managerial term demanding decision and follow-up in terms of extraordinary measures (Oxford Pocket Dictionary, 1992). A “state of emergency” demands to “be declared” or imposed by somebody in authority, who, at a
certain moment, will also lift it. Thus, it is usually defined in time and space, it requires threshold values to be recognized, and it implies rules to engagement and an exit strategy. Conceptually, it relates best to Response. [WHO Definitions: Emergencies]

**Complex Emergency** A humanitarian crisis in a country, region or society where there is total or considerable breakdown of authority resulting from internal or external conflict and which requires an international response that goes beyond the mandate or capacity of any single and/or ongoing UN country programme. [IASC]

**Graded Emergency** An acute public health event or emergency that requires an operational response by WHO. There are three WHO grades for emergencies, signifying the level of operational response by the Organization: Grade 1 (limited response), Grade 2 (moderate response), Grade 3 (major/maximal response). If a graded emergency persists for more than six months it may transition to a protracted emergency. [WHO Emergency Response Framework 2017]

**Evaluation** A systematic and impartial examination (of humanitarian action) intended to draw lessons to improve policy and practices; and enhance operational partnership and accountability. [ALNAP]

**Hazard** A possible threat of source of exposure to injury, harm or loss, e.g. conflict, natural phenomena. Hazards include biological, environmental, geological, hydrometeorological and technological processes and phenomena. [Inter-Agency Contingency Planning Guidelines for Humanitarian Assistance 2001]

**Incident Management System** The standardized structure and approach that WHO has adopted to manage its response to public health events and emergencies, and to ensure that the organization follows best practice in emergency management. WHO has adapted the Incident Management System to consist of six critical functions: Leadership, Partner Coordination, Information and Planning, Health Operations and Technical Expertise, Operations Support and Logistics, and Finance and Administration. [WHO Emergency Response Framework 2017]

**Incident Management Team** The in-country team responsible for managing and implementing the WHO response to the emergency. It is structured around the six critical Incident Management System functions and their associated sub-functions. The size and composition of the team is flexible and can vary according to the context. [WHO Emergency Response Framework 2017]

**Incident Manager** The lead of the Incident Management Team, who is responsible for strategic leadership and day-to-day management and oversight of WHO’s response to the emergency. The Incident Manager serves as the overall lead of the Incident Management Team and has delegated authority to other critical functions as they are established. S/he works with the health authorities and partners to agree on strategic priorities and objectives for the health response, fully consistent with humanitarian principles. [WHO Emergency Response Framework 2017]
**Monitoring**  The on-going process/act of observing and checking over a period of time, regularly gathering and analyzing data on emergency programme inputs and outputs.

**Operational Response**  The emergency actions that exceed the usual country-level cooperation that the WHO office in countries, territories and areas has with the Member State. [WHO Emergency Response Framework 2017]

**Operational Partnership**  The strategic partnership with identified and mutually agreed partners for an effective and efficient emergency response that exceeds the usual country-level response capacity.

**Output**  The strategic actions completed to date by an emergency operation. [WHO Global Health Cluster Guide]

**Partner**  Organizations/agencies and public health institutions that are engaged in responding to disasters, emergencies and civil strife situations and collaborate to achieve mutually agreed upon objectives

**Partnership**  The concept of “partnership” connotes shared goals, common responsibility for outcomes, distinct accountability and reciprocal obligations. Partners may include, government, civil society, UN agencies, non-governmental organizations, public health institutions, multi-lateral organizations and private companies etc. [WHO Global Health Cluster Guide]

**Public Health Event**  Any event that may have negative consequences for human health. The term events that have not yet lead to disease in humans but have the potential to cause disease through exposure to infected or contaminated food, water, animals, manufactured products or environments. [WHO Emergency Response Framework 2017]

**Risk**  An evaluation of the probability of occurrence and the magnitude of the consequences of any hazard, i.e. how likely is a hazard and what consequences will it have? [Inter-Agency Contingency Planning Guidelines for Humanitarian Assistance 2001]

**Recovery**  Decisions and actions taken after a disaster or emergency with a view to restoring or improving the pre-disaster living conditions of the affected community, while encouraging and facilitating necessary adjustments to reduce risk. [UNISDR]

**Resources**  Financial or in-kind contributions. In-kind contributions include donation of medicines and other goods and free provision of services on a contractual basis.

**Response**  Actions taken directly before, during or immediately after or immediately after a disaster or emergency in order to save lives, reduce health impacts, ensure public safety and meet the basic substance needs of the people affected. [UNISDR]

**Stakeholder**  An agency, organization, group or community that has direct or indirect interest in a particular activity, or its evaluation.
1. INTRODUCTION

Public health emergencies due to increased frequencies of natural and human-induced disasters including civil-conflicts and menace of bio-chemical, nuclear and radiation accidents; are on upward trend over last decades. Increasing urbanization and adverse climate change (extreme weather events, flood, drought, deteriorating air quality) are threatening health and survival of people not only in low and middle-income countries but also in high income countries.

At times of acute phase of an emergency, presence of multiple number of humanitarian stakeholders working with or without any partnership agreement/s make the emergency response less effective and inefficient with lots of duplication of response activities and waste of resources which are already scarce. On top of that, weak coordination and communication mechanism affect the quality and timely delivery of much needed emergency relief and services.

The Sendai Framework for Disaster Risk Reduction (2015-2030) outlines the primary responsibility of Member States to prevent and reduce disaster risk, including through cooperation with shared responsibility between central and local authorities, stakeholders and sectoral partners. The Bangkok Principles declared in March, 2016 at the International Conference on the implementation of health aspects of the Sendai Framework also recommend increased participation of the health sector representatives in multi-sectoral emergency response.

Post 2015 development agenda (Sustainable Development Goals) has also identified health emergency and security as a key indicator and indicated for effective partnership as follow:

- **The SDG 3 (Good Health and Well-being)**
  - SDG 3.4: “Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health crisis.”

- **The SDG 17 (Partnership for Sustainable Goals)**
  - SDG 17.9: “Enhance international support for implementing effective and targeted capacity-building in developing countries to support national plans to implement the SDGs, including through North-South, South-South and Triangular cooperation.
  - SDG 17.18: “Enhance the Global Partnership for Sustainable Development, complemented by multi-stakeholder partnership that mobilize and share

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knowledge, expertise, technology and financial resources, to support the achievement of the SDGs in all countries, in particular developing countries.

In addition, Climate Change Paris Agreement 2016\(^3\), World Humanitarian Summit 2016\(^4\), Habitat III Global Meeting 2016\(^5\) and IHR Global Implementation Plan that have been implemented globally in recent years, the World Health Organization (WHO) reformed its existing emergency programmes into new WHO Health Emergencies Programme (WHE).

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\(^3\) UNFCC (2016): The Paris Agreement. Available at: http://unfccc.int/paris_agreement/items/9485.php

\(^4\) World Humanitarian Summit 2016. Available at: https://www.agendaforhumanity.org/resources/world-humanitarian-summit#final-consultation-reports

\(^5\) UN HABITAT (2016): Habitat III. Available at: http://habitat3.org
Lessons learned from the Ebola outbreaks in Guinea, Nigeria, Liberia and Sierra Leone in 2014-2015 and loss of life (11 310 deaths)\(^6\) including humanitarian staff in affected countries led to structural and operational reforms in the WHO’s emergency work. As a way forward, WHO’s Health Emergency Programme (WHE) was formulated and became active in August 2016 with adoption of the Incident Management System (IMS) and operational partnership development being two of the key organizational approaches to manage emergencies.\(^7\)\(^8\)\(^9\) It led to the establishment of a single Programme (WHE), with one workforce, one budget, one set of rules and processes, one set of benchmarks and one clear line of authority.\(^10\)

In 2016, the WHO South-East Asia Region established a new department WHE/Emergency Operations (EMO) headed by the Regional Emergency Director (RED). Aligning the EMO with the global WHE Programme, the department established following 5 functional units under the leadership of the Regional Emergency Director:

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<tbody>
<tr>
<td>Ensure strategies and capacities are established for priority high-threat infectious hazards</td>
<td>Ensure country capacities are established for all-hazards emergency risk management</td>
<td>Provide timely and authoritative situation analysis, risk assessment and response monitoring for all major health threats and events</td>
<td>Ensure emergency-affected populations have access to an essential package of life-saving health services.</td>
<td>Ensure WHO emergency operations are rapidly and sustainably financed and staffed</td>
</tr>
</tbody>
</table>

To prevent, detect and respond to emergencies, the WHE Programme focuses on building country capacity in collaboration and partnership with the national, regional and global partners. The Regional Director of the WHO/SEARO has made strengthening of Emergency Risk Management and WHE programme a flagship regional priority to improve coordination mechanisms for emergency response through effective partnerships.\(^11\)

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\(^{7}\) WHO (2015). Resolution of Executive Board for reform of WHO work in health emergencies, EBSS2.R1


\(^{9}\) WHO (2016). Reform of WHO’s work in Health emergency management. 69\(^{th}\) World Health Assembly, A69/30, 05 May 2016


In order to have a timely, well-coordinated, effective and efficient emergency response, the WHE/EMO unit of WHO at the Regional Office based in New Delhi, India collaborates with various partners. Effective partnerships need focus and collaborative working across these afore-mentioned five core functional areas.

The overarching purpose of this Regional Framework on Operational Partnership is to assist and guide the WHO Country Offices, wide range of stakeholders and operational partners in strengthening mechanisms and tools of networking, coordination and communication for a sustainable partnership for timely, effective and efficient health emergency response in the South-East Asia Region.
3. RISK PROFILE

3.1 Regional Risk Profile

The South-East Asia Region is vulnerable to different types of emergencies and disasters. Countries in this region face a broad range of disasters from natural hazards including floods, cyclone, earthquakes, tsunami, landslides, volcanic eruption, heat waves, drought and others. The region also shares a high burden of outbreaks and epidemics of common infectious diseases, emerging and re-emerging diseases including zoonotic infections. Some of the recent outbreaks and threats faced by the South-East Asian countries include Influenza A (H1N1), Middle-East Respiratory Syndrome-Coronavirus (MERS-CoV), Avian influenza A (H5N1), A (H9N2), A(H5N1), Nipah virus, Japanese Encephalitis and Crimean-Congo haemorrhagic fever (CCHF), etc.\textsuperscript{12}

Figure 1: WHO South-East Asia - a highly vulnerable and priority region

\textsuperscript{12} WHO (2017). Roots for Resilience: A health emergency risk profile of the South-East Asia Region
The World Disasters Report 2015 shows that over the past decade, the Region contributed to 24% of the global mortality due to disasters and health emergencies.\textsuperscript{13} The South-East Asia Region has become a highly vulnerable region as per INFORM Risk Index\textsuperscript{14} (Figures 1 & 2).

![Risk profile for natural hazards in the South-East Asia Region as per INFORM Risk Index\textsuperscript{14}](image)

Increase in ambient temperature, humidity and adverse climate changes have been conducive for increase in vector and water-borne disease outbreaks that mostly affects children, women and other marginalized and poor sections of an affected community. The altered vector’s reproduction rates, biting behaviours and expansion in distribution of vectors to new regions are posing a serious health risk through emerging diseases like dengue, chikungunya and Zika virus-associated neurological anomalies (Figure 3).

\begin{figure}
\centering
\includegraphics[width=\textwidth]{risk-profile.png}
\caption{Risk profile for natural hazards in the South-East Asia Region as per INFORM Risk Index\textsuperscript{14}}
\end{figure}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{natural-hazards.png}
\caption{Risk for natural hazards in the South-East Asia Region}
\end{figure}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{vector-borne-diseases.png}
\caption{Risk for vector-borne diseases}
\end{figure}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{climate-change.png}
\caption{Risk for climate change}
\end{figure}

\footnotesize
\textsuperscript{13} IFRC (2015). World Disaster Report: focus on local actors, the key to humanitarian effectiveness.
\textsuperscript{14} WHO (2017). Roots for Resilience: A health emergency risk profile of the South-East Asia Region
Increase in water temperature will facilitate proliferation of diverse types of bacteria, viruses and fungi that is likely to result in increase in outbreaks of acute diarrhoeal diseases and skin infections. Poor air quality due to ambient air pollution especially in winter season has led to increase in outbreaks of acute respiratory infections. According to calculations of the World Bank Group Cartography Unit and International Monetary Fund (October 2017), contemporaneous negative impact of 1°C increase in temperature on per capita income output of Member States can be seen in the Figure 4 below:

**Feeling the heat**
Close to 60 percent of the world’s population will feel the adverse impact of rising temperatures.
The number of emergencies with health consequences is likely to continue to increase under adverse climate changes, demographic and epidemiological transitions, growing civil unrest/conflict and tensions with varying types of public health risks; natural as well as human-induced. WHO and its partners must be ready and have the capacity to respond.

### 3.2 Recent Major Health Emergencies

The South-East Asia Region is considered a ‘hotspot’ for emerging infectious diseases, including those with pandemic potential. Some of the major public health emergencies that occurred in last two decades in the Region are listed in section 3.2 (Table 1).

**Table 1: Major Public Health Emergencies in the South-East Asia Region**

<table>
<thead>
<tr>
<th>Year</th>
<th>Public Health Emergency</th>
<th>SEA Countries affected</th>
<th>Morbidity</th>
<th>Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>Gujarat Earthquake (Richter Scale 7.7) on 26 January</td>
<td>India</td>
<td>167,000 injured, 6.3 million affected</td>
<td>25,000 deaths</td>
</tr>
<tr>
<td>2003-2004</td>
<td>Avian Influenza H5N1</td>
<td>Bangladesh, Myanmar, Indonesia, Thailand</td>
<td>228 cases</td>
<td>181 deaths</td>
</tr>
<tr>
<td>2004</td>
<td>Indian Ocean Tsunami</td>
<td>Indonesia, India, Bangladesh, Sri Lanka, Thailand</td>
<td>125,000 injured</td>
<td>&gt;230,210 deaths</td>
</tr>
<tr>
<td>2005</td>
<td>Kashmir Earthquake (Richter scale 7.6) on 08 October</td>
<td>India</td>
<td>4 million became homeless</td>
<td>86,000 deaths</td>
</tr>
<tr>
<td>2006</td>
<td>Chikungunya outbreak</td>
<td>India</td>
<td>1.39 million cases</td>
<td>2,944 deaths $^{15}$</td>
</tr>
<tr>
<td>2006</td>
<td>Yogyakarta earthquake (Richter scale 6.4), 27 May</td>
<td>Indonesia</td>
<td>37,000 injured</td>
<td>&gt;5,700 deaths</td>
</tr>
<tr>
<td>2007</td>
<td>Cyclone Sidr</td>
<td>Bangladesh</td>
<td>7.5 million affected</td>
<td>&gt;5,000 deaths</td>
</tr>
<tr>
<td>2007</td>
<td>Cyclone Alia</td>
<td>India (Sunderbans) and Bangladesh</td>
<td>3.8 million affected</td>
<td>190 deaths</td>
</tr>
<tr>
<td>2008</td>
<td>Cyclone Nargis</td>
<td>Myanmar</td>
<td>2.4 million affected</td>
<td>138,000 deaths</td>
</tr>
<tr>
<td>2008-2009</td>
<td>Conflict/Civil War</td>
<td>Sri Lanka</td>
<td>60,000 wounded</td>
<td>&gt;20,000 deaths</td>
</tr>
<tr>
<td>2009</td>
<td>Chikungunya</td>
<td>Thailand</td>
<td>42,000 cases</td>
<td>--</td>
</tr>
<tr>
<td>2010</td>
<td>Dengue outbreak</td>
<td>Indonesia, Thailand, Sri Lanka, India</td>
<td>&gt;20,000 cases</td>
<td>1,500 deaths</td>
</tr>
<tr>
<td>2011</td>
<td>Floods</td>
<td>Thailand</td>
<td>13.6 million affected</td>
<td>815 deaths</td>
</tr>
<tr>
<td>2012-2015</td>
<td>Middle-East Respiratory Syndrome-Coronavirus (MERS-CoV)</td>
<td>Thailand</td>
<td>3 lab-confirmed cases</td>
<td>--</td>
</tr>
<tr>
<td>2015</td>
<td>Earthquake (Richter Scale 7.8) on 25 April</td>
<td>Nepal</td>
<td>22,303 injured, 41,199 hospitalized, 462 health facilities completely damaged, 765 partially damaged</td>
<td>9,000 deaths</td>
</tr>
<tr>
<td>2015</td>
<td>H1N1 Outbreak</td>
<td>India</td>
<td>33,000 cases</td>
<td>&gt;2,000 deaths</td>
</tr>
<tr>
<td>2015</td>
<td>Flood</td>
<td>India (Chennai)</td>
<td>1.8 million IDP</td>
<td>&gt;500 deaths</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Year</th>
<th>Public Health Emergency</th>
<th>SEA Countries affected</th>
<th>Morbidity</th>
<th>Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>Floods,</td>
<td>Myanmar</td>
<td>1 million people affected</td>
<td>103 deaths</td>
</tr>
<tr>
<td>2016</td>
<td>Flood/landslides,</td>
<td>Sri Lanka</td>
<td>52 500 people affected</td>
<td>&gt;100 deaths</td>
</tr>
<tr>
<td>2016</td>
<td>Floods/Typhoon Lionrock</td>
<td>DPR Korea</td>
<td>100 000 became homeless</td>
<td>138 deaths</td>
</tr>
<tr>
<td>2016</td>
<td>Cyclone Roanu,</td>
<td>Sri Lanka, Bangladesh</td>
<td>300 000 people affected</td>
<td>204 deaths (Sri Lanka) and 26 deaths in Bangladesh</td>
</tr>
<tr>
<td>2016</td>
<td>Mount Sinabung eruption,</td>
<td>Indonesia</td>
<td>28 536 IDPs (203 pregnant women, 869 babies, and 1573 pregnant ladies)</td>
<td>None</td>
</tr>
<tr>
<td>2016</td>
<td>Aceh earthquake (Richter Scale 6.5) on 07 December</td>
<td>Indonesia</td>
<td>1000 injured</td>
<td>100 deaths</td>
</tr>
<tr>
<td>2016</td>
<td>Zika - Grade 2 (20 Jan) declared PHEIC* on 1 February and graded down to endemic status on 18 November</td>
<td>Bangladesh, Thailand, Indonesia, India, Maldives,</td>
<td>Bangladesh: 1 case Thailand: &gt;360 cases, 2 microcephaly India: 4 cases</td>
<td>None</td>
</tr>
<tr>
<td>2017</td>
<td>Cyclone Storm Mora (May)</td>
<td>Bangladesh</td>
<td>3.3 million people affected, 260 000 IDP, 17 000 houses damaged</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>H1N1 Outbreak</td>
<td>Myanmar</td>
<td>166 confirmed cases</td>
<td>17 deaths</td>
</tr>
<tr>
<td>2017</td>
<td>H1N1 Outbreak</td>
<td>Maldives</td>
<td>222 confirmed cases</td>
<td>3 deaths</td>
</tr>
<tr>
<td>2017</td>
<td>Flood and Landslides (May)</td>
<td>Nepal</td>
<td>21 391 IDP, 41 893 house totally damaged</td>
<td>161 deaths (including 25 children)</td>
</tr>
<tr>
<td>2017</td>
<td>Flood and Landslides (May-June)</td>
<td>Sri Lanka</td>
<td>683 821 people affected, 15 897 houses damaged</td>
<td>224 deaths</td>
</tr>
<tr>
<td>2017</td>
<td>Dengue outbreak</td>
<td>Sri Lanka</td>
<td>170 075 cases from January to November</td>
<td>400 deaths</td>
</tr>
<tr>
<td>2017</td>
<td>Drought</td>
<td>DPR Korea</td>
<td>18 million people food insecure, 200 000 children with acute malnutrition</td>
<td>--</td>
</tr>
<tr>
<td>2017</td>
<td>Rohingya Refugees Conflict</td>
<td>Myanmar/Bangladesh</td>
<td>620 000 Rohingya people displaced to Bangladesh since 25 August 2017</td>
<td>199 deaths (including 78 children under 5 years of age) as on 18 November 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public health risk of outbreaks of cholera, measles, tuberculosis, malnutrition. Many cases of gender and sexual violence</td>
<td></td>
</tr>
</tbody>
</table>
3.3 Country-wise Risk Profile

The risk profile of the following eleven countries of the WHO South-East Asia Region are according to the assessments done in 2007 on implementation of WHO’s benchmarks, standards and indicators for emergency preparedness and response and risk profiling done for the Region in the ‘Roots of Resilience’.\footnote{16\footnote{WHO SEARO (2007). Benchmarks, Standards and Indicators for emergency preparedness and response. July 2007} 17\footnote{WHO (2017). Roots for Resilience: A health emergency risk profile of the South-East Asia Region}}

I. **Bangladesh**: Bangladesh is highly vulnerable to disasters from natural hazards (flood, cyclones, tidal surge, tornadoes, landslides, river erosions and droughts) and health emergencies due to water-borne, vector-borne and vaccine-preventable disease outbreaks. The country is at high risk for MERS-CoV, Zika Virus Disease and CCHF. Over the past four decades, the country has been hit by 7 of the 10 deadliest cyclones of the twentieth century. Cholera outbreaks are frequent.\footnote{18\footnote{Siddique AK, Zaman K, Baqui AH, Akram K et al. Cholera epidemics in Bangladesh: 1985-1991. J. Diarrhoeal Dis Res. 1992 Jun; 10 (2): 79-86} 19\footnote{Longini IM, Yunus M, Zaman K, Siddique AK, Bradley R, Nizam A (2002). Epidemic and endemic cholera trends over a 33-year period in Bangladesh. J. Infec Dis. 2002 Jul; 186: 920; 246-251}} Climate change is predicted to cause inundation of 10% of the land mass due to rising sea levels. The country is also vulnerable to some of the human-induced and technical hazards such as river traffic accidents, fires, building collapse, gas field explosion, terrorist attacks and political conflict.\footnote{20\footnote{WHO. Assessment of capacities using SEA Region Benchmarks for Emergency Preparedness and Response. SEA-EHA-22-Bangladesh}}

Its eastern province of Cox’s Bazar bordering Myanmar is hotspot for Rohingya Refugees crisis due to ongoing conflict in Rakhine state of Myanmar. It hosts world largest refugee camp of around 0.8 million people.\footnote{21\footnote{IOM Director General Statement on October 16, 2017; Available at: http://www.dhakatribune.com/bangladesh/2017/10/16/iom-chief-rohingya-crisis-worlds-biggest-humanitarian-disaster/}}

Partner Coordination is focused only on response but prior-arrangement for operational partnership are not in place. Risk identification, mapping and engagement of multi-stakeholders in risk management is not operationalized yet although Bangladesh has established a national Health Emergency Operations Centre (HEOC).

II. **Bhutan**: Bhutan is vulnerable to various natural disasters being in the high-risk seismic zones of IV and V. Each year; due to damage to critical health infrastructure, delivery of health facilities to affected community becomes a challenge. There is an impending risk from Glacial lake outburst floods because of increasing climate change. The country has 2674 glacial lakes of which 25 have been identified as potentially dangerous.\footnote{22\footnote{WHO. Assessment of capacities using SEA Region Benchmarks for Emergency Preparedness and Response. SEA-EHA-22-Bhutan}} It is also vulnerable to seasonal hazards such as landslides, flashfloods, windstorm, forest fire and
emerging diseases. With an ever-increasing number of vehicles and high road density, there is an increasing vulnerability of population to road traffic accidents.

There is some form of coordination mechanism at national level and the Health Emergency and Disaster Contingency Plan (HEDCP) has given the mandate for setting up of an HEOC. Technical and human resources capacity for HEOC is a challenge. Rapid Response Teams exist but their capacities on assessment of vulnerabilities are weak. However, all pharmacies and clinics in the private sector are legally obligated to participate in times of emergencies.

III. Democratic People’s Republic of Korea: The country is vulnerable to floods, typhoons, storm surge, acute malnutrition and risk of nuclear and radiation accident. Outbreaks of measles, tuberculosis, malaria, hepatitis B and avian influenza are frequent.

Apart from closed zones such as the Kaseong Industrial Complex, capacity for disease control in other regions is limited. Partners mapping and mechanism for operational capacity are lacking.

IV. India: The geographical statistics of India shows that almost 58% of the land is vulnerable to earthquake, 68% of cultivable area to drought, 8% to cyclones and 12% to floods.\(^\text{23}\) Indian population of 1.25 billion is also highly vulnerable to diseases outbreak. On an average, 30-40 outbreaks are reported every week across 36 states and Union Territories; of which outbreaks of acute diarrheal diseases, acute respiratory infections, food poisoning, measles and vector-borne diseases (malaria, dengue, chikungunya, scrub typhus, Japanese encephalitis) are most frequent.\(^\text{24}\) In addition, there are new challenges such as air pollution, heatwaves, toxic exposures from industrial, chemical and radiation leaks.

India has one Strategic Health Operation Centre (SHOC) at the National Centre for Disease Control, New Delhi and 10 similarly structured HEOC in health departments of vulnerable states, all hazards contingency plan and a well-established Integrated Disease Surveillance Programme (IDSP). It has a National Crisis Management Group and a National Disaster Response Fund.

V. Indonesia: Indonesia is located on three tectonic plates, a ring of fire with 128 active volcanoes (15% of all active volcanoes in the world). Thus, country is prone to disasters such as earthquake, tsunamis, floods, landslides, cyclones and volcanic eruptions. There are also frequent outbreaks of diarrhoea and gastroenteritis, dysentery, cholera, avian influenza, leptospirosis, hepatitis A and E, tuberculosis, HIV/AIDS, malaria, dengue fever and chikungunya. In addition, there are other human-induced vulnerabilities such as fires, forest fires, air pollution, road traffic accidents, ethnic and religious conflicts and biochemical, nuclear and radiation-related toxicities.

\(^\text{23}\) Government of India, Ministry of Home Affairs (2011). Disaster Management in India

\(^\text{24}\) IDSP, DGHS, MOHFW, Government of India. Disease Alerts/outbreaks reported and responded to by states/UTs through Integrated Disease Surveillance Programme (IDSP). Available at: http://ids p.nic.in/index4.php?lang=1&level=0&linkid=406&lid=3689
Indonesia has a national health cluster system. There are established coordination mechanism, contingency plans and national HEOC. However, leadership and coordination challenges are there at sub-national levels. The Indonesian Ministry of Health has identified the major partners working in health in government as well as private sector, academic institutions and sub-national levels. Some Memoranda of Understanding (MoUs) have been signed with these partners.\textsuperscript{25}

VI. Maldives: Maldives is vulnerable to hydro-meteorological hazards due to the country’s extremely low elevation and flat geography. Maldives regularly get affected by high frequent, low impact seasonal events such as monsoonal floods, coastal erosion, salt water intrusion and intense sea surges related flooding due to sea level rise.\textsuperscript{26} Vector-borne disease outbreaks of dengue and Chikungunya; and food and water-borne disease such as diarrhoea and intestinal parasitic diseases are common in Maldives. In January 2016, a case of Zika virus infection was reported with travel history linked to Finland.

Emergency operations are logistically difficult in Maldives due to spread of its islands in a vast ocean. Health Emergencies Coordination Committee (HECC) under MOH and partner organizations within their established coverage throughout the nation are working on establishing effective local response. The MOH is in process of setting up HEOC in its premises in 2017.

VII. Myanmar: Fifty percent of the total number of disasters from natural hazards in Myanmar were related to floods followed by storm (23%), earthquake (15%) and internal displacement (12%).\textsuperscript{27} Myanmar is undergoing civil conflict along with transition from military rule to democratic processes. The Rakhine state is vulnerable to civil conflict.

National and sub-national emergency committees are present but inter-sectoral cooperation and partnership arrangements are key challenges. The HEOC has been set up but the Incident Management Structure is yet to be established.

VIII. Nepal: Nepal has high vulnerabilities to earthquake, floods, landslides, forest fires, drought, hailstorms, avalanche, conflict and disease outbreaks. Epidemics account for high morbidity and mortality. Diarrhoeal diseases, acute respiratory infections, Japanese encephalitis, scrub typhus, kala-azar and malaria are seasonal threats and avian and human pathogenic influenza are of increasing concern.\textsuperscript{28}

The country has long-term health emergency preparedness and response plans in place along with established coordination mechanism. However, roles and responsibilities of partners are not clearly defined and not supported by administrative procedures. Nepal

\textsuperscript{25} WHO. Assessment of capacities using SEA Region Benchmarks for Emergency Preparedness and Response. SEA-EHA-22-Indonesia
\textsuperscript{26} National Disaster Management Centre, Maldives: Disaster profile and vulnerability context of Maldives. Available at: http://ndmc.gov.mv/downloads/natural-disaster/
\textsuperscript{28} WHO. Assessment of capacities using SEA Region Benchmarks for Emergency Preparedness and Response. SEA-EHA-22-Nepal
has a functional national and three regional HEOCs. The national health contingency plan is not fully established. Human resource capacity for emergency risk management is limited at sub-national level.

**IX. Sri Lanka:** Sri Lanka is vulnerable to floods, landslides, cyclones, tidal waves, tsunami, coastal erosion and droughts. Human-induced disasters include industrial and mining accidents. The country is also highly vulnerable to outbreaks of measles, rubella, acute respiratory infections, malaria, dengue, chikungunya, HIV/AIDS, Japanese encephalitis and avian influenza.\(^2^9\)

There are one national and three sub-national HEOCs. Although a robust emergency response coordination mechanism is in place but intra- and inter-sectoral coordination and partnership for emergency operations are still a challenge. Some health partners are not fully aware of their responsibilities in the health cluster mechanism.

**X. Thailand:** Thailand is vulnerable to impacts of monsoon floods, tropical hurricanes, landslides, droughts, wildfires, epidemics, civil conflict and refugee migration. The country often face outbreaks of dengue, chikungunya and recently outbreaks of Zika and Middle East Respiratory Coronavirus (MERS-CoV).\(^3^0\)

Thailand has HEOCs at national, regional and provincial levels. It has demonstrated successful operational partnership model. A cluster approach has been implemented at the national level.

**XI. Timor-Leste:** The country is vulnerable to natural hazards (landslides, flash floods, tropical storms, rural fires, drought, earthquake, marine flooding) and epidemics (acute respiratory infections, diarrhoea, cholera, typhoid, tuberculosis, malaria, dengue/dengue haemorrhagic fever and Japanese encephalitis). Human-induced vulnerabilities, marine accidents, road traffic accidents and civil conflicts are common.

Limited budget and lack of trained human resources make it essential to develop and strengthen operational partnership. There is no HEOC established until 2017.

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\(^2^9\) WHO. Assessment of capacities using SEA Region Benchmarks for Emergency Preparedness and Response. SEA-EHA-22-Sri Lanka

\(^3^0\) WHO (2012). Assessment of capacities using SEA Region Benchmarks for Emergency Preparedness and Response. SEA-EHA-22-Thailand
Various partnerships have their own mechanism of networking and coordination within their respective areas of specialty or interest. The operational partners and existing key partnership platforms are broadly categorized in following networks:

### 4.1 Members of the Inter-Agency Standing Committee (IASC)

It is the primary mechanism for inter-agency coordination relating to humanitarian assistance in response to complex and major emergencies. The IASC is managed by the Emergency Relief Coordinator (who is appointed by the UN Secretary-General) who is also the head of the UN Office for the Coordination of Humanitarian Affairs (OCHA). The World Health Organization is an active member of the IASC. Similar inter-agency coordination mechanism need to be implemented and strengthened at South-East Asia Region level.

For 2016-2017, the priorities of the IASC Working Group have been: effective response to emergencies and protracted crises, accountability and inclusivity, displacement and protection outcomes and financing. The IASC Emergency Directors Group (EDG) advises on operational issues of strategic concerns and preparing options and recommendations for the IASC on operational issues. WHO worked closely with the IASC’s EDG to develop new protocols for leadership and coordination in large-scale events due to infectious hazards, based on existing committee mechanisms.

The IASC’s cluster approach is a vital mechanism for coordinating sectoral action in humanitarian emergencies. The Global Cluster Coordination system under the guidance of EDG support the strengthening of country-level cluster and inter-cluster coordination with support of OCHA, with an overall aim of improving the quality of humanitarian response. In the country of humanitarian operation, OCHA provides platform for inter-agency coordination mechanism through setting up and conduct of IASC; and supporting humanitarian coordinator’s leadership.

### 4.2 UN Office for the Coordination of Humanitarian Affairs (OCHA)

OCHA serves as the secretariat for the critical inter-agency coordination mechanism, such as Inter-Agency Standing Committee (IASC); rapid response tools, such as the United Nations Disaster Assessment and Coordination (UNDAC) system; and the International Search and Rescue Advisory Group (INSARAG).

It brings together humanitarian actors for a coherent, effective and efficient response to emergencies. A key pillar of OCHA’s mandate is to coordinate effective humanitarian action in partnership with national and international actors. It leads the contingency planning for UN agencies and brings in a harmonized approach in the humanitarian response plan while engaging varied number of humanitarian actors. Working through its regional and country offices, OCHA urgently deploys staff at short notices to emergencies. The lead role of OCHA in operational coordination in emergencies includes assessing situations and needs, agreeing
on common priorities, developing common strategies to addresses issues, such as negotiating access, mobilizing funding and other resources and monitoring progress. It primarily supports the United Nations Resident Coordinator or Humanitarian Coordinator.

The Regional Office for Asia and the Pacific (ROAP) is based in Thailand and covers 36 countries and 14 territories. Its primary role is to support country teams in the region that do not have a local OCHA presence with the coordination of humanitarian response. The ROAP team support and facilitate cluster coordination and use of humanitarian financing tools Central Emergency Response Fund (CERF), flash appeals and consolidated appeals. It also provides assistance on information management, public information and civil-military coordination. In addition, ROAP backstops the work of OCHA Country Officers in Indonesia, Nepal, Myanmar, Philippine and Sri Lanka by providing surge capacity, training and technical support.

During a crisis situation, the OCHA-managed UNDAC system which is a standby team of volunteer emergency managers with varied skills, is deployed within 24 to 48 hours of a disaster. There are three ‘surge’ staffing options used by OCHA; prior to the recruitment of regular longer-term staff: (1) rapid and temporary redeployment of internal staff from the field and headquarters, (2) deployment of experts seconded from rosters managed by OCHA’s 11 standby-partner organizations that may be seconded to OCHA and (3) rapid temporary recruitment and deployment of experts from the Associate Surge Pool.

It is also an active member of the Inter-Agency Sub-Working Group on Preparedness. The group aims to strengthen and promote inter-agency preparedness, contingency planning and early warning processes across the IASC.

4.3 Global Health Cluster (GHC)

A functioning health cluster involves UN agencies, NGOs, community-based organizations, and community members, including between the national capital and the field, and with other sectors/clusters. WHO is the Global Health Cluster Lead Agency and it provides secretariat support through the Global Health Cluster Team in the WHO Emergency Operations Department in the Geneva headquarters.

It is mandated to build global capacity in humanitarian response in three ways: (1) providing guidance, tools, standards and policies, (2) establishing systems and procedures for rapid deployment of experts and supplies and (3) building global partnerships to implement and promote emergency preparedness and response work.31

The Global Health Cluster supports Health Cluster in countries by providing the right expertise at the right place at the right time, by building capacity of Health Cluster Coordinators and other Health Cluster staff in countries, by identifying and addressing gaps in technical knowledge and available guidance to ensure the health response based on global best

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practices and standards and by promoting and advocating the importance of humanitarian health action to ensure political and financial support for the Health Cluster.

4.4 Emergency Medical Teams (EMT)

An Emergency Medical Team is a group of health professionals (doctors, nurses, paramedics etc.) providing direct clinical care to populations affected by disasters, emergencies or outbreaks. This includes governmental (both military and civilian) and non-governmental teams and can include both national and international teams. The overall goals are to strengthen national capacity to respond to emergencies with health consequences. The scope of EMTs ranges from management of trauma due to sudden onset disasters (mass casualty management) to acute medical emergencies care in disease outbreaks of cholera, *Shigella* and Ebola. It also supports populations affected by food, conflict and protracted crises such as famine.

WHO has developed a global verification and registry system where EMTs can be classified and ready to be deployed to health emergencies. The EMTs have been categorized in three types:

- **Type 1**: (Mobile EMT: 50 patients/day), (Fixed EMT: 100 patients/day),
- **Type 2**: Inpatient surgical (with infrastructure; at least 7 major or 15 minor operations daily with at least 20 inpatient beds per one operating table),
- **Type 3**: Complex inpatient referral surgical care including intensive care capacity (At least 2 operating tables in 2 separate rooms within the theatre are, at least 40 inpatient beds and have the capacity to treat 15 major or 30 minor surgical cases a day.

In an emergency, the outcome of response depends on how quickly right expertise reaches at the right place in the right time to meet the needs of people-in-need. The EMTs are an important part of the global health workforce but the EMT initiative places a strong focus on helping every country in developing its own EMT that can arrive where they are needed in the shortest time. Emergency Medical teams need to comply with globally agreed standards and coordination mechanism in humanitarian response. WHO coordinates and supports this EMT initiative for predictable, self-sufficient and quality assured emergency medical response.

The host/affected country should have a pre-existing mechanism for EMT training, quality assurance, deployment and coordination. WHO has been coordinating development of standards, quality assurance and verification process for EMTs and guidance for EMT coordination. There are 13 EMTs which have been classified and verified through a peer-review process and more than 70 EMTs are currently going through assurance process. Thailand has approximately 70 national EMTs that are expected to undergo an accreditation programme. India has agreed to initiate the internal process for EMT registration/verification (Type 1 Fixed). Indonesia is moving forward with quality assurance and further strengthening of its EMTs for international deployment (MOH, military, Hajj Medical team, Red Crescent, Muhammadiyah NGO). Bhutan has also started the process of registration and verification of its EMT (Type 1 Fixed) by WHO’s EMT initiative process.
4.5 Global Outbreak Alert and Response Network (GOARN)

GOARN network; a global technical partnership, is a key mechanism for timely deployment of health emergency workforce with technical and operational capacities for rapid identification, confirmation and response to public health emergencies of international concern. It plays a pivotal role from alert, to risk assessment, to rapid implementation of disease control measures with emphasis on strengthening and implementation of IHR (2005) systems and capacities.

The partners include medical and surveillance initiatives, regional technical networks, networks of laboratories, United Nations agencies (e.g., UNICEF, UNHCR, UNFPA), the Red Cross and Red Crescent Societies (ICRC, IFRC), international humanitarian non-governmental organizations (International Rescue Committee, Epicentre), and national public health institutions.

WHO is an institutional partner, WHO Country Offices are network members and WHO SEARO is network hub of GOARN. The reported number of GOARN network members in the South-East Asia Region has reached to 30 in 2017 however active participation is limited. The GOARN’s 21-members Steering Committee (SCOM) approves all new additions to the network and oversees the planning, implementation and evaluation of the GOARN activities and strategic goals. The GOARN operational support team (OST) is based at the WHO office in Geneva comprising of 8 staff members.

GOARN has a significant role to play in the South-East Asia Region by building technical capacity of the members of the network in disease investigation and control skills. It has an online training programme which has been designed based on the GOARN Competency Model. GOARN partners are encouraged to undertake these courses to develop and test the necessary skills, attributes and behaviours to effectively support and respond to national and international outbreaks and public health emergencies.

4.6 Standby Partners (SBP)

WHO Standby Partners initiative is a central element of WHO’s emergency risk management system and a strong complement to WHO’s other surge and response partnership mechanisms. This form of partnership allows no-cost rapid access and deployment of highly skilled personnel of the global health emergency workforce with a broad range of humanitarian and technical profiles to support field emergency work, including information and data management, mapping, water and sanitation, nutrition, public health, logistics, project management and social work. Standby partners of WHO agree to maintain a roster of standby personnel (standby roster) for the rapid mobilization and deployment of pre-screened individuals included in the roster. Standby personnel are not WHO consultants. The

standby partner agency award an employment contract to those selected from the Standby Roster prior to deploying them to WHO.

WHO holds global agreements with six partners (International Civilian Response Corps (CANADEM), the information Management and Mine Action Programme (iMMAP), the Netherland Enterprise Agency, the NGO Consortium for the Global Health Cluster, the Norwegian Refugee Council, RedR Australia and the United Kingdom Department for International Development). This form of partnership arrangement need to be contextualized and scaled up at regional level.

4.7 Multilateral and Bilateral Development Partners

Multilateral organizations obtain their funding from multiple governments as well as from non-governmental sources and spend their funding on projects in various countries. The major multilateral organizations are all part of the United Nations. The UN Agencies which are multilateral are basically inter-governmental agencies. Multilateral partners that get engaged in emergency response are WHO, UNICEF, UNDP, UNFPA, WFP, UN Women, IOM, UNISDR, World Bank, Disaster Risk Reduction- European Commission (DIPECHO) and Global Fund to Fight AIDS, Tuberculosis and Malaria.

Bilateral agencies receive funding from the government in their home countries, and use the funding to aid low and middle-income countries. These are developmental agencies of national governments. Bilateral organizations such US CDC, USAID, DFID, JICA, DANIDA, and SIDA get involved in emergency preparedness and response.

4.8 WHO Collaborating Centres (WHO CCs)

WHO Collaborating Centres are institutions (autonomous or under national governments) such as research institutes, parts of universities or academics which are designated by the Director-General to carry out activities in support of the WHO’s programmes. In each WHO Regional Office, as at headquarters, focal points are designated to manage and coordinate statutory information and procedures on WHO Collaborating Centres.

These collaborating centres work in different areas such as communicable diseases, nursing, nutrition, mental health, public health informatics, innovations and technologies, and research training and capacity building etc. Examples of WHO CCs in the South-East Asia Region that get engaged in emergency response are National Centre for Disease Control, MOHFW, Government of India, ICDDR, b Dhaka, Bangladesh and Centre of Health Crisis, MOH, Indonesia.

To facilitate management, cooperation and networking, a global information system, on all WHO CCs, has been developed, to be accessible worldwide to WHO staff, WHO CCs, and eventually Member States and the public health community at large. Exchange of experience and collaboration between centres is supported by regular meetings at country and regional levels and on specific topics.
4.9 Regional Networks

4.9.1 Association of South-East Asian Nations (ASEAN): It is a regional intergovernmental organization comprising ten Southeast Asian Member States (Indonesia, Malaysia, Philippines, Singapore, Thailand, Brunei, Cambodia, Laos, Myanmar and Vietnam) that promote Pan-Asianism. This is a good inter-governmental platform for advocacy, stewardship and coordination mechanism for strengthening regional emergency response capacity and partnerships. ASEAN aims to promote active collaboration and mutual assistance on matters of common interests in the economic, social, cultural, peace and regional stability, agricultural, education, research trainings and in disaster management fields.

The ASEAN-Emergency Response and Assessment Team (ASEAN-ERAT) has been established to respond to a major sudden on-set disaster within the ASEAN region. It also coordinates mobilization and deployment of regional disaster management capacity and facilitates the incoming relief assistance from the Member States. Currently, there are more than 90 trained ASEAN-ERAT members and experienced emergency responders.

It has established ASEAN Coordinating Centre for Humanitarian Assistance on Disaster Management (The AHA Centre) in Nov 2011. It acts as a regional hub for information and knowledge exchange on disaster management. The AHA Centre is based in Jakarta, Indonesia.

It also has ASEAN Earthquake information Centre in Jakarta that monitors earthquake activities and to helps mitigating the effects of earthquake disasters. It also provides support in the South-East Asia Region to improve capabilities of national seismic centres in member States and in establishing a regional seismic information services.

WHO is establishing a network of HEOCs in collaboration with ASEAN that will build capacity on Incident Management Systems, establishing and running of EOC for managing health emergencies and addressing various coordination and communication challenges in the Region.

4.9.2 South Asian Association for Regional Cooperation (SAARC): The SAARC is the regional inter-governmental organization and geopolitical union of nations in South Asia. Its main objectives are to improve the quality of life and to accelerate economic growth, social progress and cultural development. It comprised of eight Member States: Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka.

It has established a SAARC Disaster Management Centre for the Member States for providing advice on and facilitating capacity building services and system development for rapid regional emergency response coordinating mechanism. It also advocates and promotes regional cooperation to preserve, protect and manage the diverse and fragile eco-systems of the Region including the need to address the challenges posed by adverse climate change and natural disasters.

4.9.3 Asia Pacific Emergency and Disaster Nursing Network: This network came into existence as a key outcome of the Joint Informal Meeting of Health Emergency Partners and Nursing Stakeholders that was convened in Bangkok in 2007. It aims to build the capacities of
nurses and midwives to fully contribute to coordinated and effective prevention, preparedness and response efforts; improved service delivery and building of community resilience during times of emergencies and disasters.

The Network has around 240 individual members from over 40 countries in Asia-Pacific Region. Most of the members come from the academic, ministries of health, nursing and midwifery professional and humanitarian organizations.

4.9.4 South-East Asian Ministers of Education Organization- Tropical Medicine and Public Health Network (SEAMEO TROPMED): It is a regional cooperation network for education, training and research in tropical medicine and public health under the South-East Asian Ministers of Education. Its member countries are Brunei Darussalam, Cambodia, Indonesia, Lao People’s Democratic Republic, Malaysia, Myanmar, the Philippine, Singapore, Thailand, Timor-Leste and Vietnam. Its highest policymaking body is the SEAMEO Council (SEAMEC) which is composed of the Ministers/Secretaries of Education of the Member Countries. Its secretariat is located in Bangkok, Thailand and it has 17 regional centres.

The network serves as a focal point in higher education and research in tropical medicine and public health. It aims to develop the capacity of individuals and institutions in delivery quality healthcare.

4.10 Private Sector Networks

With the rise of ‘Corporate Social Responsibility’ (CSR) as a standard practice in Member States, private sector actors/corporate houses invest and work in the humanitarian emergency aids and response. Examples of private sector actors are: Rockefeller Foundation, Bill and Melinda Gates Foundation, Reliance Health Foundation and Public Health Foundation of India (Public-Private Sector Model).

There are various trade chambers and professional associations of commerce in the Region which are common business platform of private companies for sharing information on trade and commerce and ideas on corporate social responsibility. These networks of companies and trade associations can be tapped for utilizing CSR for emergency readiness, response and early recovery phases. Some of the examples are as below:

Federation of Indian Chambers of Commerce and Industry: Largest apex business organization in India; reaching out to over 250 000 companies. It is investing on environment and climate change, water and sanitation and hosts a ‘Clean Air Platform’ for the private sector.

The provisional list of operational partners in the South-East Asia Region is provided in Annex 1.
5. GAPS AND OPPORTUNITIES

The commonly encountered gaps in the operational partnership arrangements for emergency response specifically in the South-East Asia Region are as under:

- Mechanism of effective coordination and communication in organizing immediate response, during emergency and recovery phase are often found weak, unclear and least effective in implementation.

- The Incident Management System (IMS) is either non-existing or are weak in structure and staffing. The trigger mechanism for activating IMS and Health Emergency Operation (HEOC) Centre/s lack clarity. The role of operational partners in readiness for emergency response, during emergency and in early recovery as a support to the MOH is not well-defined in policies and guidelines.

- Available technical expertise and operational capacity of the partners in assessments, water and sanitation, healthcare waste management, emergency health system resilience, non-communicable diseases, data management, planning, HEOC operations, incident management, project management, monitoring & evaluation and evaluation remain diffracted and not optimally tapped and utilized for effective emergency operational management. The rapid response team or public health emergency medical teams remain under-utilized for management of emergency response.

- Weak operational response capacity in food safety, chemical and radio-nuclear events, slow-onset disasters like drought need to be covered and enhanced under partnership arrangements with relevant operational partners.

- Early Warning, Alert and Response System still need to be strengthened where in different partner networks can contribute and play a coherent role.

- Priority areas for effective operational partnership (mapping of priority infectious disease outbreaks and threats) need to be developed based on recognized expertise of operational partners.

- Sustainable financial mechanism for operational partnerships for emergency response need to be strengthened.

- Pre-emergency partnership arrangements with private health sector and other potential partners are often non-existing despite potentials of ‘Corporate Social Responsibility’. The networks trade associations, chambers of commerce and business forums in the Region are untapped potentials for engaging major corporate houses/foundations in investing emergency risk management and humanitarian response activities.

Operational partnership for effective emergency response can be strategic if it is risk-informed and guide the mutual understanding for timely, effective and efficient response within available scarce resources.
6. REGIONAL FRAMEWORK ON OPERATIONAL PARTNERSHIPS

Working more closely with partners is essential as WHO cannot deliver everything alone. WHO regularly collaborates with partners to leverage and coordinate the expertise required for better emergency response. There is a need to have good coordination amongst existing partner networks in the South-East Asia Region because in actual emergency response, teams and partners will have to relate with other partnerships to avoid duplication and to ensure seamless response activities.

WHO follows certain principles and criteria for engaging with partners in formal or informal partnerships. (Box 1)

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**Box 1: Principles and Criteria for Operational Partnership**

1. **Added value in Emergency Operations**: Must be a shared vision and concept of health. Partnership demonstrates a clear added value in terms of knowledge and resources, technical expertise, and creating synergy.
2. **Clear Goal**: Must be shared goals and targets. Partnership should represent an extension of WHO’s core functions, policies and relative strengths to partnering organization.
3. **Roles of partners are clear**: Partnership arrangements must clearly articulate the expertise and strengths of partners, avoid duplication of WHO’s and partners’ activities, and the introduction of parallel systems.
4. **Partnership are guided by the technical norms and standards**: Emergency Response Framework and Emergency Preparedness and Response Benchmarks as specified by WHO.
5. **Participating Members of partners have decision-making Power**: Members must have sufficient status and authority in their own organization to influence decisions, otherwise collaboration becomes only a networking process.
6. **Adequate participation in Partner Coordination Meeting and Emergency Operations**: Members must be having sufficient time to devote to interagency activity.
7. **Important to demonstrate achievements**: Implies need for self-monitoring and/or periodic evaluation.
8. **Transaction costs related to a partnership must be evaluated**, along with the potential benefits and risks.
9. **Partnership Coordination**: A regular coordination function should continue to maintain commitment and to identify potential resources.

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34 World Health Assembly (2010). Sixty-Third World Health Assembly. WHA63.10, 21 May 2010
35 World Health Assembly (2016). Sixty-Third World Health Assembly. WHA60.10, 28 May 2016
6.1 Goal of the Framework

Build, strengthen and expand operational partnerships in the South-East Asia Region for effective emergency response through improved mechanisms of networking and coordination among operational partners.

6.2 Key Elements for Operational Partnerships for Emergency Response

WHO SEARO has identified strengthening of emergency risk management as a flagship programme; of which operational partnership for emergency response is one of the key components.36

Opportunities for building new operational partnerships and strengthening existing partnerships are to be explored through recognizing partners’ contribution and engaging them across all three phases of emergency risk management continuum i.e. during Preparedness/Readiness, Emergency Response and Early Recovery. (Figure 5)

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The following key elements are in line with the partnership criteria set by the World Health Assembly,\textsuperscript{37,38} ‘Benchmarks for Emergency Preparedness and Response’\textsuperscript{39} and ‘Emergency Response Framework’\textsuperscript{40} for building operational partnership for emergency response in the Region (Figure 6):

6.2.1 Readiness
The following elements should be considered to build and strengthen operational partnerships during preparedness phase:

6.2.1.1 Contingency Plan

The contingency planning is done in advance to get prepared well before an actual health emergency happens. WHO should support ministry of health in conduct of operational partners mapping, their expertise and strengths vis-à-vis risk and multi-hazards profile of the geographical area and beneficiary populations.

There can be developed some understanding on who will do, what, when and where (4Ws approach). The frequency of mapping of potential operational partners should be decided based on the local area needs and change in the context.

The contingency plan should consider human resources capacity, technical and logistical requirements, financial requirements, required coordination and communication mechanism. Operational partners need to evaluate and find out areas where they can contribute, support and supplement readiness for emergency response. It may also require pooling of resources for operational support and logistics.

Partnership is a key to ensuring effective and efficient operational support and logistics as joint and combined contingency plan. This should be built upon following sub-functions:

a) Coordination and Communication Mechanisms: Tools of coordination, methods of communication and standard operating procedures (SOPs) should be mutually agreed, predefined and explicitly mentioned in the contingency plan. Operational partners are expected to confirm their focal points who will take part in the health partner coordination meetings and have the authority to mobilize rapid response assistance with a requested timeframe. WHO provides technical assistance and guidance to the MOH in the activation of a health emergency response coordination group by national authorities:

i. Inter-Agency/ Inter-Sectoral Coordination Group (or Emergency Response Steering Group/Cluster) at country and regional level (e.g., Inter-Agency Standing Committee)

\textsuperscript{37} World Health Assembly (2010). Sixty-Third World Health Assembly. WHA63.10, 21 May 2010

\textsuperscript{38} World Health Assembly (2016). Sixty-Third World Health Assembly. WHA60.10, 28 May 2016


\textsuperscript{40} WHO (2017): Emergency Response Framework-2\textsuperscript{nd} Edition. Available at http://apps.who.int/iris/bitstream/10665/258604/1/9789241512299-1-eng.pdf?ua=1
II. Establishment of an operational partners’ coordination group at national level

III. Support to the MOH in the establishment of an Incident Management System

Such Inter-Agency Coordination Group should be in place before any health emergency arises. The objective, purpose, scope of work and trigger for activation of such group at different levels should be well defined and clear to each member of the group. Each Member State in the South-East Asia Region should develop and strengthen its national health cluster in coordination with WHO.

b) Supply Chain System: There should be clear and documented understanding and agreement among operational partners for ensuring end-to-end, timely and efficient provision of earmarked items relating to consumables and equipment. It should be clearly spelt who will be responsible for procurement and supply (including technical skills) of which item based on individual partner strengths and resources.

c) Field Support: There should be clearly demarcated areas of joint operational support functions when it comes to management and field support to response teams; readily deployable database/standby roster of trained workforce, functional and secure working spaces, equipment, communications and transport. To ensure timely availability, experts should be identified using a roster and pre-vetted by the Member States and/or with WHO. Agreements should be in place with their home institutions/partner agencies to release them at short notice (within 72 hours). Visa and health checks up should be completed in advance. Administrative requirements such as contractual arrangement should be in an advanced state ready to be activated without delay.

d) Financial Resources: The contingency plan should have clearly demarcated funds and specified allocations for different emergency interventions. Operational partners need to be fully aware about the financial provisions and procedures for maintaining and releasing required funds in time of emergency that they earmarked under their contingency plan.

e) Health Logistics: Contingency planning should be based on agreed joint provisions of providing technical expertise, tools, methods and means to meet the logistics needs of medical facilities, cold chain management, laboratories and blood banks. The agreement should be clear on name of items/technical expertise, maximum limit of quantity, and methods and means of procurement and supply to the emergency field.

An inventory of standby resources (general and health logistics) committed by partners should be available with the national authorities which should be maintained and updated regularly.

6.2.1.2 Develop and Expand Partnerships

Strategic partnerships are crucial to leverage comparative advantages of operational partners. Partnership arrangements should not be narrowly limited to health sector only but should be flexible for allowing space for working together with partners who have additional strengths in health-related sectors such as nutrition, water, sanitation and hygiene.
promotions (including safe and dignified burial), education, child protection, safety and security, logistics and transport, mental health psychosocial counselling (EHA Benchmark 4).

WHO and potential operational partners should discuss and clarify the broad terms of understandings for collaborative Scope of Work; though not legally binding, whilst considering the operational limitations, bottlenecks and budgetary issues. (EHA benchmark 2 and 4).

In contexts of fragile states, disasters, conflicts, complex and protracted emergencies, development and humanitarian assistance need to be complementary in making systems resilient and ready for emergencies. Such Humanitarian and Development Nexus should be recognized. Thus, expansion and strengthening of operational partnerships at country and regional level through networking and addition of new partners in GOARN, Health Cluster, Standby Partners, other public health institutions and collaboration with regional networks and private sectors stakeholders should be a priority and ongoing process to build emergency response capacity in the Region.

6.2.1.3 Financial Sustainability

Informal or formal agreement and commitments under the partnership should have sustainable mechanism of financial viability (EHA benchmark 1). The South-East Asia Regional Health Emergency Fund (SEARHEF) which was established in 2008 has been used to provide immediate financial support to 9 out of 11 Member States in 31 emergency operations with total funding support of US$ 5.2 million. The scope of SEARHEF has been expanded under approval by the Member States in the 69th Regional Committee that would strengthen key aspects of preparedness/readiness.

Financial sustainability mechanisms should allow the Member States in the Region to ensure coordination with external partners in emergency response to explore possibilities of strengthening emergency funding at country level. There is an obvious need to further expand and consolidate the emergency funds.

6.2.1.4 Strengthening Emergency Response Capacity

Preparing and building surge capacity for emergency response under operational partnerships is an important element of readiness.

Inter-sectoral capacity development of partners that are often engaged in emergency response with pooled and collective sourcing of technical competencies and training resources will further strengthen the emergency operational capacity in the South-East Asia region (EHA Benchmark 10). For example, training and capacity development of HEOC staff, EMT, GOARN and Standby Partners and potential sub-national partners that work closely at community levels.

There can a standard training course-curricula for regional and national level Rapid Response Teams and EMTs considering the regional and national multi-hazards, risks and vulnerabilities. Health or allied-health professionals from WHO and operational partners who
are or may likely to get involved in emergency operations can be offered such trainings. Coordination and management of EMTs need to be streamlined to promote more effective volunteerism during emergencies. Priority focus countries for EMT strengthening in 2017-18, are Bangladesh, Bhutan, India, Indonesia, Nepal, Sri Lanka and Thailand wherein partnerships should be built with potential EMTs.

An annual training calendar could be developed for the conduct of capacity building programmes for strengthening emergency response technical skills, attitudes and practices of response teams/ national EMTs and the key staff from health partners.

Operational Partners should conduct joint multi-sectoral simulation exercises and mock drills periodically in order to stay ready for any unexpected disasters (EHA Benchmark 2).

Thus, trained workforce across existing operational partners and standby partners should be maintained in a standby roster at national and sub-national levels.

6.2.2 Emergency Response

Operational partners should have a mutually agreed operational platform in order to deliver emergency services effectively under a Joint Operational Plan. In addition, the following elements

6.2.2.1 Information Sharing

Sharing of important information on risk and vulnerabilities mapping, potentials for health emergencies/disease outbreaks, key programme areas and technical expertise of an operational partner for emergency response is very critical for partners and resource mapping and better coordination.

Lack of information or unprocessed scattered and duplicated data in aftermath of a disaster or during emergency result in chaos and panic among public health community as well as among affected population-in-need. The national authorities in collaboration with WHO should enforce use of standard format with defined flow of information for cross-sharing of information and surveillance data so that decision-making and joint planning on utilization of scarce resources and rational allocation of emergency health service provisions can be guided appropriately.

Operational partners are expected to continue arrangement of regular communication to ensure comprehensive and transparent exchange of information relating to situational analysis, gaps identified, surveillance and alert for collective emergency response. The repository of information can be tapped by all operational partners for a coherent and complementary programming for effective emergency response and recovery.

6.2.2.2 Health Partners Coordination

Coordination, communication and inter-agency cooperation and collaboration are key elements in emergency response phase. WHO Country office in the affected country provides
leadership in health sector partners’ coordination as a technical assistance to the MOH. It assists and facilitates activation of the existing inter-agency coordination mechanism and mobilizes partners for their participation in health coordination meetings for joint rapid need assessment, 4Ws analysis and development of joint operational plan. The operational partnerships agreements organized prior to an emergency should get activated and implemented. Presence and contribution of new potential partners’ in the immediate emergency response should be recognized.

6.2.2.3 Identification of Potential Partners

There may be new emergency response actors in a specific geographical location in a particular health emergency which are noted by all for their effective and timely contribution in emergency response. WHO should be open to new opportunities of collaboration and partnership with new operational partners to expand and strengthen the partnership at local and regional level in case the situation gap analysis indicate that the needs are not being met through the existing operational partnerships for having an effective and efficient emergency response.

These new partners could be new EMTs or private sector corporate houses or private foundations. An informal understanding can be evolved during the emergency phase which can mature later into formal partnership or Memorandum of Understanding.

6.2.3 Early Recovery

6.2.3.1 Post-Disaster Need Assessment and Partnerships

The MOH in the affected country should ensure through the partners’ coordination group and enforce clear ‘exit plan/policy’ of each operational partner with proper hand-over to the concerned government department. The ‘4Ws’ analysis should be reviewed in early recovery phase.

Some of the operational partners get involved in ‘Build Back Better’ developmental interventions during the early recovery phase. Partners should be encouraged to contribute to a post-disaster needs assessment (PDNA) and explore the possibilities of informal or formal partnerships in areas of building critical health infrastructure resilient, improving surveillance and health information systems, service provisions for nutrition services and, mental health and psycho-social support.

Examples of operational partners that get more involved in the recovery phase are: World Bank, Asian Development Bank, UNDP, UNISDR and regional and private sector networks such as ASEAN-AHA Centre, SAARC and national chambers of commerce and industries.
Figure 6: Schematic layout of the regional framework’s key elements and implementation processes
WHO South-East Asia Regional Office will facilitate, oversee and provide support in the implementation of the Regional Framework on Operational Partnership for Emergency Response, in consultation and cooperation with national MOHs, WHO Country Offices and operational partners in the Region.

The Framework will be implemented through the following processes and methods:

**7.1 Governance and Stewardship**

The existing mechanisms and tools of coordination for optimal utilization and tapping of expertise and contributions of operational partners will be strengthened at country and the Regional levels. The humanitarian and development nexus should fill the gaps and strengthen both health system resilience and emergency operations for minimizing the impact of hazards and health emergencies.

The establishment of a regional forum or a platform for operational partnerships in health emergency response would support the efforts in further strengthening emergency operations. The forum or platform will bring together partners, network of HEOCs and national incident management systems.

The Emergency Response Framework and this Regional Framework on Operational Partnerships for Emergency Response are concrete actions of stewardship in building and fostering operational partnerships in the Region. WHO and the lead partner agencies will advocate, promote, facilitate and support the national authorities in strengthening the emergency health systems, operations capacities and capabilities by supplementing the unmet needs and gaps areas through mobilization and pooling of resources including required funds, technical expertise, tools and materials.

**7.2 Partners’ Coordination**

WHO takes lead in partners’ coordination in health emergencies as a technical support to the MOH in the affected country. Participation and active contribution of operational partners in the health coordination meetings is crucial and utmost important across all the three phases of emergency operations.

Networking, building and maintaining partnerships, and regularly coordinating with the interested partners for enhancing capacities on readiness, collective response and recovery through sharing of knowledge, experience, expertise and resources is a regular process. Based on prior-to-emergency mapping of operational partners in the affected country, the geographical areas and division of emergency operations work can be distributed. In case, there is no existing 4Ws mapping for an affected area in a country or new operational partners are seen contributing in emergency response then the exercise of partners mapping on 4Ws can be repeated for clarity and new opportunities for partnerships. The strengths and
contributions of each partner in facilitation of strengthening of IMS and assistance in the establishment and operationalization of Health Emergency Operations Centres will be needed.

Partners’ coordination function should be conducted on regular basis for managing dynamics of partnership arrangements, agreements and expansion of the scope of different types of partnerships. It is must for further developing and sustaining operational partnership for emergency response in the Region.

The roles and responsibilities under the partnership coordinator function should be clear and specified. Some of the key activities under the partnership coordinator function are:

- Governance and coordination mechanisms for EMT, GOARN, Standby Partners and other agencies at regional level
- Ensure the operational partners’ capacity be updated periodically through training, workshops, drills and simulation exercises
- Ensure Standard Operating Procedures and basic minimal technical standards for emergency service provisions be followed by all partners
- Identify new potential regional, national and local partners that can enhance WHO emergency response capacity through collaborations and partnerships
- Maintain and expand the database of the operational partners and networks
- Design, upkeep and improve a web-enabled platform for operational partnership for regular exchange of information, emergency risk alerts and reports on emergency operations performance evaluation
- Advocate, promote and facilitate partnership arrangements for emergency response in the South-East Asia Region
- Establish liaison and maintain rapport with prospective operational partners in the Region including the private sector.

7.3 Collective Emergency Response

Collective and synergized emergency response as a strong support in the affected country to the national authorities is the main intended outcome of this framework. Joint and coordinated efforts of the operational partnerships should range from joint rapid assessment, combined immediate response to joint operational planning.

The operational partners should proactively contact and collaborate with the MOH and WHO for participation and conduct of a joint rapid assessment using the standard tools as soon as a disaster occurs and a public health emergency is declared by a national government. As the inter-agency coordination group or inter-sectoral coordination group are activated by the national government, the partners should actively participate and contribute in situation review, gaps analysis and identification of needs and opportunities to make emergency operation effective and efficient.

Partners are expected to undertake or share specific functions at different levels within country or at regional levels. The purpose is to bring them together under this Regional
Framework for timely, effective, efficient and integrated coordinated emergency response as a strong support to national and regional capacity.

At the activation of the national incident management system, the partners should alert and activate their roster of experts based on the collective understanding of the emergency situation in the health partner coordination meetings. The standby roster can be activated for deployment of relevant expert staff. It may include re-purposing of staff and/or temporary support from the partners trained staff under prior partnership agreement for different coordination or technical expertise roles or supplementing the general or health logistics needs.

Existing operational partnership agreements among partners should enable coordinated deployment of joint Rapid Response Teams (RRTs) in the affected community within 72 hours. For example, GOARN partners may facilitate mobilization and deployment of Rapid Response Teams. As needed, the Health Cluster can also be activated. In the wake of an emergency due to an earthquake or flood where mass casualties have occurred, national EMTs can be strengthened by partners with EMT.

If authorities in an affected country determine that the event(s) require additional support, WHO SEARO may convene an emergency meeting (physical/teleconference) with relevant operational partners to mobilize regional resources for emergency response. For example, the coordination for the EMTs at the South-East Asia regional level can be facilitated so as to work in coherence with other response teams at national and regional levels in time of crisis. This should be integrated with the existing coordination mechanism for the health sector. This system, active within minutes of a disaster, uses the agreed virtual country’s coordination mechanism within the National Disaster Management Agency/Authority (NDMA) and/or Ministry of Health.

As the needs assessment brings more clarity and is discussed in detail in the health coordination group, a multi-sectoral humanitarian response plan is formulated as a wider strategy. Implementation of the Strategic/Humanitarian Response Plan requires a Joint Partners’ Operational Plan that should consider the expertise and comparative advantages of key operational partners working in emergency response to support the MOH effectively in a collective manner to avoid duplication of work while optimally utilizing scarce resources in hours of utmost need (EHA Benchmark 4).

It must ensure the optimal coverage and standardization of essential health services package, promote adherence to technical standards and best practices, and commit partners to common operational targets and reporting. It should clearly mention how health partners link with and complement other relevant sectors, for example: water and sanitation, nutrition, protection and mental well-being. While a range of technical standards may be applicable in different contexts and the operational partners may have differences in opinion on certain standards but the Sphere Minimum Standards in Humanitarian Response41 should be a common guide.

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The Inter-Agency or Inter-Sectoral Coordination Group/s should have clear protocols and processes for a collective partners’ response to a coordination of large-scale natural disasters or conflicts that require system-wide mobilization (so-called “Level 3 (L3)” emergencies). In such L3 emergencies, scope of expansion of partnership arrangement should be explored at national and/or regional level, on an as-needed basis, to include GOARN, major public health institutions and other partners effectively contributing in the emergency response.


7.4 Advocacy

There is strong need in the South-East Asia region to communicate and promote collective work of health sector better and work better with partners, networks and stakeholders in a more inclusive manner (EHA Benchmark 8). Advocacy for operational partnership through “Build, Develop and Expand” can be achieved through following modalities:

- Developing and maintaining a web-portal that will be used to
  - Advocate and promote the importance of operational partnership
  - Raise Awareness on principles of criteria of partnerships with WHO
  - Raise awareness on types of different partnerships
  - Network of operational partners
  - Priority area of partnerships based on regional hazards and vulnerability assessment and partners landscape
  - Sharing experiences, best practices and evaluation reports of recent health emergency operations in the Region
  - Annual updates of different types of partner networks
  - Gallery of images and video clips- lessons and documentary from the field
  - Host a virtual platform for Community of Emergency Responders
  - Link with relevant scientific resources, regional and global guidelines, protocol and SOPs
  - Important emergency contacts of regional coordinating lead agencies and regional networks

- Advocacy and promotional materials (information products; infographics)

- Events based activities (seminars, conferences, symposia) for raising awareness and enabling environment for operational partnership building at country levels
  - National or regional coordination and strengthening meetings/activities on:
    - EMT awareness workshop
    - National or regional GOARN awareness
    - National or regional awareness workshop for potential standby partners and other development partners and public health institutions
    - National or regional workshop for strengthening public-private sector model for emergency response
Expected Outcome of Partnerships

Following outcomes are to be achieved in line with the WHE Results Framework:\[42\]:

**Output 1.0 Effective Partnerships Framework in place at national level in WHO SEAR countries**

Output indicator:
- Availability of Regional Framework on Operational Partnership for Emergency Response as a guideline

**Output 1.1 Health operations effectively managed, in support of national and local response**

Output Indicator(s):
- Incident Management System (IMS) established at country level within 72 hours of declaration of an emergency
- Presence and active contribution of WHO Partners in Health Coordination meetings at national and local levels in emergency situations
- Joint rapid assessments conducted in partnerships with listed operational partners within 48 hours of an emergency

Key Deliverables:
- Effective management at national and sub-national levels for all health emergencies of varied grades through efficient communication, coordination and partnership

**Output 1.2 Collective emergency response by operational partners effectively coordinated.**

Output Indicator(s):
- Partner coordination mechanism in place at national and sub-national levels for all graded and protracted emergencies
- Number of partners with readily deployable rapid response team/standby roster that can be deployed within 72 hours of notice
- Number of deployments in support of emergency operations through Standby Partners, by function

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• Joint Partner Operational plan developed within 30 days for all newly graded emergencies
• Number and capacity of GOARN partners supporting alert, risk assessment and response to public health events, and emergencies
• Number and percentage of Health Clusters/health sector coordination group with a dedicated, full time Health Cluster Coordinator
• Number of verified and/or mentored EMTs at regional and national level

**Key Deliverables:**
• Increased global capacities for interoperable health emergency response through expansion and strengthening of GOARN, GHC, EMT, Standby Partners, other partnerships ensuring increased inter-operability among networks
• Consistent engagement of operational partners (of GOARN, GHC, EMT, Standby Partners) for health emergencies
• Readily deployable Internal and external roster of experts among partner organizations that can be mobilized within 24-72 hours-notice for emergency response
• Joint training and exercises undertaken in partnership and collaboration with operational partners
• Evaluation report on joint emergency operations and performance

**Output 1.3 Effective logistics and operational support rapidly established and maintained**

Output indicator:

• Number of operational partners that shared their emergency logistics resources as a support in transport, health facilities, health and general logistics and ICT

**Key Deliverable(s):**

• Operation support provided including transport, accommodation, facilities, security and ICT by partners
• Operational support provided by partners in terms of health logistics (medical supplies and equipment)

**Output 2.0 Regional expert networks and innovative mechanisms developed and/or supported and implemented in partnerships in management of health emergencies due to high threat infectious hazards (e.g. clinical management, laboratories, social sciences, data modeling)**

Output Indicator(s):

• Number of institutions contributing to regional and national expert networks and mechanism for emergency response
• Development and availability of consistent technical standards for operational partnerships and monitoring system of implementation against standards
Key Deliverables:

- Operational partnerships mechanism in place at regional, national and sub-national levels to ensure access to life saving interventions for health emergencies due to high-threat infectious hazards (e.g. Stockpiles, expert roster, SOPs for triggering of joint operations)
- Coordinated technical expertise readily available for risk assessment, event mitigation/control and response to new and evolving high-threat infectious hazards
- Quality assurance framework for EMTs implemented

Output 3.0 Resource-mobilization for sustenance and strengthening of effective partnerships for emergency response

Output Indicator(s):

- Funds contributed/mobilized in common basket under operational partnership-emergency funds
- Joint donor appeals for coordinated emergency response under operational partnerships

Key Deliverables:

- Common pooled emergency fund for strengthening partner’s emergency response capacity and deployment

There should be evaluation of thus built operational partnerships arrangements for emergency response at least once in every two years, with input both from WHO and the partner.
Annex 1

Listing and mapping of operational partners for emergency response during consultation meeting (28-29 Nov 2017 in Bangkok)
Annex 2: Matrix of Emergency Response Procedures\textsuperscript{43} under operational partnerships across WHO SEARO, WCO and Partners

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<thead>
<tr>
<th>WHO Country Office</th>
<th>WHO SEARO</th>
<th>Operational Partner</th>
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<tr>
<td><strong>Within 24 hours</strong></td>
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<tr>
<td>▪ Establish contact with operational partners and Ministry of Health</td>
<td>▪ Commence initial outreach to regional partners</td>
<td>▪ Proactively contact WHO and Ministry of Health in country for contributing in joint rapid assessment</td>
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<td>▪ Call to partners for activating Rapid Response Team</td>
<td>▪ Identify and begin deployment of candidates for in-country coordination roles. e.g. health sector, Health Cluster, EMTs, GOARN</td>
<td>▪ Activate inter-sectoral database of experts and deploy requisite human resources and other support logistics for timely, effective and efficient emergency response</td>
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<td><strong>Within 24-72 Hours</strong></td>
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<tr>
<td>▪ Support Ministry of Health in determining and implementing coordination mechanism</td>
<td>▪ Expand outreach to regional partners and request mobilization/deployment as necessary</td>
<td>▪ Participate and contribute in health coordination meetings</td>
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<td>▪ Advise Humanitarian Coordinator on need for activation of Health Cluster; if not already activated</td>
<td>▪ Lead, motivate and mobilize partners in global calls</td>
<td>▪ Identify the priority gaps, needs and opportunities in emergency operations and come forward with proposal and project interventions complementing the joint operations</td>
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<td>▪ Convene first health sector/health Cluster meeting and map partner’s emergency response</td>
<td>▪ Engage GOARN and other partners at regional level to contribute to monitoring of public health risks (e.g. impending outbreaks) and evolution of situation (complexities of risk and hazards on health)</td>
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<tr>
<td>▪ Ensure partners contribution in Joint initial situational analysis and MIRA</td>
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<td>▪ Establish EMT coordination cell within Ministry of Health, as needed</td>
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<td><strong>Within 3-10 days</strong></td>
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<tr>
<td>▪ Coordinate overall development of initial health sector/Health Cluster response strategy and action plan</td>
<td>▪ Collaborate with regional partners to mobilize resources to address operational and technical gaps - ongoing</td>
<td>▪ Activate own procurement and logistics teams for needs assessment and future projections</td>
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<td>▪ Ensure that SOPs be followed by all participating agencies in emergency operations for implementing HRP and for deployment of staff</td>
<td>▪ Ensure quality of health sector/health Cluster bulletin</td>
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- Work with partners to identify immediate priority gaps in service delivery and coverage through 4 W (Who is doing What, Where and When) matrix/exercise
- Participate in inter-cluster/sector meetings and activities
- Issue initial health sector/Health Cluster Bulletin

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<tr>
<th>WHO Country Office</th>
<th>WHO SEARO</th>
<th>Operational Partner</th>
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<tr>
<td><strong>Within 10-30 days</strong></td>
<td><strong>within 30-60 days</strong></td>
<td><strong>Mobilize resources and technical expertise for recovery and rehabilitation phase</strong></td>
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<tr>
<td>Identify, facilitate registration of new agencies with the Ministry of Health and establish sub-national hubs of operational partnerships</td>
<td>Reach out to other sectoral partners regionally, including nutrition, water sanitation and hygiene, protection, mental well-being and education.</td>
<td>Strengthen MIRA for effective and efficient emergency response considering changed and emerged priorities of population-in-need</td>
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<tr>
<td>Lead partners in development of Humanitarian Response Plan and Joint Operations Plan</td>
<td>Represent health sector/Health Cluster in regional forums, e.g. IASC teleconferences and meetings</td>
<td>Contribute in gap analysis, reporting, sharing of information for addressing unmet needs and improving emergency service delivery provisions</td>
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<td>Finalize health sector of MIRA, in collaboration with Information Management team</td>
<td>Conduct regular health partner/health Cluster meetings (e.g. daily, twice weekly)- review status of response needs, untapped potential of partners, risk and activities</td>
<td>Actively contribute in development of Joint Operational Plan contextualized to local settings and strengths of partners</td>
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<tr>
<td>Monitor effectiveness of health response and engage partners to address gaps in service delivery and coordination</td>
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<tr>
<td><strong>Within 30-60 days</strong></td>
<td><strong>Within 30-60 days</strong></td>
<td><strong>Maintain liaisons, communication and exchange of information with WHO for strengthening operational partnership</strong></td>
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<tr>
<td>Fill priority coordination gaps at sub-national levels</td>
<td>Engage regional partners on on-going basis, exchange information and advocate for additional resources/mobilization</td>
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