REPORT

UNITED NATIONS SYSTEM

WORKSHOP ON

AVIAN AND HUMAN INFLUENZA

For Asia and the Pacific

11-13 July 2007

Bangkok, Thailand

Executive Summary

Purpose of the Meeting

The objective of the workshop was to provide the UN Country Teams of South East Asia and the Pacific region a platform to focus on the next steps forward in the UN system of contingency planning by determining some definite directions and identifying specific tools for carrying out testing of country level plans. The workshop aimed to increase the readiness of UN Country Teams to support Governments in the region, particularly concerning the non-health aspects of national pandemic preparedness planning, as well as their readiness to carry out effective country level coordination in a cross-sectoral environment.

Expected Outcomes

The workshop aimed to generate the following outcomes:

1. Determine some definite directions and identify specific tools for carrying out testing of the UN Country Team contingency plans.
2. Increased knowledge of non-health aspects of the national level pandemic planning and preparedness.
3. Strengthened coordination capacity through analysis of impediments to coordination and the role of country AHI coordinator/focal points.
4. Introduction and further development of coordination tools, contributing favourably to development and effectiveness of cross-sectoral country coordination mechanisms, and to synergy among stakeholders working on AHI issues.
5. Strengthened UN system AHI network throughout the region.

Participants

Country participants included: UNCT AHI focal points (UNRC Office, UNDSS, UNDP, FAO, WHO, UNICEF, OCHA, WFP) involved in coordination, pandemic planning support and, in particular, in carrying out testing of the UNCT contingency plans;

Regional UN AHI focal points from: FAO, ICAO, ILO, IOM OCHA, OIE, UNDP, UNHCR, UNICEF (EAPRO, ROSA), UNWTO, WFP, UNESCAP, WHO (SEARO, WPRO);

Participants from: UNSIC NY and Asia Pacific, UNSIC Pandemic Influenza Contingency (PIC) Support Team Geneva and Asia Pacific, ADB, WB, ADPC; and

Regional non-UN partners, including donor AHI Focal Points were invited to participate as observers during Day 2, 12 July.

The List of Participants is in Annex 1.

CONDUCT OF THE MEETING

Each day of the workshop was divided into a number of sessions, each session with a specific focus (see Annex 2, Agenda). On Day 1, the presentations and discussions focused on the main aspects of the UN System contingency planning, a progress update on the second round reviews of UNCT pandemic plans, testing pandemic plans and simulation exercise.

Day 2 focused on national pandemic preparedness planning, particularly planning in non-health sectors such as energy; civil-military links; UN System support for pandemic preparedness planning, and UN system support in the framework of humanitarian assistance.

The final day of the workshop participated by the country AHI coordinators and focal points looked at elements of effective coordination and impediments to coordination and AHI coordination resources. The role of the UN AHI Coordinator/Focal Point was discussed and tools for country AHI coordination were presented.

THE WORKSHOP BROADLY RECOMMENDED THAT:

It is important for countries to continue to pay attention to national pandemic preparedness, especially non-health sectors.

Pandemic preparedness planning needs to have clear goals.

Pandemic preparedness planning should cover as many non-health sectors as possible. The UN system should approach pandemic preparedness broadly and in a multi-sectoral manner providing support to multiple sectors beyond support provided through WHO, FAO, or UNICEF.

Coordination with military forces for AI pandemic response planning needs to consider elements such as basic communication, cooperation, coordination and synchronization. More communication and joint working with the military is required.

Aspects of simulation exercises need to be strengthened, particularly communication strategies, roles and responsibilities of the UN Crisis Management Team.

Ministries of Health can not and should not cope with national pandemic preparedness in isolation from other sectors. Inter-ministerial approach to pandemic preparedness and planning is updated.

Vulnerability under pandemic countries needs more resources and research.

A transfer of technology and knowledge from gold standard countries to poor countries is needed because what can be done successfully in a developed country might not work in an undeveloped or developing country.

Integrated approaches to pandemic preparedness planning require advocacy.

AHI planning needs to be added to IASC contingency planning.

Table of Contents

DAY 1: Wednesday 11 July 2007 ... 6
Session 1: Welcome and Introductions ... 6
Opening Remarks ... 6
Session 2 and 3: Testing Pandemic Plans ... 7
Session 4: Simulation Exercise and closing ... 7
Aspects that need to be strengthened ... 8
DAY 2: Thursday 12 July 2007 ... 10
Session 1: Opening ... 10
Session 2: National Pandemic Preparedness Planning ... 10
Pandemic Preparedness in Non-health Sectors ... 10
Pandemic Preparedness and Civil – Military Coordination ... 11
Pandemic Preparedness in the Private Energy Sector in Thailand ... 11
Thailand Business Continuity Contingency Plan (BCCP) ... 13
Pandemic Contingency Planning in Non-Health Sectors in New Zealand ... 14
Session 3: UN System Pandemic Preparedness ... 15
Introduction to the Session ... 15
Presentation 1: Pandemic Preparedness and National Disaster Management Structures – Country Example - Cambodia ... 15
Presentation 2 ... 17
Contingency Planning in the Asia Pacific: A short introduction on contingency planning ... 17
Session 4: UNCT and Governments in Non-Health Pandemic Planning ... 19
DAY 3: Friday 13 July 2007 ... 21
Day 3: Sessions on Coordination of AHI Activities ... 21
I. Coordination of AHI Activities ... 21
1. Elements of Effective Coordination ... 21
2. Impediments to Coordination ... 22
Ways to overcome these impediments: ... 22
II. AHI Coordination Resources ... 23
DAY 3: Role of the AHI Coordinator ... 23
Conclusion ... 25
Workshop Evaluation ... 26
Annex 1: List of Participants ... 27
Annex 2: Workshop Agenda ... 35
Annex 3: Simulation Flipcharts ... 39
Annex 5: Questions for the Development of Shell Thailand Business Continuity Contingency Plan (BCCP) ... 41

DAY 1: Wednesday 11 July 2007

Session 1: Welcome and Introductions

Ms. Elizabeth Fong, UNDP Regional Director and Chair of the Day 1, opened the workshop by inviting the opening remarks from Dr. David Nabarro, Senior UN System Influenza Coordinator and Dr. Brian Davey, UN Medical Doctor, UN Medical Services.

Opening Remarks

Dr. Nabarro welcomed the participants to the 5th workshop on Avian and Human Influenza and commented on the improved coordination among agencies. He noted how the UN system has been working intensively since 2005 to respond to prepare a response to a potential pandemic and how there has been tremendous coordination from within the UN system and with other organizations and foundations including the World Bank, academia and the private sector. Despite the progress to date, avian and human influenza remains a serious threat and therefore concentrated efforts and continuance vigilance is still needed.

The objectives of the UN action plan developed by UN system and non-UN partner organizations reflect the integrated strategies that have been pursued over the last two years. This plan is divided into 5 areas of action; 1) animal health, 2) human health, 3) communication, 4) coordination, and 5) continuity under pandemic conditions. One of the principles of this workshop is to determine how the UN system is prepared to continue working with under pandemic condition. This has been a repeated theme since the first workshop in order to keep the UN system updated in its efforts to deal with a possible pandemic. At this workshop, participants will learn about a number of tools that would enable them to work more effectively, such as the Tracker.

Dr. Brian Davey gave a presentation on core and basic strategies for pandemic influenza preparations for the health of staff and families. He pointed out that although the core of pandemic preparedness planning should include administration and organization, people tended to emphasize the medical area when it comes to planning. His presentation covered core strategies and basic priorities and touched on detailed planning in areas such as business pandemic preparedness and contingency planning. He emphasized the importance of personal hygiene, provision of information and training as key elements in pandemic preparedness.

The presenter offered guidelines on what people can do personally to protect themselves from pandemic flu:

- Minimize social contact
- Become more aware
- Practice personal hygiene
- Get seasonal flu vaccinations
- Use protection according to medical services guidelines
- Take medication only if prescribed by a doctor or medical services department

Session 2 and 3: Testing Pandemic Plans

Daniela Wuerz, UNSIC Project Officer for Contingency Planning & Megan Gilgan, UNICEF Pandemic Preparedness Focal Point

Daniela Wuerz and Megan Gilgan gave an overview on the value of simulation exercises, the types of simulations and when to conduct simulations. They covered simulations for sensitization and awareness-raising, for refining pandemic plans (more detailed scenarios, time constraints introduced, identification of strengths and weaknesses) and drills for testing SOPs (focusing on specific procedures and systems). Other considerations like choosing participants, scenario-building, and skills and support for facilitation were also discussed.

Lessons from past simulations included the importance of putting people in roles in which they would have to deliver, the value of simulations in highlighting where more learning is needed, the importance of coordination and the need for streamlined communication systems. Simulations also stimulate creative problem solving.

Existing tools were introduced including table-top simulation tools available by UNSIC for UNCT preparedness and stakeholder exercise developed jointly by UNSIC and Booz Allen Hamilton used primarily for awareness-raising.

The ensuing discussions covered the role of the evaluator and the importance for evaluations to be participatory exercises fleshing out people's perceptions of the gaps and lessons learned. Although it is useful to have an outside perspective, this is not always necessary.

Country experience noted the importance of keeping the public informed as there have been misunderstandings about the simulation not being a response to a real situation. Likewise, senior management should be aware that a simulation is taking place, and commit to take part actively in the UNCT simulation.

Session 4: Simulation Exercise and closing

The afternoon of the Day 1 was dedicated for conducting a sample simulation, among the workshop participants, under two different pandemic scenarios.

Scenario 1

The Director General of WHO has just announced the elevation of the pandemic to Phase 4. This was in response to the occurrence of several small, isolated clusters of a novel influenza virus in a neighboring country. A link to H5N1 and efficient human to human transmission has been confirmed in all the clusters.

Containment operations in affected areas have been implemented by WHO and the governments concerned.

Over the next 7 days, localized outbreaks continue to be reported throughout the neighboring country, expanding in number and with some cases presenting in urban areas.

The news of the outbreaks is making news worldwide, and the public and media in your country, where no outbreaks are reported, are showing growing concern that the outbreaks in the neighboring country could spread across your national borders.

The government in your country has set up a pandemic emergency committee chaired by the Minister of Health and involving government ministries, NGO representatives and prominent private sector groups.

Scenario 2

In light of the increasing numbers of cases in localized clusters in the neighboring country, and following another meeting of the Pandemic Influenza Task Force, the Director General of WHO announces that the pandemic phase has been raised to 5.

Several businessmen who were at an IT conference in the capital of the neighboring country have returned to their homes in cities and towns, including the capita, in your country. Within days of their return, most are ill and have reported to the hospital with influenza-like symptoms.

After several days, the suspected cases are confirmed to be infected with a novel influenza virus. The government has started putting measures in place to control the spread of the virus, and is holding media briefings for situation updates on a daily basis.

Other countries have started to impose travel restrictions from and to your country. UN staff are expressing concern about the situation, and absenteeism is increasing. The local populations are hoarding food and water, and markets are having difficulty keeping shelves stocked in spite of assurances from the government that there is no need to panic.

Aspects that need to be strengthened

Ten groups took part in the simulation exercise. Each group consisted of 10 to 12 group members, an evaluator and a group facilitator. The aim was for participants to test a plan through a simulation using the UNCT Thailand plan as an example. The objective was that after returning to their countries, participants would be able to apply the process of planning a simulation exercise and carrying out a test of the UN Country Team contingency plans in their home country. Each group discussed both scenarios in the context of the UNCT Thailand Plan and suggested aspects that needed to be strengthened. The suggested areas were:

1. A key element in the communication strategy is that authorities need to speak with one voice
2. An action matrix needs to have clear definitions and it needs to be comprehensive, active, task orientated, and include ‘panic management’

3. The action matrix should be a detailed matrix covering all phases and responsibilities to ensure operational continuity; it should clearly identify:
    a. what to do
    b. who exactly will do it
    c. when they will do it (immediately; within 24 hours, etc.)

4. Clearly identified roles and responsibilities of the UN Crisis Management Team
5. Details about the composition and function of a “Central Command Centre” and interaction with GOUT/ARMY
6. Role of CMTF (TORs required), improved plan structure with cross referencing to the relevant information in the text table and annexes
7. Ensure that any government plan is linked to the Contingency and Preparedness Plan; agreements and decisions are recorded in the plan
8. Checklists attached with the plan

DAY 2: Thursday 12 July 2007

Session 1: Opening

William Paton, Director of UNSIC/PIC Geneva, the Chair of the Day 2gave the presentation outline for the day:

1. Non-health sector pandemic preparedness planning
2. UN support for pandemic preparedness planning
3. Geneva services and support for pandemic preparedness planning
4. Plenary discussion

Session 2: National Pandemic Preparedness Planning

Ingo Neu, PIC Senior Planning Officer, and Sebastian Rhodes Stampa, UNOCHA Civil Military Coordinator Officer

Pandemic Preparedness in Non-health Sectors

Ingo Neu

Dr. Ingo Neu, Regional Planning Officer, gave a presentation on pandemic preparedness in non-health sectors. People usually look at the health sector only and tend to neglect the role other sectors could and should play. Several examples were given by the presenter.

1. **Power Supply** Any interruption to the power supply will cause serious problems since most of the tools we need to cope with a pandemic rely on a steady supply of electricity.
2. **Telecommunications** Any interruption to telecommunication services will cause delays in getting information about changes in the situation, reduce capacity to guide response and manage logistics, and increase the danger of false rumors.
3. **Agriculture/Food Production** Lack of labour will cause loss of or heavy reduction in food harvests, deterioration of animal stocks, lack of food and increased problems of food distribution.
4. **Banking and Finance** Shortages of personnel will lead to difficulties in getting supplies, collapse of SMEs, poverty shocks, panicking and social unrest.
5. **Coordination with the Military** Health responses and movement might be restricted in certain areas, information flow might be interrupted, and self protection of the military might become a top priority.

Apart from mentioning APEC guidelines for functioning economies in times of pandemic, the presenter also noted factors such as government structure, size and density of population, geographic location, and resources and infrastructure that should be taken into account in pandemic preparedness planning.

Although the impact of a pandemic on the health sector and the economy would be equally terrible, economic recovery and recover in other sectors will be more difficult and take longer than in the health sector. Therefore, pandemic preparedness planning should cover as many sectors as possible. The UN system should manage to support each sector and should not limit itself to support through WHO, FAO, or UNICEF only.

Pandemic Preparedness and Civil – Military Coordination

Sebastian Stampa

This presentation offered an introduction to the potential roles and uses of the military in pandemic preparedness and response. Sebastian Rhodes Stampa, Civil Military Coordination Officer from OCHA Regional Office for Asia and the Pacific presented some guidelines for civil-military coordination including OSLO guidelines 1994. He emphasized that all the documents prepared in relation to Civil Military Coordination (CMCoord) are based on humanitarian concepts and principles.

Governments planning to use their military forces in a regional pandemic Influenza response must decide if they will deploy the military 1) as first responders or 2) in support of a multi-faceted interagency response.

Any military role should be limited and precisely defined. "The use of militaries must be a clear legislative and executive definition of what limits will be imposed on military forces for domestic support operations particularly law enforcement operations". The presenter provided examples of additional roles the military can take a lead in during a pandemic such as medical support, logistics, communications, and culling and disposal of infected poultry. Military facilities could also be used as quarantine centres.

There are several issues that could affect the use or non-use of military assets. One issue is interagency/ intergovernmental coordination and unity of effort (a clearly defined chain of command). Other issues included the balance between the primary role of the military in national defense and other forms of military assistance to Disaster Relief Operations and the levels of military preparedness. The issue is whether national security imperatives will complicate preparedness or response.

The importance of military continuity planning in the event of a pandemic will need to be considered for the maintenance of response capacities. It was also mentioned that for coordination with military forces in AI pandemic response planning, elements such as basic communication, cooperation, coordination and synchronization are needed.

Pandemic Preparedness in the Private Energy Sector in Thailand Dr. Somchai
Wongcharoenyong, Country Health Manager, The Thailand Shell Co.Ltd. and Dr. Mark Jacobs, Director of Public Health, Government o f New Zealand

Dr. Somchai Wongcharoenyong from Shell Health Services, Shell Thailand, provided a presentation on Shell Thailand's contingency planning process. It was stressed that Shell has aligned its policy and approach with the World Health Organization (WHO) and has been planning accordingly. Shell Health Services provide the lead for the planning process, which concerns most aspects of the company's operations. He pointed out that Shell Thailand is one of 80 country offices that has a country contingency plan in place. Most countries have carried out some form of exercise or testing of their plans. Thailand conducted a country table-top drill in 2006 and a global drill in 2005. To date, a group-level contingency plan is being developed, and businesses and functions (e.g. HR and IT) are developing plans to fit alongside the group and country plans. The country plan also follows the same template, which has been developed for the global, regional and levels.

For the process of contingency planning, the Group Planning Team and Working Group has met on a monthly basis since July 2005, It is responsible for setting guiding principles and policy in line with WHO, developing key communications messages and processes for employees, initiating country and business contingency planning, and reviewing and testing plans.

There are four guiding principles:

1. care for employees and families and preventative measures
2. business continuity – for business and social reasons
3. Shell General Business Principles (SGBP) underpin all actions
4. safety will not be compromised

The presentation further outlined guidelines and policies. In this respect, it is worthwhile noting that Shell has adopted a policy not to stock antivirals, except where the company's health services are the direct provider of primary and secondary medical care or where appropriate health providers cannot be found. Shell would rather endeavour to ensure that the providers prepare for a pandemic, including supplies of antivirals and antibiotics. In addition, the group-wide policies have been developed to cover a range of topics including vaccination, expatriation, repatriation or evacuation of nationals, compensation issues.

It was suggested by Shell Headquarters that all country contingency plans should also cover critical processes and people in each part of the business, communication with employees, health and hygiene measures, liaison with national governments and key stakeholders, liaison with others in the supply chain and local communities, IT resilience and working remotely or in different ways.

The Shell Thailand contingency plan outlined measures to be activated during each phase of a pandemic. In Phase 4, the regional crisis team will be activated and the Business Continuity Plan will be implemented in affected countries. For Phase 5-6, the group crisis team will be activated, while the Business Continuity Plan will be implemented globally.

Thailand Business Continuity Contingency Plan (BCCP)

Dr. Somchai Wongcharoenyong

Management Commitment and BCCP team, consisting of representatives from 5 main business units, work on the development of the Country Corporate Plan, plus the BCCP of each Business Unit (BU) function. The BU/Function Plans use the same template and a similar approach to ensure a consistent integration into a single Country Plan. The BCCP is continuously reviewed and updated with regularly drills and exercises.

The presentation laid out a list of critical issues and processes to be taken into account during the planning process, and the minimum actions required. In this regard, it emphasised the need for interaction between different groups of stakeholders in order to align their preparedness processes.

Minimum Actions Required

1. Identify Flu Pandemic Contingency Planning Team or Crisis Team and one or two alternates in case they are unavailable.
2. Ensure that the guiding principles and group policies are reflected in the plan.
3. Assess the preparations being made by the national government to close any gaps.
4. Identify other key external stakeholders and ensure that their contact details are up to date and accessible if needed.
5. Familiarize your team with the information available on the SHS.
6. Ensure the members familiarize themselves with the key tasks set out in the plan.
7. Check that others in the supply chain have some form of contingency planning in place.
8. Most importantly, identify critical people, processes, systems and applications - those that are essential to keep the business going - and put in place suitable arrangements to deal with influenza pandemic conditions.
9. Carry out some form of desktop discussion to ensure 'fit for purpose'.

Key actions in a pandemic Phase 4-5

During pandemic Phase 4-5, one activity to be undertaken is the implementation of split-office and work-from-home strategies.

Key actions in a pandemic Phase 5-6

- Align with the WHO but also take account the national government requirements and actions.
- Impose travel restrictions in line with WHO/government guidance.
- Implement group-wide policies and local contingency plans for critical processes, as long as we can operate safely.
- Provide health instructions and advice for all employees.
- Work to ensure business continuity wherever possible.
- Support national efforts to contain the spread of the pandemic and business continuity.

Questions used in the development of Shell Thailand Business Continuity Contingency Plan (BCCP) are in Annex 5.

Pandemic Contingency Planning in Non-Health Sectors in New Zealand
Dr. Mark Jacobs

Dr. Mark Jacobs, Director of Public Health, Ministry of Health, New Zealand, provided a presentation on the pandemic planning process in New Zealand. The process was initiated by the Ministry of Health and spearheaded through an Intersectoral Pandemic Group. It is supported by an explicit Government decision at the highest level to take a multi-sectoral and "whole of Government" approach, involving the private sector and the community.

Given the breadth of the initiative, the presentation emphasised the need for defining clear and explicit goals and objectives for the planning process. An outline of the objectives was provided for the eleven working groups established under the Intersectoral Pandemic Group in order to address critical areas of the national pandemic response. Each working group is led by a government department, with the Ministry of Health providing technical advice.

The presentation provided details about the process of planning business continuity in the infrastructure working group. The process initially focused on key infrastructure providers. It was eventually expanded to critical service providers, resulting in the development of planning guidelines for a wider range of businesses, such as those in the fast moving consumer goods sector. Accordingly, each major company now has a pandemic preparedness plan. For instance, the New Zealand Retailers Association has formed its own continuity plan to deal with a pandemic. The plan identifies critical issues in the fast moving consumer goods sector. It identifies a list of essential food and non-food products for distribution and the supply chain and transport resources that need to be maintained.

The presentation also provided an indication of the process of adjusting the country's legal framework to ensure swift response to a pandemic. In a joint effort, the Ministry of Health, Department of Justice, Department of the Prime Minister and the Cabinet developed the Epidemic Preparedness Act 2006. The purpose of the Act is to ensure that government agencies have adequate statutory power to prevent and address an epidemic.

The pandemic preparedness plan was eventually tested during a five-day simulation exercise in May 2007. The exercise was comprised of different modalities (e.g. table top exercises, simulation drills) and looked at testing the plan against each of its strategic goals.

The presentation concluded with a list of key aspects of the multi-sectoral process. These include:

1) **Leadership.** The Ministry of Health actively led the 'whole of government' approach, after having sought and received agreement at the highest political level. It also made sure that pandemic preparedness oversight is integrated into existing multi-sectoral processes.

2) **Common coordination arrangements.** The Intersectoral Pandemic Group and its working group structure provided a modular organisational structure, with clear leadership identified for each area of work. This also contributed to all agencies using a common terminology and integrating their communications.
3) **Advocacy.** It was important to promote active participation from all concerned parties into coordination arrangements. Dialogue with communities and professional leaders was also important.

During the ensuing discussion, the importance of interacting with the private sector was raised as it provides an opportunity for cross-fertilisation between planning processes. It was also acknowledged that pandemic preparedness plans often struggle with the breadth and scale of the challenges to be addressed. Accordingly, the need for clear and explicit goals and objectives as laid out in the presentation from New Zealand was re-emphasised. Participants suggested that an integrated approach is often difficult to reach due to mistrust between agencies. In this respect, the importance of advocacy was stressed as a way of creating confidence in the process. A question was raised over the role of UN agencies in supporting business continuity planning in non-health sectors. Participants eventually acknowledged the need for more consideration on the subject.

Session 3: UN System Pandemic Preparedness

Maggs MacGuinness, WHO Technical Officer Pandemic Planning, Cambodia
Markus Werne, Deputy Head of Office, UNOCHA Regional Office of Asia and the Pacific

Introduction to the Session

Dr. William Paton, UNSIC/ PIC Director, Geneva

Dr Paton opened the session by describing the wide variety of actors involved in planning. He referred to the National Committee on Disaster Management (NCDM) in Cambodia and outlined the actors involved such as the International Red Cross and the Aviation Ministry. He recommended that support should continue into the operational side of things and not just the strategic side.

Presentation 1: Pandemic Preparedness and National Disaster Management Structures – Country Example - Cambodia

Maggs MacGuinness, WHO Cambodia

Maggs MacGuinness from WHO Cambodia gave an overview of what needs to be established in Cambodia to strengthen the National Committee on Disaster Management (NCDM). A brief description of the written plan followed.

As part of a simulation and testing process, she described what actually happened as opposed to the plan and touched on how a plan needs to be supported by practical steps. The whole process has only very recently been completed and data is still being analysed. One issue that arose was

that any planning must incorporate a number of elements and that communications are an important factor. Most importantly, communications is an overarching group responsible for pandemic planning.

While many countries have a pandemic planning group, in Cambodia this sits under the national disaster management group. This means that agencies are now coordinating with each other. However, challenges remain in order to expand this to take in other groups that can support disaster planning. Planning activities have raised awareness and other ministries are now contacting the National Committee and requesting assistance. This has been a major step forward.

As part of the planning group, a civil/military liaison was established by engaging the Ministry of Defence. This is an important group which had initially been difficult to effectively engage with.

Within the NCDM, two pandemic focal points have been established. The focal points will work within the Ministry to kick-start awareness and to organise training at a local level. Better engagement with another group, the Disaster Management Partners Forum, was recommended and the hope is that there will be better support for pandemic planning.

The UN/government forum is very active in moving the AHI planning forward with regular meetings with government participation.

What held us back:

1. Not all the actors involved in planning have necessarily been identified due to numerous layers of government.
2. When the NCDM was flagged as the way forward there was an assumption that legislation was in place. Unfortunately, only a draft policy was in place and there were no policy guidelines. This need to be resolved,
3. It was assumed that there would be regular budgetary support. In reality, only a basic budget was available. No government funds are currently available and at the moment funding is from other areas such as third party donor bodies.
4. NCDM is being asked to coordinate 28 Ministries and this has taken the Ministry outside their comfort zone. They need the confidence to approach other Ministries with authority.

Lessons

In theory, the NCDM is the most appropriate agency to tackle the problem, but they have capacity issues when stepping outside their regular operations, which are more traditional emergencies such as floods.

Elements that could make a positive difference are;

Planning

1. Planning at a local level. Tools such as a ‘Model local plan’.
2. Support a group of local facilitators to help the local governors prepare each province and build greater local support.
3. Pandemic planning as a regular item on the Council of Ministers agenda to ensure government engagement.
4. Engaging with regional partners such as working with the NZ Government.

Messages

1. Revisit your assumptions. While it is good to go with existing structures, they may need strengthening or confidence building.
2. National policies need to be in place and supported.
3. Ensure resources are available and strengthen support for resource allocation.

Questions following the presentation

Indonesia

It appeared that Cambodia was trying to take a similar approach in Indonesia. In Indonesia, the co-ordination committee on disasters is not involved in pandemic planning. How was the link achieved? How did Cambodia establish a joint system?

A. There was a system already but it was fragile. People came to the conclusion that coordination was important and they realised that this was a good opportunity to build the disaster management system in Cambodia. This would allow the system to become robust. The current meetings are still largely supported by the UN system and while there is some political will, there needs to be active participation by third party actors, such as the UN. This will be needed for some time until the system is adequately developed. The strategic challenge is to determine who leads and how to plan from the basis of a ‘national plan’ and to adequately support local planning.

Presentation 2

Contingency Planning in the Asia Pacific: A short introduction on contingency planning

Markus Werne, Deputy Head of Office, OCHA-ROAP

Humanitarian Reform

Four pillars of Humanitarian Reform

1. Partnership
2. Humanitarian Coordinators
3. Humanitarian Financing
4. Cluster Approach

Humanitarian and disaster response has been seen as working with others through an erratic coordination method. In the past, coordination was often 'personality driven', with strong personalities supporting coordination and in other places coordination failing.

A proliferation of actors in the humanitarian sphere has put pressure on the existing systems both in terms of funding and predictability. Examples from the Tsunami response were cited.

The central aim of coordination is to build partnerships across a number of sectors in order for all actors to work together effectively. The key is to understand each other and build respect. Part of this led to the formation of IASC country teams and from there the ongoing process of humanitarian reform.

Humanitarian Coordinators are central to this process. First, greater transparency and ownership in the appointment is being implemented. This will be followed by support to ensure that good Humanitarian Coordinators continue to work within the sector to strengthen the system.

Coordination will be complimented by the development of the cluster system with accurate descriptions of global cluster leads. In the past, there has been inadequate clarity in the process. Now agencies will have defined leadership that aims to ensure consistency

To support the process there must be predictable funding through the creation of a Central Emergency Response Fund (CERF). The CERF is to help find funds for chronically under-funded emergencies.

Contingency Planning and an Overview of the Contingency Planning Structure

There needs to be a basic level of preparedness that includes a sound knowledge of the system. What is important is that contingency planning through the IASC does not replace local country planning. Preparedness of the IASC does not replace the practical steps of preparedness but is an umbrella group to support the process.

What is interagency planning?

The key to interagency planning is the division of labour and the coordination processes. It is important to ensure that the steps are followed up and not just a paper exercise.

Lessons learnt:

Lessons learnt exercises are a process and not just documents. Documents are only agreements and ways forward. It is the process and the thinking that leads to documented ideas that is important and where the learning originates.

Questions and Comments

Participant's comment that in a full pandemic it might fall on the UN to provide extended capacity. It may be that the UN is important in the cross fertilisation of ideas. Planning

methodologies are coming together. It is important to start marrying Pandemic and Disaster preparedness.

A Question was raised on the UNRC mandate to have disaster management teams, and the feasibility of having both systems in place.

Answer on the composition of the DMT: When there is a disaster and an HC is appointed then a DM Team would be formed. Within the IASC, these people should be made up from part of the existing team but the terminology is mixed.

Representative of UNCT Philippines share that the UNDMT has expanded its membership to bring in other actors to form an IASC and meets once a month. This is due to the chronic nature of disasters. The Philippines were the third country where the cluster approach was rolled out after some disastrous mud slides. The cluster approach has been used largely for preparedness activities. The government is institutionalising the cluster approach. This is leading to a convergence in the system with the government now taking a stronger lead. The continual merging will be helpful.

Question was put forward take away for individual thought: Pandemic fatigue and preparedness fatigue. How can the work that we are doing be integrated into pandemic planning? Pandemic is not only a health response but is a complex response and in some countries, a multi-agency response.

Session 4: UNCT and Governments in Non-Health Pandemic Planning

Nabila Alibhai, Monitoring and Evalution Specialist

Nabila Alibhai gave a presentation on the Pandemic Influenza Contingency (PIC) Support Team, a special unit of UNSIC created in response to a gap in the UN system in supporting multi-sectoral and multi-agency pandemic preparedness in the non-health sector.
The objectives of the PIC Team are:

- To strengthen the capacity of UN regional and country teams to provide effective support to governments and other actors to prepare for the non-health consequences of an influenza pandemic.
- To support UN regional and country team planning to maintain essential functions and staff health and safety in an influenza pandemic.
- To help national actors and their international partners to prepare for delivery of humanitarian assistance in a pandemic.

PIC has 3 objectives: human health, continuity under pandemic conditions, and humanitarian common service support.

PIC support to preparedness takes place at three levels. First, support at the global level where we have UN System Influenza Coordinator and PIC support team in place. Second, at the

regional level where we have regional planning officers in place. The officers will provide support for country-to-country coordination. They will also work closely with regional bodies to ensure that plans are aligned. Finally, at country level, we rely on the UNCT to take the necessary steps to get the UN system and countries prepared to respond to a pandemic.

In early 2006, the Secretary General asked Resident Coordinators to appoint an avian and human influenza focal point within each UN Country Team. To date, these individuals have put a tremendous amount of work into contingency planning, supporting governments, testing UNCT plans in simulation exercises and monitoring UNCT and national preparedness. PIC strategies for 2007 are:

- To measure progress in UN and national influenza pandemic preparedness.
- To advocate the need for improvement.
- To help develop and deploy tools that help the UN and its partners improve preparedness.

Closing Points by William Paton, the Chair of the Day 2

1. Pay attention to national pandemic preparedness, especially non-health sectors.
2. Can Ministries of Health cope with national pandemic preparedness alone?
3. Vulnerability needs more resource and research.
4. Pandemic preparedness planning needs to have a clear goal
5. More communication and joint working with the military.
6. It is easier to do pandemic preparedness planning in private companies such as Shell where the environment and area of work is clear.
7. A transfer of technology and knowledge from gold standard countries to poor countries is needed because what can be done successfully in a developed country might not work in an undeveloped or developing country.
8. Integrated approaches to pandemic preparedness planning require advocacy.
9. AHI planning needs to be added to IASC contingency planning.

DAY 3: Friday 13 July 2007

Day 3: Sessions on Coordination of AHI Activities

Agenda:

I. Coordination of AHI Activities

1. Elements of Effective Coordination
2. Impediments to Coordination
3. Coordination with Regional Institutions

II. AHI Coordination Resources

1. Role of the AHI Coordinator
2. Tools for Country Coordination

The third day of the workshop, chaired by Annu *Nabila Alibhai, Monitoring and Evalution Specialist*

Lehtinen, UNSIC Regional AHI Coordinator, was dedicated to coordination of avian and human influenza activities. While the workshop of November 2006 had exclusively invited coordination focal points to this event, this year's open invitation drew a wide range of participants. In particular, sixty members of various UNCTs joined discussions on how to improve coordination at country level. Because of the large number of participants, pre-assigned seating had been arranged to ensure that coordination focal points sit at the same table. Out of the five tables, two were assigned to AHI focal points. This proved especially useful for the session on impediments to coordination, where participants in break-up groups were given time to discuss their experience with coordination constraints and ways of overcoming them.

I. Coordination of AHI Activities

1. Elements of Effective Coordination

The first presentation was on the coordination study and the nine guiding principles (Annex 1). This was the first venue that offered the opportunity to receive some specific feedback on the study conducted by Brad Herbert Associates. Some of the comments and questions raised included:

- These are not necessarily 'guiding principles' as much as recommendations that could be more useful when presented in an action-oriented manner.
- Coordination is not an end in itself, but a tool to help achieve planning, containment, and preparedness related to AHI.
- What might be actually achieved when there is a strong structure and coordination mechanism?
- How is it really possible to reconcile development and emergency approaches?

- What does the study mean by designating one coordinator for the donor community? How is that possible in practice?
- Greater consistency between the UN and WB is certainly needed, but the study does not present any action-oriented solutions to this dilemma.
- The study focuses on a few countries, especially those that have had the resources to fight AI. The next study should diversify and choose more countries, especially smaller ones with fewer resources.

2. Impediments to Coordination

For this session, participants were split into five groups, as per their pre-arranged seats around 5 tables. A facilitator was assigned to each group with instructions to guide a discussion on constraints they faced in coordination and ways they had overcome them. Impediments to Coordination were identified on:

- Lack of government commitment
- Lack of government leadership
- Authority for decision making (who's taking part in meetings? High-level decision-makers?)
- Government perception of AI as a low priority (in face of other development issues)
- Lack of economic incentives
- Parallel AI structures between WB and UN (e.g. Bangladesh)
- High number of actors (lots of NGO activity; separate, uncoordinated communication materials)
- Question of roles and responsibilities (What is the UN's role? Can or should they facilitate discussions among government ministries?)
- Weak ministries (e.g. some plans are very health focused because of the domination of the health ministry)
- Too many competing priorities, difficult to bring AI to the top of the agenda
- Not enough adequately trained staff (human resources)
- Commitment and resources (both UN and government)
- Absence of a partners' forum to coordinate AHI activities
- Communication gap

Ways to overcome these impediments:

- Use the Resident Coordinator (closer working relations between the Resident Coordinator and the AI coordinator)
- Stronger support to the Resident Coordinator (could be HQ support, regional, etc.)
- Tap into UN relations to bring government ministries together
- Use of high-level officials (e.g. Dr. Nabarro)
- Donor pressure (carrot and stick approach)
- Advocacy (through presentation of worst-case scenario; e.g. Cambodia)
- Risk communication efforts (led by UNICEF as lead agency on communications)
- Sort out internal UN system relations

- Role of UNSIC and PIC in terms of informing headquarters and keeping them coordinated
- Popular leadership in terms of implementation
- UN leadership in partnership and inter-agency cooperation
- Options for governments to choose from; coordination models
- Mainstream AHI in UN development plans
- Focus on coordination mechanisms and information flow
- Harmonized policies from headquarters
- Role of regional officers to draw Resident Coordinator's attention to important AHI 'directives' from headquarters
- Regional initiatives have played a catalytic role (e.g. ASEAN, APEC)

The session ended with suggestions from the facilitator that the impediments and recommendations on how to overcome them would be categorized and circulated after the workshop for further feedback. The final product would then be included as a tool in the coordination resources guide.

3. Coordination with Regional Institutions

Dr. Koji Nabae, UNSIC Regional Coordinating Officer, gave a presentation on regional mechanisms in Asia-Pacific.

II. AHI Coordination Resources

DAY 3: Role of the AHI Coordinator

The session covered country examples of the Terms of Reference for an AHI Donor Coordination Specialist from Viet Nam, UN Coordination Specialist from Cambodia, an AI Coordinator and a UN Pandemic Preparedness Plan Coordinator from Indonesia. This covered the considerations and responsibilities for the title of the position, the level and where it would be placed (Government, UNDP or the Resident Coordinator's Office). Being based within the Government was listed in the Vietnam example as being useful in focusing government support. Questions were raised about the overlap of coordination functions and the amount of time spent on other activities.

The structure of existing and developed coordination systems, tools and mechanisms were discussed. The question was also raised as to whether there is a relationship between the efficiency and effectiveness of the UN system and the amount of resources available. Donor support for coordination was identified as an important factor in the effectiveness of coordination.

The role of existing structures, existing joint programmes and signatories to the Paris Declaration and other committing declarations was cited as important.

A discussion on leadership for UNCT contingency planning took place and it was felt in many cases that DSS was best placed to take this on. However, this varied by country and the level of progress with contingency planning. There are also varying levels of DSS support for business continuity planning. There was recognition of the importance of multi-agency support for contingency planning with responsibilities taken over by agencies with their related expertise.

The example from Indonesia highlighted the importance of a supportive, enabling government structure within which to work and the importance of commitment of government counterparts to AI issues. The challenges of decentralized government and physical access were made clear.

Guidance was requested for islands that depend entirely on imported basic supplies, particularly the circumstances under which UN staff and inhabitants should move to another island. Quarantining islands has been considered in some places.

1. Role of the AHI Coordinator

In this session, the AHI focal points from Vietnam, Cambodia and Indonesia were asked to present their respective coordination mechanisms to the participants, in order to display the variety of structures employed in this region to deal with coordination issues. This was followed by a template for Terms of Reference of an AHI coordinator as developed by UNSIC. One of the issues raised was the necessity of agreeing on a title for this position. The Resident Coordinator of India noted that the title can be problematic as 'coordinator' is generally a reference to the UN Resident Coordinator. There was a general request by all participants that a decision should be made at the HQ level on the title of this post so that there is consistency among UN country teams. The question was raised whether it was a good idea to have a separate coordination entity dealing with AHI issues. Participants also wanted a deeper insight into the kind of support the UN system can offer to the Resident Coordinator as well as coordination specialists in all the coordinating work they do.

2. Tools for Country Coordination

The final session of the third day revolved around coordination tools, developed by UNSIC based on country examples and best practices as well as other tools designed specifically to help improve coordination at the country level. Due to time constraints, the presentation of these tools was rather rushed, and participants wished they had been given the tools earlier so that they could have given better-informed feedback on how to improve the tools. While there seemed to be general appreciation for the tools, there was a sense that a better venue to receive feedback on the tools would be in regions other than the Asia-Pacific, where coordination tools have been part and parcel of how to deal with AI for the past several years. Other comments included:

- OCHA has done similar work on item 1 (list of issues to consider); hence, the request to build synergies with other similar initiatives.
- What are the elements that should be included in a national strategy? A tool to be created listing these elements.
- AHI coordinator TORs: a name should be picked for this position, and all UNCTs should be required to stick to that name, so that there are no longer different names referring to

essentially the same position; also, there should be a list of functions required of each AHI focal point, and more clarity is needed on how prescriptive this list of functions is to be.

- Start the guide with a brief description of who the tools are meant for, what they are to achieve, and how they are to be used.
- What are the expectations of an AHI focal point? How about the idea of AI coming to an end? Will positions created for AI be indefinite? Assuming that is not the case, how can a UNCT know whether it has achieved the goals expected and when it is time for AI positions to expire?
- The questions listed in some of the tools are expressed in a controlling manner; it would be more useful for these questions to have a supporting tone.

The workshop ended with a request that participants send additional comments to facilitators. The outcomes of these discussions will feed into the next version of the tools.

Conclusion

Preparedness planning takes place in a complex, multi-sectoral environment. National governments have a multitude of pressing needs, but it is important to continue to pay attention to national pandemic preparedness, especially non-health sectors. Ministries of Health can not be expected to cope with national pandemic preparedness in isolation from other sectors. Whatever the scope or focus of national governments, pandemic preparedness planning needs to have clear goals and should strive to cover as many non-health sectors as possible. The UN system should support each sector and should not limit itself to support through WHO, FAO, or UNICEF.

Coordination with military forces for AI pandemic response planning, whilst potentially sensitive, needs to consider elements such as basic communication, cooperation, coordination and synchronization. More communication and joint working with the military is required.
Regardless of who is conducting or who is involved in simulation exercises, they need to be strengthened, particularly in terms of communication strategies and the roles and responsibilities of the UN Crisis Management Team.

A transfer of technology and knowledge from gold standard countries to poor countries is needed, because what can be done successfully in a developed country might not work in an undeveloped or developing country. Integrated approaches to pandemic preparedness planning require more effective advocacy and AHI planning needs to be added to IASC contingency planning.

Workshop Evaluation

An evaluation form was distributed at the close of the workshop. Overall, participants rated the workshop sessions interesting, informative and useful (see Annex 6). On returning to their respective organizations, participants resolved to take the following actions to improve coordination:

- Take a more active role in inter-agency cooperation
- Communicate with UN agencies and partners
- Share the information of this workshop
- See whether the 9 guiding principles are in place

Annex 1: List of Participants

Country Office		First and Last Name	Title	Agency	Email
1	Afghanistan	Lucy Dela Cruz	UN Dispensary Physician	UN	lucy.delacruz@un.org
2		Sayed Mohammadullah	UN Dispensary Physician	UN	mohammadullah.abedi@undp.org
3	Bangladesh	Rune Brandrup	Coordination Specialist - UNCT AHI FC	UNRC	rune.brandrup@undp.org, rune@brandrup.net
4		Kirsty McIvor	Chief, Communication	UNICEF	kmcivor@unicef.org
5		Md. Kamruzzaman Biswas	National Professional Officer (Epidemiology)	WHO	zamank@searo.who.int
6	Bhutan	Karma Chogyal	Programme Associate - UNCT AHI FC	UNDP	karma.chogyal@undp.org
7	Cambodia	Peter Linner	UN Coordination Specialist - UNCT AHI FC	UNRC	peter.linner@un.org.kh
8		Scott Hays	UN Security Analyst	UN DSS	Scott.Hays@undp.org
9		Javier Pineda	UN Dispensary Physician	UNDP	javier.pineda@undp.org
10		Men Kimseng	UN Communication Adviser	UNDP	men.kimseng@undp.org
11		Rodger Doran	Subr-regional FP (Viet Nam, Cambodia and Laos)	WHO	
12		Maggs Mac Guinness	Technical Officer Pandemic Planning	WHO	macguinnessm@cam.wpro.who.int
13	China	Nima Asgari	Avian Influenza Coordinator - UNCT AHI FC	WHO	asgarin@chn.wpro.who.int
14	DPR Korea	Vason Pinyowiwat	Medical Officer - UNCT AHI FC	WHO	vasonp@searo.who.int
15	India	Maxine Olson	UN Resident Coordinator, UNDP Resident Representative	UNDP	maxine.olson@undp.org
16	Indonesia	Dennis Lazarus	Deputy Resident Repretative (Operations)	UNDP	dennis.lazarus@undp.org
17		Jonathan Agranoff	Avian Influenza Coordinator - UNCT AHI FC	UN ORC/ HC	jonathan.agranoff@undp.org
18		Muhammad Bey Abduh D Sonata	UN Pandemic Preparedness Plan - Coordinator	UNDP-WHO	sonatam@who.or.id
19		Dakagjin Kelwendi	UN Dispensary Physician	UNDP	duka_kell@hotmail.cam
20	Lao PDR	Irenee Dabare	DRR Operations	UNDP	irene.dabare@undp.org
21		Brigitte Beyer	UN AHI Coordination Specialist - UNCT AHI FC	UNRC	Brigitte.beyer@undp.org
22		Viengsompasong Inthavong	UN AHI Coordination Associate	UNRC	Viengsompasong.inthavong@undp.org
23		Sisomphone Thammavongsa	Security Assistant	UNDSS	sisomphone.thammavongsa@undp.org
24		Ben Burford	UN Dispensary Physician	UN	ben.burford@undp.org
25		Tony Williams	Team Leader FAO Avian Influenza Programme	FAO	tony.williams@fao.org
26		Simon Ingram	Chief of Communication	UNICEF	singram@unicef.org

Country Office		First and Last Name	Title	Agency	Email
27	Malaysia	Daratul Baida	Asst. Representative (Operations) - UNCT AHI FC	UNDP	daratul.dzulkifly@undp.org
28		Rudi Luchmann	Deputy Representative	UNICEF	Rluchmann@unicef.org
29		Maya Fachrani Faisal	Project Officer	UNICEF	mffaisal@unicef.org
30		Elaine NG	Administrative Assistant	WHO	NgE@maa.wpro.who.int
31	Maldives	Patrice Coeur-Bizot	UN Resident Coordinator/Humanitarian Coordinator/UNDP Resident Representative/UNFPA Representative	UNDP	patrice.coeur-bizot@undp.org
32		Johan Fagerskiold	Deputy Representative	UNICEF	jfagerskiold@unicef.org
33		Rosanna Senga	UN Coordination Specialtist	UN ORC	anna.senga@undp.org
34	Mongolia	Altannavch Tsevegjav	UN Dispensary Physician	UNDP	altannavch.tsevegjav@undp.org
35		Ulzii-Orshikh Luvsansharav	CSR Programme Officer	WHO	ulziiorshikhl@mog.wpro.who.int
36	Myanmar	Kanokporn Coninx	(TBC) - UNCT AHI FC	WHO	coninxk.whomm@undp.org
37		Tin Zar Lwyn	UN Dispensary Physician	UN	
38		Saw Ler Wah	Assistant Representative	FAO	saw.lerwah@fao.org
39	Nepal	Sarita Pandey	UN Dispensary physician	UNDP	sarita.pandey@undp.org
40		Vincent Omuga	Humanitarian Affairs Officer	UN OCHA	omuga@un.org
41		Mohamed Rasheed	Administrative Officer	WHO	rasheedm@searo.who.int
42	Pacific	Adriana Carvalho Friedheim	Humanitarian Affairs Officer	UN OCHA	Carvalho-friedheim_ocha@undp.org
43	Papua New Guinea	S.M.M.Nizar	Communication Officer,	UNICEF	mnizar@unicef.org
44		Liduvina Gonzalez	CSR and Response Epidemiologist	WHO	gonzalezl@png.wpro.who.int
45	Pakistan	Muhammad Fawad Khan	Surveillance Coordinator	WHO	khanmu@pak.emro.who.int
46		Waseem Ashraf	Admin Associate	UN-Habitat	waseem@unhabitat.org.pk
47	Philippines	Ronaldo Reario	National Disaster Response Advisor	UN OCHA	regie.reario@undp.org
48	Pacific	Adriana Carvalho Friedheim	Humanitarian Affairs Officer	UN OCHA	Carvalho-friedheim_ocha@undp.org
49	Sri Lanka	Pote Chumsri	Representative (Sri Lanka and Maldives)	FAO	pote.chumsri@fao.org
50		Chris Du Toit	Chief Security Advisor	UN DSS	christ.dutoit@undp.org
51		Gordon Weiss	Communication Chief	UNICEF	gweiss@unicef.org
52		Hendrikus Raaijmakers	Technical Officer, Emergency Health Management	WHO	hendrikus@whosrilanka.org
53	Thailand	Yuxue Xue	Deputy Resident Representative	UNDP	yuxue.xue@un.org
54		Barbara Orlandini	Manager - UNCT AHI FC	UNRC-IASU	barbara.orlandini@un.or.th

Country Office		First and Last Name	Title	Agency	Email
55		Patnarin Sutthirak	Coordination Analyst	UNRC-IASU	Patnarin.sutthirak@un.or.th
56		Yoko Nishimoto	Programme Office	UNDP	yoko.nishimoto@undp.org
57		Carlos Frias	Deputy Security Adviser	UNDSS - UNESCAP	friasc@un.org
58		Surachai Vichankaiyakij	Medical Officer	UNESCAP	vichankaiyakij@un.org
59		Songkiet Bubang	Facilatator Unit	UNESCAP	bubang@un.org
60		Pornthida Padthong	Communication Officer	UNICEF	ppadthong@unicef.org
61		Vijju Kasayapanandha	Senior Admin Officer	UNICEF	vkasayapanandha@unicef.org
62		Nigoon Jitthai	Migrant Health Programme Manager	IOM Thailand Office	njitthai@iom.int
63		Somchai Peerapakorn	National Professional Officer (Programme)	WHO	somchai@searo.who.int
64		Chadin Tephaval	Communication Officer	WHO	chadir@searo.who.int
65	Timore Leste	Geraldine Arias	Head of RC Unit - UNCT AHI FC	DSRSG/RC/HC	geraldine.arias@undp.org
66		Mary Ann Q. Maglipon	Communication Officer	UNICEF	mmaglipon@unicef.org
67		Megan Counahan	Epidemiologist	WHO	meganc.whodili@searo.who.int
68	Viet Nam	David Payne	Partnerships and Coordination Specialist - UNCT AHI FC	UNDP	david.payne@undp.org
69		Rudy Juanito	Security Advisor	UNDSS	rudy.juanito@undp.org

Regional Office		First and Last Name	Title	Agency	Email
70	FAO ROAP	Laurence Gleeson	Regional Manager	FAO	Laurence.Gleeson@fao.org
71		Wantanee Kalpravidh	Project Coordinator	FAO	wantanee.Kalpravidh@fao.org
72		Christine Ahlers	Animal Production Officer	FAO	christine.ahlers@fao.org
73	ILO SRO	Jiyuan Wang	Deputy Director	ILO Sub-regional Office for East Asia	wangjy@ilo.org
74	IOM	Maria Nenette Motus	Migrant Health Regional Programme Manager	IOM Regional Office	nmotus@iom.int
75	UNDP RCB	Elizabeth Fong	Regional Manager	UNDP Regional Office	elizabeth.fong@undp.org
76		Nescha Teckle	CPR Team Leader	UNDP Regional Office	nescha.teckle@undp.org

Regional Office		First and Last Name	Title	Agency	Email
77		Scott Cunliffe	Regional Disaster Reduction & Recovery Advisor	UNDP Regional Office	scott.cunliffe@undp.org
78	UNESCAP	Yu Kanosue	Associate Social Affairs Officer	UNESCAP	kanasue@un.org
79	UNICEF HQ	Megan Gilgan	Pandemic Preparedness Focal Point	UNICEF	mgilgan@unicef.org
80	UNICEF EAPRO	Mary Henderson	Regional Avian and Pandemic Influenza Focal Point	UNICEF	mahenderson@unicef.org
81		Madeline Eisner	Regional Adviser, Communication	UNICEF	meisner@unicef.org
82		Tani Ruiz	Communication Officer	UNICEF	truiz@unicef.org
83		Susan MacKay	Programme Communication Officer	UNICEF	smackay@unicef.org
84		Tung Khac Tran	Communication Officer	UNICEF	tktran@unicef.org
85	UNHCR	Irina Rakhimova	Administrative Officer	UNHCR	rakhimov@unhcr.org
86	UNOCHA ROAP	Markus Werne	Deputy Head of the Office	UN OCHA	werne@un.org
87		Sebastian Rhodes Stampa	Civil Military Coordination Officer	UN OCHA	rhodesstampa@un.org
88		Akiko Yoshida	Associate Expert	UN OCHA	yoshida@un.org
89	WHO SEARO	Maureen E. Birmingham	Team Leader, Epidemiologist	WHO, SEARO/CSR Sub-Unit, Bangkok	birmingham@searo.who.int
90		Augusto Pinto	Medical Officer, Epidemiologist	WHO, SEARO/CSR Sub-Unit, Bangkok	pinto@searo.who.int
91		Yolanda V. Bayugo, MD	Training Activities Coordinator	WHO, SEARO/CSR Sub-Unit, Bangkok	bayugo@searo.who.int
92	WFP	Anthony Craig	WEP Asia AHI Focal Point	WFP	anthony.craig@wfp.org
93		Mitchell Carlson	WFP Adviser/Consultant	WPF	mitchell.carlson@wfp.org
94	UNSIC	Daniela Wuerz	Project Officer for Contingency Planning	UNSIC, New York	daniela.wuerz@undp.org
95		Elham Sayedsayamost	Country Occordination Specialist	UNSIC, New York	elham.seyedsayamdost@undp.org
96		William Paton	Director	PIC Geneva	paton@un.org
97		Nabila Alibhai	Monitoring and Evaluation Specialist	PIC Geneva	alibhai@un.org

Regional Office		First and Last Name	Title	Agency	Email
98		Allan Bell	Regional Planning Officer - Europe & Central Asia	UN OCHA, Geneva	bell1@un.org
99		Jean Luc Tonglet	Regional Planning Officer - Middle East	UN OCHA, Cairo	tonglet@un.org
100		Mapy Gaspar Rosas	Regional Planning Officer - Latin America & the Caribbean	UN OCHA, Panama	gasparm@un.org

Observer – Day 1		First and Last Name	Title	Agency	Email
101	New York	Brian Davey	Director, UN Medical		daveyb@un.org
102	New York	Henrietta De Beer	Human Resources Specialist Policy and Compensation	UNDP	henrietta.debeer@undp.org
103	Geneva	Pascale Gilbert-Miquet	WHO Medical Director		gilbertmiquetp@who.int
104	Comoros	Attoumane Affane	UN Dispensary Physician		attoumane.affane@undp.org
105	Madagascar	Randria Narison Noro Lalao	UN Dispensary Physician	UNDP Antananarivo - Madagascar	norolalao.randrianarison@undp.org
106	Tanzania	Simon Emuron	UN Dispensary Physician		Simon.emuron@undp.org
107	Chad	Enyegue Arsene Mamert	UN Dispensary Physician		aenyegue@hotmail.com
108	Eritriea	Filmon Haile	UN Dispensary Physician		filmon.haile@undp.org
109	Zambia	Teoliza O. Almendras	UN Dispensary Physician		teoliza.almendras@undp.org
110		Dario Aleoria	UN Dispensary Physician		
111		Diallo Alpha Ousmane	UN Dispensary Physician		diallo.alpha@undp.org
112		Diane Collari	UN Dispensary Physician		collar3333@yahoo.com

Regional Inter-Agency Team, Bangkok Office (UNSIC, ADB, OCHA, UNDP, WHO)	First and Last Name	Title	Agency	Email
113	Annu Lehtinen	Regional Avian & Human Influenza Cooordinator	UNSIC (UNDP)	lehtinena@un.org
114	Koji Nabae	Regional AHI Coordination Officer	UWHO	nabae@un.org
115	Ajchara Vararuk	Regional Avian & Human Influenza Consultant	ADB	vararuk@un.org
116	Ingo Neu	Regional Planning Officer, Asia Pacific	UNOCHA	neu@un.org
117	Achara Jantarasaengaram	Humanitarian Affairs Analyst	UNOCHA	jantarasaengaram@un.org

Partners -Day 1	First and Last Name	Title	Agency	Email
1	Kwanpadh Suddhi-Dhamakit	Human Development Specialist	The World Bank	kwanpadh@worldbank.org
2	Stephane P.Rousseau	Regional Coordinator (Greater Mekong Subregion CDC Project	ADB	gms.cdc.rc@gmail.com

Partners -Day 2	First and Last Name	Title	Agency	Email
3	Stephane P.Rousseau	Regional Coordinator (Greater Mekong Subregion CDC Project	ADB	gms.cdc.rc@gmail.com
4	Eleanora de Guzman	Country Coordinator, AIBCC, Viet Nam	AED (Academy for Education Development)	noradeguzman@gmail.com
5	Bounpheng Philavong	Senoir Officer, Human Development Unit, Bureau for Resouces Development	ASEAN Secretariat	b.philavong@aseansec.org
6	Gracyana Rompas	Avian Influenza Pandemic Preparedness Consultant	ASEAN-USAID	grace@aseansec.org
7	Michael Cole	Adviser - Aid Quality and Effectiveness	AusAID	michael.cole@ausaid.gov.au
8	April Compingbutra		CARE, USA	acompingbutra@care.org
9	Andrew Bates	Diaster Management and Humanitarian Assistance	COE (Center for Excellence in Disaster Management and Humanitarian Assistance)	andrew.bates@coe-dmha.org
10	Pattama Vongratanavichit	Program Officer (Development)	Embassy of Canada	pattama.vongratanavichit@international.gc.ca
11	Iida Niemi		Embassy of Finland	iida_niemi@formin.fi
12	Claeisse Hervet	Assistant to the Regegional Counseller	French Embassy	claeisse.hervet@diplomatie-gov.fr
13	Toshiki Ono	First Secretary	Embassy of Japan	toshiki.ono@mofa.go.jp

14	Alain Vandersmissen	Coordinator - Avian Influenza	European Union	alain.vandersmissen@ec.europa.eu
15	Anne Harmer	Programme Officer in health, European Union	European Union	anne.harmer@ec.europa.eu
16	Reinhard Patchrowski		German Embassy	wi-10@bangk.auswaertigesanit.de
17	Liviu Vedrasco	Avian Influenza Coordinator	IRC	Liviu.Vedrasco@theIRC.org
18	James Hopkins	Manager of Public Health Program	Kenan University	jimh@kiasia.org
19	Richard Coker	Researcher	University of London	richard.coker@lshtm.ac.uk
20	Bill Kehoe	Logistics Officer	Marine Forces Picific (PACOM)	william.kehoe@usmc.mil
21	Rick Kohler	Marine Forces Pacific G-3	Marine Forces Picific (PACOM)	richard.kohler@usmc.mil
22	Brett Jackman	CSF-503 Plans Officer	PACOM	brett.jackman@usmc.mil
23	Robert Schultz	Chief Medical Officer	PACOM	rgsras@gmail.com
24	Shehlina Ahmed	Regional Health Adviser	Plan International Asia Regional Office	shehlina.ahmed@plan-international.org
25	Muhammad Awais Butt	Associate Director, Health Equity, SEARP	Plan International Asia Regional Office	muhammad.awais@plan-international.org
26	Katherine Bond	Plan International Asia Regional Office	The Rockefeller Foundation	kbond@rockfound.org
27	Pen Suwannarat		The Rockefeller Foundation	pen@rockfound.org
28	Molly Brady	Avian Influenza Adviser	USAID/RDMA	mobrady@usaid.gov
29	Sudarat Damrongwatanapokin		USAID/RDMA	sdamrongwatanapokin@usaid.gov

Observer – Day 2	First and Last Name	Title	Agency	Email
1	Pimruk Sirimongkolkasem	Student Tanaka Business School - Imperial College London		

Speaker – Day 2	First and Last Name	Title	Agency	Email
1	Somchai Wongcharoenyong	Country Health Manager, Thailand Shell Health Services	The Shell Company of Thailand LTD.	S.wongcharoenyong@shell.com
2	Mark Jacobs	Director of Public Health	Gov. of New Zealand	Mark_Jacobs@moh.govt.nz
3	Jonathan Abrahams	Director/Team Leader	ADPC	jabrahams@adpc.net
4	John Abo	Technical Managers	ADPC	fjbabo@adpc.net

Annex 2: Workshop Agenda

UNITED NATIONS SYSTEM WORKSHOP ON AVIAN AND HUMAN INFLUENZA
11-13 JULY 2007
NAI LERT PARK HOTEL
BANGKOK, THAILAND

DAY 1: WEDNESDAY 11 JULY 2007

8:00 – 08:30 Registration

Session 1: Welcome and introductions
8:30 – 8:40 Opening remarks, *Mr. G. Giridhar, Resident Coordinator AI Thailand*

8:40 – 8:50 Welcoming words, *Dr. David Nabarro, UN System Senior Coordinator for Avian and Human Influenza (video message)*

8:50 – 9:20 Welcome; Priorities in medical management of pandemic Influenza, *Dr. Brian Davey, UN Medical Director*

9:20 – 9:40 Introduction of the workshop agenda and participants, *Chair Elizabeth Fong, Regional Director, UNDP Regional Center*

MORNING: United Nations System Pandemic Contingency Planning

Session 2: Status of the UN System pandemic contingency planning
9:40 – 10:00 Main aspects of UN System contingency planning, and progress update on 2nd round of review of UNCT pandemic plans, *Daniela Wuerz, Contingency Planning Coordinator, UNSIC New York*

10:10– 10:30 Coffee Break

Session 3: Testing pandemic plans
10:30 – 10:45 Objectives of simulation exercises and different types of simulations, *Megan Gilgan, Avian and Human Influenza Focal Point, UNICEF*

10:45 – 11:05 Existing tools for simulations and how to conduct simulations based on existing tools, *Daniela Wuerz, Contingency Planning Coordinator, UNSIC New York*

11: 20 – 11:45 Setting the scene for the afternoon exercise, *Daniela Wuerz, Contingency Planning Coordinator, UNSIC New York*

12:00 – 13:30 Lunch

AFTERNOON: Simulation Exercise

Session 5: Simulation exercise: testing assumptions in UNCT pandemic plans.

13:30 – 17:15 Session instructions and division to groups. The exercise unfolds. *Daniela Wuerz and Megan Gilgan, Lead Facilitators*

17:15 Closing of the Day, Chair

DAY 2: THURSDAY 12 JULY 2007

MORNING: **National pandemic preparedness planning – planning beyond health**

Session 1: **Opening and Introduction *(Main Ballroom – A)***
8:30 *Chair William Paton, Director, UNSIC/PIC Geneva*

Session 2: **National pandemic preparedness planning**
08:40 – 09:00 Pandemic Preparedness of Non-Health Sectors; What, why, how? *Dr. Ingo Neu, Senior Pandemic Planning Officer, UNSIC/PIC Bangkok*

09:15 – 09:45 Pandemic Preparedness in the civil-military sector: What do we know, what do we need to know? *Sebastian Rhodes Stampa, Civil-Military Coordination Officer, OCHA ROAP*

10:00 – 10:15 Coffee break

10:15 – 10:45 Pandemic Preparedness in the (private) Energy Sector. *Dr. Somchai Wongcharoenyong, Country Health Manager, Shell Thailand*

11:00 – 11:45 Pandemic Contingency Planning in non-health sectors in New Zealand. *Dr. Mark Jacobs, Director of Public Health, Ministry of Health, New Zealand*

12:00 – 13:30 Lunch break

AFTERNOON: **UN System support for Pandemic Preparedness Planning**

Session 3: **UN System Support in the Framework of Humanitarian Assistance**
13:30 – 14:00 Humanitarian Response (HRR, Contingency Planning): Opportunities for UNCTs to integrate and support pandemic preparedness activities in countries. *Markus Werne, Deputy Head of the Office, OCHA –ROAP*

14:20 – 14:35 Pandemic preparedness and National Disaster Management Structures - Country example: Cambodia*, Maggs MacGuinness, Pandemic Planning Officer, WHO Cambodia*

14:50 – 15:05 Coffee break

Session 4: **UNCT and Governments in Non-health Pandemic Planning**
15:05 – 15:25 Support to the UNCTs and Governments in non-health pandemic planning - Objectives, strategy and the way forward, *UNSIC / Pandemic Influenza Contingency (PIC) Support Team, Nabila Alibhai, Monitoring and Evaluation Specialist, UNSIC/PIC Geneva*

15:40 – 16:10 **Plenary Discussion**

16:10 – 16:30 **Closing Remarks and Next Steps**
Chair William Paton, Director, UNSIC/PIC Geneva

****Regional non-UN partners, including donor AHI Focal Points, will be invited to participate as observers during Day 2 of the workshop.*

DAY 3: FRIDAY 13 July 2007

****Day 3 sessions are tailored for country AHI Focal Points and Coordinators.*

MORNING: **Coordination of Avian and Human Influenza Activities**

Session 1: **Opening of the Day 3**
8:30 – 8:45 Welcome note and introductions, *Chair Annu Lehtinen, Regional Avian and Human Influenza Coordinator, UNSIC Asia and Pacific*

Session 2: **Elements of effective coordination**
8:45- 9:00 Outcomes of the coordination study; brief overview of the coordination study and nine guiding principles, *Elham Seyedsayamdost, Country Coordination Specialist, UNSIC New York*

9:00 – 9:30 Group discussion on principles and their possible implementation

9:30 – 9:45 Discussion summary and recommendations, Session facilitators

09:45 – 10:00 Coffee break

Session 3: **Impediments to coordination**
10:00 – 10:30 Analysis of obstacles related to the national environment, facilitators
- Group discussion and sharing of experience

10:30 – 11:00 Analysis of obstacles related to the UNCT, facilitators
- Group discussion and sharing of experience

11:0 – 11:30 Analysis of obstacles related to coordination as an issue in itself, facilitators
- Group discussion and sharing of experience

11:30- 12:00 Discussion summary and recommendations, Session facilitators

12:00 – 13:30 Lunch break

AFTERNOON: **AHI Coordination Resources**

Session 3: **Role of the UN AHI Coordinator/Focal Point**
13:35 – 13:40 Examples of country level TORs, Chair

13:40 – 13:55 Country Example: AI Donor Coordination Specialist, *David Payne, Vietnam*

13:55 – 14:10 Country Example: UN Coordination Specialist/ AHI Focal Point, *Peter Linnér, Cambodia*

14:10 – 14:25 Country example: AI Coordinator, *Jonathan Agranoff, Indonesia*

14:25 – 14:40 Generic Terms of Reference for AHI Coordinator/Focal Point, *Elham Seyedsayamdost*

14:40 – 15:00 Group discussion

15:00 – 15:15 Coffee break

Session 4: Tools for country AHI coordination
15:15 – 15:30 Presentation of AHI Coordination Tools developed by UNSIC, *Elham Seyedsayamdost*

15:30 – 16:00 Group discussion: feedback on tools and other tools to be developed

Session 5: Meeting recommendations
16:00 – 16:30 Group discussions, plenary and consolidation of recommendations

Session 6: Coordination with Regional Institutions
16:30 -16:45 Coordination with regional institutions**,** *Dr. Koji Nabae***,** *Regional Coordinating Officer, UNSIC Bangkok*

****UNCT AHI Focal Points and Coordinators form the primary group of participants during Day 3 of the workshop.*

Annex 3: Simulation Flipcharts

1. Spell check, convey to convene
2. Communication Strategy required, detailed matrix covering all phases and responsibilities.
3. More specificity in response actions matrix (Table 8) with detailed actions and responsible agencies.
4. Greater Clarity: A. Interaction with GOUT./ARMY
B. Role of CMTF (TORs)
5. Response Action Matrix (Table8) needs to be much more comprehensive, active, Task orientated, take into consideration panic management of staff as were as general.
6. Review and revise tables 5 and 6.

1. Develop external communication strategy.
2. Create an action matrix to ensure operational continuity.
3. Clearly identify roles and responsibilities of CMT.
4. Update preparedness action matrix.

Aspects	Action Points
1. Government plan linking to the Contingency and Preparedness Plan.	Build a dynamic two-way communication between government and UNCT.
2. Communication	-Establish a more defined communication plan (i.e. staff information, media, inter agency) -Re-strategize the official spokesperson (free-up the RC.)
3. Critical Staff workplace	-Clarify the critical staff across to an at-home office. -Identify at which phase critical staff are able to work at-home.
4. Acronyms/Definitions	Provide a list of acronyms and glossary.
5. Plan Format	Make it more user-friendly

2. Detailed Check for different "phases"
    - What to do?
    - Who exactly will do it?
    - When? (immediately; within 24 hours, etc.)

3. Details about the composition and function of a "Central Command Centre"

4. Improve plan structure with cross referencing the relevant information in the text table and annexes.

General Points:

- Need to speak with one voice
- Checklists will be useful
- Scattered information
- Agreement/decisions need to have been made and recorded in plan
- What needs to be done when not clear

*CMT/SMT/CT confusion-what are the roles?

Internal communication modality spelled out
External communications and role of UN visa versa government not clear

*Plan for phases 4 and 5 should be separately spelled out differences in agency ability to work from home need to be addressed.

Different perceptions of what program can be carried out need to be reconciled.

*How to track staff not clear when Tamiflu world be dispensed not clear.

Annex 5: Questions for the Development of Shell Thailand Business Continuity Contingency Plan (BCCP)

Maintaining Essential Business Activities

- Identifying and analyzing in advance the essential operations, processes and equipment
- Q: how can you continue to operate safely with 25-50% of the workforce absent over a 2-4 month period?

Critical operation and processes

- Which of your facilities or assets are critical to business continuity?
- Given limited resources, what are the priorities?
- Is Government intervention likely for reasons of national security of supply? Have different scenarios been discussed with relevant Government departments?
- Have businesses (and service functions) identified and prioritised a list of essential or time-critical operations (for example: essential maintenance; or year-end accounts)?
- Are there other pressure points (daily/weekly/monthly)?
- What are the implications of shut-down; are shut-down procedures in place; and have they been communicated?
- Have businesses established minimum safety thresholds for staffing for each operation and process?

Critical staff

- Have you identified high-risk staff (e.g. health workers, offshore and marine staff) and key staff, for whom alternates need to be named in advance?
- Have you thought of splitting key staff into different teams at different locations?
- Have you identified the core competencies (and numbers required) for each operation and process and considered alternative internal or external sources of manpower?
- Have procedures been agreed with supervisors for reporting absenteeism and for dealing with sick employees?
- Have you identified additional health care workers who are available or can be trained if necessary?

Supply Chain

- Have you identified the key suppliers, contractors and service providers for each priority operation?
- How will you cope with the reduced capacity of these suppliers, contractors? Have you discussed your contingency plans with them?
- How will you cope with the reduced capacity of customers to lift products?
- Have you discussed your plans with them and discussed their plans? Do they mesh?
- Have you identified and planned for delivery of essential non-health care services (e.g. power, drinking water, transport, communications)?

Alternative Location

- For which operations and under what circumstances would it be necessary or possible to use a fall-back location or work from home?

- What would be the transport, IT and other implications of working from different locations?

Welfare

- How would you support continuing operations with welfare, catering, health, hygiene and other arrangements?
- What social or psychological support or advice is available for staff? Would outside resources be necessary or available?

Health Facilities

- Have discussions taken place between the Company and health authorities to assess the likely availability of local health care facilities?
- Has the HSE/Occupational Health department developed a detailed plan - separately or as part of this contingency plan for the prevention or treatment of a pandemic.

Knowledge Management

- What steps must be taken to preserve or store records, knowledge, back-ups so that they are accessible in shared locations if key people are ill?
- What IT systems are managed or controlled by external parties; and what contingency plans have they put in place in the event of a pandemic?