Informal Consultation to Develop APSED (2010) Supplementary Indicators

9-10 September, Manila, Philippines

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SUMMARY

An informal consultation to develop APSED (2010) supplementary indicators was held from 9-10 September 2010, Manila, the Philippines. About 20 experts (temporary advisors) and WHO staff at all three levels (the country, regional office and headquarters level) attended the consultation meeting.

APSED (2010) is an updated Asia Pacific Strategy for Emerging Diseases that was originally developed in 2005. The updated Strategy will serve as a road map for Member States in two WHO regions – the South-East Asia Region and the Western Pacific Region, to build up the core capacity requirements under the revised International Health Regulations, known as IHR (2005). The consultation was organized following the recommendation of the fifth meeting of the Asia Pacific Technical Advisory Group (TAG) for Emerging Diseases in July 2010.

APSED (2010) aims to build sustainable national and regional capacities and partnerships to ensure public health security through preparedness planning, prevention, early detection and rapid response to emerging diseases and other public health emergencies. The eight "focus areas' for capacity building efforts include: 1) Surveillance, Risk Assessment and Response, 2) Laboratory, 3) Zoonoses, 4) Infection Prevention and Control, 5) Risk Communication, 6) Public Health Emergency Preparedness, 7) Regional Preparedness, Alert and Response, and 8) Monitoring and Evaluation. APSED (2010) seeks to build on the common approach and maximize the benefits already achieved under APSED (2005).

The objectives of the informal consultation were:

- To identify APSED (2010) components that are not addressed by the IHR Monitoring Checklist and require supplementary, additional indicators
- To identify a minimum set of supplementary APSED Performance Indicators

The participants were provided with the background information about the monitoring of IHR and APSED implementation. A series of discussions were made to propose and identify supplementary indicators that would be required for APSED (2010). The consultation has concluded the following:

(1) Monitoring & evaluation is an integral component for IHR and APSED (2010). However, the key issues such as ownership, collection and quality of data, and assessment burden must be kept in mind when developing an M&E system that can meet the accountability and learning needs of its diverse stakeholders.

(2) Whilst providing a solid basis, the IHR tool does not capture the entire scope and detail of APSED (2010) and additional supplementary component indicators are required to monitor APSED (2010) implementation at both country and regional levels. The balance should be made to address the need for additional indicators and an assessment burden on Member States and WHO.

(3) Developing high-level performance indicators to measure the performance of the systems functioning together is an ambitious endeavour. It is exceptionally challenging and few, if any, examples exist in the area of public health security. More discussions and work would need to be carried out. Nevertheless, six performance indicators were identified through the process of this consultation and discussed in detail from technical and operational perspectives. These provide a sound starting point for further development and discussion with APSED stakeholders. The importance of qualitative information or quality-related information has been recognized and emphasized, as it is extremely powerful in helping better understand how well the system is performing and helping focus on areas for improvement. The six indicators suggested include the following:

- Proportion of urgent events in the past 12 months with risk assessment carried out at national level
  - Number of urgent events reported in the past 12 months
  - Proportion of urgent events with risk assessment carried out
  - Proportion of these with risk assessment carried out within 48 hours of receiving the reports
  - Proportion of these with risk assessment that utilized sex disaggregated data
  - What lessons were learnt, and how could the quality of risk assessment be improved?

- Number of events in the past 12 months that met the national standard definition/criteria with further investigation conducted after a risk assessment
  - Proportion of these followed by a rapid response within 48 hours at national level
  - Proportion of these with technical support from WHO
  - What lessons were learnt, and how could these results be improved?

- Number of surveillance and response updates published on an official website

- Proportion of events of potential public health emergency of international concern that were notified to WHO from the National IHR Focal Points in the past 12 months
  - Proportion of these that were notified within 24 hours of assessment
  - Proportion of these that were infectious disease events
  - What lessons were learnt, and how could these results be improved

- Average time from verification request from WHO to provision of information from the National IHR Focal Points

- Number of outbreaks or events annually reviewed by expert group
  - Proportion of outbreak with perceived satisfaction by expert group
  - Number of reports available to document review progress, experiences and lessons learnt, and plans for improvement

(4) To strengthen the M&E system, including strengthening the annual Member State IHR and APSED monitoring process, enhancing the M&E function of annual TAG, fostering the development and update of the National Workplans and conducting a final evaluation. In particular, more efforts should be made to strengthen and support Member States' system for collecting and analysing data and information, including those related to IHR and APSED indicators.

1. INTRODUCTION

APSED (2010) is a revision and update of the Asia Pacific Strategy for Emerging Diseases, originally developed in 2005 as a bi-regional 5-year strategy to provide a common strategic framework for countries and areas of the Asia Pacific Region to strengthen their capacity to manage and respond to disease outbreaks and acute public health events. While APSED (2010) continues to focus on emerging diseases, it has now widened its scope to also address threats posed by other public health emergencies. To meet these needs, the activities of the original five programme 'focus areas' of APSED will be continued and expanded, and three new Focus Areas were added for priority capacity building, including Monitoring and Evaluation[1].

APSED (2010) proposes a simplified common M&E framework to be developed for Member States, WHO and stakeholders to monitor and evaluate progress in strengthening core capacities in each of the eight Focus Areas. Central to this framework will be a defined set of APSED indicators, drawn from the mandatory IHR monitoring questionnaire. In addition, a small number of supplementary indicators are proposed to be developed to monitor progress in areas that are essential to national capacity strengthening and require special regional needs for support.

At the Fifth Meeting of the Asia Pacific Technical Advisory Group (TAG) on Emerging Diseases in July, 2010, the TAG recommended that, taking into account the mandatory IHR monitoring tool, WHO should work with partners to "develop a minimum set of APSED indicators and agreed on mechanisms that should be used for result-based monitoring of APSED (2010) implementation progress."

1.1 OBJECTIVES

The objectives of the informal consultation were:

1. To identify APSED (2010) components that are not addressed by the IHR Monitoring Checklist and require supplementary, additional indicators
2. To identify a minimum set of supplementary APSED Performance Indicators

1.2 ORGANIZATION

The informal consultation was held from 9-10 September 2010, in the WHO Regional Office for the Western Pacific, Manila, the Philippines. Attending the informal consultation were temporary advisers with either monitoring and evaluation expertise or experience in emerging infectious disease (EID) programme management, as well as staff from WHO Country Offices and Regional Office in the Western Pacific Region, the WHO South-East Asia Regional Office and WHO Headquarters. The List of Participants and Timetable are included in Annexes 1 and 2.

[1] The eight Focus Areas of the APSED (2010) are 1) Surveillance, Risk Assessment and Response; 2) Laboratory; 3) Zoonoses; 4) Infection Prevention and Control; and 5) Risk Communication. 6) Public Health Emergency Preparedness; 7) Regional Preparedness, Alert and Response; and 8) Monitoring and Evaluation.

2. PROCEEDINGS

2.1 PLENARY 1: INTRODUCTION TO APSED (2010)

2.1.1 APSED (2010): Focus areas, components and relationship to IHR (2005)

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The Asia Pacific Strategy for Emerging Diseases (APSED) is a bi-regional strategy to provide a common framework for the countries and areas of the Asia Pacific to strengthen their capacity to manage emerging disease threats. In July 2009, the fourth annual meeting of the Asia Pacific Technical Advisory Group (TAG) on Emerging Infectious Diseases recommended that APSED be continued beyond its scheduled end in December 2010, and revised for a further five year period with an expanded scope to include non-infectious disease events, in-line with the International Health Regulations (2005).

Beginning in late 2009, an intensive consultative process with Member States, TAG members, experts and partners was initiated to review the progress of and experiences of APSED and to develop a revised strategy – APSED (2010). The new strategy has been developed to guide national and regional preparedness efforts for future threats to health security. It continues to focus on building capacity to manage and respond to emerging disease threat, but now also addresses capacity building needs to also address other acute public health events in-line with IHR requirements.

To meet these needs, the original five[2] programme 'focus areas' of APSED have now been expanded to eight: 1) Surveillance, Risk Assessment and Response, 2) Laboratory, 3) Zoonoses, 4) Infection Prevention and Control, 5) Risk Communication, 6) Public Health Emergency Preparedness, 7) Regional Preparedness, Alert and Response, and 8) Monitoring and Evaluation. APSED (2010) seeks to build on the common approach and maximize the benefits already achieved under APSED (2005).

2.1.2 APSED (2010) Focus Area 8: Monitoring and Evaluation

Ms Qiu Yi Khut, Technical Officer, Communicable Disease Surveillance and response, DSE, WHO WPRO

Many M&E activities were implemented and key issues identified during the first phase of APSED. M&E must be seen as one of the core businesses of WHO and Member States, and should be addressed as an essential APSED focus area. A strong need was identified by stakeholders for a common, simplified M&E framework which should include harmonization with international monitoring requirements such as the International Health Regulations Monitoring Framework. Capacity-building and country ownership of M&E should also be a fundamental part of APSED M&E efforts in the future, and appropriate funding for M&E activities should also be sought and allocated.

From the experiences and lessons learned from APSED (2005) and the advice from TAG, Monitoring and Evaluation has now been included as Focus Area 8 in the revised APSED (2010). M&E is an integral part of strategy implementation in order to meet two critical management needs – accountability and learning. Accountability is essential to demonstrate to stakeholders (Member States, WHO, donors and partners) that the

[2] The Original five APSED program areas were 1) Surveillance and Response, 2) Laboratory, 3) Zoonoses, 4) Infection Control, and 5) Risk Communication

priorities identified under APSED are correct, that it is effective in achieving its objectives and that funds are being used appropriately. Learning is important to understand what is working, what can be done better, and the reasons why, in order to ensure that decision-making is evidenced-based and that a process of continual improvement can be implemented.

In APSED (2010), M&E processes are proposed to be directed at Country- and Regional-level. At Country-level, workplans and APSED Indicators (composed of selected IHR Monitoring Indicators and a minimum set of 'supplementary' indicators) will form the basis of the M&E structure, and will be supported by efforts to strengthen M&E capacity. At Regional-level, a strengthened annual TAG mechanism will review both country and regional progress, and make recommendations for the next year of work.

2.1.3 Discussion: Country experiences of APSED monitoring and evaluation

In China, there have been the ongoing efforts for M&E. Any M&E should pay more attention to the data quality. After the development of indicators, the issue of how to collect the data must be eventually addressed. The establishment of an appropriate platform will be a challenge, for example one where countries can continually update their information (rather than an annual process) should be considered. Both qualitative data as well as quantitative data should be considered when developing APED (2010) M&E.

In Mongolia, the Ministry of Health developed a national strategic plan in line with APSED. APSED M&E tools such as the Common Indicators Assessment checklists were helpful for the country to identify gaps and monitor the progress. National counterparts were particularly interested in component level M&E, which was found to be important and useful to identify areas for improvement and for activity planning. However indicators for APSED (2010) should go beyond component indicators, to attempt to address some measurement of goals or objectives. As M&E has become more routine in Mongolia (and more than an annual process), there is more interest to monitor results and track progress and results.

The Lao People's Democratic Republic has been used as a 'model' country for APSED review during the first phase of the Strategy. Many APSED M&E activities implemented since 2007 were very useful to remind stakeholders of what has been planned, what has been achieved and what still needs to be achieved. The National EID workplan developed using the APSED framework was very useful to share ideas and coordinate with other stakeholders. However, the workplan was sometimes seen as a WHO plan at the beginning, even though it was the national plan with the combined work of many stakeholders. At same time, in Lao PDR there are many stakeholders, with many different agendas and projects (e.g. World Bank AI Plan, ADB/CDC Phase 1), and every month different indicators or reviews were implemented for different purposes. National counterparts emphasizes that the workplan and M&E activities critical, but that there must be one plan, and one M&E system. To achieve this, stakeholders should be involved to make consensus and the M&E plan together, but challenges will lie in ensuring both a collaborative process and a strong, focused outcome.

In the experience of the Philippines, the APSED monitoring tools appeared to be very long and difficult for national counterparts to complete in a short period of time. The tools require coordination with other partners and offices, and it was difficult to get the right people together to answer. In 2009, national counterparts developed their own M&E using the workplan itself, and also identified other activities outside of APSED to focus on. There is a need to have both Regional-level and Country-level indicators, to assist the country to know that is it on the right track. A national planning exercise for APSED (2010) is also currently being planned.

In Malaysia M&E appears not to be institutionalized and is commonly perceived as an obligation to be completed because someone has asked for it. The information requested is not readily available, or sometimes answers may be based on one person's comment or opinion (as opposed to a multi-sector process). There are many competing assessments, frameworks and tools in use which creates a great deal of confusion, especially since many of the indicators are similar (but not exact). Too many M&E may create a burden for the country and the WHO Country Office. What is needed is a simple, relevant M&E system that is institutionalized and owned by the implementers themselves.

SEARO countries seem to be suffered from too many assessments issued by donors and partners. Assessments may be similar, but not identical, creating a real burden on countries. Countries are at different levels in terms of size, disease burden and development etc – thus even if a common tool were developed, it may not be suitable for all. Ownership and simplicity will be critical for a functional M&E system, but a challenge for APSED (2010) will be to create an M&E tool with minimum indicators, that is able to capture the level of detail needed.

2.1.4 Plenary Discussion

Four key points may be highlighted in the context of developing an M&E framework for APSED (2010):

1. *Rationalize:* There is universal consensus that M&E is important and helpful – the challenge is how to rationalize process and plans and how to simplify and harmonize existing and competing M&E systems under a common framework.
2. *Ownership:* M&E has a range of stakeholders, none more critical than the Member States. If they do not see value in the process, then data quality questionable. From the country experiences shared, different countries have different levels of buy-in and different levels of success and ownership of M&E. Transforming the sense of 'burden' to a sense of ownership will be critical.
3. *Focus:* There are different levels within countries (national/sub-national/local); across the region (large/small countries; resource rich/poor countries) and within APSED (activity/component/performance level) – where should the focus lie? Maybe more result or performance-based indicators are needed.
4. *Process Issues:* Individual bias and attitudes towards M&E will affect process issues such as data collection (e.g. individual bias, quality of response if seen as a chore or burden)

2.2 PLENARY 2: IHR / APSED MONITORING FRAMEWORK

2.2.1 Overview of the IHR Monitoring Framework

Dr Xing Jun, Medical Officer, National Capacity Monitoring, IHR Coordination, WHO HQ

The IHR (2005) came into force on 15 June 2007, as a global agreement to ensure maximum public health security while minimizing interference with international traffic and trade. It is a legally binding instrument for WHO and the signatory countries to abide by the same rules to secure international health. The new approach moves away from pre-determined controls and measures towards a focus to on containment at source and a broader range of threats met by adapted response.

Under the IHR (2005), countries committed to a new obligation to meet the minimum standards of national core capacity to detect, respond to and manage public health events. In order to monitor the progress of countries in achieving these core capacities, the IHR Monitoring Framework was developed which identifies eight core capacity areas to be strengthened, across IHR relevant hazards and points of entry. From these eight areas, a list of indicators was derived through a series of technical consultations and field tests. The tools now available for monitoring IHR Core Capacity development are a monitoring checklist and indicators, the States Parties Questionnaire and a web-based tool. The expected outputs of this monitoring are reports at individual country level and aggregated regional and global level.

Challenges in developing the Monitoring Framework include making a global tool relevant for a diversity of countries, harmonizing with existing strategies and overcoming different understandings of monitoring tools.

2.2.2 M&E and Possible Ways Forward

Mr Graham Rady, Asia Programs Quality and Development Adviser, Asia Regional Branch and Asia Bilateral Branch, AusAID

Monitoring and evaluation are critical to meet the two critical performance management needs of accountability and learning. The stakeholders involved include Member States (to assess their capacity building needs, gaps and lessons learned), WHO and the international health community (to monitor achievement of IHR obligations), and development partners (to confirm that APSED is a quality/good investment). In APSED (2010), M&E is proposed to be implemented through a strengthened annual Member State review process, enhanced TAG mechanism, development and review of National workplans, as well as a final Evaluation.

The primary focus of an APSED M&E system should be on assessing and enhancing capacity building outcomes and changes. Any system should be pragmatic and feasible, not idealistic. Taking into consideration the significant assessment burden placed on countries and the content overlap in competing assessment formats, the mandatory IHR Monitoring Framework offers an opportunity to rationalise systems of information collection. However, IHR and APSED are not identical, so there may be a need for additional information collection to fill gaps.

There are many ways of doing M&E depending on various needs. APSED (2010) is a strategic framework, and multiple levels of M&E information can be identified. At the lowest 'Activity-level', activities implemented under the APSED framework produce

outputs (i.e. Components) and expected results. At the next level – 'Component-level' – APSED components contribute to the delivery of an output (i.e. Focus Area) and its purpose. At the highest level – 'System-level' – APSED Focus Areas contribute to the overall APSED system, and its associated goal. At the 'System-level', performance indicators are required to monitor how well the system functions as a whole. At 'Component-level', outcome indicators are required to monitor how well the APSED components contribute to the functioning of the Focus Area (Annex 3).

2.2.3 Discussion

The IHR Monitoring Framework should not be seen just as a tool for scoring countries, but also as an advocacy process to raise awareness of IHR requirements with Member States. In developing countries the focus of respondents has been more on technical details, with the IHR Monitoring Framework tool functioning as a guide or checklist for improvement. Developed countries have focussed more on the outcomes described in the tool, rather than prescriptions of how to achieve those outcomes. Ideally the IHR Monitoring Framework would focus at this outcome/output level, as these describe what IHR aims to achieve. But developing countries may find the input/process stage useful to guide their capacity building efforts, which is why this stage remains in the tool.

It is acknowledged that interpreting the data generated by the tool is challenging. When completing the tool, countries are asked to list documentation – but not to provide. The monitoring process is more about practice than verification, which may make it difficult to ensure quality of, and to interpret information. The IHR tool appears to be too complicated for some countries. The actual people responding to the tool may also change over time, which is add to the challenges in ensuring consistent data for interpretation.

2.3 SUPPLEMENTARY 'COMPONENT' INDICATORS

Given the synergies between IHR and APSED, a large amount of information collected by the mandatory IHR Monitoring Framework Questionnaire will be able to be used to monitor and evaluation progress in APSED Focus Areas and Components (i.e. 'Component-level' M&E and indicators). However, there will be some Components requiring additional "component-level" indicators. A minimum set of indicators that are result-based are also needed. This issue was recognized by the TAG, who recommended that the IHR monitoring tool be taken into account when developing a minimum set of APSED indicators.

2.3.1 Group Discussion 1: Identifying Gaps and Needs for 'Component' Indicators

In the first group discussion, participants were tasked with identifying APSED Focus Areas and Components that were adequately addressed under the IHR Monitoring Framework. At the same time, Focus Areas and Components that are not adequately addressed and will require supplementary component-level indicators, were also identified.

Participants were divided into three groups, with each group assigned to different APSED Focus Areas. Using the IHR Monitoring Framework Checklist and the APSED (2010) draft

strategy document, each group was asked to identify which APSED Focus Areas and Components could be sufficiently monitored using the information collected by the IHR tool, and which Focus Areas required the development of additional supplementary component indicators in order for M&E to be adequately implemented. Annex 4 shows the list of APSED Focus Areas and Components that will be most likely to requiring supplementary component-level indicators.

2.4 SUPPLEMENTARY 'PERFORMANCE' INDICATORS

Results-based monitoring was identified by the Fifth TAG Meeting as a focus of M&E in APSED (2010). To monitor the achievement of system-level results, the term and use of 'performance indicators' is proposed. 'Performance' can be defined as progress towards the achievements of results and in the context of APSED implementation, is used to describe how well a system (established or enhanced through efforts under the APSED framework) functions. To measure this performance, 'performance indicators' are proposed to be designed to measure the functioning or performance of the systems established and strengthened under the APSED approach.

2.4.1 Group Discussion 2: Identifying Potential Performance Indicators

Using the proposed APSED M&E framework (see Annex 3), building on the past experiences and lessons learned and following the proposed guiding principles (see Box 1), a preliminary list of potential performance indicators was identified through the pre-meeting "brainstorming" and group discussions during the meeting.

Box 1. Guiding principles for selecting performance indicators*:

- **S**pecific – clear, precise and unambiguous
- **M**easurable – can measure performance or functions of the systems strengthened under APSED (2010)
- **A**chievable – can be feasibly implemented in terms of economic cost, data availability, collection, analysis and reporting at country level
- **R**elevant – to the programme(s) on emerging disease and/or public health emergency management and reflective of results of combined capacities across individual Focus Area and Components (e.g. an indicator that may reflect the combined capacity building efforts of risk assessment, rapid response, accurate laboratory diagnosis, and risk communications)
- **T**ime-bound

** A minimum set of performance indicators (no more than ten) will be selected.*

Annex 5 shows the preliminary list of possible performance indicators identified through this "brainstorming" and group discussion process.

2.4.2 Group Discussion 3: Prioritizing Performance Indicators

Both group and plenary discussions were held in order to prioritize the proposed performance indicators. In addition to the guiding principles, the following more detailed aspects and process were considered and examined when prioritizing and identifying a final proposed list of performance indicators: definition, APSED (2010) objectives addressed, rationale (e.g. which focus areas may contribute to the indicator), method of computation, data collection and source, frequency of measure, gender issues and limitations. Among these factors to be examined or considered, the importance of data collection feasibility has been emphasized.

These further group discussions found that some indicators in the preliminary list (Annex 5) were overlapped and duplicated, such as indicator D, E, and F. Some indicators were still more for "component-level" indicators, such as Indicator T on the national public health emergency plan) and Indicator K on risk communication.

Through the "prioritization" process, the final list of proposed performance indicators have been identified and showed in Annex 6.

3. FINDINGS AND CONCLUSIONS

3.1 FINDINGS

3.1.1 Supplementary 'Component' Indicators

Established Focus Areas of APSED were mostly covered by indicators in the IHR Monitoring Tool, with the exception of Risk Communication were all three Components require supplementary component indicators. Of the three new Focus Areas in APSED (2010), Regional Preparedness, Alert and Response (Focus Area 7) and Monitoring and Evaluation (Focus Area 8) require supplementary indicators for all components, while Public Health Emergency Preparedness (Focus Area 6) requires supplementary indicators for some of its six components such as response logistics.

Whilst providing a solid basis, the IHR monitoring tool does not capture the entire scope and details of APSED (2010). Overall, only about 50% of all the components in APSED (2010) were identified to be adequately covered by indicators in the IHR Monitoring Framework. In another word, significant number of supplementary component indicators for APSED (2010) would be needed.

3.1.2 Supplementary 'Performance' Indicators

Over the course of three rounds of group discussion, the list of proposed performance indicators was proposed, revised and prioritized to the following:

1. Proportion of urgent events in the past 12 months with risk assessment carried out at national level
   - Number of urgent events reported in the past 12 months
   - Proportion of urgent events with risk assessment carried out
   - Proportion of these with risk assessment carried out within 48 hours of receiving the reports
   - Proportion of these with risk assessment that utilized sex disaggregated data
   - What lessons were learnt, and how could the quality of risk assessment be improved?

2. Number of events in the past 12 months that met the national standard definition/criteria with further investigation conducted after a risk assessment
   - Proportion of these followed by a rapid response within 48 hours at national level
   - Proportion of these with technical support from WHO
   - What lessons were learnt, and how could these results be improved?

3. Number of surveillance and response updates published on an official website

4. Proportion of events of potential public health emergency of international concern that were notified to WHO from the National IHR Focal Points in the past 12 months
   - Proportion of these that were notified within 24 hours of assessment
   - Proportion of these that were infectious disease events
   - What lessons were learnt, and how could these results be improved

5. Average time from verification request from WHO to provision of information from the National IHR Focal Points

6. Number of outbreaks or events annually reviewed by expert group
   - Proportion of outbreak with perceived satisfaction by expert group
   - Number of reports available to document review progress, experiences and lessons learnt, and plans for improvement

3.2 CONCLUSIONS AND NEXT STEPS

An M&E system must be grounded in practicality. The key issues such as country's ownership, collection and quality of data, and assessment burden must be kept firmly in mind when developing an M&E system that can meet the accountability and learning needs of its diverse stakeholders.

Whilst providing a solid basis, the IHR tool does not capture the entire scope and detail of APSED (2010) and additional supplementary component indicators are required to monitor APSED (2010) implementation at both country and regional levels. The balance

should be made to address the need for additional indicators and an assessment burden on Member States and WHO.

Developing high-level performance indicators to measure the performance of the systems functioning together is important, but an ambitious endeavour. It is exceptionally challenging and few, if any, examples exist in the area of public health security. Six performance indicators were identified through the process of this consultation and discussed in detail from technical and operational perspectives. These provide a sound starting point for further development and discussion with APSED stakeholders.

Performance indicators are a component of M&E that need to be in from the beginning, but similarly with core capacity building, they are a component that can be built and improved on over the period of the strategy. It was concluded that the process of defining the performance indicators was a valuable exercise to explore the feasibility of implementing each indicator. The process generated much thinking and discussion which should be continued to further improve on this preliminary set of performance indicators. Feasible mechanisms for use of these indicators would need to be developed in consultation with key stakeholders, especially Member States.

There is the need to strengthen the Member State's M&E system, including strengthening the annual Member State IHR and APSED monitoring process, fostering the development and update of the National Workplans and conducting a final evaluation. In particular, more efforts should be made to strengthen Member States' system for collecting and analysing data and information, including those related to IHR and APSED indicators. WHO should provide its technical support to countries in strengthening the Member States' M&E system, when needed.

At the regional level, the annual TAG meeting should continue to provide a venue to discuss the issues related to the APSED (2010) M&E and recommend next steps.

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ANNEX 2: TIMETABLE

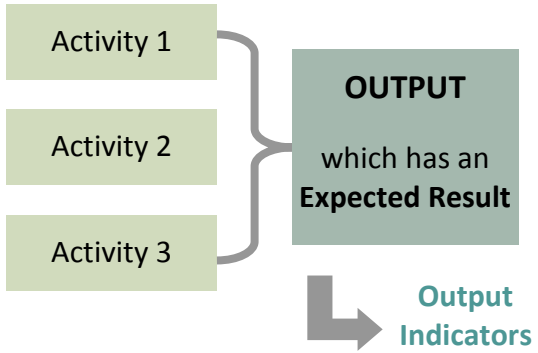
Time	Day 1 – Thursday 9 September	Time	Day 2 – Friday 10 September
08:15 – 08:30	Registration	08:30 – 09:00	Plenary 3: Group Discussion 2 Feedback – Group 1 – Group 2 – Group 3
08:30 – 09:00	Opening Session – Opening remarks – Self-Introduction – Objectives – Administrative Announcements – Group Photo	09:00 – 10:00	Group Discussion 3: Prioritizing Performance Indicators – Group Discussion – Feedback
09:00 – 10:30	Plenary 1: Introduction to APSED (2010) – APSED (2010): Focus areas, components and relationship to IHR (2005) – APSED (2010) Focus Area 8: Monitoring and Evaluation – Plenary Discussion: Country experiences of APSED monitoring and evaluation		
10:30 – 11:00	*Coffee Break*	*10:00 – 10:30*	*Coffee Break*
11:00 – 12:00	Plenary 2: IHR/APSED Monitoring Framework – Overview of the IHR Monitoring Framework – M&E and Possible Ways Forward – Introduction to Group Discussions	10:30 – 12:00	Group Discussion 4: Defining Performance Indicators
12:00 – 13:00	*Lunch*	*12:00 – 13:00*	*Lunch*
13:00 – 15:30	Group Discussion 1: Identifying Gaps and Needs for Supplementary Component Indicators – Group Discussion – Feedback	13:00 – 15:30	Closing Session – Feedback from Group Discussions 3 & 4 – Next Steps – Closing Remarks
15:30 – 16:00	*Coffee Break*		
16:00 – 17:30	Group Discussion 2: Identifying Performance Indicators – Introduction and identification of 'Performance Indicators'		

ANNEX 3: A MONITORING AND EVALUATION FRAMEWORK FOR APSED

Activity Level

Activity → Output + Expected Result
Activities contribute to delivery of an **Output** (i.e. APSED component), which has an **Expected Result**

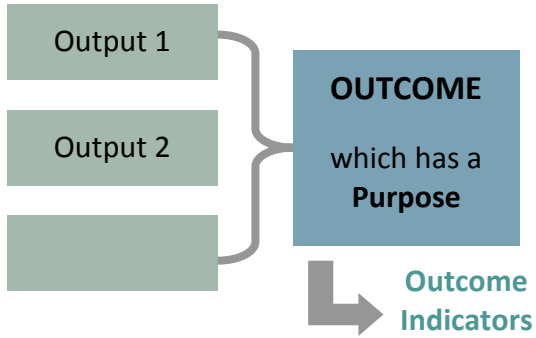
Output Indicators



Component Level

Output → Outcome + Purpose
Outputs (APSED components) contribute to delivery of an **Outcome** (i.e. Focus Area), which has a **Purpose**

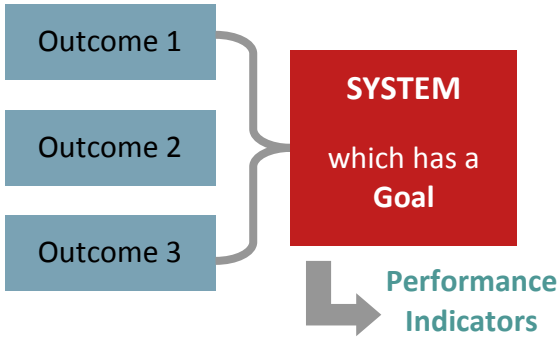
Outcome Indicators



System Level

Outcome → APSED (2010)
Outcomes (Focus Areas) contribute to delivery of **System** (i.e. APSED (2010)), which has a **Goal**

(System) Performance Indicators



ANNEX 4: GROUP DISCUSSION 1 – IDENTIFYING GAPS AND NEEDS FOR COMPONENT INDICATORS

Preliminary Mapping of APSED (2010) Focus Areas and Components against the IHR Monitoring Framework Indicators

Focus Area	Key Components	Comments	Adequate / Inadequately addressed
1. Surveillance, Risk Assessment and Response	1.1. Event-based surveillance	– Distinctly separate from IBS – EBS complements IBS in APSED	– **Not fully addressed**
	1.2. Indicator-based surveillance	– Distinctly separate from IBS – EBS complements IBS in APSED	– **Not fully addressed**
	1.3. Risk assessment capacity	– Not distinctly identified – Annex 2 as assessment tool in EBS – APSED allows country flexibility to develop risk assessment capacity at different levels	– **Inadequately addressed**
	1.4. Rapid response capacity	– Found in PH emergency response – Unlinked to surveillance	– **Not fully addressed**
	1.5. Field epidemiology training	– Found in human resource component versus surveillance for APSED – Mentioned as a strategy and only as additional achievement – Not a strategy but actually carried out in APSED	– **Inadequately addressed**
2. Laboratory	4.1. Accurate laboratory diagnosis	– Explicitly addressed	– Adequate
	4.2. Laboratory support for surveillance and response	– Vaguely addressed – explanation includes lab surveillance, but doesn't address as a whole	**Inadequately addressed**
	4.3. Coordination and laboratory networking	– Explicitly addressed	– Adequate
	4.4. Biosafety	– Explicitly addressed	– Adequate
3. Zoonoses * IHR indicators assume coordination mechanism already exists (under pre-requisites column in IHR indicator)	3.1. Sharing of surveillance information		– Adequate
	3.2. Coordinated response		– Adequate
	3.3. Risk reduction		– **Inadequately addressed**
	3.4. Research		– **Inadequately addressed**
4. Infection Prevention and Control	4.5. National Infection Prevention and Control (IPC) structure	– Adequately addressed	– Adequate
	6.1. IPC policy and technical guidelines	– Adequately addressed	– Adequate
	6.2. Enabling environment	– under the definition of 'enabling environment' Not covered in detail, partially addressed	– **Inadequately addressed**

Focus Area	Key Components	Comments	Adequate / Inadequately addressed
	4.6. Supporting compliance with IPC practices	– Adequately addressed	– Adequate
5. Risk Communications	5.1. Health emergency communications	– Outbreak communications has the narrow scope as compared with emergency communication	– **Inadequately addressed**
	5.2. Operation communications	– May be partially available, but still required supplementary indicators	– **Inadequately addressed**
	5.3. Behaviour-change communications		– **Inadequately addressed**
6. Public Health Emergency Preparedness	6.3. Public health emergency planning	– Adequately addressed	– Adequate
	6.4. National IHR Focal Point function	– Consistent between IHR and APSED	– Adequate
	6.5. Points of entry preparedness	– IHR indicators need to be simplified and modified (IHR checklists have the broader list as compared with APSED)	– Adequate
	6.6. Response logistics	– Broadly addressed, however specifics such as stockpiling, staff movement, mobilizing processes or 'how to do it' not addressed	– **Inadequately addressed**
	8.1. Clinical case management	– Partially available, doesn't capture all aspects	– **Inadequately addressed**
	6.7. Health care facility preparedness and response	– How prepared are the health care facilities, is prepared is not included	– **Inadequately addressed**
7. Regional Preparedness, Alert and Response	7.1. Regional surveillance and risk assessment	– None under the IHR checklists	– **Inadequately addressed**
	7.2. Regional information-sharing system	– None	– **Inadequately addressed**
	7.3. Regional preparedness and response	– Nonce	– **Inadequately addressed**
8. Monitoring and Evaluation	1.1. Country-level monitoring (including workplan and APSED/IHR indicators)	– Need for harmonization between national plan for IHR or National plan for APSED	– **Inadequately addressed**
	1.2. Regional level monitoring: Technical Advisory Group	– Missing by nature – No indicators to monitor regional level activities	– **Inadequately addressed**
	1.3. Evaluation	– Missing by nature – No indicators to monitor regional level activities, or if TAG recommendations were implemented	– **Inadequately addressed**

ANNEX 5: GROUP DISCUSSION 2 – IDENTIFYING POSSIBLE PERFORMANCE INDICATORS

Possible Performance Indicator: a preliminary list
A. % of events where the national and international experts at country level agree that the time from onset of initial case (or "index case") to [laboratory] confirmation of the pathogen was adequate *(* standard will be different for every outbreak pending on location &lab capacity)*
B. Number of events of potential international concern that were notified to WHO from the National IHR Focal Points in the past 12 months – Number of these that were notified within 24 hours? – Number of these that were infectious disease events? – What lessons were learnt, and how could these results be improved (qualitative answers acceptable)
C. Average time from verification request from WHO to provision of information from IHR NFP
D. Proportion of urgent events with timely risk assessment carried out at national level within 48 hours
E. Proportion of risk assessments in the past 12 months that utilized gender disaggregated data
F. Proportion of events identified by the EBS in a country where risk assessment is done and documented within 48 hours of the event being reported
G. % of investigations done by national RRTs where investigation results are shared either formally or informally with WHO (e.g. Country Office team)
H. Number of events that met the national standard definition/criteria for further investigation after a risk assessment – Number of these events that were followed by a rapid response (within 48 hours) – Proportion of responders to these events that were women/men?
I. Proportion of events to which a rapid response (<48 h) occurs if the event meets the national standard definitions/criteria for further investigation after a risk assessment
J. % of RRT teams units [in each country **OR** at national or provincial level] where at least one member of the RRT team has completed FETP or modified FETP course
K. Proportion of outbreaks/events of national or international concern in the last 12 months where [the risk communication plan was implemented **OR** populations and partners were informed of a real or potential risk within 24 hours following confirmation of the event]
L. Satisfaction of media and public on government's risk communication during an outbreak
M. % of countries (routinely) collecting age and gender disaggregated surveillance data
N. Number of surveillance updates published on MOH website in English
O. Number of regional surveillance reports on priority diseases (such as dengue) published
P. % of countries who report surveillance data on priority diseases on an annual or semi annual frequency to WPR regional or country offices (excluded are HIS data which are collected by HSS). Priority diseases to be identified in a consultative manner with some countries where the disease is not present to be excluded for those diseases)
Q. Number of outbreaks or event investigations published (within the next 5 years)
R. Review of selected outbreaks detection and response by expert group (proportion of outbreaks with perceived satisfaction)
S. Proportion of outbreak of priority diseases with laboratory confirmation
T. The national public health emergency plan: – Is funded – Is reviewed – Is exercised – Has Risk Communications component – Has Response Logistics component

ANNEX 6: GROUP DISCUSSION 4 – PRIORITIZING PERFORMANCE INDICATORS

Performance Indicator	Analysis and Comments
(1) Proportion of urgent events in the past 12 months with risk assessment carried out at national level – Number of urgent events reported in the past 12 months – Proportion of urgent events with risk assessment carried out – Proportion of these with risk assessment carried out within 48 hours of receiving the reports – Proportion of these with risk assessment that utilized sex disaggregated data – What lessons were learnt, and how could the quality of risk assessment be improved?	**Advantages** – It can be a "SMART" indicator (see Box 1). – It can address three out of five of APSED objectives: early detection, rapid response and preparedness – Relevance: This indicator can measure the combined capacities of surveillance, response, laboratory and risk communication etc. – Measurable: figures can be shown as a “proportion”. Denominator is clear – Achievable: Does not require additional resources, information is normally available such as surveillance reports, outbreak investigation reports etc. – Risk assessment is a priority component of APSED (2010) Focus Area that needs to be further strengthened in the coming 5 years – Can cover both qualitative + quantitative aspects **Limitations** – Difficult to standardize the definition of "urgent events" among countries (it will be based on national guidelines) – Not mentioning the capacity at the sub-national level (it may need extra data collection)
(2) Number of events in the past 12 months that met the national standard definition/criteria with further investigation conducted after a risk assessment – Proportion of these followed by a rapid response within 48 hours at national level – Proportion of these with technical support from WHO – What lessons were learnt, and how could these results be improved?	**Advantages** – Meets the guiding principles (see Box 1) – Can address multiple APSED objectives (2, 3, 4 and 5) – Emphasis on "timely" response to outbreaks and urgent events – Reflect the combined capacity of risk assessment, rapid response, laboratory, risk communication, infection control and clinical management, regional preparedness and outbreak response etc. – Covers both qualitative + quantitative aspects – Disaggregated data collection brought up as a setting of a higher bar – Lessons learnt is important and captured – feeds into M&E ‘process’ of a country **Limitations** – Need clear decision-making process and mechanism – Data availability in some countries

Performance Indicator	Analysis and Comments
(3) Number of surveillance and response updates published on an official website (especially MOH website) in English	**Advantages** – It is specific, clear and precise – easy to measure. – This indicator contributes to all APSED 2010 objectives – Reflects the combined capacity of surveillance, risk assessment and response, laboratory, risk communication and regional preparedness, alert and response – The indicator facilitates sharing of information among the region and ensures political commitment, transparency and accountability – It facilitates sharing of country experience and lessons learnt in capacity building – This may also contribute to increase gender awareness through gender analysis **Limitations** – Language barriers (need translation cost and support in some countries) – Need to have technical support (e.g. guideline and writing skills etc)
(4) Number of events of potential public health emergency of international concern that were notified to WHO from the National IHR Focal Points in the past 12 months – Proportion of these that were notified within 24 hours of assessment – Proportion of these that were infectious disease events – What lessons were learnt, and how could these results be improved	**Advantages** – Definable (#events notified within 24 hours/total # potential PHEIC). The IHR decision instrument or tool is available to provide four criteria to assess such events. – In line with APSED objectives 2, 3, 4, 5 – Data is easily available from both the country and WHO – It measures the combined capacity of event detection (surveillance system), risk assessment capacity, investigation/verification. – It allows the comparison of progress over time – Provides an opportunity for the strengthening of the function of the NFPs and interagency collaboration (e.g. information sharing and coordinated or joint assessment) **Limitations** – Difficult to compare across countries – Difficulty to have clear cut of "24 hours of assessment"
(5) Average time from verification request from WHO to provision of information from IHR NFP	**Advantages:** – Definable – In line with APSED objectives 2, 3, 4 and 5 – Data is easily available from both the country and WHO **Limitations** – Mainly measure the performance of the IHR NFP

Performance Indicator	Analysis and Comments
(6) Number of outbreaks or events annually reviewed by expert group – Proportion of outbreak with perceived satisfaction by expert group – Number of reports available to document review progress, experiences and lessons learnt, and plans for improvement	**Advantages** – It can be a "SMART" indicator (see Box 1). – It can address multiple APSED objectives (1, 2, 3, 4, 5) – It measures the combined capacity of surveillance, risk assessment, response, field epidemiology training programme, risk communication, zoonoses collaboration (if it is a zoonoses outbreak), infection control, public health emergency preparedness, and WHO regional preparedness and response system) – More qualitative approach with more in-depth information to be obtained – Shows transparency and team work – Long-term benefits to enhance the programme **Limitations** – Requires technical guidance on the review (national capacity), especially at this beginning. – Time consuming – May be politically and/or culturally sensitive in some counties