

TECHNICAL CONSULTATION ON NATIONAL CROSS-SECTORAL COLLABORATION BETWEEN SECURITY AND HEALTH SECTORS

Report of the Technical Consultation on National Cross-Sectoral
Collaboration between Security and Health Sectors



HONG KONG SAR, CHINA, 13-14 DECEMBER 2018

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The report of the technical consultation was produced by Professor Colin McInnes with input from Mr Sean Cockerham.

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LIST OF ACRONYMS

APORA	African Partner Outbreak Response Alliance
CBRN	Chemical, biological, radiological and nuclear
CDC	US Centers for Disease Control and Prevention
CME	WHO Core Capacity Assessment, Monitoring and Evaluation Unit
EMT	WHO Emergency Medical Teams Initiative
EOC	Emergency Operations Centres
HSI	WHO Health Security Interface
ICMM	International Committee on Military Medicine
IHR	International Health Regulations
MoU	Memorandum of understanding
NCF	National Collaboration Framework
NGO	Non-governmental organisation
PHEIC	Public health emergencies of international concern
SAR	Special Administrative Region
SimEx	Simulation exercise
SOP	Standard operating procedure
SPH	WHO Strategic Partnership for IHR and Health Security
VERTIC	Verification Research, Training and Information Centre
WHO	World Health Organization

EXECUTIVE SUMMARY

In October 2017, the international military and civilian health sectors came together for the first time in Jakarta, Indonesia, to agree on a shared vision for strengthening collaboration to enhance national, regional and global health security. The participants including public health and military officials, international organizations, partners and donors, concluded that a national framework for collaboration between civilian and military health and security sectors is necessary for effective health security governance.

The WHO Strategic Partnership for IHR and Health Security (SPH) brought the civilian and military health sectors together again in Hong Kong on 13-14 December 2018 to identify how to move forward in improving national capabilities for the prompt detection and response to health emergencies. The Technical Consultation on National Cross-Sectoral Collaboration between Security and Health Sectors included 51 expert participants representing 19 Member States, as well as partners, WHO and non-governmental actors. The [draft National Collaboration Framework \(NCF\) for the Military and the Civilian Health Sectors](#), prepared by WHO SPH, was circulated to participants.

The participants emphasized that it is critical to ensure civil-military collaboration for preparedness, not just joint action in times of emergency. Bioterrorism was singled out as a particularly challenging problem, with specialized capacities located heavily within the military and information sharing challenges between the military and civilian health sectors.

There was discussion of best practices, challenges and lessons learned from past experiences of joint efforts of national military and civilian health sectors. Participants highlighted the need for formal agreements to embed collaboration, as well as engagement at the highest levels of governments – but also the value of developing lower level cooperation and trust through teaching programs, secondments and training exercises.

A key point of discussion was to ensure that agreements are flexible and tailored to the national context. Militaries have different roles and competencies in different countries. Participants agreed that militaries cannot be seen only as a last resort, and they have capabilities for preparedness that go far beyond that of rapid response to emergencies.

The expert participants emphasized the importance of mapping the

health security resources of the civilian and military health sectors (i.e. infrastructure, human resources and transportation networks) to identify synergies and areas for collaboration. For WHO, the meeting provided critical input and consensus on the NCF that will enable the next step of piloting the framework in several countries. Four Member States – Ghana, Indonesia, Thailand and Uganda – requested at the close of the meeting for WHO to pilot the NCF in their countries to enhance civil-military collaboration for emergency preparedness and to test the framework for global implementation.

Discussions in the consultation covered outbreaks, natural disasters, accidents, and deliberate events, including chemical, biological, radiological and nuclear (CBRN) events that require the coordination of specialists. Participants reached conclusions in the following key areas:

I. Promoting strategic collaboration

- Decision making, and coordination will vary by context but the need for preparedness is constant.
- Mechanisms should be multi-level, addressing international, national and regional concerns.
- Frameworks need to be formal and embedded in legislation, but sufficiently flexible to accommodate the unexpected.
- Engagement at the highest levels is essential in developing good governance and setting national policy; top-down leadership can bring together multiple agencies at the strategic level.
- A high level inter-ministerial body which meets on a regular basis is of significant benefit.
- Health emergencies require a multisectoral approach, and a One Health perspective is important given the range of agencies and issues involved.
- Collaboration is not only about emergencies – it may also be about day-to-day health promotion and prevention. Populations need health security in normal conditions as well as crises.

II. Coordination

- Effective coordination is enabled by the establishment of formal cooperation agreements, appropriate for context, and with clear identification of roles. This should not prevent informal channels from emerging within this formal context.
- Where possible, existing arrangements should be built upon rather than the negotiation of new agreements.

- Coordination mechanisms may fall under broader processes than health emergency preparedness.
- Joint risk assessment can identify disease as the common threat.
- A common communications strategy facilitates consistent messaging and engagement with the general public, and especially with communities at risk.
- Developing trust is vital, both between sectors and on a one-to-one basis.
- Testing, including SIMEX and field exercises, and after-action reviews ensure that coordination works effectively and is valuable in developing trusting partnerships.
- Physical co-location (e.g. at border crossings) can strengthen coordination.
- There is potential value in developing a community of practice.

III. Engaging the military: developing ways of working together

- The concern that militaries should only be used as a last resort in humanitarian crises is much reduced compared to a decade ago.
- Militaries are often seen mainly in terms of a rapid response capability, but the scope of their capabilities for health emergencies is wider and deeper than this.
- The benefits of cooperation are not one-way – militaries also benefit not least through providing their own medics with valuable experience.
- Cooperation can be embedded through involvement in learning and teaching/professional development programmes and training; in sharing information on relative capacities pre-crisis (e.g. liaison officers and secondments); and in an awareness of who will be talking to whom, and working with whom, on an individual basis.
- Beginning with simple, small steps has proven effective, such as joint seminars and table top exercises. This can be complemented by regular liaison meetings at regional levels so that “you know who you are talking to” and the process of cooperation becomes routine.

IV. Differences between public health and national security

- Different militaries have different roles and competencies. For some the risk of war may be very low and civil assistance relatively important (including, for some, a constitutional obligation),

but this is not the case for all; some countries also have constitutional limits on militaries being used within the state.

- Militaries and the civilian health sector have both positive and negative views of each other.
- Militaries are seen by the civilian health sector as being better resourced, which provides opportunities for additional capacity.
- Bio-terrorism poses specific problems, particularly for information sharing and specialized capacities which are located heavily in the military with little civilian awareness.
- There is added value in clarifying the different roles, technical requirements and limits of the military and civilian health sectors.
- The military and civilian health sectors have different approaches to problems – such as discipline and flexibility – which can complement each other.
- The military and civilian health sectors may also have different terminology and operational standards, while data sharing may be compromised by secrecy and/or incompatible systems.

V. Budget

- Budgets are not simply for the duration of an emergency – they also need to cover preparedness and post-event recovery.
- Ministries of finance need to be engaged to approve budgets, and engaging legislatures may also be important when oversight is in place.
- Not all governments may be able to establish sufficient contingency funding to meet the added demands of military involvement in a health emergency, including post-operational replacement of assets.

Recommendations for countries and WHO

For countries

1. Meaningful agreements – that is agreements which possess both authority and a requirement for action – should be developed and agreed upon to embed collaboration in national contexts.
2. A matrix can be used to identify where military resources can support IHR (2005) core capacities.
3. “Low level” initiatives, such as involvement in knowledge building and secondments, should be introduced as cost-effective means of developing cooperation.
4. Programmes to develop trust at the individual level can be established and complementary initiatives undertaken at the sectoral level.

5. Training programmes can be instituted, from tabletop to field exercises, to ensure mutual understanding and effective joint working between the military and civilian health sectors.

For WHO

1. Revising and finalizing NCF based on the input received from Member States, partners and non-state actors during the technical consultation in Hong Kong.
2. Piloting of the NCF in countries should be undertaken as soon as possible.
3. To work together with partners for the piloting and implementation of the NCF.



INTRODUCTION

The International Health Regulations (IHR, 2005) require 196 States Parties to detect, assess, report, and respond to potential public health emergencies of international concern (PHEIC) in a timely manner at all levels of government. Improving collaboration between the health and security sectors has been identified as an area with the potential to unlock substantial gains in national capacities to prevent, detect and respond to public health emergencies. The value of greater collaboration between these two sectors has been highlighted by informal collaborations usually formed during crises. For example, the Ebola outbreak in West Africa provided a catalyst for many regional actors to explore ways of strengthening cross-sectoral collaboration. Critically, however, to ensure more effective collaboration in the long-term, identifying pathways for collaboration must also be undertaken outside of an emergency context.

On 24-26 October 2017, the WHO Strategic Partnership for IHR and Health Security (SPH) and the government of the Republic of Indonesia, as chair of the International Committee of Military Medicine, convened the *Managing Future Global Public Health Risks by Strengthening Collaboration between Civilian and Military Health services*¹ meeting in Jakarta, Indonesia. The meeting participants, including public health and military officials from 44 countries, international organizations, partners and donors, concluded that “a national framework for collaboration between civilian and military health and security sectors is necessary for effective health security governance... in line with the principles set forth in the International Health Regulations (IHR 2005).” The Jakarta Call to Action resulting from the meeting tasked WHO with “the development and implementation of a collaborative framework for public health and military/security sectors.”

Following up on the Jakarta Call to Action, 51 participants representing 19 Member States, partners, WHO and non-governmental actors, met for the *Technical Consultation on National Cross-Sectoral Collaboration between Security and Health Sectors in Hong Kong, SAR*, 13-14 December 2018. A *draft National Collaboration Framework for the Military and the Civilian Health Sectors*, prepared by WHO SPH, was circulated to the expert participants to solicit feedback and reach consensus.

¹ WHO, Meeting Report: *Managing future global public health risks by strengthening collaboration between civilian and military health services* WHO/WHE/CPI/2018.49 (WHO: Geneva, 2018).

Meeting Objectives

- Enhance countries' capacities under the IHR (2005) requirements to prevent, detect and respond to potential public health emergencies including pandemics.
- Facilitate the sharing of experiences between countries to identify best practices.
- Assist in the process of developing a framework for military and civilian health collaboration.
- Explore how WHO and partners can support the development of a collaborative framework at the national level.

The National Collaboration Framework (NCF) is designed to guide Member States in the development of civil-military collaboration for the enhancement of country IHR (2005) capacities. Improving civil-military health collaboration is part of the broader requirement to work in a multisectoral manner for IHR (2005) implementation. Multisectoral approaches are needed to address global health security challenges that transcend traditional sectoral boundaries. Such approaches also promote good governance by building accountability across sectors and encouraging policy coherence and broader participation in policy processes to catalyze practical actions and operations.

Militaries can provide technical expertise, human resources and material capacity, and an ability to respond quickly and deploy in challenging environments. The need for improved preparedness for health emergencies of natural, accidental or deliberate origin includes chemical, biological, radiological, nuclear (CBRN) preparedness, for which the specialist knowledge and resources may be located in the military health sector.

The overarching objective for WHO in the *Technical Consultation on National Cross-Sectoral Collaboration between Security and Health Sectors* is to achieve consensus on the NCF and ensure that countries can be equipped with an agreed-upon framework to be piloted in several countries along with WHO tools and guidance in multisectoral engagement. The testing and piloting can also provide a multi-country study of how to improve military and civilian health collaboration at the national level for enhanced preparedness.

Expected Outcomes of the Consultation

- Awareness of progress and challenges in collaboration between the security and civilian health sectors and of the strong linkages to IHR (2005) and health security.

- Consensus on good practices and implementable next steps for synergizing the sectors' capacities in preventing, detecting and responding to public health events.
- Agreed elements of a framework on how to develop a collaborative framework for the security and civilian health sectors at the national level.
- Developed ideas for supportive activities for the development and implementation of a collaborative framework for collaboration between the security and civilian health sectors at the national level.

DAY ONE

WELCOME AND OPENING REMARKS

The meeting was opened by [Dr Stella Chungong](#), Chief of the WHO Core Capacity Assessment, Monitoring and Evaluation Unit (CME), who spoke of the significant increase in disease outbreaks threatening global health security and the importance of IHR (2005) as a framework for the coordination and management of events that may constitute a public health emergency of international concern. Dr Chungong emphasized that partnerships and multisectoral approaches are vital in moving IHR (2005) implementation forward and noted that WHO has been charged with developing the NCF to promote functional capabilities through national civil-military health collaboration.

[Dr Lawrence Kerr](#), Director, Office of Pandemic and Emerging Threats, US Department of Health and Human Services, said the 2017 meeting



in Jakarta represented a watershed moment in enabling the health and security sectors to sit at the same table and agree on a shared vision for collaboration. He noted that “we have come a long way, especially in regard to infectious disease,” and that partnerships are vital in moving forward.

[Dr Iwan Trihapsoro](#), Colonel Doctor in the Indonesian Armed Forces, provided a summary of the Jakarta meeting and presented a video of that meeting, which emphasized the value of collaboration between the civilian health and military sectors.

SESSION 1: INTRODUCTION TO COLLABORATION BETWEEN THE MILITARY AND CIVILIAN HEALTH SECTORS FOR IHR (2005) AND HEALTH SECURITY

SESSION 1: Objective

This first plenary session was introduced by [Mr Ludy Suryantoro](#), Team Leader, WHO Strategic Partnership for IHR and Health Security (SPH). The session was designed to provide examples of collaboration between the military and civilian health sectors at the national level, and to discuss best practices, challenges and lessons learned. The session also introduced the draft National Collaboration Framework (NCF) to the expert participants.

SESSION 1: Discussion

Mr Suryantoro emphasized the importance for health security of multisectoral coordination that reflects national priorities, and sustainable financial and technical investments across sectors. He articulated the aim of the meeting as enhancing preparedness capacity through improving collaboration between the civilian health and military sectors.

Mr Suryantoro said the focus of the meeting is the development of implementable actions, achievement of agreement on good practices, and advancement of the NCF, enabling the framework to be piloted and tested with the goal of future global implementation. The results of the Hong Kong consultation will also inform key messages in the Global Health Security 2019 Conference (GHS 2019), to be held in June in Sydney, Australia.

Professor Colin McInnes, a WHO consultant, placed civilian health and military collaboration in a historical context. He identified the long-standing relationship between health and the military, which originated in the need to address health threats to military readiness but developed to now include formal relationships for military assistance in delivering health aid. He then outlined the draft NCF and identified the five areas of challenge and opportunity which structured it: promoting strategic collaboration; mechanisms for coordination; developing ways of working together; differences between public health and national security; and budgetary issues.

The aim of the NCF is to guide, promote and enable national compliance with IHR (2005) through improved collaboration between military and civilian health sectors, strengthening preparedness through efficient and effective use of existing resources. An understanding of the importance of a collaborative approach to preparedness that will result in an adequate response to public health emergencies underpins the process. WHO will support countries in developing and formalizing a context-specific national collaboration framework for the military and civilian health sectors, using the NCF as guidance.

Dr Adam Kamradt-Scott of the University of Sydney presented interim results of a major survey of military and health officials sponsored by the Australian Research Council. The survey found that when militaries were used the vast majority of them had volunteered to help, rather being ordered to assist; that the argument that militaries should only be used as a last resort has become less prominent in policy circles; and that more guidelines are needed for how militaries should be used. Dr Kamradt-Scott also said that research on the West Africa Ebola outbreak suggested the deployment of militaries might have a positive effect on local populations in providing reassurance. He emphasized that different national militaries are organised differently and there is a need to better identify the different roles, technical requirements and limits of national militaries.





Country experts then gave presentations and engaged in a roundtable discussion of experiences, best practices and challenges in national military-civilian collaboration. **Thailand** outlined its top-down approach, which brings multiple agencies together at the strategic level. Within this national plan, individual sectors develop their own operational plans but also collaborate with other sectors. **Gabon** provided its experience of four Ebola outbreaks in which the military was called on for rapid response and to provide security for health workers, but no formal coordination mechanisms existed. **Tunisia** described its long experience of the civil-military health sectors working together and the advantages this provided in terms of rapid response and deployment. Efforts are now being made to collaborate on a joint media strategy to ensure consistent messaging. Cooperation with Germany enabled development of an epidemic and bio-terrorist response capacity, including mobile laboratories, which increased civil-military collaboration.

Romania presented the results of EU ModEX 2017-18, the largest civil-military exercise held in Europe, allowing urban search and rescue teams, emergency medical teams and other response assets to train their preparedness for deployment in the context of a full-scale exercise. Because of its size, the exercise incorporated international engagement and underscored the value of a multisectoral approach in preparing and responding to health emergencies. The Philippines' experience was largely based in response to natural disasters where a strong overarching body and organogram were used to facilitate collaboration. The challenge is in strengthening and sharing technical knowledge. However simple, small steps (such as lectures and table top exercises) have proven effective. Preparing for the threat of bio-terrorism is particularly difficult for collaboration because of the challenge of sharing confidential information in real time.

In discussion, **Romania** emphasized the need for the civilian and military health sectors to work together on a day-to-day basis, not just during crises, in order to build trust and relationships. **Japan** emphasized how different national histories might affect approaches to collaboration –

Japan's own history resulted in a comparatively weak capacity to deal with infectious disease but a much stronger capacity for chemical incidents. Moreover, Japan commented that government departments have a "natural tendency to work in silos," while cautioning that collaboration must not undermine a department's capacity to deliver on its core tasks. [Uganda](#) identified the major challenge of dealing with disease outbreaks in areas of conflict and reported that cross-border areas can be insecure allowing disease to spread. [Thailand](#) emphasized that the security threat varies between different countries, so that for some the threat of war might take precedence while for others war was unlikely and more effort could be spent on civilian emergencies. The importance of formal agreements as well as personal relationships to build trust was emphasized by a wide range of participants.

SESSION 1: Outcomes

The presentations and expert discussion were supportive of efforts to improve collaboration and the benefits of existing collaborations were highlighted. The importance of high-level engagement and of formalizing agreements in a legislatively meaningful way was emphasized, along with the importance of building trust at the local level. Variations in local context requires a no "one size fits all" approach to collaboration, while conflict, bio-terrorism and porous borders pose particular challenges.

SESSION 2: THE CASE FOR COLLABORATION BETWEEN THE MILITARY AND CIVILIAN HEALTH SECTORS – PREPARING FOR AN EPIDEMIC (WORLD CAFÉ).

SESSION 2: Objective

This session, in the World Café format, was moderated by [Timothy P. Hughes](#), International Program Manager, BTRP Cooperative Threat Reduction, DTRA, USA. The purpose was to discuss the themes in the draft NCF and move toward consensus in areas including interoperability, technical areas of collaboration, and cross-sectoral areas of collaboration. Participants identified and addressed key considerations in collaborating during the preparedness phase and determined benefits and challenges with the goal of establishing implementable practices. A scenario on influenza was introduced to kick start discussion in the World Café, in which the participants were divided into five groups that rotated among five tables, with each table covering a topic related to the draft NCF.



Topics for each table

Table 1 – Preparedness

- What aspects of military and civilian health sector collaboration should particularly be addressed during the preparedness phase?
- How are emergency preparedness plans and procedures for military and civilian health sector collaboration developed in your respective countries?

Table 2 – Impartiality and Neutrality

- How to ensure the military's need for impartiality and provision of security with the civilian health sectors need for neutrality and vice versa?
- Is there an inherent conflict between the viewpoints?
- How can this be addressed during the preparedness phase?

Table 3 – Joint exercises/training

- What are the benefits of joint trainings for the military and civilian health sector during the preparedness phase?
- What areas lend themselves to joint training?
- What are the main aspects to consider when planning joint exercises to improve preparedness?

Table 4 – Technical areas of collaboration

- Which of the eight IHR Core Capacities lend themselves to collaboration between the military and civilian health sector during the preparedness phase?

- Acknowledging the military’s expertise in the areas of incident management, specifically planning, health care delivery and provision of security, how can it best support the civilian health sector during preparedness?

Table 5 – Formalizing collaboration

- What are the mechanisms for formalizing collaboration between the military and civilian health sector? Does collaboration happen informally?
- What needs to be in place for informal collaboration to occur between the military and civilian health sector?

SESSION 3: WORLD CAFÉ FEEDBACK

In this session, also moderated by [Timothy P. Hughes](#), participants presented results of the World Café as summary answers to the questions that were discussed at each of the tables.

Table 1: Preparedness

I. What aspects of military and civilian health sector collaboration should particularly be addressed during the preparedness phase?

Participants’ findings were:

- Foster trust and integration: getting to know you, then plan, and exercise.



- Define emergency preparedness plan with all sectors integrated.
- Predefine explicit and formally defined command and control structure.
- Define roles and responsibilities: who has the mandate to take act? who has what capabilities? Who has authority to make a decision? To implement?
- Map resources – human resources, transportation networks, infrastructure.
- Country specific context is essential.

II. How are emergency preparedness plans and procedures for military and civilian health sector collaboration developed in your respective countries? Participants' findings were:

- National legislation has a convening/forcing function.
- High-level support is important for both planning and response, up to and including political leaders.
- Perception and motivation of non-health sectors is a challenge – seen as not relevant to their core mission.
- For lower-level health emergencies there tends to be no plans for integration of military sector (lack of interest), whereas at disaster level there is more support.
- Multisectoral coordination mechanisms and engagement in planning and response using a One Health approach are vital, as is a defined focal point.
- Identifying budgeting mechanisms and funding is critical.
- Existing national public health emergency plans need to add a chapter on civilian-military collaboration.
- Exercises and simulations are important in improving plans.

Table 2: Impartiality and Neutrality

How to ensure the military's need for impartiality and provision of security with the civilian health sectors need for neutrality and vice versa? Is there an inherent conflict between the viewpoints? How can this be addressed during the preparedness phase? Participants' findings were:

- Preparedness policies have to exist before the emergency within a legal and operational framework, with multisectoral roles, action plans, finances and length of intervention agreed. A focus on pre-emergency collaboration is important.
- Roles and tasks will depend on the emergency – e.g. in a health

crisis, the health sector will lead and the military supports; vice versa may be true in a conflict situation.

- Roles of ministries and NGOs are decided by committee, especially in controversial areas.
- There is a need to engage in trust building activities.
- Training/exercises are vital.
- There is a need to understand the context.

Table 3: Joint Exercises/Training

I. What are the benefits of joint trainings for the military and civilian health sector during the preparedness phase? **Participants' findings were:**

- Disasters/CBRN are multisectoral so collaboration is vital, but the question of who takes the lead is essential.
- Offers opportunities to test and clarify lines of authorities and roles.
- Allows understanding of strengths and weakness of different agencies/knowing who would be better placed.
- Builds opportunities to exchange information.
- Sectors may use different techniques to achieve the same thing, so if there is any disconnect this is an opportunity to discover them and adjust systems and ensure interoperability.
- Opportunity to meet and build a common understanding and trust, as well as understand different organizational cultures, ways of thinking and uses of language/terms.
- Teaches the incident command structure.
- Builds trust – including in terms of knowing what your partner agency can do.
- Allows comparisons of legal and policy frameworks, and increases the understanding of how these are applied.
- Team building benefits for both sectors.

II. What areas lend themselves to joint training? **Participants' findings were:**

- All hazard exercise/ disaster and chemical, biological, radiological, and nuclear (CBRN).
- Pandemic flu.
- Refugee health.
- War zone issues, e.g. surveillance within a war situation / what



would happen when you deploy civilians in a military situation?

- Surveillance and response.
- Logistics, stockpiles and supplies – delivery of products and ensuring security of personnel, supplies and equipment.
- Risk assessment and risk communication.
- Law enforcement.
- Incident command structure / system – practice joint command and approach to operations.

- **Type of exercises:** All lend themselves to joint training, but there are particular strengths of full-scale exercises as this will reveal limitations of capacities and capabilities.

III. What are the main aspects to consider when planning joint exercises to improve preparedness? **Participants' findings were:**

- Analysis of existing preparedness gaps to reveal the training needs for targeted sectors.
- “Real world situations”.
- Setting clear goals (e.g. to demonstrate capacities, share the operational picture).
- Ensuring the relevant participants: whom do you call?
- Usually the participants are from the operational level; people at the strategic level are usually unavailable – sometimes they would benefit the most.
- Have a legal framework that would support the needs for the exercise.
- Understand what resources participants/partners/organizers bring into the exercise.
- Ensure a robust follow-up to the exercise.
- Develop a career path that would allow participants to make use of the training gained through the exercise.

Table 4: Technical Areas of Collaboration

- I. Which of the eight IHR Core Capacities lend themselves to collaboration between the military and civilian health sector during the preparedness phase? **Participants' findings were presented as the matrix below:**

Table 1. IHR core capacities by technical area that participants identified as lending themselves to civil-military collaboration for health emergency preparedness.

IHR Core Capacity	Technical Areas					
	Point of Entry	Infections/ Vaccination	Zoonosis	Food safety	Chemical	Nuclear and Radiation
Leg / Policy		X			X	X
Coordination	X	X			X	X
Surveillance		X		X		
Response	X	X	X		X	X
Preparedness		X			X	X
Risk Communication		X				
Human Resources	X	X	X	X	X	X
Lab		X	X		X	X

II. Acknowledging the military’s expertise in the areas of incident management, specifically planning, health care delivery and provision of security, how can it best support the civilian health sector during preparedness? *Participants’ findings were:*

- Sharing information about technical capacities (mapping resources and capabilities) .
- Strengthening event-based surveillance.
- Leveraging military and civilian experience in joint training, simulation exercises and planning.
- Logistical support, medical counter measures, vector control.
- Hazard-specific laboratory capacity.
- Preparedness for events that cross borders (in-country and cross border coordination of health response, surveillance, control of movement, accredi-



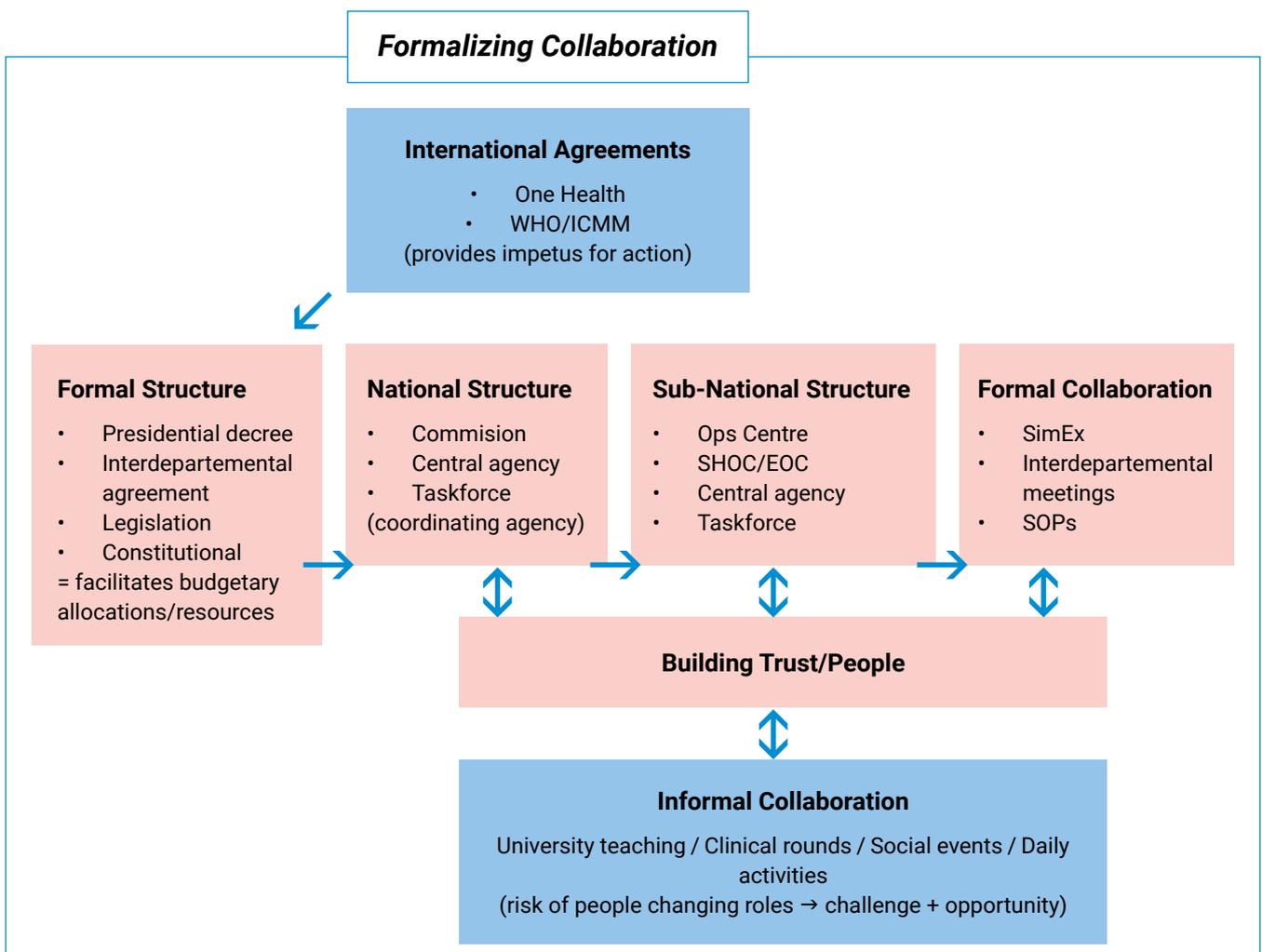
- tation of cross-border public health responders).
- CBRN response capacity.
 - Protecting national pathogen inventory.
 - Promoting access to health care.
 - Training /SOPs on deliberate events and forensic investigation.

Table 5: Formalizing Collaboration

What are the mechanisms for formalizing collaboration between the military and civilian health sector? Does collaboration happen informally? What needs to be in place for informal collaboration to occur between the military and civilian health sector?

Participants' findings were illustrated in the figure below:

Figure 1. Mechanisms for formalizing collaboration between the military and the health sectors



Summary Outcomes of the World Café

The need for a formal yet flexible framework supported by SOPs is crucial. Testing is necessary, up to and including large scale exercises and supported by regular in-person meetings – as [Thailand](#) commented “you need to know who you are talking to.” The establishment of informal relations within formal frameworks can help smooth over unforeseen difficulties. Exchange of information on relative capacities and capabilities and the mapping of resources within each sector – human resources, transportation networks, infrastructure, etc. – is important in providing the basis for collaboration.

Decision-making and coordination mechanisms will vary by country context and may on occasion be the subject of legal constraints. Mechanisms for collaboration should be flexible as well as multi-level, addressing international, national and sub-national collaborations. Mechanisms for collaboration also vary between conflict and non-conflict situations.

Key technical areas lend themselves to collaboration between the military and civilian health sectors. Their identification provides a foundation for consensus-building and operationalization.





SESSION 4: OVERCOMING CHALLENGES AND IDENTIFYING ESSENTIAL TECHNICAL AREAS FOR COLLABORATION

SESSION 4: Objectives

This session was moderated by [Dr Edward Nyarko](#), Surgeon Commander, OIC Public Health, Ghana. The session was designed to identify cultural and organizational differences between the civilian and military health sectors as a step towards building trust and understanding for functional collaboration, and to discuss the essential technical areas for collaboration.

SESSION 4: Discussion

The session began with an open discussion, facilitated by the moderator, on civilian health views of the military and vice versa. Military views of the civilian health sector tended to be of a well-trained workforce, more democratic and smarter than the military, but that does not always know how to share with the military – sees the military as a “tool.” [Tunisia](#) said military views of the civilian health sector also include a lack of clear command and control processes, not always having the clearance to deliver on promises, and indecisive.

Participants agreed that civilian health perspectives of the military were not always positive. Key negative impressions include a focus on weapons which cause harm, high budgets with potential opportunity costs for other areas of government expenditure, and secrecy, which prevents access to information. [Indonesia](#) said the civilian view of the military also included a “rigid” approach to following rules. More positive views were of untapped resources, a disciplined approach to problems, dedication to mission, promptness and quick reactions. Participants

identified three common tropes, none of which were necessarily accurate: that collaboration diluted the military's mission; that collaboration securitized health; and that the military is ordered to volunteer. In conclusion, participants agreed that both sectors saw value and differences in the other.



The discussion was followed by a series of presentations. [Tanzania](#) described its own strong integration of the civilian and military health sectors, which begins at the planning and preparedness stage. A constitutional obligation for the military to serve community needs in peacetime and a lack of civilian health care meant a greater reliance on military resources.

[Jordan](#) reported a very positive community view of its military, which is oriented to working in partnership with other government agencies. The military provides health care for the extended families of the armed forces, which means direct military care for a large percentage of the population. Jordan also identified areas of collaboration between the civilian and military health sectors in surveillance, immunization programmes, preventive measures, sharing of data on pandemics, and training workshops.

The [USA](#) described constitutional limitations on the use of its armed forces domestically. As a result, internal civil health collaboration is with Homeland Security while collaboration with the military is external facing. Interagency cooperation on health security matters can be conducted through the National Security Council. The relationship between the Centers for Disease Control and Prevention (CDC) and the security sector is "highly strategic and not based on the allocation of resources." Cooperation focuses on disease control, biosecurity and biosafety, medical countermeasures (vaccines), emergency response and information sharing.

The Verification Research, Training and Information Centre (**VERTIC**) shared the results of its recent report on emergency response planning in Central Asia, published as part of its EU-funded work on strengthening legal frameworks for biosafety and biosecurity in Central Asia. The **VERTIC** report determined that there is little literature on civil-military cooperation on emergency preparedness at the national level; that most countries have some form of civilian health/military coordination mechanism, but the degree of formalized arrangements with clear roles and responsibilities varies; that there is a need for communication and training between sectors, including developing common terminology and trust; and that the beginnings of regional civil-military cooperation are starting to emerge.

Uganda identified as enablers of cooperation its constitution, policy, and specific legislation to allow cooperation and structures at strategic and operational levels. The civilian health and military sectors train together and share resources, including military incident management systems which can be used in civilian health emergencies. However, Uganda needs to finalize a MoU and conduct a SimEx to concretise cooperation.

Although **Georgia** has no experience of a major health emergency, the civilian health and military sectors are beginning to work together on laboratory networking and disease surveillance. Cooperation also extends to free flu vaccination programmes for the military and some joint research programmes. Georgia is also preparing to conduct joint exercises.

In open discussion, the moderator identified two gaps about which little had been said: risk communication and laboratories. Participants raised the possibility of developing a community of practice to share tools and asked WHO to explore how collaboration might be achieved in complex emergencies where there is no functioning government.



SESSION 4: Outcomes

The civilian and military health sectors have both positive and negative views of the other. Mutual trust is therefore essential and could start with networking informed by an analysis of the best levels at which to meet. The discipline of the military and open-mindedness of the civilian health sector can be combined effectively when working together, a collaboration aided by identifying a common threat to focus on (namely, a disease outbreak).

Different constitutional and legislative frameworks in countries mean different national solutions will be required – no one size fits all. Nevertheless, an incident control centre and clear chain of command would assist management of most health crises.

The first day of the consultation concluded with participants having identified and agreed upon essential technical areas for collaboration and beginning to build consensus on the NCF, as well as on joint civil-military training, exercises, coordination and trust building.

DAY TWO

SESSION 5: GUIDANCE AND TOOLS FOR COLLABORATION BETWEEN THE MILITARY AND CIVILIAN HEALTH SECTORS

SESSION 5: Objectives

Participants in this session discussed how to operationalize the key technical areas for collaboration agreed upon during the first day of the meeting. The session was moderated by [Ms. Madina Andreyeva](#), Legislative Consultant, EU CBRN. The session was designed to explore existing guides and tools available to support countries in developing collaboration at the national level and to share examples of mechanisms for collaboration. WHO presented tools and training modules designed to facilitate multisectoral engagement and support countries in strengthening health security capacities.

SESSION 5: Discussion

[Mr Glenn Lolong](#), of WHO SPH, introduced the health and security mapping tool developed by SPH. The tool is an evidence-based platform designed to facilitate information sharing between sectors. The tool includes a dashboard which presents an overview of health security resources (with more detail through drop down menus), a repository for

relevant documents and assessments and a display of potential areas of collaboration.

The tool has the potential to map the health security resources of the civilian and military health sectors, such as expertise, infrastructure, human and financial resources. The expert participants during the first day of the consultation described such mapping as important to identify synergies and areas for collaboration between the sectors.



Mr Ludy Suryantoro, team leader of WHO SPH, introduced WHO's health security interface. An environment of growing global risk, whether from natural outbreaks, the deliberate or accidental release of biological hazards, or the intentional use of chemical agents, requires collaborative and responsive efforts. An increasingly multi-disciplinary, multi-level and multi-sectoral approach is needed to address risks and coordinate preparedness and response between actors in the public health and security sectors. The WHO Health Emergencies Programme in 2017 initiated the Health Security Interface (HSI) project, which promotes interaction and collaborative decision-making among the multi-sectoral actors involved in the preparation and response to public health challenges.

The interface provides documents on a range of areas including guidelines and training. Mr Suryantoro identified three pillars on which the interface is based: increased horizontal collaboration, accelerating coordination between WHO headquarters and regional and country offices, and increasing cooperation with external partners.

WHO SPH is working closely with the HSI to enhance civil-military collaboration, as well as with the WHO Emergency Operation Centers (EOC) team, which promotes best practices and standards for EOCs, and with the WHO Emergency Medical Teams initiative (EMT).

Dr Ian Norton, WHO Emergency Medical Teams (EMT) Initiative Manager, discussed the EMT initiative. The focus is to ensure quality of care in emergencies – “good intentions are not enough, standards have to be maintained.” To this end, EMT certifies individuals and groups as meeting minimum standards for deployment in sudden onset emergencies. The initiative also facilitates sharing of best practices and develops training packages.

Militaries play an essential role in emergencies by providing a means of rapid response. Militaries are usually the fastest to arrive and can provide logistics to carry medical teams to where they are needed. Militaries can also benefit from emergency response through providing their own medics with valuable experience. But there is no double standard – militaries providing assistance must meet the same standards as all others involved.

Finland introduced its Security Strategy for Society, a 2017 government resolution, and shared a video of its 2017 exercise designed to enhance national and global security. Security services play a key role in health security in Finland as part of a whole of government approach, with its Security Committee (consisting of permanent secretaries of government ministries) key to assisting the government not only during crises but

also during normal times: “Populations must be secure in normal conditions as well as crises.” The free flow of information between agencies, and the importance of teamwork in developing ownership of the process was also emphasized. Finland has a long tradition of intersectoral cooperation and of a whole society approach, which is embedded in law. But its experience demonstrates the importance also of informal processes in ensuring effective collaboration – “It is not institutions that collaborate but people.”

Portugal also identified the importance of exercises in developing effective collaboration and discussed the country’s 2018 SimEx to test its Ebola contingency plan. The SimEx was important in exploring real life challenges and was followed by a table top exercise with civil and military participants as well as international partners. The results of these exercises demonstrated that the civilian sector wanted more from the military but that there were constitutional barriers to this, and that bioterrorist events were heavily dependent on military expertise. Portugal also noted that its exercises began a decade ago on a small scale, but now risked becoming “uncontrollable” as more and more agencies became involved – including both national and international observers.

Singapore outlined its unique context: as a small state with compulsory military service, civil-military interactions are commonplace. In particular its small size allows a flat structure for emergency preparedness and relative ease of communication – “we pick up the phone and call.” The ministries of Health, Defence and Home Affairs all have expertise relevant to health security, and the Singaporean armed forces has its own centre for communicable diseases. Routine collaboration includes regular meetings and information sharing on external health threats and biothreats. In addition, the Singaporean military has surveillance systems which provide epidemiological information to the Ministry of Health. Exercises helped to build trust and find gaps which needed to be closed. Focusing on a common threat – disease – enabled collaboration.



The subsequent roundtable discussion among the expert participants focused on six questions:

1. The [USA](#) asked about the role of UN peacekeepers in areas of conflict, especially during complex emergencies. Dr Norton replied that, for WHO, peacekeepers tried to provide a stable environment to deal with a disease outbreak and could only operate within the terms of their mandate. WHO provided the peacekeepers with information on disease spread and prevention, while the peacekeepers provided WHO with information on threats to safety and security.
2. A number of participants asked how civil-military collaboration addressed ongoing health problems in addition to emergencies. [Singapore](#) replied that its military is considered part of the war on disease and that, although the focus is on communicable disease threats, the high percentage of the population that passes through the military means the military can play a role in health education and promotion. Moreover, data from military service can be used to monitor population health trends. [Finland](#) also commented on how conscription enabled the country to address non-communicable diseases such as obesity and smoking.
3. [Uganda](#) asked how lessons from exercises were evaluated and used. [Finland](#) replied that it used a process of internal validation during the exercises by testing procedures, and then external validation through feedback following the exercise.
4. [China](#) asked how the capabilities of individual EMTs were disseminated to identify who would be best to respond to a specific emergency. Dr Norton replied that there is a directory of EMTs specifying their areas of certification, and that EMT participation in exercises gives an indication of what their capabilities are. WHO is also developing a toolkit for EMTs which would lead to a community of practice.
5. The [Philippines](#) asked whether non-governmental organizations (NGOs) needed to be accredited as meeting EMT minimum standards. Dr Norton replied that they did.
6. [Malaysia](#) asked about points of entry in cases when legislation may limit public health access to military sites. Dr Suryantaro replied for WHO that IHR (2005) requires that this be addressed at the national level, while recognizing that national contexts differ and that there is no one solution to this.

SESSION 5: Outcomes

The military is valuable, and often essential in providing a rapid response capability during health emergencies, but there is a critical role for quality assurance both among the military and NGOs. Collaboration is not simply for emergencies but ongoing and may involve a whole of society approach drawing resources across multiple sectors. However, the more sectors and agencies that are involved the more complex operations become.

WHO can offer tools and guidance to support countries in developing multisectoral coordination mechanisms and in mapping resources to identify areas for civil-military collaboration.



SESSION 6: KEY STEPS TO FORMALIZE COLLABORATION BETWEEN THE MILITARY AND CIVILIAN HEALTH SECTORS

SESSION 6: Objectives

This session, moderated by [Dr Laurette Mangouka](#) of Médecine Interne et Infectiologie, Hopital d'instruction des Armées, Gabon, was designed for the expert participants to discuss and question the NCF while at the same time achieving consensus around issues discussed in the World Café on the first day of the consultation.

The session used a scenario based on “Global Land,” a fictional country which is at high risk of an outbreak and is faced with the question of how the military can support the civilian health sector in health emergency preparedness. Participants in the consultation worked in groups to address seven questions with the objective of reaching agreement on feasible ways forward in formalizing collaboration between the sectors.

SESSION 6: Outcomes from Working Group Discussions

I. Why is it important to formalize military and civilian health sector collaboration?

- There was consensus among the expert participants that an agreed-upon, formal framework has to be in place addressing governance and legal issues, though no one size fits all. As [Uganda](#) commented: “Different countries have different systems, but all countries have disasters.”

II. What existing capacity is there in your country for preparedness planning and coordination between the military and civilian health sector? How can existing capacity be strengthened to better manage collaboration between the military and civilian health sector? Are new structures needed to manage preparedness planning and coordination, if yes, what kind?

- There is a need for the space which allows civil-military collaboration to be flexible.
- There is a need to address issues of specialist language where misunderstandings might arise.
- Physical co-location at the operational level can strengthen collaboration – e.g. at border posts.
- Regional structures make it easier for different sectors to talk to each other.

- Joint risk assessment is important in identifying a common threat to bring sectors together and could prove to be a foundation for collaboration.

III. What type of agreements (MoU, SoP, SoMA, SoFA etc.) are suitable for formalizing collaboration between military and civilian health sector?



- Wherever possible, existing arrangements should be built upon rather than developing new agreements.
- Different legislative contexts will require different solutions – for some, MoUs may not be possible because of legislative constraints, whereas for [Indonesia](#), for example, a MoU is essential for budgetary approval.

IV. What are the biggest obstacles to formalizing military and civilian health sector collaboration?

- Obstacles include data sharing, budget imbalances, cultural differences and a lack of leadership/willingness to overcome differences when they arise. These can be overcome by establishing cross-sectoral working groups on specific issues (eg CBRN, immunisation).

V. What existing capacity and processes for monitoring, review and evaluation exist between military and civilian health sector, as well as inside each organisation? How can these capacities and processes be enhanced to improve collaboration?

- Mechanisms specific to collaboration in emergencies tend not to exist but may fall under the umbrella of broader monitoring processes.

VI. Does ministry of finance, ministry of interior and parliament play a role in formalizing the collaboration between the military and civilian health sector? Do any other sectors need to be involved?

- Without the engagement of a ministry of finance to approve budgets, collaboration would be significantly weakened. Parliamentary involvement varies by context but may be essential if agreements are to be legally binding. Involvement of the ministry of interior may be important for national emergencies, but not for international engagements.

- There is a need to raise the awareness of parliamentarians on the importance of collaboration.

VII. How do the military and civilian health sectors interact with one another and at what level? How do they interact? Are their respective roles and responsibilities clearly defined?

- There is a need to clearly define and formalize roles, and also to recognise that some sectors of government may be responsible for only limited areas in an emergency.



SESSION 7: COUNTRY PERSPECTIVES ON PRACTICALITIES IN DEVELOPING A NATIONAL FRAMEWORK FOR COLLABORATION BETWEEN MILITARY AND CIVILIAN HEALTH SECTORS

SESSION 7: Objective

The objective of this session, moderated by [Simo Nikkari](#), Director, Centres for Military Medicine and Bio-threat Preparedness FDF Logistics Command, Finland, was for countries to consider how to implement a framework for collaboration between the military and civilian health sectors.

SESSION 7: Discussion

Participants heard presentations from [Mongolia](#), [Thailand](#), [Ghana](#) and [Indonesia](#). While all four countries agreed on the value of collaboration, their histories demonstrated different levels of development and engagement. Whereas Thailand, for example, has been engaged in a structured and formal process since the events of 9/11 and the anthrax attacks of 2001, in contrast developments in Ghana had tended to be ad hoc and not well structured. While Indonesia had an extensive range of collaborative links, this was less so in the case of Mongolia. All four presentations agreed that formal links were desirable, while also identifying how links may already be present through, for example, military medic training in civilian hospitals, or military hospitals being open to the public. The presentations also emphasized that the benefits were not solely for

the civilian health sector and that the military also gains from collaboration.

In roundtable discussion, [Romania](#) pointed out that, despite socio-economic differences between countries, collaboration is widespread and that there was significant agreement among participants that the best way to identify

best practices was through exercises. Romania therefore proposed building a network to share information about exercises and inviting international observers to exercises with WHO acting as a focal point.

WHO asked whether there was potential for supra-national organizations to leverage capacities. [Ghana](#) responded that “this was the way to go” and identified the success of APORA (African Partner Outbreak



Response Alliance) in areas where borders were porous. **Japan** pointed out that the legal basis provided by MoUs is important for sustainability. **China**, however, suggested that MoUs might not be necessary if collaboration is embedded in organizational mandates, and that informal routes might prove quicker in reacting to events than formal mechanisms that are embedded in MoUs.

SESSION 7: Outcomes

Strengthened collaboration can start by building on existing links, such as military medic training in civilian hospitals, and be expanded through joint training and simulations that build trust and shared capacities. This collaboration has benefits not only for the civilian health sector but for the military as well. Collaboration is often prompted by political needs arising from real world developments rather than from identifying technical gaps, although the mapping of technical areas for collaboration provides focus and priorities for implementation. Collaboration is a process of developing ways of working together and countries are at different stages of this process. The process will differ according to context, although some elements may be common including the importance of exercises, high-level government support, and flexible cooperation agreements.



SESSION 8: MOVING FORWARD WITH THE NATIONAL COLLABORATION FRAMEWORK FOR MILITARY AND CIVILIAN HEALTH SECTORS



This session, moderated by [Mr Ludy Suryantoro](#), WHO SPH team lead, was designed to allow participants to discuss next steps for the NCF. Mr. Suryantoro began by thanking participants for their input. For WHO, moving forward with the NCF is about working together and mobilization for the implementation of IHR (2005) and country capacity building.

Summary closing inputs from expert participants

- [Gabon](#) suggested that a step-by-step approach may be best, with WHO taking the first step.
- [Georgia](#) called the meeting valuable for the opportunity to share experiences, given its own lack of health emergencies.
- [Ghana](#) commented that the next steps at country level were clear – completing the JEE, formalizing high level agreements, and establishing collaboration at low levels.
- [Japan](#) commented that civil-military collaboration should be promoted at national levels.
- [Jordan](#) said that WHO had already taken the lead and must now be supported by countries.
- [Dr Kamradt-Scott](#) of Sydney University invited participants to complete his survey on military assistance in health emergencies and offered to make the results available in translation as requested.
- [Malaysia](#) identified the importance of updating strategic plans.
- [Thailand](#) offered to host a follow-up meeting to discuss feedback on NCF implementation.
- [Tunisia](#) said the consultation had provided an opportunity to solidify cooperation, which is in the early stages. Tunisia suggested

that military officers might brief national International Committee on Military Medicine (ICMM) points of contact and that WHO present the NCF at the ICMM annual congress.

- **Uganda** identified the need to ensure that WHO country-level offices are on the same page as WHO Headquarters with this since countries must go through them.
- **USA** commended the meeting for providing concrete examples of joint working and emphasized that no single sector can secure a country against infectious disease. The USA cautioned, however, that the meeting might consist primarily of like-minded participants and suggested that more skeptical voices should be engaged in the development of the NCF.

Four Member States – Ghana, Indonesia, Thailand and Uganda – requested at the close of the meeting for WHO to pilot the NCF in their countries to enhance civil-military collaboration for emergency preparedness and to test the framework for future global implementation.

Mr Suryantoro, WHO SPH Team Lead, pledged that WHO will build on the momentum of the meeting, engaging Member States and partners to strengthen multisectoral collaboration and accelerate IHR (2005) implementation for national, regional and global health security. Mr Suryantoro said WHO would pilot the NCF in volunteer countries along with WHO guidance and tools to facilitate preparedness between the civil and military health sectors.

WHO is developing a package of support for Member States that includes NCF guidance, a multisectoral preparedness coordination guide and tools, and mapping of country resources that can be leveraged for civil-military collaboration in health security strengthening. The objective is to increase country ownership of health security, addressing inter-ministerial and cross-sectorial communication and coordination challenges. Mr Suryantoro said WHO plans to report progress on the effort at the Global Health Security 2019 Conference in June in Sydney, Australia, and to use the Sydney conference as a platform to raise awareness among Member States of the potential benefits of civil-military collaboration and of the WHO guidance available to support countries.



Ms Romina Stelter, WHO SPH, provided participants with a high-level summary of the technical consultation, which particularly established the importance of context-specific cooperation agreements, common risk communication strategies, and of ensuring coordination and building trust through testing, including SimEx, field exercises and after action reviews.

Ms Stelter said cooperation and trust can be embedded through teaching/professional development programs, joint training, liaison officers, secondments and the establishment of procedures for information sharing. She noted that militaries are often seen in terms of rapid response capability but their scope and means are much greater. The military and civilian health sectors have different approaches to problems, which can complement each other in building country capacities for health emergency preparedness.

Dr Stella Chungong, Chief of the WHO Core Capacity Assessment, Monitoring and Evaluation Unit (CME), closed the meeting by reflecting on the progress made since the international civilian and military health sectors first came together in Jakarta in 2017. The shared vision that manifested as the Jakarta Call to Action has resulted in the creation of the NCF and the identification of concrete steps to operationalize collaboration. Dr Chungong urged participants in the consultation to be champions in their own countries and beyond for strengthening collaboration and implementing the NCF.

Recommendations for countries and WHO

For countries

1. Meaningful agreements – that is agreements which possess both authority and a requirement for action – should be developed and agreed upon to embed collaboration in national contexts.
2. A matrix can be used to identify where military resources can support IHR (2005) core capacities.
3. “Low level” initiatives, such as involvement in knowledge building and secondments, should be introduced as cost-effective means of developing cooperation.
4. Programmes to develop trust at the individual level can be established and complementary initiatives undertaken at the sectoral level.
5. Training programmes can be instituted, from tabletop to field exercises, to ensure mutual understanding and effective joint working between the military and civilian health sectors.

For WHO

1. Revising and finalizing NCF based on the input received from Member States, partners and non-state actors during the technical consultation in Hong Kong.
2. Piloting of the NCF in countries should be undertaken as soon as possible.
3. To work together with partners for the piloting and implementation of the NCF.

Next Steps

- Consensus by Member States on the NCF guides and tools, as well as key actions for development of military and civilian collaboration for health security preparedness at national level.
- To pilot and test the guide and tools presented at the Hong Kong consultation in several countries.
- To share the outcomes at the global health security conference in Sydney, Australia, June 2019.
- To continue to assist countries in development of their national collaboration plans, including use of resource mapping and multisectoral preparedness coordination tools.

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