



Asia Pacific Strategy for Emerging Diseases (2010): **Progress Report 2011**

WHO Regional Offices for South-East Asia and Western Pacific



WORLD HEALTH ORGANIZATION





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INTRODUCTION

The Asia Pacific Strategy for Emerging Diseases (APSED) was designed to promote public health security through preparedness planning for, prevention and early detection of and rapid response to emerging diseases and other public health emergencies.

APSED (2010) lays out a clear path for countries to work towards a common goal. The Strategy promotes a collaborative approach, bringing together all partners in health security and fostering cooperation across focus areas. The Strategy was designed by front-line stakeholders to be practical, by adopting sound underlying principles and taking into account specific needs of the regions. All proposed activities are practical and achievable, and progress is measurable.

The following report summarizes progress made in each focus area in the first year of implementation of APSED (2010) against a five-year workplan. The report addresses cross-cutting issues, captures key achievements and challenges, and documents lessons learnt.


RESULTS

Focus Area 1: Surveillance, risk assessment and response

Early interventions triggered by early detection and assessed risk of potential outbreaks and other public health events are the basis for public health security. It is envisioned that in five years all Member States will be able to demonstrate that their surveillance, risk assessment and response systems provide timely and accurate information that enables an evidence-based approach to decision-making for public health action.



In the Western Pacific Region, efforts have focussed on developing key regional systematic risk assessment tools and methodologies and establishing clear risk assessment functions within ministries of health. At the regional level, efforts have concentrated on designing a population and geographically representative system for indicator-base surveillance (IBS), while continuing to improve sensitive, rapid, event-specific information from operational event-base surveillance (EBS), and strengthening field epidemiology training (FET) as an effective capacity-building tool for public health professionals.




Steady progress has been made in improving risk assessment capacity in the Western Pacific Region. Achievements have been reported in the identification of departments and personnel assigned to risk assessment within the ministry of health. In Viet Nam, the risk assignment function has been assigned to the General Department of Preventive Medicine within the Ministry of Health, while in the Lao People's Democratic Republic, the National Centre of Laboratory and Epidemiology has been assigned as the agency responsible for risk assessment of human health outbreaks and acute public health events. Challenges have been identified in assisting countries in internalizing the concept of risk assessment and embedding it into routine activities. Adaptation of training materials to the local context and effective use of relevant case studies could help countries to overcome these challenges.


Key results include a nationwide roll-out of a revised IBS system in Cambodia, with improvements in timeliness, comprehensiveness and adherence to case definitions. A number of countries including the Lao People's Democratic Republic have conducted consultations on IBS and priority diseases, and have revised and aligned case definitions across IBS systems. In other countries, including Mongolia, active consultations on updating IBS systems are still in progress. Agreeing on case definitions has been a common challenge; experience has shown that consultations with clinicians and laboratory specialists are instrumental in this regard and should not be underestimated.

Some countries, including China, have made significant advances in utilizing information technology (IT) systems to support data capture, archiving and reporting for IBS diseases. In China, an Internet-based platform for data collection has been developed, and the first comprehensive assessment of the web-based national notifiable diseases reporting system was completed in 2011.

In the WHO South-East Asia Region, all 11 countries have lists of priority diseases, conditions and case definitions for surveillance, and have units designated for surveillance of public health risks. In addition, 10 of the 11 countries analyse surveillance data on epidemic-prone and priority diseases at least weekly at national and subnational levels. However, more work needs to be done to strengthen detailed analysis of data, for example, to monitor trends and establish thresholds at community level for priority events.

At the country level, capacity for detecting and assessing the risk of acute respiratory infections, influenza-like-illness (ILI) and severe acute respiratory infection (SARI) was strengthened in 2011. Several indications of progress have been reported. In Bhutan, for example, the national influenza laboratory recently submitted a request to start the process of designation as a WHO-recognized National Influenza Centre. In Indonesia, the Early Warning Alert and Response System (EWARS) has been implemented in nine provinces, ILI has been surveillance established at 20 sentinel sites and SARI surveillance has been established in 10 sentinel sites. Also in Indonesia, the Field Epidemiology Training Programme (FETP) has been revitalized to strengthen the public health workforce in surveillance and epidemiology, and district surveillance officers and health managers from 33 provinces have been re-trained in emerging and re-emerging disease surveillance and outbreak response. In Timor-Leste, steady progress is being made to strengthen the epidemiological capability of the Ministry of Health to underpin surveillance activities (two officials have completed field epidemiology training and one is currently enrolled in FETP in Indonesia). However, in this country, human resource capacity and development are significant constraints.





Progress has also been made in strengthening integrated disease surveillance, outbreak investigation and response by offering training for all district public health officers and community health centre managers. The quality and utilization of disease surveillance data at the health facility and district levels have been improved in three districts, and the national manual on integrated disease surveillance and response is currently being revised. A National Committee for Disease Outbreak Control has been formed and work is being undertaken to create a platform to collect, improve access to and analyse surveillance data. In Nepal, national consultation meetings were held in 2011 to initiate and define structural components of integrated disease surveillance. In addition, a National Policy on Integrated Disease Surveillance was developed, and a National Steering Committee and Technical Working Group were formed. In Bangladesh, strategies and guidelines for the integrated disease surveillance system have been updated, and a plan of action with standard operating procedures (SOPs) and updated reporting forms has been developed. In Thailand, the core capacity requirements of the International Health Regulations (IHR) were strengthened by intersectoral collaboration between provincial/district rapid response teams and public health authorities at points of entry.


In January 2011, a global guideline called “Rapid Risk Assessment of Acute Public Health Events” was developed and published online with significant input from the WHO South-East Asia and Western Pacific Regional Offices; related training materials are being developed and the WHO collaborating centre in the Bureau of Epidemiology, Thailand, has agreed to support the delivery of a Regional Training of Trainers Workshop on Event Surveillance and Risk Assessment for WHO staff and national participants. This guideline and workshop are expected to provide key support for the establishment of designated focal points for risk assessment within ministries of health and National IHR Focal Points.

In Timor-Leste, the risk assessment function has been allocated to a unit and an individual within the Ministry of Health. To date, two formal risk assessments have been undertaken (one on zoonotic infections and another on avian influenza). However, more work is necessary to establish a system robust enough to allow the systematic identification of risk (i.e. before assessment can take place). In Thailand, surveillance linkages between IHR and the International Food Safety Authorities Network (INFOSAN) have been recently strengthened through the development of a roadmap for food safety risk assessment.

Focus Area 2: Laboratories

Efficient and reliable public health laboratories are an essential part of any public health system that aims to effectively respond to emerging diseases. Most Member States in the Asia Pacific region have some form of public health laboratory system supporting public health services, but these laboratory systems are often disease-specific. It is envisioned that in five years all Member States will have an efficient public health laboratory system for the early detection of known pathogens or hazards and capacity for the early identification of unknown/novel pathogens or hazards.

With APSED (2010), public health diagnostic laboratories may exist at the subnational and national levels if supported by a national or regional public health reference laboratory system. As a first step, in the Western Pacific Region, an inventory of national laboratory capacities was completed in 2011.



To support Member States to establish public health laboratory systems, a guidance document describing the role of public health laboratories for alert and response is being developed. Since quality assurance is a crucial aspect of this system, an international external quality assurance programme (EQAP) for emerging diseases will be established. To lay the foundation for EQAP, a pilot study for the molecular diagnosis of dengue has been conducted in Viet Nam and the Philippines. Lessons learnt from this pilot are being applied to the establishment of EQAP to cover all dengue-endemic Member States in the Western Pacific region.



China set up a national Influenza laboratory network in 2011. Similarly, Cambodia, with national laboratory policies and strategies already in place, has taken steps to develop a national laboratory network. In the Lao People's Democratic Republic, a National Health Laboratory Policy has been drafted to address public health diagnostics, while national-level coordination for laboratories remains a challenge.

In the South-East Asia Region, all countries have basic capacity to use polymerase chain reaction (PCR) for diagnostic purposes, and regional laboratories have been identified to provide additional diagnostic services for less common infectious diseases. Currently, relatively few countries have diagnostic laboratories certified or accredited to international standards. In addition, only a few countries have conducted laboratory biorisk assessments. Although laboratory professionals have been trained in biosafety and biosecurity, much more needs to be done to strengthen regulations, policies and strategies to implement guidelines. At the regional level, a meeting was organized in Bangkok in 2011 to discuss laboratory-based disease surveillance and forge regional networks of laboratories for priority emerging infectious diseases (EIDs). Furthermore, a regional network of laboratories known as LabNet has been established in the South-East Asia region.

At the national level, India has developed a protocol to identify human health and animal health laboratories with relevant diagnostic capacity for EIDs and zoonoses, and has plans to develop criteria for designation of reference laboratories. In Indonesia, a laboratory information management system (LIMS) has been developed at the National Institute of Health Research and Development (NIHRD). Also, a national laboratory road map has been developed, and a network of 44 laboratories dealing with emerging and re-emerging infections has been established. Laboratory staff have been trained in PCR, biosafety and biosecurity, and an established quality assurance programme continues to conduct annual assessments. In Timor-Leste, recognition of the pivotal role laboratory diagnosis plays in outbreak detection and response has been growing. The National Health Laboratory (NHL) in Dili is intended to serve as a national public health reference laboratory, but current capacity is limited by staff inexperience and lack of education and training opportunities. In 2011, a laboratory twinning initiative between NHL and University of Sydney was established to help strengthen local capacity. Preparations have been made for biosafety training (BSL1 to

BSL2) in first quarter of 2012. However, much work remains to be done to draft and operationalize policies and procedures. In Nepal, progress was made towards the establishment of a National Influenza Centre laboratory, including training on influenza virus culture and characterization.

Focus Area 3: Zoonoses

Zoonotic diseases account for approximately 75% of emerging infectious diseases, a proportion that is expected to increase according to trends in recent years. It is envisioned that in five years Member States will have a functional coordination mechanism for zoonotic diseases that will enable sharing of surveillance information, coordinated risk assessment and response and development of risk reduction strategies through collaborative approach.


At the regional level, the Food and Agriculture Organization of the United Nations (FAO), the World Organisation of Animal Health (OIE) and WHO have established a tripartite mechanism to coordinate and implement activities for surveillance and response of zoonotic diseases at the human–animal interface. A series of regional workshops were organized jointly to advocate a “One Health” approach for surveillance, response and research of EIDs and zoonoses. Also noteworthy is the very close collaboration of WHO

with the Secretariats of the Association of Southeast Asian Nations (ASEAN) and the South Asian Association for Regional Cooperation (SAARC) to strengthen surveillance and response capacity and cross-border collaboration for highly pathogenic emerging diseases.



In the WHO Western Pacific Region, these mechanisms have already helped to establish routines for sharing essential information between key animal and human health stakeholders for epidemiological surveillance and response. The number of countries with established coordination mechanisms for zoonotic diseases has also grown. In April 2011, the President of the Philippines formally established the Philippines Inter-Agency Committee on Zoonoses. In Cambodia, the Zoonoses Technical Working Group was established with the participation of the Ministry of Agriculture, Forestry and Fisheries, Ministry of Health, FAO, OIE, WHO and the Wildlife Conservation Society. A draft national zoonoses policy and plan were developed and are currently subject to formal approval. A formal agreement between the two ministries has been signed, with clear identification of roles and responsibilities. In Viet Nam, a ministerial circular was issued to guide coordination and

collaboration among different units within public health and animal health sectors in the prevention and control of zoonotic diseases. The Lao People’s Democratic Republic has also succeeded in establishing an animal–human collaboration mechanism, which has been approved at central and provincial levels and



operationalized with contact lists and SOPs developed for all 17 provinces. One key common challenge has been ensuring functionality of the newly introduced mechanism. For most countries, though it is premature to conclude, it is expected that close collaboration among multisectoral stakeholders through regular consultation and joint training, and support to priority zoonoses will be instrumental in building trust and establishing long-lasting sustainable coordination for zoonotic diseases.


All countries in the South-East Asia Region have established a coordination mechanism between animal and human health sectors for the detection of and response to zoonotic events, but functionality has been influenced by the prevalence of some diseases, for example, outbreaks of avian influenza, anthrax and other zoonotic diseases of common interest. The majority of countries have prioritized zoonotic diseases of national importance and have access to national or international laboratories to confirm priority zoonotic events.

At the country level, Indonesia has transformed its avian influenza coordination committee (KOMNAS) into the National Zoonoses Commission to address emerging and zoonotic diseases of national importance. A strategic plan has also been developed for NIHRD to become a WHO collaborating centre, focusing on technical areas of work related to the human–animal interface and involving both animal and health sectors. In addition, integrated surveillance performed by the human health and animal health sectors has been strengthened. At the local level, district surveillance officers in the human health sector have conducted joint avian influenza field investigations with participatory disease surveillance and response (PDSR) officers in the animal health sector. In addition, India has developed a plan to make an institutional arrangement for surveillance of priority zoonotic events at state and district levels. In Timor-Leste, a coordination mechanism between the Ministry of Agriculture and the Ministry of Health has been established and is supported by decree law; however, few events have occurred to test its functionality. In 2009 and 2010, joint outbreak investigations and response training involved players from both ministries, and more recently, several joint outbreak verification investigations have been conducted in response to H5N1. Significant challenges include the lack of an animal surveillance system and limited laboratory capacity to diagnose human infections.

Focus Area 4: Infection prevention and control

Establishing effective infection prevention and control (IPC) practices in health care settings is essential for reducing the risk of nosocomial transmission and preventing exposure of entire communities to the danger of infection, particularly in emerging disease outbreaks. Health care facilities without solid IPC practices are part of the problem rather than solution in outbreaks and public health emergencies. It is envisioned that in five years IPC will become an integral part of the national health care systems, with IPC resource centres set up in each country to support health care facilities in strengthening routing IPC practices in outbreaks.

In the WHO Western Pacific Region, Member States have made important progress in establishing national organizational structures (e.g. national multidisciplinary IPC committee) and ensuring their functionality with the development of country-specific national IPC policies, technical guidelines and training tools.



However, overall, IPC has not yet become an integral part of health care facilities. With the implementation of APSED (2010), emphasis will be placed on establishing national IPC resource centres that will be used for routine IPC and can be built on and expanded during outbreaks.

In Cambodia, a national IPC working group was established and national IPC policy, plan and guidelines were developed, approved and put in place. A rolling programme of staff training has been put in place along with a rolling programme of providing IPC tools to practise the skills acquired through training. In Viet Nam, with oversight provided by a national multidisciplinary expert committee, the National Infection and Prevention and Control Master Plan (2011–2015) was developed and approved. The Lao People's Democratic Republic has succeeded in setting up a National Infection Control Committee at the central level and hospital infection control committees (HICC) in central and provincial hospitals, supported by a dedicated IPC training unit equipped with a newly developed national IPC training package.

In the South-East Asia Region, considerable work needs to be undertaken to strengthen capacity for IPC. However, although not all countries have multidisciplinary IPC committees, only Timor-Leste does not have national IPC policies and operational plans. To help address this gap, work was undertaken between August and December 2011 to establish a national infection control unit at the National Hospital. Its purview is to develop the functions, tasks and responsibilities of and/or for infectious control practices in the hospital. The Ministry of Health is currently reviewing the unit's work. IPC training has been conducted; however, translating the lessons into practice within health care settings across Timor-Leste remains a big challenge. In Thailand, the National IPC Committee, established many years ago, had become relatively inactive. However, following a study tour and a subsequent national meeting, a number of activities took place in 2011 supported by a WHO collaborating centre in Hong Kong (China), resulting in the revitalization of the committee and the development of a national IPC training course and curriculum. In Bhutan, with the support of WHO, work began in 2011 on the development of a national plan to strengthen IPC capacity at all levels. In Indonesia, a national IPC working group has been established. In addition, a national IPC technical guideline and an IPC managerial guideline have been developed, along with an IPC practical handbook and a guideline for surveillance of hospital acquired-infections. IPC has been included in hospital accreditation system indicators, and IPC committees have been established in 100 avian influenza referral hospitals. In addition, negative pressure isolation rooms have been established in 10 avian influenza referral hospitals with WHO support in partnership with United Nations Office for Project Services (UNOPS).



Focus Area 5: Risk communication

Effective communication is critical in managing emerging infectious diseases and other public health threats, particularly in the early stages when decisive actions have to be taken in times of uncertainty. It is envisioned that in five years all Member States will have functional risk communication mechanisms as well as an institutionalized risk communication structure within the ministry of health. With these mechanisms in place, it is expected that the ministry of health will have the capacity to engage the media, public and other stakeholders in sharing information in a timely and transparent manner, minimizing public unrest and increasing public trust and confidence in government officials when communicating on public health emergencies.

In the WHO Western Pacific Region, in 2011, Member States focused on enhancing structural arrangements and coordination for risk communication by identifying focal points/teams, and developing appropriate SOPs for health emergency communications. At the regional level, mechanisms for developing national capacities have been established, in line with national needs and capacity gaps.

In the Philippines, the National Center for Health Promotion, Department of Health, has finalized planning for risk communication including the identification of appropriate spokespersons at the local level. In Cambodia, a draft risk communication plan for pandemic influenza currently awaits ministerial approval. In the Lao People's Democratic Republic, focal points and teams for risk communication have been identified at the Center for Information and Education for Health and a national risk communication plan is being developed. In Viet Nam, a newly established subcommittee on risk communication, with a focal point for risk communication identified, has been mobilized for the recent outbreaks in the country.



Major challenges identified by Member States have included the absence of an operational framework and structure for risk communication within the ministry of health, lack of long-term risk communication plan to better manage public health outbreaks, a relative difficulty in articulating risk communication vis-à-vis health education and health promotion, and reactive communication arrangements between human health and animal health sectors during public health outbreaks of zoonotic origin.

In 2011, countries in the South-East Asia Region also focussed on enhancing structural arrangements for risk communication. To date, all 11 countries have identified risk communication partners and stakeholders and have “spokespersons” in place for public health emergencies. Ten

of the 11 countries have developed risk communication plans, and seven countries (Bangladesh, Democratic People's Republic of Korea, Indonesia, Myanmar, Thailand and Timor-Leste) have also developed SOPs, policies or guidelines on the release of information during a public health emergency.

In Maldives, these arrangements were strengthened when the country faced its worst outbreak of dengue in five years, in 2011. Response was coordinated through a task force consisting of stakeholders such as the Ministry of Health, Ministry of Home Affairs and Environment, and Maldives National Defence Force, in collaboration with nongovernmental organizations (NGOs) like the Maldivian Red Crescent Society. A senior health official conveyed information to the media. With WHO support, stakeholders – from municipal workers to NGOs and the media – were trained in communications for behavioural impact (COMBI) for dengue. Subsequently, a network involving the participants was established, but it has not been active. In Thailand, spokespersons for public health emergencies have been identified in every department of the Government, and risk assessment and risk communication are being incorporated as core components of every public health response plan. There are plans to establish a specific health risk communication team. In Indonesia, a national risk communication plan has been developed along with SOPs, policies and guidelines. Risk communication materials for avian influenza have also been developed, including an instruction manual for community empowerment, posters and leaflets. A COMBI project on avian influenza has also been initiated in Central Java. In India, a Task Force on Risk Communication for Avian and Pandemic Influenza has been established within the Ministry of Information and Broadcasting. This task force has reviewed the national risk communication and media plan. In Timor-Leste, although good progress had been made to increase the capacity of national communication staff, mostly in relation to pandemic (H1N1) 2009, this momentum waned somewhat in 2011. At present, the Ministry of Health does not have a strong public information or risk communication section and there remains a challenge to develop and operationalize a risk communication plan as well as SOPs, policies or guidelines on the release of information during a public health emergency.

In all countries, the key challenge remains coordinating risk communication by ensuring that the task forces and networks respond effectively during an emergency. Risk communication workshops and simulation exercises are being planned to strengthen this area.

Focus Area 6: Public health emergency preparedness



National preparedness for responding to acute public health emergencies is vital to mitigate negative impacts not only on health, but also economic and social development. It is envisioned that in five years Member States will have an overarching, flexible national public health emergency preparedness and response plan and a national command and control coordination structure for health response, which is supported by a functional emergency operations centre (EOC) within the health sector. The key components of preparedness activities include public health emergency planning, strengthening the National IHR Focal Point

functions, points-of-entry preparedness, response logistics, clinical case management and health care facility preparedness and response.

In the WHO Western Pacific Region, the focus has been on retaining attention to pandemic influenza preparedness and response plans. It has been a clear choice to build generic public health emergency preparedness and response plans based on lessons learnt from the pandemic influenza experience without losing the “pandemic influenza” expertise.


In the Lao People’s Democratic Republic, a National Plan for Public Health Emergency Preparedness and Response was drafted, and three Hospital Preparedness for Emergencies (HOPE) training workshops were conducted. In addition, SOPs for outbreak deployment have been developed for rapid response teams that include clinical experts. In Viet Nam, as part of preparedness activities, a hospital exercise module including mass casualty management was developed and used in training conducted in a number of hospitals.

With the aim of testing and maintaining the functions of the National IHR Focal Points and the WHO IHR Contact Point, an annual regional exercise called “IHR Exercise Crystal” was conducted in December 2011. The two-day intensive exercise, in which Member States of the WHO Western Pacific Region participated, successfully validated the accessibility of the National IHR Focal Points through various means of communication, and tested their assessment of public health events and notification process according to IHR (2005).




In the WHO South-East Asia Region, a detailed assessment tool for preparedness and response, known as “Benchmarks, Standards and Indicators for Emergency Preparedness and Response”, has been used to comprehensively assess capacities in emergency preparedness and response in Bangladesh, Indonesia, Myanmar and Nepal. Other countries are scheduled to complete their assessments by June 2012. Results of these assessments will be used as the basis for national planning and preparedness, but to date, this process has been taken forward only in Nepal. In addition, assessments of national logistics arrangements were undertaken in 2011 in Bhutan and Myanmar, both of which have updated SOPs for stockpile mobilization. It is expected that the results will be used to feed into the process of developing the proposed guideline on establishing response logistics within the health sector.

At the national level, in July 2011, a recently developed pandemic assessment tool was used in the Democratic People’s Republic of Korea to assess the national response to pandemic influenza A(H1N1) 2009 in the context of IHR. Following the assessment, steps were taken to revise the national pandemic plan, including an element related to logistics. Significant progress has also been achieved in Indonesia. The Director General of Disease Control and Environmental Health has been assigned as the National IHR Focal Point (and is routinely reporting public health events to WHO) and a national multisectoral IHR (2005) implementation committee has been established. A national guideline has been developed to define the



necessary core capacities at points of entry, and IHR training has been organized for the chief of the Sub Directorate of Surveillance and Outbreak Response and staff in the Ministry of Health and at points of entry. Training for port health officers at 20 strategic points of entry has been conducted, and a model for “in-service” IHR training for port health officers has been set up. Training has been conducted for hospital staff on avian influenza case management and for primary health care staff on early detection and treatment. Guidelines on pandemic preparedness and response and pandemic containment have been developed, and containment contingency plans have been developed in 10 high-risk provinces. Training modules on pandemic preparedness in health care facilities have been prepared, and a national pandemic influenza vaccine deployment plan has been developed. In Timor-Leste, progress was made in the strengthening of the National (IHR) Focal Point functions and points-of-entry preparedness. Staff were recruited to work in port health (an IHR coordinator and one port health officer in each of the air, sea and land crossings); two study tours involving Ministry of Health staff were supported to learn about port health facilities in Jakarta and Surabaya. In addition, the country’s first port health offices were established at a seaport and an international airport. The Ministry of Health conducted an interministerial workshop on IHR implementation, and an assessment mission to review IHR laws and regulations was undertaken between 11 and 15 April 2011. In addition, a simulation exercise on health aspects of emergency preparedness and response was undertaken, and health cluster contingency plans were reviewed and updated. In Thailand, with support from WHO, the International Communicable Disease Control Unit at Suvannabhum International Airport conducted a short training course for two fellows from Maldives. In addition, the Migrant Health Project has strengthened the surveillance system in all nine temporary shelters along the Thai-Myanmar border by revising the current disease surveillance guidelines.

In Bangladesh, significant progress has also been made. A number of IHR committees are being formed, including a National IHR Coordination Committee, a National IHR Technical Committee, and a National IHR Core Group. Formation of coordination committees and competent authorities with terms of reference for the proposed designated points of entry are now at the approval stage. A review of national legislation, regulations and other instruments to support IHR (2005) implementation has recently been undertaken, and a new law has been drafted in relation to implementation of IHR. The core alert and response capacities of health facilities and ports were assessed in 2009 and 2011, and strategies, guidelines and SOPs for IHR (2005) and for the management of public health events of international concern (PHEIC) at points of entry have been developed. There has also been advocacy with multisectoral partners for implementation of IHR (2005) at all levels including points of entry. The Shahjalal International Airport, the Port of Chittagong (seaport) and Benapole land port have all been designated as points of entry with concurrence of relevant ministries, including Ministries of Civil Aviation, Shipping and Customs (approved by the Director General of Health Services and pending approval by the Ministry of Health and Family Welfare). A “Second National Avian and Pandemic Influenza Preparedness and Response Plan, Bangladesh: 2011–2016” in the context of IHR (2005) was also finalized.



Focus Area 7: Regional preparedness, alert and response

APSED (2010) envisions a regional system developed to provide quality services in monitoring and alerting emerging diseases and acute public health emergencies, producing risk assessment products, supporting rapid response through its enhanced global and regional networking and sharing relevant information.

In 2011, a tool for systematic event screening risk assessment was first piloted and consequently established for daily use at the regional level. The tool was also implemented in the Lao People's Democratic Republic. Progress has been made in the testing of rapid risk assessment tools for acute public health events with the intention of adding them to systematic risk assessment at the regional level in the near future.

The Pacific Syndromic Surveillance System, a simplified surveillance system for outbreak detection, has been expanded to cover all 22 Pacific island countries and areas. Reports have been received on time from on average of 19 countries and areas each week. A surveillance summary (IBS) with an overview of current events (EBS) is disseminated every Thursday on PacNet. The system has been operational for 18 months and has proven to be a success—resulting in a seven-fold increase in outbreak detection and reporting according to an independent external review. For many Pacific island countries and areas, this has been their first timely and functional surveillance system.



The first year of APSED (2010) was a year of recognition and growth for the newly established open access online journal, Western Pacific Surveillance and Response (WPSAR). The goal of the journal is to create a platform for timely information sharing within the Western Pacific region and globally to enhance surveillance and response activities.

The concept of a Regional Emergency Operations Centre was developed in consultation with key partners, including the United States Centers for Disease Control and Prevention (CDC). Ensuring timely sharing of information on the surveillance of and response to public health events by countries at the regional level is expected to be a critical point.

In the South-East Asia Regional Office, work was commenced in 2011 and continues in 2012 to review and refine SOPs for event surveillance, risk assessment and event response and management. This work will be supported by a dedicated software package and links to the internal WHO Event Management System. Procedures will be harmonized with the unit responsible for responding to natural disasters, and will be tested through table-top and simulation exercises.

Focus Area 8: Monitoring and Evaluation

Monitoring and Evaluation (M&E) is a new focus area for capacity-building under APSED (2010) and is an integral component of its implementation. It aims at meeting accountability and learning needs; it is led and owned by Member States; and it is integrated with other existing M&E systems (e.g. IHR monitoring or those of other donor or partner programmes) to achieve harmonization and synergy in monitoring, evaluation and reporting to reduce duplication of efforts. Central to the successful implementation of a country-owned M&E system is the establishment of an integrated national and regional planning and review process. The process proposed by APSED (2010) includes the formation of a national-level M&E team represented by each focus area, regular national-level planning and review meetings with participants from each APSED focus area and other in-country stakeholders, as well as a regional forum (e.g. annual TAG meeting) that brings together Member States, WHO, donors and partners to review regional progress, discuss common issues and recommended priority actions. In order to monitor the progress of implementation in countries, several workplan milestones, IHR monitoring indicators and six supplementary APSED (2010) performance indicators are utilized, as data collection, verification, analysis and reporting are coordinated by the national M&E team.

In late 2011, the WHO Regional Office for the Western Pacific developed a draft guide to assist Member States in establishing an integrated planning and review process. A number of countries, including Cambodia, the Lao People's Democratic Republic, Mongolia and Viet Nam, have been planning M&E work and establishing an integrated planning and review process. Ensuring harmonization and standardization among different partners working on APSED focus areas has been identified as a major area of challenge; however, the development of a national M&E workplan and the organization of planning and review meetings as a forum to bring all relevant in-country partners together should facilitate the process.

In the WHO South-East Asia Region, only two countries, Indonesia and Timor-Leste, have developed implementation plans based on APSED (2010), although other countries (for example India) have used the APSED framework to inform the development of plans to confront EIDs. In addition, Thailand is also in the process of formulating a new national strategic plan for preparedness and response to EIDs using IHR, One Health, and the APSED framework as important references. In addition, to supplement and inform APSED monitoring, comprehensive 2011 monitoring data on the implementation of IHR are available from all 11 countries in South-East Asia and are being used to monitor progress against APSED objectives. In addition, based on formal and informal communication, it is now expected that all countries in the South-East Region will request a two-year IHR (2005) implementation extension plan; significant work is being undertaken to advocate for and support the development of plans based on APSED, including the supplementary indicators. At the country level, in Indonesia, an IHR monitoring framework (a checklist format for supervision, monitoring and evaluation) has been developed at various levels of governance.



Mainstreaming gender

APSED (2010), through its implementation, aims to address and enhance gender mainstreaming by: (1) supporting and participating in relevant advocacy and awareness activities; (2) participating in gender mainstreaming initiatives that have clear implications for addressing emerging diseases; and (3) addressing gender through the identification and implementation of specific actions where appropriate, given its importance in relation to emerging diseases.



Reports from Member States have highlighted gender-mainstreaming efforts in the areas of data collection in surveillance and outbreak investigation (Cambodia) and organization of gender surveillance studies on dengue and acute watery diarrhoea (National Centre of Laboratory and Epidemiology, Lao People's Democratic Republic) and ensuring equal gender representation in the field epidemiology training courses.

In Indonesia, some work on gender mainstreaming has been undertaken. Achievements in 2011 include the development of a "Gender Responsive

Health Care Guideline" for Ministry of Health staff and the translation, printing and distribution of a book, Addressing sex and gender in epidemic-prone infectious disease, among echelon 1 and 2 Ministry of Health staffs.

Some Member States have acknowledged challenges in implementing emerging disease programmes if gender mainstreaming is not seen as a priority while other social and environmental factors and needs seem to gain wider acceptance. It was also found difficult to instigate substantial change in individual behaviour or attitudes through promoting equal gender ratios in meeting/training participation or gender disaggregated data collection and analysis.

Suggestions made by countries for mainstreaming gender in emerging disease programmes include the effective use of study results for advocacy and reviewing policies at their early development stages against WHO regional and global guidance documents to embed gender considerations.




CONCLUSIONS

The first year of APSED (2010) implementation was devoted to planning. Most countries have established national planning and review processes and have succeeded in developing national APSED workplans by adapting APSED (2010) across eight focus areas.

The most common issues unaccounted for by countries were the vertical structures of ministries and other relevant sectors that hinder multisectoral collaboration.

The APSED framework has gone a long way in bringing partners together, working as a team, breaking silos, often co-sharing funds and preventing duplication of resources. However, the practice of setting up individual projects, sometimes parallel but not necessarily complementary to APSED workplans, remains. Oftentimes, these projects have independent monitoring and evaluation mechanisms, and are driven by individual donor interests and requirements. A key lesson learnt is that further efforts must be made in advocating APSED (2010) as a common framework directly linked to improving Member States' IHR (2005) core capacities, and supporting APSED-focused activities for enhancing multisectoral collaboration.





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