

## PANDEMIC PREPAREDNESS FORUM

**Thursday, 4 November 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: Pandemic Preparedness as part of a Multi-Hazard Approach**

*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 Marilyn dela Vega Go, Team Leader, Public Health in Emergencies Team, Asian Disaster Preparedness Centre

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#### **Organizations present:**

1. Asian Disaster Preparedness Center (ADPC)
2. Asian Institute of Technology, IRD
3. Concern
4. DAI
5. International Organisation for Migration
6. Rapid Asia
7. Thai Red Cross Society
8. United Nations System Influenza Coordination (UNSIC)
9. World Health Organisation (WHO)

*Total: 15 (including speakers)*

#### **14:00 Opening and introductions of participants**

- As Chair of the Forum, Dr Marilyn Go welcomed everyone.
- She reviewed the theme for the November forum - 'Pandemic Preparedness as a part of a Multi-Hazard Approach' and its importance.
- Dr Go reviewed the forum agenda and asked if anyone had any other agenda items to add - None announced
- Dr Go introduced Dr Pinto and provided a brief background on his achievements and experience.

#### **Presentation: 'Aspects of Communicable Disease Surveillance and Response, in the context of Multi-Hazard Preparedness'**

#### **14:10 Presentation by Dr Augusto Pinto, Medical Epidemiologist, WHO Regional Office for South East Asia (SEARO) DES subunit, Bangkok**

Dr Pinto emphasized that his presentation involved his personal experiences with disasters, pandemic preparedness and response and his experiences with the most recent H1N1 pandemic.

Dr Pinto highlighted the importance of a multi-sectoral approach to Pandemic preparedness and response through the 'Readiness Framework', in which all parts of society are involved in all three phases of pandemic management – 'Readiness', 'Recovery' and 'Response'.

Dr Pinto discussed the complexities but necessity of incorporating contact tracing into all response efforts. Contact tracing responses include understanding the patho-physiology of the disease, the area it has infected, and the mortality of the disease.

Dr Pinto discussed the importance of an accurate risk assessment to prioritize response efforts and achieve appropriate and effective risk management. Dr Pinto identified the aspects which are key to an accurate risk assessment which include: the characteristics of the disease, the likelihood of its spread and the consequences.

Dr Pinto acknowledged that contact tracing and response efforts are reliant on the availability and effectiveness of surveillance systems.

Dr Pinto reported that the most recent pandemic experiences seem to have convinced countries and regions that pandemics are a global affair and that investment in laboratory systems, surveillance and response systems is a regional interest.

### **15:15 Q&A**

**Q: Mr Hitoshi Murakami (UNHCR)** To what extent has Humanitarian Pandemic Preparedness (H2P) been implemented into routine programmes?

**A: Dr Pinto** When the focus is community, Humanitarian Pandemic Preparedness can potentially be integrated into one of the parallel programmes focused in the community - namely health, disaster and mass organisation. The extent of integration at the moment varies. H2P countries which have had longer implementation time managed to incorporate processes to facilitate integration, such as the endorsement of a pandemic influenza module into all Nepal Red Cross trainings. National societies which carried out preparedness planning following the overall disaster management framework and which involved other sectors of the organisation are steps ahead in ensuring that pandemic preparedness is hinged on overall disaster response plans. As H2P tools and guidelines are simple and practical, these can be easily integrated into existing community-based programmes in health and disaster management. National societies have been encouraged to look into this.

**Q: Dr Go** To what extent is contract tracing integral to a response result? When do you advise it is started and stopped?

**A: Dr Pinto** Understanding the dimension of the problem is a key part of determining the answer to this question and will depend on the type of disease. The active case finding step is important. It is necessary to have an understanding of the details around cases detected (ie how many other people are at risk?) otherwise you underestimate the needs, and the problem gets out of hand. e.g measles – same contact tracing in epidemic.

**Comment: Dr Go** If we correlate contact tracing in line with WHO how far do we go until you decide not to do anymore contact tracing? For example, if a disease is in phase 6 (the disease is a pandemic, everybody has the disease or is at a large risk) is it worth continuing to invest in contact tracing?

**A: Dr Pinto** H1N1 was reported as globally phase 6 (WHO system). If the disease is phase 6 then just treat the cases. Each country has its own individual regional, national system and gauges its level independently.

**Comment: Hitoshi Murakami** - A hospital in Japan in phase 6 continued to do contact tracing. They traced all passengers who flew from US by contacting all local health centers. Dr Hitoshi questioned was whether this strategy was economically necessary, or to reassure the population.

**Comment: Dr Pinto** commented that Ebola is an example of a disease with a high case fatality and contact tracing is essential.

**Q: Dr Minet** What level preparedness is required for the impending typhoon in Haiti on the background of cholera outbreak?

**A: Dr Pinto** suggested that a risk assessment would include the types of diseases that go with a typhoon such as Vector Borne diseases.

All systems put in place may be destroyed with arrival of cyclone.

Haiti is an example of where public and private sectors all need to combine their approaches.

**Comment: Esther Lake** From personal experience diagnosis and recording of H1N1 cases is incomplete. Inefficiencies in contact tracing like this put vulnerable populations such as the victims of floods in Nth Thailand, are at increased risk of morbidity and mortality.

**Comment: Dr Minet** 'Silent transmission' is always an issue with Influenza and makes it always impossible to contain influenza.

**Comment: Dr Pinto:** Initial models for first phase containment of H1N1 were based on the assumption that influenza would be spreading from rural areas. This was not necessarily the case so the models used were not appropriate and consequently the response efforts were not effective.

Dr Go summarized Dr Pinto's lecture and thanked Dr Pinto and everyone else for their contributions.

**Presentation: 'CARE's Community Based Avian and Pandemic Influenza Risk Reduction Models in the Mekong Region'**

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**15.40** Presentation by Ms. Jacquelyn Pinat, Regional Program Manager, CARE Australia

Ms Pinat presented the different AHI risk reduction models that CARE has piloted at the community level in Cambodia, Laos, Vietnam and Myanmar.

Dr Pinat reported CARE's decision to implement their AHI models at the community level, stemmed from the acknowledgement that it takes a long time to get governments to put systems in place. The CARE AHI models mirrored strategies taken at the National level which made them sustainable and consequently contributed to building the capacity of communities.

The process started with awareness raising activities including community theatre, education in schools and Universities. They also conducted community surveillance models in 3 of 4 countries, and worked with poultry traders, in markets and backyard slaughter houses to educate on multi-sectoral stakeholder engagement and bio security. These activities are consistent with WHO activities with Governments at the National level.

Ms Pinat reported some of the challenges to the success of the models included:

- Absorptive capacity – the models relied on the availability of community members volunteered time.
- Geographical distribution of villages created obstacles to follow up.
- Weak systems- "community level work is only as successful as your next layer of support".
- Economic and social barriers to behaviour change.

Ms Pinat reported that the program will conclude in March 2011 when all the data collected will be published.

(PowerPoint presentation can be reviewed on UNSIC website)

**16:22 Q&A**

**Q: Dr Minet** Why were no models rolled out in Thailand?

**A: Dr Pinat** AusAID funded the project and they felt there was more need in other countries, and Thailand has good systems in place already.

**Q: Daniel Lindgren** Can you expand on the social barriers to behavioral change you encountered? ie Value chain (middle vendors) why aren't they adopting these practices?

**A: Ms Pinat** CARE's models were focused on smaller poultry chain projects. Barriers to behavior change were encountered with middle vendors due to:

1. The lack of collaboration between the government and the private sector.
2. The unregulated and uncontrolled movement of poultry across borders..

Care did not get to work with middle vendors unless it was in the sphere of the community projects they had.

**Q: Esther Lake** – Is there any thought to progressing economic incentives?

**A: Ms Pinat** – At the community level (back yard poultry level) there are economic incentives in the form of stable household economies.

In the business environment (Markets) sellers saw economic incentives through the increase in the market value of their healthy products. Sellers reportedly felt people bought from them more if they looked like they adopted safe practices.

**Comment: Dr Minet:** Biosecurity standards on farms in Thailand are reportedly high as a result of farmers needing licenses to practice and needing to meet licensing standards to maintain business. The reality is the farmers are poorly informed and practices are poorly implemented and regulated.

**Comment: Dr Pinat:** Awareness and knowledge does not necessarily transport into behavior change – there have been no big outbreaks recently so momentum to maintain good practices is waning.

**Q: Daniel Lindgren** : What economic differences did you see across countries?

**A: Ms Pinat** - Across all 3 countries CARE saw market production was improving. Myanmar used a more expensive model so it was more difficult to see advantages in the short term. The model did show fewer bird deaths and more hatchability which would have been more beneficial to the owners in the long term.

Cambodia was able to use a cheaper model which was easily adaptable and was less cost intensive. Sellers saw an increase in their income after 1-2 cycles.

Despite some teething problems with some models (e.g South Vietnam,) after the first 2 cycles all the CARE models in each country saw production increase.

**Comment:**

**Esther Lake:** Education is key to promoting incentives.

**Dr Pinat:** Backyard incentives were health and production, CARE hasn't worked at the buyer level. FAO lobbies for the trade change issue with the governments.

**Q:** Are any of the models going to expand to animal systems in general? Noted that the Lao system was the only one to include human illness – what effects have you seen in this area? Was there some extra value in this? Did CARE find that the health workers were approached regarding animal health problems?

**A: Ms Pinat** CARE found that a suspected case in animals would generate more intensive surveillance in humans, which increased surveillance and diagnosis of human cases. The surveillance team facilitated a cross-sectoral approach

**Q: Dr Go**

1. How do we harmonize animal alerts with human health alerts to make an integrated and harmonized alert and early warning system?

2. Economic results show costs, but how do you cost the loss of life? Could cost of life prove an incentive for behavior change?
3. 'Events based surveillance' - What is meant by events?

**A: Dr Pinat**

1. Part of model is the alert to the health organizations, so CARE tried to harmonize this way.
2. Gross margins were used as economic incentives. CARE held discussions with households and communities and in focus groups, on how much it will cost if you get sick versus protecting oneself.
3. Example of Laos given – house to house gathering of surveillance information was performed.

Dr Go summarized the presentation and thanked Ms Pinat and CARE for sharing their experiences.

**16:40 Organizational updates and any other business**

**UNSIIC** - Michelle Delaney

Next PPF will be Thursday 2<sup>nd</sup> December. Theme – 'Donors Plans for 2011'. Donors are invited to discuss what area they want to contribute to.