

PANDEMIC PREPAREDNESS FORUM

Thursday, 10 June 2010, 2-5pm
Imperial Queen's Park Hotel, Sukhumvit Soi 22, Bangkok



*Organised by the
United Nations System Influenza (UNSIC) Asia-Pacific Regional Hub*

Theme:
**Information and Communication Technology (ICT) as
a Tool for Strengthening Pandemic Preparedness**

*The minutes, presentations and other information about this and past Pandemic Preparedness
Forums can be found on the United Nations influenza website at
<http://un-influenza.org/node/3730>*

Chair: Dr. Hitoshi Murakami, Regional Coordinating Officer, United Nations System
Influenza Coordination, Asia-Pacific Regional Hub

Organizations present:

1. Academy for Education Development (AED)
2. American Red Cross
3. Food and Agriculture Organisation (FAO), RAP
4. LIRNEasia
5. London School of Hygiene and Tropical Medicine (LSHTM)
6. Mekong Basin Disease Surveillance (MBDS)
7. Rapid Asia
8. Thai Red Cross Society
9. United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA/PIC)
10. United Nations System Influenza Coordination (UNSIC)
11. World Health Organisation, WPRO

Total: 17

14:00 Introductions of participants

14:15 Project updates

UNSIC: Will hold a Pandemic Preparedness Forum Core Group Meeting on Monday, 28 June 2010. The meeting will plan the content of the forum for the remainder of 2010 and strategize the future of PPF taking into account the transition of UNSIC.

LSHTM: As part of its Asia-Flu Cap project, LSHTM will shortly look at health system resources across six countries (Cambodia, Indonesia, Laos, Taiwan, Thailand and Vietnam). This next phase which begins in July will involve interviewing stakeholders and policymakers on their

experience of previous pandemics with regards resource mobilization. The results will be shared with the PPF.

WHO: The WHO Bi-regional Strategy for Outbreak Prone Diseases is currently being revised. It is designed as a strategy for member states of the WHO Western Pacific Regional Office and the South-East Asia Regional Office, to build capacity in the areas of surveillance, response, preparedness, laboratory capacity, zoonotic diseases and risk communication. It also aims to provide a framework on the work done on influenza pandemic preparedness and response. This new strategy will cover WHO's work for the next five years and should be approved shortly.

The WHO South-East Asia Regional Office (SEARO) is organizing a meeting on influenza research, following up from a global meeting held in Geneva in 2009 which set out to develop a public health research agenda for influenza. The SEARO meeting will follow the same format as the Geneva meeting, but will focus on innovation and policy research. The meeting will be held from 18-20 August in Deli.

Presentation: 'Real Time Health Early Warnings Dissemination System for Unscathed Populations (Heads-up): Pilot in India and Sri Lanka'

14:20 Presentation by Mr. Nuwan Waidyanatha, Real-Time Biosurveillance Program (RTBP) Project Director and LIRNEasia Senior Researcher

(Please see PowerPoint presentation slides on website)

15:20 Q&A

Q: (OCHA/PIC) Where is the collected data held after it has been collected?

A: The data is held in one central location at present, because it is being piloted in a small area. However, in the future since the volume of data is not significantly high, the data will be decentralized, with each district holding its own database or on the open web-space. There will also be one location where this decentralized information is stored centralized.

Q: (WHO) Why does the system not align with the case definitions of communicable and non-communicable diseases, as most countries already have a national for disease definition.

A: The system focuses on symptoms of diseases and the main complaints of symptoms by patients, rather than definitions of diseases. This is because most patients are provided treatment in the test countries based on symptoms.

(WHO) A number of problems of a system which focuses on a set number of diseases is that it is limited to only detecting those diseases, which makes it difficult to identify a new disease.

A: The idea of the system is to look at all communicable diseases and non-communicable diseases to identify trends in the long term.

(UNSIC) This type of event-based surveillance system can probably more-widely pick up events in the community as they are taking place. Also, in the case of Sri Lanka, the data collectors are not medical specialists so they are unable to identify diseases.

Q: (WHO) When inputting the definitions of diseases, could the system introduce a simple drop down menu on the application instead for diseases?

A: At present this is not possible because of the limited nature of the mobile phone screen.

Q: (IFRC) The system has been piloted in one district, in which the complexities may be small in number. How does the project plan to roll the system out on a larger scale where the complexities will be much larger?

A: The system was built to identify if it works on a basic level. To employ the system at a national level, more research will need to be undertaken first. The next round of research will

move from 12 hospitals to an entire district. The lessons from this next phase will then be used to widen the project to provincial level and national level. It is a gradual process that will take time.

Q: (LSHTM) The project may need to invest in the human resource side of the system, in order to ensure its success. Has the project looked at the cost and benefit of the system by comparing it to the previous paper-based system approach?

A: Indeed, the human resources need to be introduced to solve the problem of the delay of the system. Regarding the cost benefits, this has been looked at to some extent (see presentation slide 34). The cost of transferring the data is greatly cheaper by mobile phone versus by using the postal service.

Q: (LSHTM) Are there other digital-based approaches which could be used that may show greater results, for example computer-based collection of data?

A: The Government of India has provided computers for the inputting of data. However, problems have arisen due to limited electricity supply. In addition, when a computer breaks down, the users are reluctant to have it repaired because they either do not know how, the process is difficult or the cost is high. Mobile handsets are easy to repair and cheap to replace.

Q: (FAO) Regarding the system's problems with spelling, has the project looked into applications to assist with this? For example, Microsoft Word offers solutions to spelling through 'Spellcheck' and shorthand prompting. Are these types of solution available for the system?

A: For computers the software has converged so is usable across hardware. But for mobile phone hardware this is not yet the case. For example, Nokia uses a T9 standard but it is not compatible with all mobile handsets. For the next phase of the project, other ways of digitizing this information will be investigated.

Q: (UNSIK) What is the principle analysis the data analysis solution (named T-cute) provides?

A: It does the detection of case clustering both in geographical space and time-line using spatio-temporal scan statistics. Health officials need training to really get the best out of such sophisticated analysis.

Presentation: 'Using mobile phone panels for community-based monitoring'

15:50 Presentation by Mr. Daniel Lindgren, Founder, Rapid Asia

(Please see PowerPoint presentation slides on website)

16:35 Q&A

Q: (AMC) How much time did it take to develop the technological part of the project?

A: It is difficult to say as the technological side of the process is ongoing. Initially, Rapid Asia began to look at the design one year ago. But to set up a similar panel, it could take up to as little as two weeks. What takes time is the administrative side of the project – signing contracts, liaising with donors, etc. The technology is suitable for short term projects who want real impact monitoring of the project. The system ensures the engagement of the stakeholders in the project.

Q: (LIRNasia) Regarding the technological challenges the system faced, why could some of the phones not access the internet through wireless application protocol (WAP)?

A: There can be some difficulties, for example if a phone is brought from overseas. But most phones can receive the link. Also, the timing of sending out the link is important. Initially the links were sent out early in the morning, when the network lines were busy. It proved more effective to send the links out at off-peak periods.

Q: (LIRNEasia) Has the project considered using a Gmail application for email, for example, to enable the operation off-line?

A: These type of things can be developed overtime. The main priority is for the system to work anywhere - in the most basic conditions with the simplest phones. If this application is possible on most phones, then it is something that Rapid Asia will look at.

Q: (OCHA/PIC) Are the costs of mobile and WAP connections born by participants or Rapid Asia?

A: Yes, and Rapid Asia provides incentives and reimbursements to participants to counteract these costs, so that they are encouraged to stay on the panel.

Q: (OCHA/PIC) What is the advantage of the mobile-phone based survey compared to a web-based survey?

A: The main advantage is that most people have access to a mobile phone whereas not everyone has access to a computer. If a web-based application is used, there may be difficulties finding participants as the penetration levels for computers are low.

Comment: (UNSIK) RTBP's solution which was presented earlier is specifically customized for infectious disease surveillance, especially using the technical analysis software called TQ. Rapid Asia's solution on the other hand focuses on programme monitoring.

(WHO) The Rapid Asia's system set up to collect qualitative data, whereas RTBP's system is focused rather on gathering quantitative data.

17.00 Close of meeting.