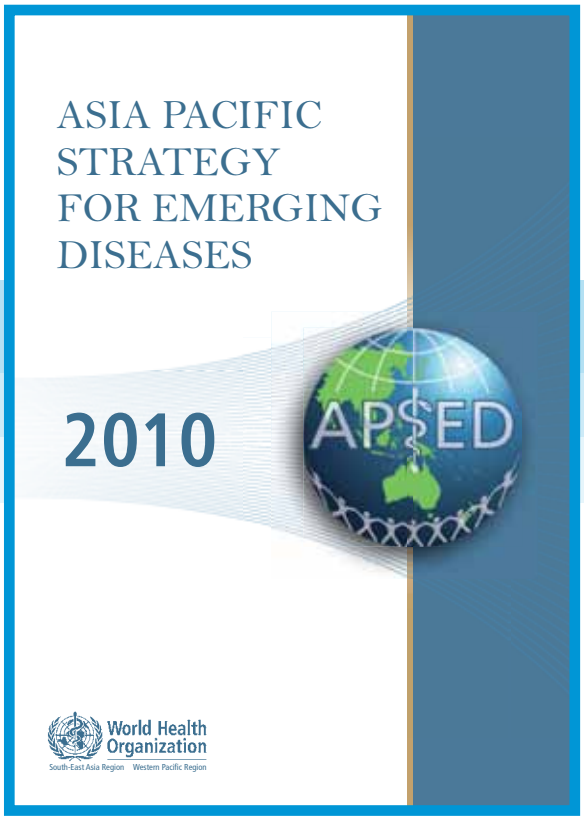
Meeting Report

Informal Consultation to Develop Supplementary Indicators for the Asia Pacific Strategy for Emerging Diseases (2010)



Manila, Philippines
9–10 September 2010

World Health Organization
Western Pacific Region

REPORT

INFORMAL CONSULTATION TO DEVELOP SUPPLEMENTARY INDICATORS FOR THE ASIA PACIFIC STRATEGY FOR EMERGING DISEASES (2010)

Manila, Philippines
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NOTE

The views expressed in this report are those of the participants in the Informal Consultation to Develop Supplementary Indicators for the Asia Pacific Strategy for Emerging Diseases (2010) and do not necessarily reflect the policies of the Organization.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for governments of Member States in the Region and for those who participated in the Informal Consultation to Develop Supplementary Indicators for the Asia Pacific Strategy for Emerging Diseases (2010), which was held in Manila, Philippines from 9 to 10 September 2010.

CONTENTS

Keywords:

Data collection – methods / Communicable Diseases, Emerging – epidemiology / Disaster planning / Risk assessment / Health status indicators

SUMMARY

The Informal Consultation to Develop Supplementary Indicators for the Asia Pacific Strategy for Emerging Diseases (APSED 2010) was held in Manila, Philippines from 9 to 10 September 2010. About 20 experts (i.e. temporary advisors) and World Health Organization (WHO) staff members attended.

The objectives of the informal consultation were:

(1) to identify APSED components that are not addressed by the International Health Regulations (IHR 2005) monitoring framework and require supplementary indicators, and

(2) to identify a minimum set of supplementary APSED performance indicators.

Participants were provided with background information about the monitoring and evaluation (M&E) of IHR and implementation of APSED. A series of discussions took place on identifying supplementary indicators required for APSED.

The informal consultation concluded that M&E is integral for IHR and APSED. However, 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 diverse stakeholders. Further, while providing a solid basis, the IHR monitoring framework does not capture the entire scope and detail of APSED, and additional supplementary component indicators are required to monitor APSED implementation at both the regional and country levels. However, balance should be struck between the need for additional indicators and the assessment burden on Member States and WHO.

Developing high-level performance indicators to measure the performance of the systems functioning together is an ambitious endeavour. Few, if any, examples exist in the area of public health security. Although more discussions and work must be carried out, six supplementary 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 was also emphasized, as it is powerful in helping understand how well the system is performing and focus on areas for improvement. In particular, more efforts should be made to strengthen and support Member States' systems for collecting and analysing data and information, including those related to IHR and APSED indicators.

The six indicators suggested include the proportion of urgent events in the past 12 months with risk assessments carried out at the national level, number of events in the past 12 months that met the national standard definition or criteria with further investigation conducted after a risk assessment, 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, average time from verification request from WHO to provision of information from the national IHR focal points, and number of outbreaks or events annually reviewed by an expert group.

1. INTRODUCTION

The Informal Consultation to Develop Supplementary Indicators for the Asia Pacific Strategy for Emerging Diseases (APSED 2010) was held at the World Health Organization (WHO) Regional Office for the Western Pacific in Manila, Philippines from 9 to 10 September 2010. Attending the consultation were temporary advisers with either monitoring and evaluation (M&E) expertise or experience with emerging infectious disease programme management, as well as staff members from WHO country offices, in the Western Pacific Region, Regional Office for South-East Asia, and Headquarters. The list of participants and timetable are included in Annexes 1 and 2.

APSED (2010) is a revised version of the strategy originally created in 2005 as a biregional 5-year strategic framework for countries and areas of the Western Pacific and South-East Asia Regions to strengthen their capacity to manage and respond to disease outbreaks and acute public health events. While APSED continues to focus on emerging diseases, it has now widened its scope to address threats posed by other public health emergencies. To meet these needs, the activities of the original five programme focus areas of APSED were expanded, as three new focus areas have been added for priority capacity-building, including M&E.[1]

APSED now 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 International Health Regulations (IHR 2005) monitoring questionnaire. In addition, a small number of supplementary indicators will 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 on APSED in July 2010, the group recommended that, taking into account the mandatory IHR monitoring framework, WHO should work with partners to develop a minimum set of APSED indicators and mechanisms that should be used for results-based monitoring of APSED implementation progress.

1.1 Objectives

(1) To identify APSED components that are not addressed by the IHR monitoring framework and require supplementary indicators, and

(2) To identify a minimum set of supplementary APSED performance indicators.

[1] The eight focus areas of APSED are (1) surveillance, risk assessment and response; (2) laboratory; (3) zoonoses; (4) infection prevention and control; and (5) risk communication. Three focus areas were added: (6) public health emergency preparedness; (7) regional preparedness, alert and response; and (8) monitoring and evaluation.

2. PROCEEDINGS

2.1 Plenary 1: Introduction to Asia Pacific Strategy for Emerging Diseases (2010)

2.1.1 Asia Pacific Strategy for Emerging Diseases: Focus areas, components and relationship to International Health Regulations

Dr Li Ailan, Medical Officer, International Health Regulations, Division of Health Security and Emergencies, WHO Regional Office for the Western Pacific, spoke about how in July 2009, the Fourth Annual Meeting of the Asia Pacific Technical Advisory Group on Emerging Infectious Diseases recommended that APSED (2005) be continued beyond its scheduled end in December 2010, and revised it for a further 5-year period with an expanded scope to include noninfectious disease events in line with IHR.

Beginning in late 2009, an intensive consultative process with Member States, technical advisory group members, experts and partners was initiated to review the progress of and experiences of APSED (2005) and to develop a revised strategy, APSED (2010). The new strategy was 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 threats, but now also addresses capacity-building needs to address other acute public health events in line with IHR requirements.

To meet these needs, the original five 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 a common approach and maximize the benefits already achieved under APSED (2005).

2.1.2 Asia Pacific Strategy for Emerging Diseases focus area 8: Monitoring and evaluation

Ms Qiu Yi Khut, Technical Officer, Emerging Disease Surveillance and Response, Division of Health Security and Emergencies, WHO Regional Office for the Western Pacific, noted that many M&E activities were implemented and key issues identified during APSED (2005). M&E must be seen as one of the core businesses of WHO and Member States, and should be addressed as an essential APSED (2010) focus area. A strong need was identified by stakeholders for a common, simplified M&E framework that should include harmonization with international monitoring requirements such as the IHR 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 learnt from APSED (2005) and the advice from the technical advisory group, M&E has now been included as focus area 8 in APSED (2010). M&E is an integral part of strategy implementation to meet two critical management needs: accountability and learning. Accountability is essential to demonstrate to stakeholders (i.e. Member States, WHO, donors and partners) that the 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, to ensure that decision-making is evidenced-based and that a process of continual improvement can be implemented.

In APSED, M&E processes are proposed at the regional and country level. At the 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 in countries and areas. At the regional level, a strengthened annual technical advisory group mechanism will review both country and regional progress and make recommendations for the next year.

2.1.3 Discussion: Country experiences of Asia Pacific Strategy for Emerging Diseases (2010): Monitoring and evaluation

In China, efforts have been ongoing for M&E regarding APSED, with particular attention to data quality. Therefore, after the indicators are developed, the country feels that the issue of how to collect data must be addressed. The establishment of an appropriate platform will be a challenge, for example, regarding how countries and areas can continually update data (rather than through an annual process). Both qualitative data as well as quantitative data should be considered when developing APSED indicators.

In Mongolia, the Ministry of Health developed a national strategic plan in line with APSED. APSED M&E tools, such as common indicator assessment checklists, were helpful in identifying gaps and monitoring progress. National counterparts were particularly interested in component-level M&E, which was found to be useful in identifying areas for improvement and activity planning. However, the country feels that indicators for APSED 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 in monitoring results and tracking progress and results.

The Lao People's Democratic Republic was used as a model country for a review of APSED (2005). Many APSED M&E activities implemented since 2007 were useful in helping stakeholders focus on planning, achievements and what still needs to be achieved. The national emerging infectious disease workplan, developed using APSED, was helpful to share ideas and coordinate with other stakeholders. However, this workplan was seen as a WHO plan, although it was the national plan completed through the combined work of many stakeholders. In the Lao People's Democratic Republic, there are many stakeholders, and every month different indicators or reviews are implemented for different purposes. Although the country emphasized that the workplan and M&E activities are critical, there must be one plan and one M&E system to avoid duplication and extra work. To achieve this, stakeholders should agree on the M&E plan together, but challenges will lie in ensuring both a collaborative process and a strong, focused outcome.

In the Philippines, APSED monitoring tools were too detailed 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 address them. In 2009, national counterparts developed their own M&E using the workplan, and also identified other activities outside of APSED to focus on. The country feels that there is a need to have both regional- and country-level indicators to assist a country in knowing that it is on the right track.

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. However, the information requested is often not readily available, or sometimes answers may be based on one person's comment or opinion (as opposed to a multisectoral process). There are many competing assessments, frameworks and tools in use, which create confusion, especially since many of the indicators are similar. Too many M&E indicators may create a burden for the country and the WHO Country Office. Malaysia feels that what is needed is a simple, relevant M&E system that is institutionalized and owned by the implementers.

Likewise, countries and areas in the South-East Asia Region seem to suffer from too many assessments issued by donors and partners. Assessments may be similar, but not identical, creating a burden on countries and areas. However, countries and areas are at different levels in terms of size, disease burden and development; thus, even if a common tool was developed, it may not be suitable for all. The Region feels that ownership and simplicity will be critical for a functional M&E system, but a challenge for APSED 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 were highlighted in the context of developing an M&E framework for APSED:

(1) *Rationalize.* There was universal consensus that M&E is important and helpful. The challenges are how to rationalize the 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 Member States. If they do not see value in the process, then data quality is questionable. From the country experiences shared, different countries and areas 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 is critical.

(3) *Focus.* There are different levels within countries and areas (e.g. national, subnational and local), across a region (e.g. large and small countries, and resource-rich and -poor countries) and within APSED (e.g. activity, component and performance level), but it is unclear where the focus should lie. Perhaps more results- 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 and quality of response if seen as a chore or burden).

2.2 Plenary 2: International Health Regulations–Asia Pacific Strategy for Emerging Diseases monitoring framework

2.2.1 Overview of the International Health Regulations monitoring framework

Dr Xing Jun, Medical Officer, National Capacity Monitoring, IHR Coordination, WHO Headquarters, explained that IHR 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 and areas, ensuring that they abide by the same rules to secure international health. The new approach moves away from predetermined controls and measures towards a focus on containment at the source and a broader range of threats met by adapted response.

Under IHR, countries and areas are committed to a new obligation to meet the minimum standards of national core capacity to detect, respond to and manage public health events. To monitor the progress of countries and areas in achieving these core capacities, the IHR monitoring framework was developed, which identifies eight core capacity areas to be strengthened across 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 the country level and aggregated regional and global levels.

Challenges in developing the monitoring framework include making a global tool relevant for various countries and areas, harmonizing it with existing strategies and overcoming different understanding of monitoring tools.

2.2.2 Monitoring and evaluation and possible ways forward

Mr Graham Rady, Asia Programmes Quality and Development Adviser, Asia Regional Branch and Asia Bilateral Branch, Australian Agency for International Development, stated that M&E for APSED is vital in meeting the two critical performance management needs of accountability and learning. Stakeholders involved include Member States (to assess their capacity-building needs, gaps and lessons learnt), WHO and the international health community (to monitor achievement of IHR obligations) and development partners (to confirm that APSED is a quality investment). Regarding APSED, M&E is proposed to be implemented through a strengthened annual Member State review process, enhanced technical advisory group 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 areas and the content overlap in competing assessment formats, the IHR monitoring framework offers an opportunity to rationalize 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 conducing M&E, depending on various needs. APSED is a strategic framework, and multiple levels of M&E information can be identified. At the lowest activity level, activities implemented under APSED produce outputs (i.e. components) and expected results. At the next level, the component level, APSED components contribute to the delivery of an output (i.e. a focus area) and its purpose. At this level, outcome indicators are required to monitor how well the APSED components contribute to the functioning of the focus area (Annex 3). At the highest level, the 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.

2.2.3 Discussion

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

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

2.3 Supplementary component indicators

Given the synergies between IHR and APSED, a lot of information collected by the mandatory IHR monitoring framework questionnaire will be used to monitor and evaluate 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 results-based is also needed. This issue was recognized by the technical advisory group, which recommended that the IHR monitoring framework 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 were 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 checklist and the APSED 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 for M&E to be adequately implemented. Annex 4 shows the list of APSED focus areas and components that will require supplementary component-level indicators.

2.4 Supplementary performance indicators

Results-based monitoring was identified by the fifth technical advisory group meeting as a focus of M&E in APSED. To monitor the achievement of system-level results, the term and use of performance indicators was 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 APSED functions.
Performance indicators were proposed to be designed to measure the functioning or performance of the system established and strengthened under the APSED approach.

2.4.1 Group discussion 2: Identifying potential performance indicators

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

Box. Guiding principles for selecting performance indicators*

- *Specific.* Clear, precise and unambiguous
- *Measurable.* Can measure performance or functions of the systems strengthened under APSED
- *Achievable.* Can be feasibly implemented in terms of economic cost, data availability, collection, analysis and reporting at the country level
- *Relevant.* To the programme(s) on emerging diseases 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)
- *Time-bound.*

* A minimum set of performance indicators (no more than 10) will be selected.

Annex 5 shows the preliminary list of possible performance indicators identified through this process.

2.4.2 Group discussion 3: Prioritizing performance indicators

Both group and plenary discussions were held 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 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) overlapped and were duplicates, such as indicators 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 has been identified in Annex 6.

3. CONCLUSIONS

3.1 Supplementary component indicators

3.1.1 Established focus areas of APSED were mostly covered by indicators in the IHR monitoring framework, with the exception of risk communication. All three new components require supplementary component indicators. Of the three new focus areas in APSED, regional preparedness, alert and response (focus area 7) and M&E (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.

3.1.2 While providing a solid basis, the IHR monitoring framework does not capture the entire scope and detail of APSED. Overall, only about 50% of all components in APSED were identified to be adequately covered by indicators in the IHR monitoring framework. Many supplementary component indicators for APSED are needed.

3.2 Supplementary performance indicators

3.2.1 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 assessments carried out at national level;

(2) number of urgent events reported in the past 12 months;

(3) proportion of urgent events with risk assessments carried out;

(4) proportion of urgent events with risk assessments carried out within 48 hours of receiving reports;

(5) proportion of urgent events with risk assessments that utilized sex-disaggregated data;

(6) lessons learnt, and how the quality of risk assessment could be improved;

(7) number of events in the past 12 months that met the national standard definition or criteria, with further investigation conducted after a risk assessment;

(8) proportion of events followed by a rapid response within 48 hours at the national level;

(9) proportion of these with technical support from WHO;

(10) lessons learnt, and how these results could be improved;

(11) number of surveillance and response updates published on an official website;

(12) proportion of events of potential public health emergency of international concern that were notified to WHO from national IHR focal points in the past 12 months;

(13) proportion of these that were notified within 24 hours of assessment;

(14) proportion of these that were infectious disease events;

(15) lessons learnt, and how these results could be improved;

(16) average time from verification request from WHO to provision of information from the national IHR focal points;

(17) number of outbreaks or events annually reviewed by expert group;

(18) proportion of outbreaks with perceived satisfaction by expert groups; and

(19) number of reports available to document review progress, experiences and lessons learnt, and plans for improvement.

3.3 Next steps

3.3.1 An M&E system must be grounded in practicality. The key issues such as country or area'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.

3.3.2 While providing a solid basis, the IHR monitoring framework does not capture the entire scope and detail of APSED, and supplementary component indicators are required to monitor APSED implementation at both country and regional levels. The balance should strike to address the need for additional indicators and an assessment burden on Member States and WHO.

3.3.3. Developing high-level performance indicators to measure the performance of the systems functioning together is an 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.

3.3.4 Performance indicators are a component of M&E that need to be included from the beginning, but similar to 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 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.

3.3.5 Member States' M&E systems must be strengthened, including the annual Member States IHR and APSED monitoring process, fostering the development and update of 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 and areas in strengthening their M&E systems, when needed.

3.3.6 At the regional level, the annual technical advisory group meeting should continue to provide a venue to discuss the issues related to APSED M&E and to recommend next steps.

ANNEX 1

LIST OF TEMPORARY ADVISERS AND SECRETARIAT

1. TEMPORARY ADVISERS

Dr FENG Zijian, Director, Disease Control and Emergency Response Office, Chinese Centre for Disease Control and Prevention, 27, Nanwi Road, Xuanwu District, Beijing 100050, People's Republic of China. Tel no.: (8610) 6313 1219. Fax no.: (8610) 6315 2572. E-mail: fengzj@chinacdc.cn; zijianf@hotmail.com

Dr Jeffrey McFARLAND, Influenza Coordinator, China GDD Coordinator, China, Country Director, China, US Centers for Disease Control and Prevention, Unit 7300 Box 0061, DPO AP 96521, United States of America. Tel no.: (8610) 8532 2634. Fax no.: (8610) 8532 6363. E-mail: jwm5@cdc.gov

Mr Graham RADY, Asia Programs Quality and Development Adviser, Asia Regional Branch and Asia Bilateral Branch, Australian Agency for International Development, P.O. Box 887 Canberra A.C.T. 2601, Australia. Tel no.: (612) 6206 4826. Fax no.: (612) 6206 4036. E-mail: Graham.Rady@ausaid.gov.au

Dr Enrique A TAYAG, Director IV, National Epidemiology Centre, Department of Health, Tayuman, Sta. Cruz, 1000 Manila, Philippines. Tel no.: (632) 743 1937/712 6780. Fax no.: (632) 743 6076. E-mail: erictayag4health@yahoo.com

2. SECRETARIAT

Dr Takeshi KASAI, Director, Health Security and Emergencies, World Health Organization, Regional Office for the Western Pacific, P.O. Box 2932, 1000 Manila, Philippines. Tel no.: (632) 528 9730. Fax no.: (632) 521 1036. E-mail: kasait@wpro.who.int

Dr LI Ailan, Medical Officer (IHR), Health Security and Emergencies, World Health Organization, Regional Office for the Western Pacific, P.O. Box 2932, 1000 Manila, Philippines. Tel no.: (632) 528 9784. Fax no.: (632) 521 1036. E-mail: lia@wpro.who.int

Ms Qiu Yi KHUT, Technical Officer (Communicable Disease), Communicable Disease Surveillance and Response, World Health Organization, Regional Office for the Western Pacific, P.O. Box 2932, 1000 Manila, Philippines. Tel no.: (632) 528 9920. Fax no.: (632) 521 1036. E-mail: khutq@wpro.who.int

Dr Tamano MATSUI, Medical Officer/Epidemiologist, FETP Coordinator, Communicable Disease Surveillance and Response, World Health Organization, Regional Office for the Western Pacific, P.O. Box 2932, 1000 Manila, Philippines. Tel no.: (632) 528 9828. Fax no.: (632) 521 1036. E-mail: matsuit@wpro.who.int

Dr Bee Lee ONG, Zoonetic Disease Epidemiologist, Communicable Disease Surveillance and Response, World Health Organization, Regional Office for the Western Pacific, P.O. Box 2932, 1000 Manila, Philippines. Tel no.: (632) 528 9914. Fax no.: (632) 521 1036. E-mail: ongb@wpro.who.int

Dr Satoko OTSU, Medical Officer, World Health Organization, Regional Office for the Western Pacific, P.O. Box 2932, 1000 Manila, Philippines. Tel no.: (632) 528 9916.
Fax no.: (632) 521 1036. E-mail: otsus@wpro.who.int

Dr Jeffrey PARTRIDGE, Epidemiologist (Influenza Surveillance), Communicable Disease Surveillance and Response, World Health Organization, Regional Office for the Western Pacific, P.O. Box 2932, 1000 Manila, Philippines. Tel no.: (632) 528 9732. Fax no.: (632) 521 1036.
E-mail: partridgej@wpro.who.int

Dr Charuni SENANAYAKE, Technical Officer (Programme Budget), Communicable Disease Surveillance and Response, World Health Organization, Regional Office for the Western Pacific, P.O. Box 2932, 1000 Manila, Philippines. Tel no.: (632) 528 9839. Fax no.: (632) 521 1036.
E-mail: senanayakec@wpro.who.int

Ms YEO Wen Qing, Risk Communication Officer, Communicable Disease Surveillance and Response, World Health Organization Regional Office for the Western Pacific, P.O. Box 2932, 1000 Manila, Philippines. Tel no.: (632) 528 9944. Fax no.: (632) 521 1036.
E-mail: yeow@wpro.who.int

Dr Chin Kei LEE, Epidemiologist, Communicable Disease Surveillance and Response, World Health Organization, 401 Dongwai Diplomatic Office Building, 23, Dongzhimenwai Dajie, Chaoyang District, Beijing 1000600, People's Republic of China.
Tel no.: (8610) 6532 7189. Fax no.: (8610) 6532 2359. E-mail: leec@wpro.who.int

Dr Reiko TSUYUOKA, Epidemiologist, Communicable Disease Surveillance and Response, World Health Organization, Ban Phonxay, 23 Singha Road, Vientiane, Lao People's Democratic Republic. Tel no. : (856 21) 35 3902. Fax no.: (856 21) 35 3905.
E-mail: tsuyuokar@wpro.who.int

Dr Harpal SINGH, Technical Officer, World Health Organization, 1st Floor, Wisma UN, Block C, Komplek Pejabat, Damansara, Jalan Dungun, Damansara Heights, 50490 Kuala Lumpur.
Tel. no.: (603) 2093 9908. Fax no.: (603) 2093 7446. E-mail: singhh@wpro.who.int

Dr LUO Dapeng, Medical Officer, Communicable Disease Surveillance and Response, World Health Organization, Government Building-VIII, Olympic Street – 2, Ulaanbaatar 13, Mongolia.
Tel no.: (976 11) 32 7870. Fax no.: (976 11) 32 4683. E-mail: luod@wpro.who.int

Dr Ariuntuya OCHIRPUREV, Project Officer, Communicable Disease Surveillance and Response, World Health Organization, Ministry of Health, Government Building – VIII, Olympic Street – 2, Ulaanbaatar 13, Mongolia. Tel no.: (976) 11327870.
Fax no.: (976) 1132 4683. E-mail: ochirpureva@wpro.who.int

Dr Ma. Nerissa DOMINGUEZ, National Professional Officer, Communicable Disease Surveillance and Response, World Health Organization, National Tuberculosis Centre Building, Second Floor Building 9, Department of Health, San Lazaro Hospital Compound, Sta. Cruz, Manila, Philippines. Tel no.: (632) 528 9766. Fax no.: (632) 731 3914.
E-mail: dominguezn@wpro.who.int

Dr Gyanendra GONGAL, Technical Officer, Veterinary Public Health, Communicable Disease Surveillance and Response, World Health Organization, Regional Office for South-East Asia, New Delhi, India. Tel no.: (9111) 2337 0804 Ext. 26647. Fax no.: (9111) 2337 0197.
E-mail: gongalg@searo.who.int

Dr XING Jun, Medical Officer, National Capacity Monitoring, International Health Regulation Coordination, World Health Organization, 20, Avenue Appia - CH 1211, Geneva, Switzerland. Tel no.: (4122) 791 2193. Fax no.: (4122) 791 4667. E-mail: xingj@who.int

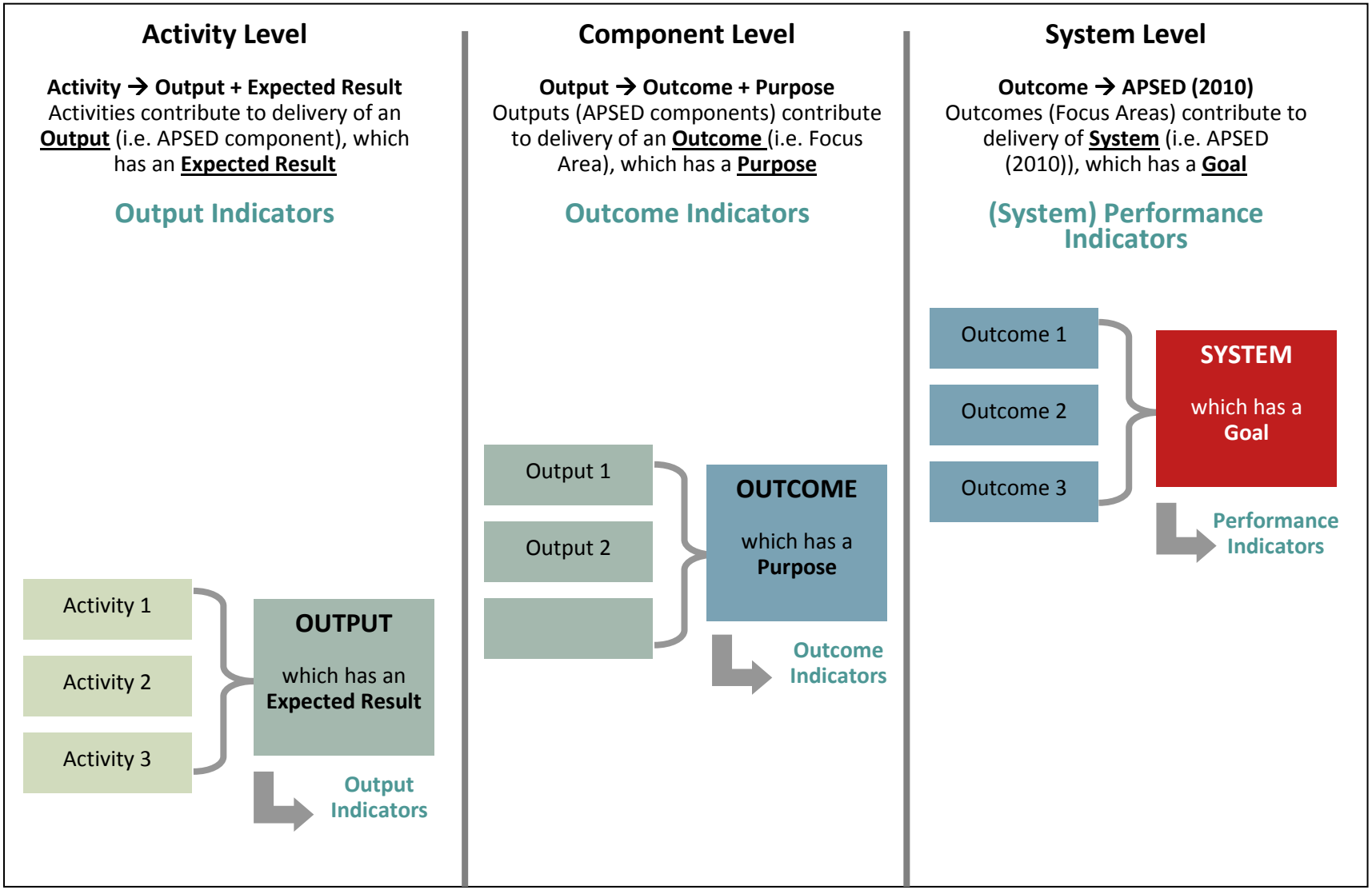
TIMETABLE

Time	Day 1 – Thursday 9 September	Time	Day 2 – Friday 10 September
08:15 – 08:30	Registration		
08:30 – 09:00	**Opening Session** – Opening remarks – Self-Introduction – Objectives – Administrative Announcements – Group Photo	08:30 – 09:00	**Plenary 3: Group Discussion 2 Feedback** – Group 1 – Group 2 – Group 3
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	09:00 – 10:00	**Group Discussion 3: Prioritizing Performance Indicators** – Group Discussion – Feedback
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 2

ANNEX 3

A MONITORING AND EVALUATION FRAMEWORK FOR APSED



GROUP DISCUSSION 1 – IDENTIFYING GAPS AND NEEDS FOR COMPONENT 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**

ANNEX 4

Focus Area	Key Components	Comments	Adequate / 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**
	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**

Focus Area	Key Components	Comments	Adequate / 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 – 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

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