

Development of an Evaluation tool for  
Assessment of National Pandemic  
Strategic Responses in Member States of  
the South-East Asia Region

Report of an informal consultation

*WHO-SEARO, 22–24 November 2010*



**World Health  
Organization**

Regional Office for South-East Asia



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## Background

Pandemic influenza H1N1 2009 emerged in April 2009 and spread rapidly to all continents. The first cases in the WHO South-East Asia Region were reported in Thailand on 12 May 2009. On August 10, 2010 the world was declared to be in the post-pandemic period. At present, most countries are reporting a pattern of influenza that is similar to seasonal influenza.

Since the onset of the regional outbreak of avian influenza, WHO-SEARO has been supporting Member States to build capacity for pandemic preparedness, including development and testing of National Influenza Pandemic Preparedness and Response Plans.

However, to date, few countries have formally undertaken an assessment of their strategic response to pandemic influenza H1N1 2009. A careful evaluation of the degree to which Member States were prepared, and of the actual response they mounted would likely provide important lessons to support revision of national pandemic plans and would also help Member States and SEARO identify gaps where additional support may be required to strengthen core capacities as required under IHR (2005).

In order to facilitate a review of national responses, it was proposed that a regionally appropriate pandemic response draft assessment tool be developed covering the following technical areas:

- (1) Command and control, logistics and operations
- (2) Surveillance, risk assessment and epidemiology
- (3) Laboratory capacity
- (4) Communications
- (5) Public health interventions including non-pharmacological interventions and vaccination (availability, prioritization and uptake)
- (6) Clinical management, infection control and healthcare facility preparedness
- (7) Measures for the vulnerable (migrants and displaced persons, elderly, children, people with chronic disorders and pregnant women).

To further facilitate the development of this assessment tool, an informal consultation with invited experts from Member States was organized from 22-24 November 2010 in New Delhi, to review the draft tool and provide recommendations on how to improve it. This report provides an account of the proceedings of this meeting and the guidance provided to improve the assessment tool.

## **Opening session**

The consultation commenced with remarks from the Director of Communicable Diseases, WHO-SEARO, Dr Sangay Thinley. A review of national responses to the recent pandemic provides an opportunity to identify gaps in capacity and revise preparedness plans. To date, within the SEA Region only Thailand has undertaken such a review and made the results available. Developing an assessment tool will help to provide a structure to such assessments and will help to ensure consistency of approaches. Although it is an informal consultation, the subject to discuss is important and participants should concentrate on developing a quality product. Dr Thinley welcomed the participants and invited them to introduce themselves. Dr Thinley then invited Dr Ibrahim Yasir Ahmed, Director-General of Health Services, Ministry of Health and Family, Republic of Maldives to chair the meeting.

An overview was then provided of the contents of the meeting folder, the agenda and the background to the development of the assessment tool. All countries in the Region have a pandemic plan and some had already revised their initial plan prior to the onset of the pandemic. Some were now planning for a third version. To date, although some countries had held meetings to review their responses, most had not yet undertaken a formal structured assessment of their response.

The objectives of the consultation were:

- (1) to present, discuss and finalize a draft national pandemic assessment tool and
- (2) to discuss arrangements for visits to Member States.

The expected outputs were

- (1) to reach consensus on the final national pandemic assessment tool, including a guideline for assessors and
- (2) to agree on objectives, expected outputs and provisional arrangements for planned national assessments.

The main reference documents that provided the source material for the assessment tool include the WHO Guideline “Pandemic Influenza Preparedness and Response – A WHO Guidance Document (2009)”,

which lists required national and WHO actions at different stages of the pandemic, a WHO “Checklist for influenza pandemic preparedness planning (2006)” and tools that were developed for the National Strategic Pandemic Review, Thailand in late 2009.

In designing the tool, it had been assumed that an assessment would most likely take 8-10 working days, and that assessors might have to cover more than one technical area of work. The tool was intended to make use of both qualitative and quantitative approaches and many questions are deliberately ‘open-ended’. The tool was designed with questions and spaces, not to simply be filled in by someone; it was designed for an assessor to ask questions face to face (or to request relevant information such as organograms, documents etc) and to follow-up with additional questions based on the responses obtained. With this approach, it was expected that there would probably also be a different person recording the answers. The draft tool was divided into seven sections, but one issue the consultation was expected to address was whether the grouping of topics made sense, including taking into account whether the arrangement would facilitate logistic arrangements (does the structure of the tool mirror the organization within a Ministry of Health?). Each section of the tool has the same basic structure and consisted of:

- (1) A section on ‘infrastructure’ and coordination, (who does what, and for labs / hospitals, the physical infrastructure);
- (2) A section on preparedness (was this area included in a pandemic plan, did it prove useful);
- (3) A section on the detail of strategy / policy / arrangements for this area, including any changes that occurred over time;
- (4) A section on monitoring of this area of work;
- (5) A section on guidelines and training; and
- (6) A section with open-ended questions on lessons learned.

As well as considering whether the grouping of topics was useful, participants were asked to consider if anything important was missing and whether the tool was too detailed. If any particular tool was considered to be too long, the question to consider would be whether it was actually too long because it needed to be split into different topics. It was also suggested that participants should consider how they might expect to use a report that was developed as a result of a review, and whether some detail might be helpful to advocate for change. It was also highlighted that the

intention is to develop a guide to accompany the questionnaires. Arrangements for the working groups were then described, including the roles of chairpersons, rapporteurs, facilitators and note takers.

A presentation was made by Dr Woraya Luang-on, Medical Officer, Senior Professional Level, Bureau of Emerging Infectious Diseases, Department of Disease Control, Ministry of Public Health (MoPH), Thailand, entitled “Joint WHO-MoPH Review of Pandemic Response in Thailand - 18 August – 6 December 2009”. The objectives of this initiative were to review Thailand’s response to pandemic influenza and document achievements and strengths, identify areas where further strengthening was needed and to provide recommendations on how to close identified gaps and address potential challenges. Assessors from the MoPH and WHO were divided into seven teams (consisting of 3-11 persons per team) to review each strategic area. Each team spent approximately one week per area to conduct their rapid review. Schedules were accordingly set up to discuss and exchange experiences with concerned authorities at their workplaces. The teams met with key stakeholders, including the private sector, schools, village health volunteers and community leaders, through a series of field trips. On the last day of each assessment, a short briefing was given to the authorities and administrators and an official final report was subsequently delivered to the concerned authorities. The seven areas covered were:

- (1) Surveillance and epidemiology;
- (2) Laboratory capacity;
- (3) Public communications;
- (4) Public Health control/prevention measures, including infection control;
- (5) Clinical management;
- (6) Logistics, commodities and operations; and
- (7) Special policies and measures for vulnerable, non-Thai populations residing in Thailand.

Recommendations from the review on clinical management included the development of a regional ‘knowledge network’ on clinical management, improved arrangements for healthcare facility preparedness (including outpatient, triage and hospital admission), revitalization of the National Infection Control Committee and better understanding of strategic arrangements for laboratory diagnosis.

Recommendations for risk communication were divided into four areas,

- (1) Planning;
- (2) Information dissemination and media management;
- (3) Listening and understanding risk perception; and
- (4) Coordination of communication activities.

Each area was considered in terms of impact, consistency and whether capacity was strengthened. Recommendations for planning included development of a pandemic plan and a crisis manual; and that communications should be fully integrated into arrangements for emergency management and that procedures should be tested through tabletop exercises. It was also recommended that senior communication decision makers should be better engaged in emergency communication planning activities. For coordination of communications, it was noted that strong working relationships and mechanisms were already established, but that not all key actors were involved. There was also evidence of a lack of synergy, weak coordination of messages and a lack of clarity over roles and responsibilities. Strong mechanisms were in place for listening and understanding risk perception, including call centres, media monitoring and feedback from village health volunteers. However, data were not well organized, analyzed and integrated into the decision making process.

Recommendations for laboratory activities included:

- (1) Development and implementation of a comprehensive national laboratory programme;
- (2) Expansion of the number of facilities with PCR testing capability;
- (3) Delegation of higher laboratory functions to centres of excellence;
- (4) Better communication of laboratory policy; and
- (5) Improved arrangements for quality assurance and laboratory biosafety.

The highest priority recommendation for surveillance was the development of a comprehensive, five-year strategic plan describing a vision for influenza surveillance and control in both pandemic and inter-pandemic periods. Specific recommendations included a greater emphasis on surveillance of hospitalized pneumonia patients, better capture of denominator data to assess trends and disease burden, the adoption and

implementation of unified surveillance case definitions based on clinical criteria for Influenza like illness (ILI) and pneumonia. It was recommended that surveillance should actively involve health care delivery by the private sector and influenza surveillance data should be made routinely available to Thai clinicians and the general public,

Recommendations for operations and logistics included a critical review of the existing pandemic plan, improved contingency planning and a better delineation of roles and responsibilities of partner agencies. It was noted that internal coordination within MoPH lacked clarity and could be improved with an Incident command system. At sub-national level, there appeared to be sub-optimal coordination with Department of Disaster Prevention & Mitigation. Finally, it was recommended that there should be better clarification of roles with partners outside MoPH, for example the Ministry of Defence and the Thai Red Cross.

Public health control measures were divided into a number of different categories and examined in terms of strengths and challenges. With regard to surveillance and screening, strengths included comprehensive 'case detection' systems at local level and good adaptation to local context (it was, however, noted that school absenteeism data could also be collected). Challenges included the development of an appropriate strategy for proportionality of extensive screening and exclusion policies, a lack of knowledge about what was cost-effective, the need to avoid excessive burden while being comprehensive and the need of a clear statement of specific goals (i.e. reducing severe morbidity vs reducing transmission). A key recommendation was a policy to stratify the intensity of screening according to risk setting & potential benefit, with a focus on special needs schools, high risk health care settings and closed institutions such as prisons). It was also recommended that the practicality, utility and cost-effectiveness of screening should be evaluated (i.e. the sensitivity and specificity of algorithms, the impact and the cost). Measures applied included thermal screening, positive practise and aircraft cleaning. Challenges were presented by the lack of evidence of efficacy (e.g. for thermal screening), the high volume of travel in and out of Thailand and a lack of evidence to inform decisions about when to start and stop the measures applied. Recommendations included consideration of an evaluation of the effectiveness and cost-effectiveness of interventions and the development of plans for possible reintroduction of measures in a second wave, including a timetable for introduction and stepping-down of measures. In considering school closures and screening, identified strengths

were the existence of a comprehensive school screening system, the institutional knowledge acquired over experienced difficulties and the presence of data to analyse. Key challenges included ongoing lack of evidence of effectiveness and inconsistency of approaches (with closure decided on a 'case by case' basis). It was strongly recommended that a rigorous evaluation of the impact of school closures by Bangkok Metropolitan Authority and districts should be undertaken.

Important challenges to improving the health of migrants in Thailand during the pandemic included:

- (1) Political commitment towards the consistency of the registration system;
- (2) Budgetary constraints;
- (3) Limited perception of the National Preparedness Plan; and
- (4) Limited knowledge about the health-seeking behaviour of unregistered migrants.

Several recommendations were made, including:

- (1) An improved dialogue between UN agencies and the government to promote migrant-friendly policies;
- (2) Development and piloting of financing options;
- (3) An expansion of the migrant health worker / volunteer schemes;
- (4) Strengthened surveillance networks that reach unregistered migrants; and
- (5) Improved mechanisms to coordinate the production and distribution of Information, Education and Communication (IEC) material in relevant languages.

The outcomes of the review were utilized in a number of ways. Firstly, clinical, epidemiologic and laboratory findings were applied in revising and updating surveillance and control strategies, clinical management guidelines and SOPs, ICS during the first wave response, and in preparation for upcoming waves. Secondly, the preliminary outcome of the joint assessment was reported to the MoPH war room and national advisory committee and recommendations communicated to concerned MOPH offices. Lastly, lessons learned are being used to develop a new national strategic preparedness and response plan for avian and pandemic influenza, which may also incorporate a broadened scope to cover other emerging infectious diseases.

## **Day 1: Afternoon session**

### **Surveillance, risk assessment and epidemiology, clinical management, infection control and healthcare facility preparedness**

#### **Working Group 1: Surveillance, risk assessment and epidemiology**

In general, the tool appears quite long and complex. Much of the information that it seeks to gather at the beginning, i.e. on infrastructure, roles and responsibilities, etc. is likely to already be very well known by informants, so collecting it might be of limited value and it may be simpler for the assessor to ask for documents, reports, an organizational chart / organogram or an existing description of the surveillance system. The title of this questionnaire could simply be reduced to 'surveillance', since it is self-evident that collection of this data would be linked to risk assessment and epidemiological analysis. Similarly, the specific sections related to these risk assessment and epidemiology in the tool can be dropped. The format in which the questions are presented makes it difficult to understand the purpose of the enquiry without additional guidance (i.e. a facilitators' guide would be useful). It may be helpful to try to collect some more quantitative data. Similar questions should also be merged to help simplify the tool. It is also unclear who is supposed to answer the questions and whether information needs to be gathered at different levels of the system (national and sub-national). Some questions are also possibly too open-ended. The question on infectious disease modelling is not clear and a more useful way to approach this topic is probably to ask if data is used to try and predict trends or patterns of disease. The question relating to WHO support needs to be re-written to be more 'neutral' and less ambiguous.

#### **Working Group 2: Clinical management, infection control and healthcare facility preparedness**

The working group for clinical management, infection control and healthcare facility preparedness highlighted several issues also described above, for example that some initial questions might be avoided by simply asking for documents describing the organization of the healthcare system. Useful feedback included the need to rephrase some questions to avoid

the use of ambiguous or imprecise words, for example, with “how many healthcare facilities have a functional Infection Control Committee” it would be necessary to define what ‘functional’ means in that context. The group expressed the need to look more closely at healthcare delivery at local / community level, including whether arrangements were established for assessment of severity of illness and whether criteria for transfer of patients had been developed and implemented. The suggestion to include a section in the tool on awareness of critical incidents could be improved by asking if countries have a system in place to encourage reporting. The last section of the tool on lessons learned could also include a section where countries are encouraged to document examples of best practice. A useful suggestion was the addition of a question about conducting a ‘death audit’ in the section on monitoring and evaluation. It would also be useful to ‘capture’ any experience on the usefulness of prophylactic oseltamivir in healthcare workers. The section referring to hospital accreditation should also be changed to reflect the fact that systems for accreditation are not widespread in the Region, so it could instead refer to ‘external quality assurance’ or simply ‘registration’.

## **Day 2: Morning session**

### **Laboratory capacity, communications**

#### **Working Group 3: Laboratory capacity**

An important suggestion made by this working group and subsequently endorsed by the meeting was that describing the tools in terms of ‘assessment’ may not be helpful as the word sometimes carries an element of threat. Therefore, consideration should be given to changing ‘assessment’ to ‘review’. In the section on infrastructure, a question is posed as to whether resources are ‘sufficient’, but no qualification is given; therefore it was suggested that it can be re-phrased to ask ‘did’ you experience shortages?’ and / or ‘were resources enough to serve the needs of policy / decision makers in terms of diagnosis and surveillance. Since laboratory capacity for influenza diagnosis is known to vary widely in countries of the Region, the document needs to somehow incorporate a flexible enough approach that all countries will find to be useful. If examples of best practice are requested, it would be important to capture

examples of good international collaboration. Lastly, where capacity for laboratory diagnosis was increased during the pandemic, one issue that has arisen is whether there is a plan for how these laboratories will be used in the post-pandemic period, so there should be a question related to this.

## **Working Group 4: Communications**

The majority of comments received during this session were similar to those already expressed by other working groups, for example the need to simplify the tool, avoid language that is open to different interpretation and provide guidance on which organizational level the questions should be directed. This tool refers to 'internal' and external communications, but no explanation was given and the difference was not self-evident. Since internal communications within public health agencies supporting the pandemic response is a component of information management, this ambiguity may be addressed if this component of the tool only considers external (media and community level) communications. One suggestion was that better 'qualitative' information might be obtained through focus group discussion rather than a questionnaire. This led to discussion about how the tool could be fundamentally restructured so that instead of being presented as a questionnaire, it could instead define the information needed to undertake a review and suggest different methodologies to acquire this information (including questionnaires, semi-structured interviews, observational studies, a review of available data, focus groups, etc.). Another useful suggestion was that if the focus of the review is to revise pandemic plans, then the approach and structure of the questions could be adjusted to reflect this and effectively 'steer' the kind of thinking that the question would generate in the respondent.

## Day 2: Afternoon session

### **Public Health Interventions, including non-pharmacological interventions and vaccination (availability, prioritization and uptake), command, control and coordination, logistics and operations and information management.**

The session commenced with a presentation by Dr Jayantha Liyanage, IVD, WHO SEARO on the “WHO Evaluation instrument to assess implementation of National pandemic (H1N1) vaccine deployment and vaccination plans”. In July 2009 the Strategic Advisory Group of Experts on Immunization (SAGE) met to consider the issue of pandemic vaccine and issued a summary of conclusions and recommendations. Firstly, they noted that the severity of the pandemic was considered to be moderate, with most patients experiencing uncomplicated, self-limited illness, but that some groups appear to be at increased risk for severe disease and death from infection. The group identified three objectives that countries could adopt as part of their pandemic vaccination strategy, namely:

- (1) Protecting the integrity of the health-care system and the country’s critical infrastructure;
- (2) Reducing morbidity and mortality; and
- (3) Reducing transmission of the pandemic virus within communities.

Accordingly, they recommended that all countries should immunize health care workers as a first priority.

The plan for pandemic vaccine deployment in the Region was then outlined. Both Thailand and India purchased the vaccines from national funds. As a pre-requisite for shipment of vaccines supplied by WHO, countries were asked to sign a letter of agreement and develop a vaccine deployment plan – to be agreed by the Regional Office and WHO/HQ. In the SEA Region, vaccine was shipped to Bangladesh, Bhutan, DPR Korea, Maldives, Myanmar, Sri Lanka and Timor-Leste (although Myanmar did not use the vaccine). In addition, AD syringes and safety boxes were supplied and some of the operational costs were borne by WHO. To assess vaccine deployment, an *“Evaluation instrument to assess implementation of National pandemic (H1N1) 2009 vaccine deployment and vaccination plan”*

was developed, with the objective to gather basic data and assess the degree of implementation of activities that were outlined in national vaccine deployment plans. The key components defined in this tool were management and organization, vaccination strategies, supply chain logistics, public information and communication and post-marketing surveillance. To date, seven Member States responded (of these, Bangladesh, Maldives, Sri Lanka, Thailand and Timor-Leste conducted vaccination and Indonesia and Nepal did not use the vaccine). Key findings from countries of the Region were outlined. All countries except Timor-Leste had a section in their pandemic plan on use of pandemic vaccine, but not all components were comprehensively addressed. For most countries, the development of detailed plans started only in October 2009. Nepal, Sri Lanka and Indonesia had customs, legal and regulatory barriers to import the vaccines. The duration between receipt of vaccines and vaccination varied between countries, i.e. Bangladesh (7 days), Maldives (2 days), Sri Lanka (14 days), Thailand (14 days), and Timor-Leste (4 days). Inconsistent information was obtained from several countries about completion of vaccination campaigns. In most countries, the public sector was mainly responsible for the key activities in vaccine deployment and vaccination. Bangladesh, Maldives, Sri Lanka and Thailand received funds as needed from national and/or external sources and in Bangladesh, Maldives, Sri Lanka and Thailand, the supply chain logistics and vaccination activities were adequately supported. Several countries reported public concern about safety, efficacy and need to receive the vaccine. Complete coverage data was available only from Maldives and Thailand. Adverse events following immunization (AEFI) surveillance was in place in Bangladesh, Maldives, Sri Lanka and Thailand. Higher rates of reporting were seen in Thailand. Challenges encountered during the assessment included uncertainty over who should complete the form and that at times, follow-up clarifications were needed to find answers to open-ended questions.

Some critical questions that the proposed assessment tool could address are:

- (1) Vaccine deployment and vaccination campaign issues and include them in the updated pandemic preparedness plan,
- (2) Perceptions of the relevance, efficacy and safety of vaccination to policy makers, programme managers, service providers and the general public,

- (3) Legal and regulatory issues,
- (4) Utilization of existing immunization services and curative care services for vaccination and scope of their use in future,
- (5) Competing with other priority public health problems including planned vaccination campaigns,
- (6) Communication methods and challenges and
- (7) Analysis of reported and investigated Adverse Events Following Immunization (AEFI).

The discussions focused mostly on how the initiative to develop a pandemic assessment tool could help to address issues that were not covered sufficiently well by this WHO-HQ questionnaire. One issue was to ask whether sufficient detail had been included in preparedness plans on how to target some risk groups, for example those with chronic diseases. Another interesting question would be to explore why some issues were not included in a pandemic plan, i.e. whether there was an assumption that vaccine would not be made available, or whether it was because key stakeholders involved in vaccination had not been engaged in the planning process.

### **Working Group 5: Public health interventions, including non-pharmacological interventions and vaccination (availability, prioritization and uptake)**

This working group also echoed many of the suggestions already made in other sessions. The most important suggestion of this group was that the sections on Points of Entry and on pandemic vaccine should be removed and should become distinct 'stand alone' tools. The rationale for this was that they are sufficiently important and distinct to merit more attention; and that the responsibilities for these functions probably rest with different people / departments within and outside the Ministry of Health. It was also noted that public health interventions included a large number of different components (i.e. oseltamivir prophylaxis, case isolation, contact tracing, use of masks for cases, contacts and service providers, hand hygiene, respiratory hygiene, cleaning and disinfection, development of messages, posters, provision of hand wash in public places, temperature screening, health surveillance, workplace / school closure, adjustments in working patterns and cancellation of mass gatherings) and that often multiple

interventions were applied at the same time. In addition, there were probably two critically important different phases of the response, i.e. containment and mitigation. Therefore, a much more pragmatic approach would be to ask how this 'bundle' or 'recipe' of possible interventions were applied during these two phases, rather than to ask how each of them (individually) were used at different stages. With respect to the section on pandemic vaccine, suggestions included the addition of questions on whether any survey of acceptability of vaccine had been conducted and whether any operational difficulties had been encountered with other, concurrent vaccination programmes and whether Adverse Events Following Immunization (AEFI) related to pandemic vaccine was included in the country's existing AEFI surveillance system.

## **Working Group 6: Command, control and coordination, logistics and operations and information management**

This session also reiterated issues raised in previous sessions about whether required information could be more easily obtained by requesting organograms, and adopting a more simple approach. Because this assessment tool is quite long, the group was specifically asked if they agreed that these topics logically belonged together or could be split: the consensus was that they should remain together. One element the group felt important to capture was the degree to which command, control and coordination arrangements adopted for the pandemic were similar to those for other disasters in that country (whether a national disaster was officially declared or not). Similarly, it might be useful to ask if countries have a number of similar disaster preparedness and response plans (possibly suggesting a need to consider an 'all hazards' approach). One proposal for the section on logistics was the addition of a question on whether a policy / mechanism existed to supersede normal regulatory procedures in an emergency situation, for example for the importation / exportation of biological materials or pandemic vaccine. Another specific suggestion in the section on information management was whether information overload was an issue and if so, how this was addressed. Another important suggestion was that the tool should seek to ascertain whether steps were taken to document decisions and changes in policy made throughout the response.

## Day 3: Morning session

### Measures for the vulnerable, next steps and closing

#### Working Group 7: Measures for the vulnerable

The most important outcome of this group was consensus on two decisions, firstly to move the section on measures for migrants and displaced persons into a separate tool, and secondly, to integrate the remaining content on 'risk groups' into the relevant sections of other assessment tools (i.e. arrangements for surveillance, delivery of healthcare, communications, pandemic vaccine for risk groups should be incorporated into the tools for these technical areas). In addition, a distinction should be made between migrants and displaced persons, because their status and needs are often quite different. It was clarified that there are internationally agreed definitions of 'migrant', 'refugee' or "displaced person". However, it would be important for anyone considering these issues at country level in the context of pandemic preparedness and response to have a clear understanding of how these groups are defined in their country and what their legal status and entitlements to health care are. Specific recommendations included the need to document how the pandemic may have impacted on the delivery of other services for vulnerable groups.

#### Summary of main recommendations

Prior to the conclusion of the meeting, a summary was provided of the main recommendations arising from the previous two days. Firstly, the overall approach of the document should be changed so that it is a 'guideline' rather than an assessment tool. The language and form of the questions should also be adjusted to focus on the revision of pandemic plans. The qualitative approach should be retained, but this element should incorporate more structure and ambiguous words should be avoided. In addition, consideration should be given to the incorporation of more quantitative elements. The modular structure should be retained and the intention should be that each component could be used as a "stand alone" document to assess that technical area. Greater clarity was required over the types of questions that should be directed to *different organizational levels* to address (i.e. what should be reviewed at national

level, what at the local level?). A facilitator's / reviewer's guide should be developed which could describe some of the details that may be useful to collect. Similarly, a facilitator's guide could also help to provide some contextual information (i.e. why is it useful to ask this question?) and give suggestions on how the information obtained may help with the revision of a new plan. Each of the different tools should aim to capture how and why the strategy / policy for different technical areas changed over time, what the triggers for these changes were and what the implications might be for any future revision of plans. Public health interventions should be considered at two different stages, containment and mitigation, whereas for surveillance / screening, it is more useful to consider how arrangements changed from being focused on the initial detection of pandemic influenza cases, to initial spread, to monitoring trends and to the post-pandemic stage. The sections on Points of Entry, pandemic vaccine and migrants / displaced persons should be made separate "stand alone" sections of the guideline.

## **Discussion on next steps for revision of the guideline and final comments**

The next step will be for the secretariat to revise the document and develop it as a guideline. A limited external review of some specific components may also be useful. After a final version is available, consideration will be given to approaching some countries to undertake either an internal or a joint review. The first such review could also effectively be a pilot and help with further revision of the document if required. There would also be a need for discussion on the most efficient arrangements for any review, including the most feasible size of the team, the length of the review and the itinerary of the review team.

The Chair invited the participants to provide some final comments and reflections on the two-day deliberations. The consultation was important to present the country perspective, to enhance the likelihood that any proposed review process would be feasible, and to foster local 'ownership'. It was stressed that the resulting guideline should be as 'user-friendly as possible. There would need to be discussion internally within each country about whether a pandemic review would be considered helpful, how it might be conducted and who might be involved (including potentially other line ministries, UN agencies and partners). Also, although

this guideline will focus on reviewing health sector responses, it will also be important to learn from the response of other sectors, especially if re-drafting a new pandemic preparedness and response plan will adopt an “all hazards” and multi-sectoral approach. Some reservations were expressed on how enthusiastic countries would be to undertake a comprehensive review; there is a sense that some were experiencing a degree of “planning fatigue”. However, if the guideline is drafted in a generic way, it may also prove useful to countries outside the SEA Region. Although the primary objective of the guideline and any related pandemic review will be the revision of pandemic plans, it will also have utility in creating and documenting institutional memory on what happened in each country. It will also provide a good opportunity to document best practices and lessons learned, which would constitute a regional and global public good

## List of participants

### **Bhutan**

Mr Tandin Dorji  
Chief Program Officer  
Department of Public Health  
Ministry of Health  
Royal Government of Bhutan  
Thimpu, Bhutan  
Tel: +975 2 322602  
Email: tandindorji@health.gov.bt

### **India**

Dr L Swasticharan  
Chief Medical Officer (EMR)  
Directorate General of Health Services  
Ministry of Health and Family Welfare  
Government of India  
Nirman Bhavan (Room 149, 'A' Wing)  
Maulana Azad Road  
New Delhi-110 011, India  
Tel: 911123061469  
Email: drswasti@yahoo.com

Dr J. C. Suri  
Senior Chest Physician &  
Head of Dept  
Safdarjung Hospital  
New Delhi  
Tel: 27100958, 09810097259  
Email: jcsuri@rediffmail.com

### **Indonesia**

Dr Ira Wignjadiputro  
ARI Subdirector  
Directorate General DC & EH,  
MoH Indonesia  
Jl. Percetakan Negara No 29  
Jakarta Pusat 10560  
Indonesia  
Tel: +62 21 42873416  
Email: sin\_ik\_1999@yahoo.com

### **Maldives**

Dr Ibrahim Yasir Ahmed  
Director General of Health Services, Ministry  
of Health and Family  
Male'  
Republic of Maldives  
Tel: +9603313373  
Email: yasir@health.gov.mv

### **Nepal**

Mr Rakesh Thakur  
Senior Public Health Administrator,  
Epidemiology and Disease Control Division,  
Ministry of Health & Population  
Kathmandu, Nepal  
Tel: +9851077168  
Email: rrrthakur@hotmail.com

### **Sri Lanka**

Dr Vasu Jayasinghe  
Medical Officer  
Epidemiological Unit  
Ministry of Health  
Colombo 10  
Sri Lanka  
Tel: +94 112 695 112  
Email: wasujayasinghe@gmail.com

### **Thailand**

Dr Rungrueng Kitphati  
Medical Officer, Senior Professional Level  
Bureau of Emerging Infectious Diseases  
Department of Disease Control  
Ministry of Health  
Nonthaburi, Thailand  
Tel: (662) 590 3155  
Fax: (662) 590 3397  
Email: drrungrueng@hotmail.com

Dr Woraya Luang-on  
Medical Officer, Senior Professional Level  
Bureau of Emerging Infectious Diseases  
Department of Disease Control  
Ministry of Public Health  
Nonthaburi, Thailand  
Tel: (662) 590 3158  
Fax: (662) 590 3812  
Email: lworaya@hotmail.com

## **WHO Country Office**

### **India**

Dr Sampath Krishnan  
National Professional Officer  
Communicable Diseases  
WHO Representative's Office,  
India

### **Indonesia**

Dr Graham Tallis  
Medical Officer  
Epidemiology  
Communicable Diseases  
WHO Representative's Office  
Indonesia

### **Nepal**

Dr Nihal Singh  
Medical Officer (CSR)  
WHO Representative Office  
Nepal

### **WHO-SEARO**

Dr Sangay Thinley  
Director  
Department of Communicable Diseases  
WHO-SEARO  
New Delhi

Dr Quazi Monirul Islam  
Director  
Department of Family Health and Research  
(FHR/SEARO)  
WHO-SEARO  
New Delhi

Dr Athula Kahandaliyanage  
Director  
Department of Health Systems  
Development (HSD)  
WHO-SEARO  
New Delhi

Dr Arun Thapa  
Coordinator, Immunization and Vaccine  
Development  
WHO-SEARO  
New Delhi

Dr Rajesh Bhatia  
Regional Adviser  
Blood Safety and Clinical Technology  
WHO/SEARO  
New Delhi

Dr Roderico Ofrin  
Regional Adviser  
Emergency and Humanitarian Action (EHA)  
WHO-SEARO  
New Delhi

Ms Vismita Gupta-Smith  
Public Information and Advocacy  
WHO-SEARO  
New Delhi

Dr Jigmi Singay  
Regional Adviser  
Disease Surveillance and Epidemiology Unit  
WHO-SEARO  
New Delhi

Dr Suzanne Westman  
Medical Officer  
Outbreak Alert and Response  
Disease Surveillance and Epidemiology Unit  
WHO-SEARO  
New Delhi

Dr Madhu P Ghimire  
Medical Officer  
Disease Surveillance and Epidemiology Unit  
WHO-SEARO  
New Delhi

Dr Ayana Yeneabat  
Medical Officer  
Disease Surveillance and Epidemiology Unit  
WHO-SEARO  
New Delhi

Dr Gyanendra Gongal  
Medical Officer  
Disease Surveillance and Epidemiology Unit  
WHO-SEARO  
New Delhi

Dr Yogesh Choudhri  
Medical Officer  
Disease Surveillance and Epidemiology Unit  
WHO-SEARO  
New Delhi

Dr Richard Brown  
Public Health Specialist  
Disease Surveillance and Epidemiology Unit  
WHO-SEARO  
New Delhi

Dr Supriya Bezbaruah  
Communication Officer  
Disease Surveillance and Epidemiology Unit  
WHO-SEARO  
New Delhi

Dr Rim Kwang IL  
Medical Officer (Surveillance)  
Disease Surveillance and Epidemiology Unit  
WHO-SEARO, New Delhi

Mr R Krishnan  
Technical Officer (Admn.)  
Disease Surveillance and Epidemiology Unit  
WHO-SEARO  
New Delhi

Mr Rohit James  
Clerk  
Disease Surveillance and Epidemiology Unit,  
WHO-SEARO

Mr Sunil Rajput  
Clerk  
Disease Surveillance and Epidemiology Unit,  
WHO-SEARO

## Agenda

### **Day 1: 08:45 - 12.30: Opening Session, Sri Lanka Room, First floor, WHO-SEARO**

- 08.45-09.00 Registration
- 09.00-10.30 Individual participant review of pandemic assessment documents
- 11.00-11.15
- Opening of the Consultation – CDS, Dr Sangay Thinley
  - Introduction of participants
  - Nomination of Chairperson
  - Administrative announcements, Dr Richard Brown
- 11.15-11.45 Introduction to the Consultation: Overview of the pandemic assessment initiative, outline of the meeting agenda and arrangements for working groups – Dr Richard Brown
- 11.45-12.30 Assessment of the National Strategic Pandemic Response in Thailand (presentation and discussion) Dr Woraya, Thailand

### **Day 1: Surveillance, risk assessment and epidemiology, clinical management, infection control & healthcare facility preparedness, Sri Lanka Room**

- 13.30-15.00
- Working Group sessions, Sri Lanka Room and Thai Room
  - Surveillance, risk assessment and epidemiology, Group 1 – Sri Lanka Room
  - Discussion of draft Surveillance, risk assessment and epidemiology assessment tool – facilitator Dr Suzanne Westman
  - Clinical Management, HCF Preparedness and IC, Group 2 – Thai Room
  - Discussion of the draft Clinical management, HCF preparedness & IC assessment tool – facilitator- Dr Madhu Ghimire
- 15.30-17.00
- Plenary session, Sri Lanka Room
  - Feedback on Surveillance, risk assessment and epidemiology (45 min)

- Feedback on the Clinical management, infection control & healthcare facility preparedness tool

### **Day 2: Laboratory capacity, Communications, Sri Lanka Room**

- 09.00-10.30
- Working Group sessions, Sri Lanka Room and Thai Room
  - Laboratory capacity, Group 1 – Sri Lanka Room
  - Discussion of draft Laboratory capacity assessment tool – facilitator Dr Rajesh Bhatia
  - Communications, Group 2 – Thai Room
  - Discussion of the draft Communications assessment tool – facilitator, Dr Supriya Bezbaruah
- 11.00-12.30
- Plenary session, Sri Lanka room
- Feedback on the draft Laboratory assessment tool
  - Feedback on draft Communications tool

### **Day 2: Public Health Interventions, command & control, logistics and operations, Sri Lanka Room**

- 13.30-15.00
- Working Group sessions, Sri Lanka Room and Thai Room
- Public Health Interventions, including non-pharmacological interventions and vaccination (availability, prioritization and uptake, Group 1 – Sri Lanka Room
  - Discussion of the Public Health Interventions assessment tool – facilitator- Dr Richard Brown
  - Command, control and coordination, logistics and operations, Information Management, Group 2 – Thai Room
  - Discussion of draft Command, control and Coordination, logistics and operations, Information Management assessment tool - facilitator Dr Roderico Ofrin

- 15.15-16.45 Plenary session, Sri Lanka room
- Feedback on the Public Health Interventions assessment tool
  - Feedback on Command, Control and Coordination, logistics and operations, Information Management
- 16.45-17.00 The WHO Evaluation instrument to assess implementation of National pandemic (H1N1) vaccine deployment and vaccination plans – Dr Jayantha Liyanage, IVD

### **Day 3: Measures for the Vulnerable and Next Steps, Sri Lanka room**

- 09.00-10.30 Working Group session (in plenary), Sri Lanka Room
- Measures for the Vulnerable
  - Discussion of the ‘Measures for the Vulnerable’ assessment tool – facilitator Dr Richard Brown
- 11.00-12.00 Discussion on next steps –Dr Richard Brown
- 12.00-12.15 Closing remarks and closing of meeting



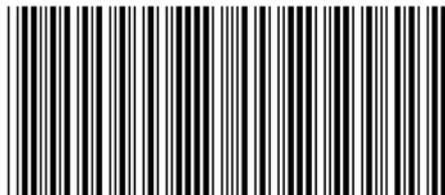
Pandemic influenza (H1N1) 2009 emerged in North America in April 2009. By the time the pandemic was declared over on 10 August 2010, at least 76 302 cases of Pandemic (H1N1) 2009 and 2054 deaths had been reported from the South-East Asia Region. A careful assessment of national responses and the support provided by WHO would yield important lessons for the revision of national pandemic preparedness plans, and to identify gaps where additional technical support may be required to strengthen core capacities, as required under IHR (2005). In order to facilitate a review of national responses, a proposal was therefore made to develop a regionally appropriate pandemic response assessment for use by Member States. With this objective, an informal consultation with invited experts from the Region was conducted in New Delhi from 22-24 November 2010 to review and revise a draft assessment tool. This report provides an account of the proceedings of this meeting and of the guidance provided to improve the assessment tool.



**World Health  
Organization**

**Regional Office for South-East Asia**

World Health House  
Indraprastha Estate,  
Mahatma Gandhi Marg,  
New Delhi-110002, India



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