23rd Meeting of the Pacific Public Health Surveillance Network (PPHSN) Coordinating Body (CB)

29–30 March 2019, Denarau, Fiji

Report of meeting

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1 Introduction

1. Participants were welcomed to the meeting (Annex 2: List of participants).

Election of Chairperson

2. Dr Eric Rafai, Fiji, was re-elected Chairperson of the 23rd PPHSN-CB Meeting.

3. The meeting adopted its agenda.

2 PPHSN membership and governance

2.1. Acknowledgement of outgoing CB members and welcome to incoming members

4. The Chair welcomed new CB members, American Samoa, Federated States of Micronesia, Tuvalu, and Wallis and Futuna, and acknowledged the outgoing members, Northern Mariana Islands, Marshall Islands and Tokelau.

Decisions

5. The meeting:
   i. acknowledged the three outgoing core members of PPHSN-CB: Marshall Islands, Northern Mariana Islands and Tokelau;

   ii. welcomed the incoming core members: American Samoa, Federated States of Micronesia (FSM), Tuvalu and Wallis and Futuna;

   iii. recognised the usefulness of a variety of evaluation tools to assess IHR attributes, noting they contribute evidence towards determining the status of IHR capacities (e.g. use of CDC guidelines for evaluation of public health surveillance systems).

2.2 Review of the 22nd PPHSN-CB meeting report

6. The Chair asked for comments on the report of the 22nd PPHSN-CB meeting in 2018.

7. **Global Outbreak Alert and Response Network deployment**: WHO requested an amendment of paragraph 10. For a GOARN deployment, the organisation the deployed person belongs to covers the salary, but WHO covers travel, per diem and insurance including provision for medical evacuation if necessary.

8. WHO further clarified that to be deployed by GOARN, people must be affiliated with an organisation or institute. Ministries of Health (MOH) can become partners of GOARN. IPNC (Institut Pasteur de Nouvelle Caledonie), SPC, PIHOA (Pacific Island Health Officers Association) and PPHSN are all GOARN partners and can be the technical institution for GOARN deployment.

9. The secretariat noted that as PPHSN is a GOARN partner, PICT professionals could be deployed through PPHSN, provided their government or agency agreed to continue their salary.

10. **Surveillance Technical Working Group (STWG)**: The TOR for the STWG included a proposal that PPHSN adopt the IHR Monitoring and Evaluation Framework as a guide for monitoring and evaluating national surveillance systems. WHO noted that the joint external evaluation (JEE) of IHR capacity includes surveillance assessment, but it is a different type of assessment from that provided by the CDC guidelines for evaluating a surveillance system. There are various tools for this purpose.

11. The Chair suggested the STWG could consider the most appropriate tools for assessments.

2.3 Update on PPHSN review

12. Dr Paula Vivili, Director of SPC's Public Health Division (PHD), said the terms of reference (TOR) for the PPHSN review were circulated last year. The secretariat now has funding for the review and will re-circulate the TOR, requesting any comments from the CB within the next two weeks. There was a delay in engaging the review consultant, but that should be resolved shortly.

13. IPNC and American Samoa confirmed they wished to see the TOR.

Decisions

14. The meeting
    i. noted that the secretariat will immediately re-circulate the terms of reference for the review of PPHSN and its services to the Coordinating Body, allowing a two-week period for comments, and will incorporate amendments received;

    ii. agreed that the secretariat should then proceed with recruiting a consultant for the PPHSN review, which is expected to be completed in six months (allowing two months for the recruitment process and three months for the conduct of the review).

3 PacNet, communication, networking and advocacy

3.1 Update on PacNet use

15. SPC (Christelle Lepers) presented an update on PacNet:

- The number of subscribers has increased by 19% in the past two years
- 85% of subscribers are based in PICTs, and 67% in PICT MOHs
- More alerts are being circulated through PacNet
- Surveillance reports for mass gatherings are also shared on PacNet
- PICTs are posting more outbreak situation reports – 91% increase between 2016 and 2018
- 8788 alerts have been posted since PacNet began in 1997

16. The increased usage may reflect the training provided by the DDM-SHIP programme, which has now produced several cohorts of PICT graduates.

17. There are variations in data quality and analysis, and the timeliness of reporting. It is important for control efforts that outbreaks are reported promptly. The Pacific Outbreak Manual (available from SPC) has a template for outbreak reports, but other formats are acceptable, e.g. media releases used to alert the public at the national level can serve as reports and can be posted to PacNet. Message size is limited to 900 KB.

18. PacNet also acts as a communication tool for PPHSN members. This function is currently underused but is useful for obtaining feedback on an unusual case, or to advise of a training opportunity, as IPNC did recently.

19. Subscribers can access the PacNet archive of all messages posted since 1997. The archive is searchable.

Discussion

20. The Chair raised the question of moving PacNet from an email system to a social media/mobile platform in the interests of rapid dissemination of alerts and mobile access.

21. SPC noted that both WHO and SPC monitor social media for relevant information, including event-based surveillance. Information that can be verified is shared on PacNet and the alert map. PacNet is restricted to health professionals, whereas social media platforms are in the public domain.

22. Participants agreed that use of social media platforms would improve access and could avoid delays, but were concerned about verification of information and trust in the validity of the data posted. Another suggestion was to explore the use of a suitable app for PacNet, rather than a social media platform. The PPHSN review will be asked to consider the issue.

23. PIHOA noted WHO's work in syndromic surveillance and asked if there had been consideration of this work feeding into PacNet. PPHSN is also becoming more involved in vector surveillance and antimicrobial resistance (AMR). This information could be added to the map in future.

24. Cook Islands is experiencing a dengue outbreak. However, lack of epidemiological capacity creates delays in verification of information and sharing alerts. This lack of capacity is region-wide. The map is good but could be even more useful if alerts included number of cases (e.g. of DENV 1) to provide context.

25. IPNC said PacNet is a useful way for the region to share information that, importantly, is relevant and verified. Information on AMR could also be shared in future.

26. WHO said the increase in PacNet subscribers suggests it is time to reflect on the method of communication. As traffic increases, there is a need to highlight alerts that require action in comparison to routine surveillance reports. For example, under the IHR mechanism, WHO has a secure site (EIS) where IHR focal points can post information that requires attention.

27. SPC agreed on the value of considering different levels of alerts, or setting up a more restricted list (e.g. for Directors of Health or EpiNet teams) for information on emerging or urgent threats. SPC has an interactive map that allows numbers to be added to alerts, but PICTs must agree to share numbers.

28. Dr Vivili added that the team meets at the beginning of the week to consider new information and its reliability. Providing real-time alerts would be challenging as PICTs must agree to the release of information before it can be added to the map. SPC sometimes learns about an outbreak from the media, but the country does not give permission to post the information. He agreed there is potential to align PacNet and WHO syndromic surveillance reports to provide one alert system.

29. FNU said Fiji's MOH has established a Viber group for health professionals (about 120 to date) as a discussion platform. This 'grapevine' sometimes indicates that an outbreak is happening even though the information has not been validated or officially reported. Technology changes how information is disseminated and it is useful to consider how PacNet can adapt.

30. Palau (online) said PacNet is a simple solution for getting information out – its success depends on its users. Palau agreed with WHO's suggestion on highlighting key alerts for action.

3.2 PPHSN website redevelopment

31. SPC said the new PPHSN website will be launched in June. It will be hosted on the Healthy Islands portal that is being developed. SPC was asked as the focal point to redevelop the PPHSN website. Now members are asked to provide information for posting, or a ministry contact who can provide up-to-date information (noting it will be in the public domain). Partners are also welcome to post reports and links. The French version of the website is being developed and should be ready for launching in June also.

32. Resources such as posters and manuals will be posted on the website. As part of evolving PPHSN communication, links to information and reports on the website could be posted on PacNet. The website could potentially be used to share routine surveillance reports, with PacNet reserved for alerts and outbreak information.

Discussion

33. Federated States of Micronesia (FSM) asked if the platform could be used as a repository to archive documents. During its recent JEE process, FSM had difficulty retrieving all the required documents.

34. SPC has considered setting up country pages on the PPHSN website or on the portal, but all information posted will be in the public domain. The URL will refer to PPHSN, not to SPC.

35. The Chair encouraged PICTs to use the website and suggested seeking endorsement from PHOH and agreement that countries and MOH can share information when the website is ready.

Decisions

36. The meeting:
    i. noted the update showing increases in the number of health professionals subscribing to PacNet, and number of alerts being shared on PacNet;

    ii. expressed interest in exploring the use of social media platforms as additional tools for sharing alerts, but emphasised that verifying information is critical;

    iii. requested that the PPHSN review consider the points raised on use of social media for PacNet;

    iv. requested Pacific Island countries and territories (PICTs) and PPHSN partners to share stories and documents related to surveillance and response activities with the PPHSN-CB Focal Point for uploading to the new PPHSN website due to be launched at the next regional meeting in June 2019.

4. LabNet update

37. On behalf of LabNet, SPC (Jojo Merilles) described the laboratory network in the Pacific Island region and the number of level 1, 2 and 3 labs in PICTs and their accreditation status (i.e. formal recognition by an accreditation body, as opposed to certification of specific competencies). In PICTs, there are 20 Level 1, 4 Level 2, and 12 Level 3 labs.

38. As part of the current AFD project, SPC and PIHOA have conducted mentoring and coaching of lab staff, using either WHO SLIPTA (Stepwise Laboratory Quality Improvement Process Towards Accreditation) or LQMS (Laboratory quality management system) checklists; 57 lab officers from 6 PICTs have been trained on LQMS, and 81 officers from 8 PICTs on IATA standards for shipping samples. There has also been support for improving lab management processes and protocol development. Beyond the AFD project**,** other PPHSN partners including IPNC and WHO have provided various lab capacity building initiatives.

Proposed stepwise approach to laboratory accreditation

39. PICTs choose if they will pursue accreditation, realising that the process requires resources and that standards have to be maintained year on year. The first requirement is top management commitment to the process and allocation of resources, followed by an assessment of existing capacity. LabNet is helping countries identify gaps and develop plans of action. To be accredited, labs must address all 12 QSEs (Quality System Essentials).

40. LabNet proposes an aligned mechanism to help countries gain accreditation. The goal is not the accreditation certificate itself, but rather improved capacity to provide quality service and care.

4.1 LabNet catalogue: updated version

41. The LabNet catalogue provides a list of defined labs, details about each country lab facility (name and contacts), testing and referral information for PPHSN relevant diseases, and referral laboratories and shipping information. It was last updated in 2015. SPC is now updating the catalogue and has received information from 11 labs and is waiting for information from others.

Discussion

42. Participants discussed the cost of the accreditation process, the ongoing cost for maintaining that status, and whether countries are willing to pay for external accreditation services.

43. SPC confirmed that the support package for capacity building is provided by partners. But the fees for accreditation and the cost of maintaining accreditation are a country responsibility.

44. IPNC said the choice of accreditation must be made strategically by each country with full realisation of what is involved in obtaining and maintaining the status. LabNet will provide capacity building support regardless of whether or not labs are seeking accreditation.

45. Cook Islands said PHOH need to know more about the required workforce and skill mix to plan appropriate lab and pharmaceutical services throughout the region. These services take up a considerable proportion of health budgets. A regional body for pharmacy heads has been proposed. Is there a similar body for laboratory heads?

46. Dr Berlin Kafoa, SPC, said the first regional meeting of pathologists and lab technicians was held recently and they formed the Pacific Islands Society for Pathology. Some of the workforce issues will be discussed at the Directors of Clinical Health meeting. The society may be able to provide data on the regional workforce.

47. Tuvalu said its challenge is lack of human resources and staff turnover. There are plans in place to build the capacity of the lab as a result of recent meetings on AMR. Accreditation will have to wait till these challenges are resolved.

48. WHO recognises that in addition to SIS establishing their own lab capacity, access to capacity is equally important. Proper shipment of samples, and timeliness of results, is critical in an outbreak.

49. IPNC is considering expanding and strengthening its services to the region by
    - setting up an outbreak taskforce that could provide diagnostic services when an event is confirmed;
    - making teams available to support the response to an emergency.

Decisions

50. The meeting:
    i. noted the current status, progress in implementation of laboratory support services and ongoing initiatives to strengthen laboratory capacity in the Pacific;

ii. noted the proposed roadmap for laboratory accreditation, starting with a decision and commitment from country health authorities, and agreed that the roadmap will be further discussed and refined by the LabNet technical working body;

iii. requested Pacific Island countries and territories (PICTs) to nominate an in-country focal point (i.e. laboratory quality improvement champion) who will be responsible for ensuring that countermeasures are implemented for identified quality gaps and limitations in laboratory systems and that implementation is monitored;

iv. further requested PICTs to provide updated laboratory information (i.e. registry of focal officers, contact details, laboratory services provided, referral and shipping information) to the PPHSN Focal Point, to enable SPC to update the LabNet Catalogue, noting that SPC will facilitate sharing of the information with stakeholders.

5. EpiNet

51. SPC (Jojo Merilles) said EpiNet's focus is preparedness and response based on establishing multidisciplinary national outbreak response teams in countries. The focal point maintains a directory of Pacific EpiNet teams (and list of members) for each team. The directory includes country focal points for data management, clinical medicine, laboratory, field investigation, and public health management. Some lists also include the IHR focal point.

52. Countries decide on team members based on appropriate expertise. They are typically nominated by the Director of Health. The outbreak manual provides guidance on team requirements.

53. Twice a year, the focal point (SPC) asks all countries to provide details of their EpiNet teams so the registry can be brought up to date. Details for most PICTs are updated to 2018. Information for five PICTs (Papua New Guinea, Solomon Is., Palau, Nauru and Fiji) is further out of date.

5.1 Selection of Surveillance Technical Working Group (STWG)

54. SPC (Jojo Merilles) noted that the 22nd PPHSN meeting agreed on a process for establishing a seven-member STWG. Nominations for members were called for in July 2018. Only two nominations were received, so the date was extended but no more nominations came in. The STWG has therefore not been established.

55. One of the tasks proposed for the STWG is to update the Pacific Outbreak manual. Ad hoc technical bodies may have to be established to take on these tasks.

Discussion

56. Participants noted that the current Pacific Outbreak Manual has inconsistencies in the level of advice it provides, being specific in some areas but not others. However, it is a good working tool for EpiNet teams to get started. The manual is a work in progress. Following requests to standardise disease thresholds for PICTs, SPC is recruiting a consultant to set up a system.

57. FSM said its national IHR focal point team is the EpiNet focal point. The national focal point, which came about as a result of the JEE process, will coordinate work and request technical assistance when needed.
58. WHO noted that the national IHR focal point must be an agency, not an individual. WHO also suggests that NFPs include agencies in other sectors such as disaster response and animal health. Countries are asked for updated NFP lists annually.

59. The Chair proposed approaching PHOH at next week's meeting to ask for outstanding information on EpiNet teams.

60. Cook Islands agreed, and suggested sending information on EpiNet teams quarterly to PHOH so they can ensure systems are staffed.

61. In place of the STWG, the meeting supported the establishment of an hoc technical body with a 50/50 balance between agencies and PICT members. The following PPHSN members volunteered to take part: American Samoa, Cook Islands, Guam, IPNC, PIHOA/CDC and SPC. The Auckland Public Health Service, which monitors disease in PICTs, was also suggested as a potential member.

Decisions

The meeting:

i. requested PICTs to note the key roles of EpiNet team members, and to ensure that the membership of the team is able to meet and satisfy all the roles;

ii. agreed that other sectors (e.g. disaster management) should also be represented on EpiNet teams;

iii. noted that PPHSN is ready to assist in building capacity and asked PICTs to indicate their needs;

iv. recognised the importance of all PICTs providing an updated registry of EpiNet focal points to the PPHSN-CB;

v. agreed that information on the members of country EpiNet teams should be sent quarterly to their respective Heads of Health to ensure they are well informed and able to take steps if necessary to see that systems are appropriately staffed;

vi. agreed to establish an ad hoc Surveillance Technical Working Group, with at least 50% of members to be PICT representatives, and noted the following volunteers: American Samoa, Cook Islands, Guam, CDC/PIHOA, IPNC and SPC, with the Auckland Public Health Service also suggested as a potential member.

5.2 Strengthening regional response: Global Outbreak Alert and Response Network (GOARN) training and Emergency Medical Teams

62. Dr Angela Merianos, WHO, noted that GOARN Tier 2 training for partner agencies had been tentatively scheduled for May 2019 in Vanuatu. The training has been deferred and is now unlikely to take place in 2019.

63. GOARN was established in 2000 to coordinate responses to international public health

emergencies, when countries require surge capacity or additional expertise as a result of a disease outbreak or natural disaster. GOARN support is available on request. CDC, SPC, PIHOA and IPNC are GOARN partners.

64. Emergency medical teams (EMTs) were established as a result of medical assistance arriving too late for emergency surgery, etc. in disaster events. To ensure rapid deployment, the EMT initiative helps countries to develop their own teams. Partners decided on three levels of accreditation for EMTs. Fiji Tonga and Solomon Islands have EMTs. The Fiji team is currently seeking level 1 accreditation – Primary care. There is a quality assurance process for setting up an EMT. PICTs who wish to set up a team can contact WHO. After the EMT is verified, it goes on an international roster that countries can select from when necessary. Not every EMT has to go on international deployment. The primary aim is to strengthen in-country capacity for rapid field response.

Discussion

65. The Chair described his first-hand experience of Fiji's establishment of an EMT with support from WHO and DFAT. The process has taken three years to date. One of the challenges for PICTs is to acquire the required cache of equipment and capacity. DFAT has provided equipment worth FJD 1 million, including for a field hospital.
The Australian and New Zealand EMTs have been very helpful and PICTs should seek their support in setting up EMTs. The Fiji EMT will undergo verification shortly and other PICTs could observe if they wish.

66. WHO noted in relation to training that Tier 2 training is immersion training, which takes several days using scenarios in field-like conditions. It also includes the soft skills needed by teams working under stress and in difficult conditions over a period of time. The training allows identification of team leaders and people with the right skills. It is an intensive and expensive exercise compared to Tier 1 training, which involves table-top exercises. WHO will conduct a table-top training session at the PHOH meeting.

67. In answer to FSMs question on the process for GOARN assistance, WHO said the request has to come from the MOH. It is referred to Geneva, which puts the information out to the GOARN network, checks the country's needs and goes back to GOARN for CVs. CVs are sent to the requesting country to select, based on availability, background, etc. of personnel. WHO is trying to foster a local network to provide support in the Pacific.

6. PICNet

6.1 Update on regional IPC guideline development

68. Dr Salanieta Saketa (SPC) said Fiji and Cook Islands have established national plans for AMR (antimicrobial resistance) surveillance and have set up multi-sectoral committees to oversee the work. Eight other countries are in the process of developing national action plans (Kiribati, Marshall Islands, Solomon Islands, PNG, Tonga, FSM, Palau and Samoa). The plans should include a budget.

69. In 2015 and 2017 there were calls by PICTs to strengthen surveillance for AMR, including for overseas medical referrals. The regional IPC (infection prevention and control) guideline, which was developed in 2010, was reviewed in 2016. Under the AFD project, terms of reference have been prepared for a consultancy to finalise the regional guideline and assist in updating national IPC guidelines for Solomon Islands, Kiribati, Samoa and Cook Islands in 2019.

70. PICNet was set up to support infection control in PICTs. However, at present the network is dormant. A technical working group is proposed to strengthen PICNet, with the WG's role to include ensuring the revised guidelines are sound and appropriate in the PICT context.

71. Challenges for IPC include lack of microbiology capacity in PICTs. Countries have different levels of capacity for deciding on methodologies and technologies for AMR surveillance and not all countries are able to carry out antibiotic sensitivity testing. However, most have one or more GeneXpert machines that could be used effectively for AMR testing.

72. There is also a need for research – there is little regional information on the prevalence of AMR (except for MDR-TB and some for MRSA) or on AMR stewardship, e.g. prescribing habits in health clinics and hospitals. SPC, WHO and the University of Queensland have drafted a funding proposal for establishing a regional mechanism for antimicrobial stewardship and resistance.

Discussion

73. CDC suggested mapping PPHSN work on AMR against IHR capacities to show where there are gaps and what support is required.

74. WHO noted the importance of monitoring and evaluation of activities contributing to IHR implementation and the need to collect evidence of activities. Good document control will facilitate the JEE process in countries.
WHO also suggested consideration of developing assessment tools as part of updating the IPC guidelines, e.g. on supply chain management.

75. FSM said there is a current study on AMR stewardship in local settings in three PICTs. The results will be presented to PPHSN.

76. American Samoa currently reports cases of AMR to CDC and asked if reports should also go to PICNet.

77. Dr Saketa (SPC) said there are plans to develop a regional reporting mechanism for AMR to escalate reports to GLASS (Global Antimicrobial Resistance Surveillance System). Some PICTs post AMR data to WHONET. Reporting advice could be included in the regional IPC guideline.
PICTs are being encouraged to develop an AMR /One Health Committee to act at a national level.

78. The Chair said Fiji is on the second round of its AMR plan but there is need for more support and more involvement of other sectors. (Referring to paragraph 3.2. of meeting paper 5, he said Fiji has a good governance structure for AMR, which includes other sectors and academic institutions. SPC will revise the paragraph).

6.2 One Health

79. Dr Saketa (SPC) said the 22nd PPHSN-CB and 6th Pacific Heads of Health Meeting endorsed the resolutions of the first One Health Consultative Workshop in April 2018, which included 'strengthening partnerships between the human, animal and environmental health sectors'.

80. In November 2018, SPC, as the PPHSN-CB focal point, co-convened the Oceania Planetary Health Forum with IUCN (International Union for Conservation of Nature), University of Sydney and Edith-Cowan University. The concept of Planetary Health focuses on the impacts on human health that result from human disturbance or destruction of Earth's ecosystems (with animals considered as part of the biotic environment). The concept is broader than One Health.

81. Taking the One Health/Planetary Health approach forward in PICTs requires interaction between the human, animal health, and environmental sciences and interconnected systems to address priority risks, e.g. AMR (identified as a top priority by WHO) and zoonoses. Most PICTs have limited capacity in veterinary/animal health and environmental health so the challenge is to find ways of acting that fit PICT settings

82. The second One Health/Planetary Health Consultative Workshop is tentatively planned for June 2019 with the objective of advocating for support and resourcing of One Health/Planetary Health approaches at national and regional levels and with development partners.

Discussion

83. The Chair said the health fraternity is the biggest contributor to AMR. Before going to other sectors, surveillance systems must be put in place in the health sector. This is a basic issue that PICTs must address first.

84. FNU supported the Chair but said the external environment was critical to health. PICT water and sanitation deficiencies have severe impacts on population health.

85. Guam also noted the social determinants of health.

86. SPC said concept papers will be developed for the next One Health meeting. There will also be consultation with PPHSN members on developing a roadmap to take the One Health approach forward.

Decision

87. The meeting:
    i. agreed that anti-microbial resistance (AMR) is a high priority for the region requiring a multi-sectoral approach, with appropriate resourcing of infection prevention and control (IPC) and AMR activities required at both national and regional level in terms of finances and human resources;

    ii. noted the progress made so far in enhancing microbiology capability, the review of the Regional IPC and national guidelines, and updating of national AMR guidelines;

iii. agreed that an assessment tool be provided as an annex to the revised IPC guideline.

7 DDM-SHIP (Data for Decision-Making – Strengthening Health Interventions in the Pacific)

7.1 Status update: DDM-SHIP accreditation; flexibility in schedule and delivery of course

88. SPC (Jojo Merilles) said that at the end of 2018, more than 300 health officers from 17 PICTs had completed at least one of the 5 modules of the Postgraduate Certificate in Field Epidemiology (PGCFE) course. Eight have officially graduated after completing all modules. Another 97 are eligible to graduate, but only 17 of these 97 students have completed their FNU enrolment documents, which is a requirement for graduation.

89. Around 100 health officers from various PICTs are expected to graduate from the PGCFE course at the end of 2019. New cohorts of the PGCFE course will be initiated in six PICTs in 2019. The minimum requirement for entry is three years' experience and a recommendation.

90. Funding for PGCFE implementation is reliant on external sources. Aligning the course schedule, national work plans and funding can be difficult. It is also important that SHIP-DDM is integrated with the work of those attending courses to ensure it is effective for improving health information systems.

Training materials

91. There are plans to develop a handbook for SHIP; a training manual for trainers delivering the PGCFE, Postgraduate Diploma in Applied Epidemiology (PGDAE) and Masters in Applied Epidemiology (MAE) courses; and a training manual for PGCFE, PGDAE and MAE students, with a guide on preparing for and learning from the training, including assessment criteria.
The course is to be translated into French, and accreditation by a French university is being discussed with FNU.

Discussion

92. WHO said the statistics on SHIP training are useful in mapping PICT health capacity and should be presented in reports to PHOH and to countries to complement existing information on the Pacific health workforce.

93. Cook Islands is engaging with the Australasian Epidemiological Association, Australasian Faculty of Public Health Medicine and NZ College of Public Health Medicine to discuss how doctors with a masters in public health can be lifted to fellowship level.

94. The Tuvalu representative said she had completed module 4 of the PGCFE. It is important that MOH commit to sustaining the programme. One challenge is the length of the training, which stretches over 3 years. Staff have left before completing the training. A condensed programme would encourage completion.

95. SPC said that in response to similar requests from other PICTs, it is now possible for students to

complete the course in 1 year of full-time study or a maximum of 2 years. (Further details are given below – 7.3 FNU presentation.)

96. IPNC said the University of New Caledonia is thinking of developing a master degree in health. When translated, the DDM course could be delivered through the University of New Caledonia.

97. SPC and FNU confirmed that accreditation of the course is being discussed with the university.

7.2 DDM-SHIP update – PIHOA

98. PIHOA (Dr Mark Durand) said that in the US-Affiliated Pacific Islands, 50 courses have been conducted for 232 participants. To date, 95 have successfully completed all courses.

99. An important aspect of the course is the integration of training with needs at national level. Several templates for standard operating procedures (e.g. weekly reporting on communicable disease surveillance) have been developed during the course. The course has also resulted in the development of a regional good – an *Outbreak response after-action report and improvement plan workbook*.

100. The impact of DDM training is demonstrated in the increase in Weekly Outbreak Disease Surveillance reports with 90% of PICTs now producing reports in comparison to 10% in 2105. This result is testament to the work of countries themselves and also the combined efforts of PPHSN and technical partners, and FNU, which has made a tremendous contribution. DDM-SHIP supports the development of health information systems (HIS) and there has been good feedback on measurable improvements in HIS related to DDM SHIP.

101. Now that a critical mass of people have qualified to epidemiology technician level, the next step is to advance identified students to masters level in consultation with country health leaders on capacity needs. Partners are encouraged to continue their engagement in this next step through teaching the course and supporting the relevance of its content, which could also feed into the SHIP handbook. There is some PIHOA funding for this engagement.

Discussion

102. WHO acknowledged the course's focus on after-action reviews, which is part of the IHR M&E framework, and also on research findings, which can lead to changes in the way processes are conducted.

7.3 DDM-SHIP accreditation – FNU

103. Dr Donald Wilson (FNU) described the course modules and the pathway to entry to the PGCFE. (He noted that to comply with FNU course naming requirements, the DDM course is now called the PGCFE). Criteria include a health professional with a bachelor degree, or five years' experience in the health sector, and a supervisor's reference. Many of those who have completed the course have gained entry based on experience (mature entry) but have had no opportunity previously to gain qualifications.

104. Referring to the 2018 request to FNU for flexibility in the timing of enrolment for candidates (to coincide with funding cycles), Dr Wilson said the five modules now comprise one course that runs over 1 year of full-time study, or 2 years part-time. This allows students to enrol for semester 1 or semester 2, with no need to re-enrol for the duration of the course.

105. The degree of Master in Applied Epidemiology (MAE) has been revised with aim of achieving TEPHINET (Training Programs in Epidemiology and Public Health Interventions Network) accreditation, which enables graduates to take part in global initiatives.

106. There is a need for more one-on-one training and recruitment of a mentor has been suggested. Some regional students struggle with scientific English and academic writing, which is why a 65% average at diploma level is required for entry to the masters programme.

107. A large number of students (97 of 231) have completed the PGCFE course but are still waiting to graduate because they have not completed enrolment. A birth certificate is a requirement for enrolment but many do not have one. A December graduation is possible for these students if countries can assist in providing them with birth certificates. Countries and participants and supervisors have been informed of this situation through SPC and PIHOA. (A passport is not a substitute for a birth certificate.)

Discussion

108. SPC noted that TEPHINET is an allied member of PPHSN and there have been discussions with them on accreditation.

109. American Samoa asked if FNU could provide the list of student names for each PICT so they could be assisted to get their birth certificates. She also asked if DDM SHIP is applicable to hospital staff, not only public health staff.

110. SPC and PIHOA confirmed that hospital workers, and laboratory and environmental health officers have also enrolled. In Fiji, infection control nurses and others have enrolled. An expression of interest is disseminated across the Fiji MOH.

111. FNU asks PICT governments to provide their MOH human resource plans so the university can develop relevant courses. But this information is often not forthcoming.

112. WHO supported FNU comments on matching training to country workforce requirements. Pipeline planning of HR requirements for the health workforce is critical to sustaining progress.

113. Dr Vivili suggested that some course participants may be satisfied with having completed the course and do not necessarily want to graduate.

114. FSM recommended that students graduate. Graduation and evidence of qualifications are incentives for performance.

115. The Chair proposed SPC and PIHOA follow up the issue with relevant PHOH at next week's meeting.

116. Cook Islands said a strategic recommendation addressing the issue should be made to PHOH so the meeting does not have to revisit it.

117. FNU, in a similar vein, said the university has regional commitments to PICT HR capacity, but its entry requirements mean some PICTs have not been able to enrol any students in the MBBS programme (as an example) because they have not met the required pass mark. Is there a place for having a caveat on these entry requirements and putting the idea before PHOH?

118. Dr Vivili suggested further work between FNU and partners on possible changes to policy and internal processes before bringing the issue to PHOH.

Decisions

119. The meeting:

i. noted the progress update on the SHIP programme;

ii. noted the request to nominate in-country experts to contribute to the SHIP handbook and manual development;

iii. noted the importance of including SOPs for registration and processing of participants in the SHIP handbook;

iv. requested PICTs to identify mentors to provide ongoing support to SHIP students throughout their training;

v. requested PICTs to implement/develop selection criteria for SHIP DDM candidates which comply with enrolment requirements;

vi. asked PICTs to create positions for SHIP-DDM graduates commensurate with the qualifications acquired in accordance with national public service requirements (noting, as an example, that additional surveillance positions were created in Vanuatu);

vii. encouraged PICTs to continue to co-invest in, and co-own the SHIP-DDM programme;

viii. acknowledged the contribution of FNU to the SHIP programme, including its flexibility in ensuring the enrolment requirements are not a barrier for potential students.

8. Regional surveillance and Pacific health security – WHO

8.1 Update on the Pacific Syndromic Surveillance System (PSSS) / Early Warning, Alert and Response System (EWARS)

120. Dr Angela Merianos, WHO, said the PSSS IT platform has been adapted from the EWARS platform. The system provides a weekly summary table of information by country, reporting site and syndrome. The five syndromes monitored are acute fever and rash, diarrhoea, ILI, prolonged

fever, and DLI (dengue-like illness).

121. A benefit of the system is that it produces trend graphs in real time. However, because the system is not designed as a regional tool it is difficult to see what the data means for countries with very few cases.

122. The EWARS system was designed for emergency response. 'EWARS in a box' includes a mobile phone with software uploaded, mini server, and mini solar panels to generate power. Data that is entered is uploaded to the server when there is connectivity. WHO can share more information on 'EWARS in a box', which is easy to use, especially in disaster situations.

123. The system is low cost, simple to operate and requires little training. However not all countries are entering their data directly. IT support for the system is based in Europe so modifications take longer than ideal. To overcome these issues, there have been very preliminary discussions with Watershed Intervention Systems Health–Fiji (WISH Fiji) and Tupaia regarding adaptation and improved visualisation. (Tupaia is a platform that provides a dashboard of accessible data from across countries' information systems. It has funding from Australia (DFAT) for three years.) Tupaia has offered to improve the visualisation of data. Data privacy is an issue however.

124. In relation to development of the PSSS, WHO has two questions for countries:
    - Will working with Tupaia require additional approvals to share country data with them? Tupaia already works with several PICTs (https://www.tupaia.org/).
    - Is the current list of syndromes sufficient e.g. should acute jaundice syndrome, acute neurological syndrome, SARI and others be added?

Discussion

125. Dr Saketa said she had seen a recent demonstration of the Tupaia system and was impressed with its functionality for collection and visualisation of data.

126. FNU suggested it may be useful for people involved in some of the projects discussed at the meeting to attend so they could clarify details. This seems to be in accordance with the PPHSN terms of reference.

127. FSM said country-level information systems are often very basic, e.g. FSM collects and processes information on syndromes manually. The HIS is being developed, but there is a need for more expertise. Perhaps PPHSN, or the STWG can advise. FSM reports to EWARS as one country, but reporting as four states would provide greater sensitivity and improve surveillance information.

128. The Chair said Fiji would require additional approvals for release of data. He suggested the question of adding more syndromes could be put to the ad hoc STWG.

129. SPC (Sunia Soakai, Deputy Director of PHD, SPC) noted that countries may have legitimate concerns about security in relation to an open platform such as Tupaia.
In regard to FSM's comments, he said development partners/agencies must give serious consideration to the provision of support for country efforts to develop their HIS. Countries are

under pressure to feed data into regional and global systems and need help to provide accurate and timely information. The Pacific Health Information Network (PHIN), which is being revived at present, is one possible means of providing support. Some countries have had help from the World Bank and Asian Development Bank to develop eHealth strategies, but the process is ad hoc.

130. Participants agreed that the use of systems such as Tupaia should be discussed at the regional PPHSN meeting when all PICTS are represented. They also agreed that the ad hoc STWG will be asked to explore adding syndromes to the Pacific syndromic surveillance system

Pacific disasters

131. Dr Merianos presented a brief summary of data on disasters that have occurred in PICTs in the past 10 years. The most frequent disasters are storms and floods followed by earthquakes, volcanic activity and drought. Even though droughts are less frequent, they have affected the most people. In the past 10 years, PNG, Vanuatu, Fiji and Solomon Islands experienced many more disasters than other PICTs. Some PICTs such as PNG are vulnerable to multiple events.

132. Modelling data suggests that the total number of cyclones is declining over time, but the intensity of cyclones (category 4 or 5) is increasing.

133. Dr Saketa mentioned that higher temperatures may also constitute a disaster, with people suffering heat stress and other effects.

8.2 Update: Epidemic and emerging disease alerts

134. Christelle Lepers (SPC) presented the map of epidemic and emerging disease alerts in the Pacific. The map provides a picture of diseases circulating in the region and contributes to preparedness for regional public health threats. It is updated weekly (on Mondays) and posted to PacNet as a PDF in English and French. There is also an interactive web-based version: http://www.spc.int/phd/epidemics/

135. The map draws on multiple sources of information, which are screened using a standard Epidemic Intelligence System. The usefulness and accuracy of the map depend on the quality and timeliness of reporting from PICTs. Earlier in the meeting, there was a suggestion of adding 'number of cases' to the map, providing countries give permission.

136. A survey of PacNet members in November 2016 showed that 97% of respondents (n=68) from 22 PICTs and 4 countries outside the region used the map for their work. A similar percentage said the information met their expectations. The map information is now being integrated into national surveillance reports.

Discussion

137. FSM said the map is very useful and provides good information without including 'number of cases'.

138. PIHOA said the main usefulness of the map relates to assessing the risk to neighbouring countries

and knowing what is circulating. The additional amount of work required to add numbers may not be worthwhile.

139. The Chair said the map is also useful in providing information to higher levels of government. It is an easy way for non-experts to see what is happening.

140. Cook Islands recognises the sensitivity around numbers, especially as many PICT economies rely on tourism. At the moment, there are 24 cases of dengue in Cook Islands and there is concern it could be spread to New Zealand. It is also useful to know where cases are coming from. She encouraged a culture of transparency, which leads to better public health decisions, including in neighbouring countries.

141. SPC said that if PICTs feel there is a need to add information on numbers it could be added to the summary that is sent to PacNet, again if the country agrees.

142. Dr Merianos said SPC and WHO both ask countries for the same data. She suggested a recommendation that SPC and WHO should coordinate weekly by teleconference to share reports and data.

8.3 Update: IHR, APSED III and PaHSeC

143. WHO (Dr Merianos) presented an update on implementation of the IHR (International Health Regulations) APSED III (Asia Pacific strategy for emerging diseases and public health emergencies), and PaHSeC (Pacific Health Security Coordination Plan).

144. PaHSeC is a voluntary agreement by PICs and Pacific development partners to take collective action to increase regional health security through accelerating IHR implementation for preparedness and response. Core partners include WHO, SPC, PIHOA, CDC, World Bank, DFAT and MFAT. It was endorsed by Pacific Health Ministers in 2017.

145. IHR/APSED activities to end of February 2019 included multi-sectoral workshops to increase the number of PICs completing their State Party Annual Report (SPAR); table top exercises in several countries (GOARN TTx, Emergency Medical Team SimEx, and Crystal); and support for conducting a JEE in several PICTs, including observing the process in other countries. Activities are mapped to ensure countries are receiving equitable support for health security.

146. FSM completed its JEE in August 2018 – the first Pacific country to do so. One of FSM's laboratory technicians joined the external evaluation team for the Grenada JEE.

147. The State Party Annual Report is the only mandatory component of the IHR monitoring and evaluation framework. Other components include after-action reviews, the JEE and simulation exercises.

148. Challenges for IHR implementation include the functioning of National IHR Focal Points. High staff turnover is a factor in countries self-assessment of their low performance in this area.

8.4 PaHSec risk communication initiative

149. Dr Merianos (WHO) described an initiative to strengthen risk communication in the Pacific. The responsibility is often not well defined, many countries do nor have a dedicated risk communication officer, and partners do not use common terminology. Many PICTs have requested training in risk communication.

150. WHO, SPC, CDC and PIHOA (as a group of technical partners) have discussed how to provide support in the PICT context, develop common approaches and terminology, and build a toolkit of training resources.

151. The group proposes to conduct a survey of PICT needs for support. They will then draft an action plan. Actions may include developing a training package, a set of templates that can be used for emergency announcements etc., and a more coordinated approach to providing support in a crisis by sharing requests with partners.

Discussion

152. SPC said several agencies have risk communication resources. The group has been a useful opportunity to work together to support countries in a way that meets their needs.

153. The Chair noted the usefulness of evaluating the impact of risk communication after a crisis has passed.

154. Cook Islands commented that risk communication is part of public health training and can help minimise risks e.g. in an outbreak situation.

Decisions

155. The meeting:
    i. noted the updates on PSSS (Pacific Syndromic Surveillance System)/EWARS, and Pacific disasters;

    ii. agreed that early warning information systems suitable for the Pacific (e.g. EWARS, with Tupaia as a potential partner) will be discussed in the regional PPHSN meeting when all PICTS are represented;

    iii. agreed that the ad hoc Surveillance Technical Working Group (STWG) will explore adding or replacing syndromes in the PSSS;

    iv. agreed that SPC and WHO will coordinate weekly by teleconference on alert reports.

9. Upcoming events and other matters

9.1 Update on AFD project

156. SPC provided a summary of activities under the AFD-SPC project to strengthen PPHSN services – a EUR 3 million project signed in March 2018.

157. The project's three main components are enhanced surveillance (including laboratory mentorship), development of vector control skills (including entomology training), and preparation for emerging risks (including AMR and infection prevention and control).

9.2 PPHSN membership

158. SPC said PPHSN members have requested that PPTC (Pacific Paramedical Training Centre) should become an allied member of PPHSN. At present it is an observer. PPTC is a LabNet member.

159. At the 22nd meeting of the CB in 2018, a recommendation was made that PIHOA should become a full member of the PPHSN-CB following the PPHSN review. The review has been delayed so it is suggested that PIHOA should become a permanent allied member immediately.

160. The Chair confirmed the meeting's agreement with the suggested changes in the membership status of both PIHOA and PPTC.

9.3 PPHSN Regional Meeting (June 2019) and 24th PPHSN-CB Meeting (2nd part of 2019)

161. SPC said the 2019 PPHSN meeting is scheduled for 3–7 June 2019 (tentative).

162. A One Health consultative workshop will be held in conjunction with the PPHSN meeting.

163. It is suggested that the next PPHSN-CB meeting will be held in September 2019 to allow time for recommendations to be developed for the PHOH meeting. The meeting will be held back-to-back with the AFD Project Steering Committee meeting.

164. FNU asked whether a report of the PPHSN review would be ready for the September meeting. Other participants supported holding the meeting after completion of the review.

165. Dr Vivili (SPC) said the meeting could be scheduled for the second half of 2019 when a draft of the review report is available. The final date will be confirmed in consultation with the Chair of PPHSN-CB.

Decisions

PPHSN membership

166. The meeting
    i. agreed that PIHOA will become a permanent allied member of the PPHSN-CB;
    ii. agreed that PPTC (Pacific Paramedical Training Centre, based in NZ) will become an allied member of PPHSN.

Upcoming meetings

167. The meeting

    i. noted that the PPHSN Regional Meeting will be held in June 2019;

ii. agreed that the 24th PPHSN-CB meeting will be held in the second half of 2019;

iii. requested that a draft report of the PPHSN review be made available before the next PPHSN-CB meeting;

iv. agreed that the One Health meeting will be held in June 2019, back to back with the PPHSN Regional Meeting.

10 Key decision points

168. The meeting reviewed the key decision points and agreed that the revised points will be finalised and sent to them for their final approval.

11 Close of meeting

169. The Chair thanked all participants and partners for their contribution to the discussions and support of the important functions of the PPHSN and declared the meeting closed.

170. Dr Vivili thanked the Chair for his excellent conduct of the meeting.

23rd Meeting of Pacific Public Health Surveillance Network Coordinating Body

29–30 March 2019, Denarau, Fiji

Summary of Key Decision Points

Introduction

1. The meeting:

    i. introduced the members of the Pacific Public Health Surveillance Network Coordinating Body (PPHSN-CB);

    ii. reappointed Fiji as Chair of the 23rd PPHSN-CB Meeting;

    iii. adopted the agenda.

Coordinating Body Membership and Governance

2. The meeting:

    i. acknowledged the three outgoing core members of PPHSN-CB: Marshall Islands, Northern Mariana Islands and Tokelau;

    ii. welcomed the incoming core members: American Samoa, Federated States of Micronesia (FSM), Tuvalu and Wallis and Futuna;

    iii. recognised the usefulness of a variety of evaluation tools to assess IHR attributes, noting they contribute evidence towards determining the status of IHR capacities (e.g. use of CDC guidelines for evaluation of public health surveillance systems).

PPHSN review

3. The meeting

    i. noted that the secretariat will immediately re-circulate the terms of reference for the review of PPHSN and its services, allowing a two-week period for comments, and will incorporate amendments received;

ii. agreed that the secretariat should then proceed with recruiting a consultant for the PPHSN review, which is expected to be completed in six months (allowing two months for the recruitment process and three months for the conduct of the review).

PacNet, communication, networking and advocacy

4. The meeting:

i. noted the update showing increases in the number of health professionals subscribing to PacNet, and number of alerts being shared on PacNet;

ii. expressed interest in exploring the use of social media platforms as additional tools for sharing alerts, but emphasized that verifying information is critical;

iii. requested that the PPHSN review consider the points raised on use of social media for PacNet;

iv. requested Pacific Island countries and territories (PICTs) and PPHSN partners to share stories and documents related to surveillance and response activities with the PPHSN-CB Focal Point for uploading to the new PPHSN website due to be launched at the next regional meeting in June 2019.

LabNet update

5. The meeting:

i. noted the current status, progress in implementation of laboratory support services and ongoing initiatives to strengthen laboratory capacity in the Pacific;

ii. noted the proposed roadmap for laboratory accreditation, starting with a decision and commitment from country health authorities, and agreed that the roadmap will be further discussed and refined by the LabNet technical working body;

iii. requested Pacific Island countries and territories (PICTs) to nominate an in-country focal point (i.e. laboratory quality improvement champion) who will be responsible for ensuring that countermeasures are implemented for identified quality gaps and limitations in laboratory systems and that implementation is monitored;

iv. further requested PICTs to provide updated laboratory information (i.e. registry of focal officers, contact details, laboratory services provided, referral and shipping information) to the PPHSN Focal Point, to enable SPC to update the LabNet Catalogue, noting that SPC will facilitate sharing of the information with stakeholders.

Update on EpiNet

6. The meeting:

i. requested PICTs to note the key roles of EpiNet team members, and to ensure that the membership of the team is able to meet and satisfy all the roles;

ii. agreed that other sectors (e.g. disaster management) should also be represented on EpiNet teams;

iii. noted that PPHSN is ready to assist in building capacity and asked PICTs to indicate their needs;

iv. recognised the importance of all PICTs providing an updated registry of EpiNet focal points to the PPHSN-CB;

v. agreed that information on the members of country EpiNet teams should be sent quarterly to their respective Heads of Health to ensure they are well informed and able to take steps if necessary to see that systems are appropriately staffed;

vi. agreed to establish an ad hoc Surveillance Technical Working Group, with at least 50% of members to be PICT representatives, and noted the following volunteers: American Samoa, Cook Islands, Guam, CDC/PIHOA, IPNC and SPC, with the Auckland Public Health Service also suggested as a potential member.

Update on PICNet

7. The meeting:

i. agreed that anti-microbial resistance (AMR) is a high priority for the region requiring a multi-sectoral approach, with appropriate resourcing of infection prevention and control (IPC) and AMR activities required at both national and regional level in terms of finances and human resources;

ii. noted the progress made so far in enhancing microbiology capability, the review of the Regional IPC and national guidelines, and updating of national AMR guidelines;

iii. agreed that an assessment tool be provided as an annex to the revised IPC guideline.

Update on DDM-SHIP

8. The meeting:

i. noted the progress update on the SHIP programme;

ii. noted the request to nominate in-country experts to contribute to the SHIP handbook and manual development;

iii. noted the importance of including SOPs for registration and processing of participants in the SHIP handbook;

iv. requested PICTs to identify mentors to provide ongoing support to SHIP students throughout their training;

v. requested PICTs to implement/develop selection criteria for SHIP DDM candidates which comply with enrolment requirements;

vi. asked PICTs to create positions for SHIP-DDM graduates commensurate with the qualifications acquired in accordance with national public service requirements (noting, as an example, that additional surveillance positions were created in Vanuatu);

vii. encouraged PICTs to continue to co-invest in, and co-own the SHIP-DDM programme;

viii. acknowledged the contribution of FNU to the SHIP programme, including its flexibility in ensuring the enrolment requirements are not a barrier for potential students.

Regional surveillance and Pacific health security

9. The meeting:

i. noted the updates on PSSS (Pacific Syndromic Surveillance System)/EWARS, and Pacific disasters;

ii. agreed that early warning information systems suitable for the Pacific (e.g. EWARS, with Tupaia as a potential partner) will be discussed in the regional PPHSN meeting when all PICTs are represented;

iii. agreed that the ad hoc Surveillance Technical Working Group (STWG) will explore adding or replacing syndromes in the PSSS;

iv. agreed that SPC and WHO will coordinate weekly by teleconference on alert reports.

PPHSN membership

10. The meeting

i. agreed that PIHOA will become a permanent allied member of the PPHSN-CB;

ii. agreed that PPTC (Pacific Paramedical Training Centre, based in NZ) will become an allied member of PPHSN.

Upcoming meetings

11. The meeting

i. noted that the PPHSN Regional Meeting will be held in June 2019;

ii. agreed that the 24th PPHSN-CB meeting will be held in the second half of 2019;

iii. requested that a draft report of the PPHSN review be made available before the next PPHSN-CB meeting;

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