REPORT

26th PACIFIC PUBLIC HEALTH SURVEILLANCE NETWORK (PPHSN) COORDINATING BODY (CB) MEETING

19th August 2024, Nadi Fiji

Co-sponsored by the World Health Organization (WHO)
and the Pacific Community (SPC)

Report prepared by the Pacific Community

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Abbreviations

AFD	Agence Française de Développement (French Development Agency)
ANU	Australian National University
CB	Coordinating Body
CDC	(United States) Centers for Disease Control and Prevention
COVID-19	Coronavirus disease
DFAT	(Australian Government) Department of Foreign Affairs and Trade
EpiNet	Epidemiology Network
ESR	Institute of Environmental Science & Research
EU	European Union
EWARS	Early Warning, Alert and Response System
FETP	Field Epidemiology Training Programme
FNU	Fiji National University
GOARN	Global Outbreak and Response Network
IHR	International Health Regulations
IPC	Infection Prevention and Control
JEE	Joint External Evaluation
LabNet	Laboratory Network
LIMS	Laboratory Information Management System
MAE	Master of Applied Epidemiology
MOA	Memorandum of Agreement
NCD	Non-Communicable Disease
NPT	National Philanthropic Trust
PGDAE	Post Graduate Diploma in Applied Epidemiology
PGCFE	Post Graduate Certificate in Field Epidemiology
PICTs	Pacific Island Countries and Territories
PICNet	Pacific Infection Prevention and Control Network
PIHOA	Pacific Islands Health Officers Association
POM	Pacific Outbreak Manual
PPHSN	Pacific Public Health Surveillance Network
PSSS	Pacific Syndromic Surveillance System
PVN	Pacific Vector Network
RCCE	Risk Communication and Community Engagement
RRT	Rapid Response Team
SHIP-DDM	Strengthening Health Intervention in the Pacific – Data for Decision-Making
SPAR	States Parties Self-Assessment Annual Report
SPC	Pacific Community
TEPHINET	Training Programs in Epidemiology and Public Health Interventions Network
TOR	Terms of Reference
TWB	Technical Working Body
USAPIs	United States Affiliated Pacific Islands
USyd	University of Sydney
WPRO	WHO Western Pacific Regional Office
WHO	World Health Organization

Acknowledgements

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Meeting opening

1. Opening of the meeting with a prayer by Co-chair, Ms Joanne Mariasua of Vanuatu.

2. Co-chair, Dr Joseph Takai, Tonga acknowledged and introduced all key participants. He also presented the morning's agenda for adoption and approval. Dr Takai then allowed for the introduction round for in-room and virtual participants (refer to Annex 2– Participants List).

3. Ms Amy Simpson (SPC) reminded that the 26th CB meeting was originally a 4-day meeting scheduled in May which was postponed due to the civil unrest situation in Nouméa and expressed her appreciation for everybody's flexibility. The meeting housekeeping rules were outlined, and the availability of the PPHSN meeting documents online was noted.

25th PPHSN-CB meeting review

Amy Simpson, Team Leader - Surveillance, Preparedness and Response Programme, Public Health Division, SPC Suva

4. The 25th PPHSN-CB meeting was held on 24 July 2023 in Hawaii. There were four recommendations from the 25th CB meeting:
    a. Implement a formal process for tracking progress on the recommendations of the PPHSN-CB meetings
        i. Secretariat to develop the tracking tool.
        ii. Core and allied members to monitor and report updates and progress of recommendations form PPHSN meetings.
    b. Secretariat to invite a working group to review the format of CB meetings and circulate a concept paper to CB members for comment before planning for the next CB meeting begins.
    c. PIHOA to disseminate findings from PIHOA-commissioned evaluation of the SHIP-DDM programme.
    d. Allied partners to support PICTs with updating national pandemic preparedness plans.

5. Status updates:
    a. The tracking tool for recommendations development is still ongoing.
    b. The working group and concept paper for meeting format remains in progress.
    c. The findings from SHIP-DDM evaluation were disseminated by PIHOA last year and will be presented during this meeting.
    d. Ongoing support from the allied partners to help the Pacific Island develop pandemic preparedness plans.

PPHSN External Review report

Dr Meru Sheel, Associate Professor, Infectious Diseases, Immunisation and Emergencies, The University of Sydney

6. The PPHSN review was undertaken last year, by a team from the University of Sydney, University of Queensland and Griffith University. Contribution was acknowledged from the Technical Advisory Group (TAG) (Solomon Islands MHMS Representative, CDC, SPC and WHO), the study participants and SPC administration team. Since the establishment of PPHSN in 1996 there has been no formal review of the network.

7. The goals and objectives of the review were to:
   a. Identify strengths and weaknesses of PPHSN
   b. Identify opportunities and make recommendations for improvement
   c. Assess roles of the PPHSN in supporting regional preparedness, alert, and response in alignment with the IHR (2005)
   d. Examine the governance, communication structures, and actors involved in PPHSN
   e. operational activities and how they contribute to the PPHSN goals, objectives, and sustainability
   f. Examine status, impact, and progress of each service network
   g. Examine if PPHSN provides effective mechanism for sub-regional coordination
   h. Develop recommendations for the next 5 years

8. The review process included:
   a. Fortnightly TAG meetings
   b. Study development and design in consultation with TAG
   c. Regular feedback from TAG and other technical members from the region where needed
   d. Iterative and consultative process
   e. Mixed-method study including document review, survey of PPHSN users, Focus group discussions, PSSS data analysis and LabNet data analysis.
   f. The full methodology, results, conclusions and recommendations are available in the Report “Review of the Pacific Public Health Surveillance Network, 2023”

PPHSN Governance

9. Key strengths of the network governance are:
   a. PPHSN is effective at implementing core strategies for developing surveillance system, training in applied epidemiology and surveillance, dissemination of information and extending communication network
   b. The Coordinating Body is identified as central to steering PPHSN activities and its objectives.

10. Identified weaknesses of network governance included:
   a. Lack of clear and well-defined structure within PPHSN
   b. Lack of clarity on responsibility and reporting, that affected the network’s overall effectiveness in responding to public health challenges in the Pacific
   c. Critical issue of sustainable funding for PPHSN, and lack of knowledge and clarity about funding mechanisms
   d. Lack of up to date, well formulated and interlinked service arms
   e. Sense of geographical segregation between the North and South of the Pacific or US affiliated countries.

11. Recommendations for the Governance of PPHSN
    a. Revise Terms of Reference, roles and responsibilities
    b. Ensure strong mechanism for ongoing, stable funding managed with transparency
    c. Greater alignment between network's core objectives and relevant frameworks
    d. Focus on One Health
    e. Use indicator-based performance monitoring framework
    f. Establish coordinated mechanism to provide technical support and assistance

Governance Discussions

12. Dr Nemia Bainivalu (Solomon Islands) highlighted the focus on One Health and the need to establish multi-sectoral One Health communities at country and regional levels. PPHSN and the CB need to consider other partners at the regional level, including the Food and Agricultural Organization, World Organization for Animal Health and United Nations Environment Programme.

13. Chair Dr Joseph Takai (Tonga) recognised the importance of the One Health approach for PPHSN and its governance. He stated some countries have progressed with their national muti-sectoral approach on One Health.

14. Ms Meru Sheel (USyd) said consideration for the PPHSN strategic plan will be determining which One Health actions are at a national level versus which require a regional approach.

15. Dr Eric Rafai (SPC) agreed that PPHSN has a role to play for regional One Health activities. He further emphasised the need for multisectoral health workforces and utilising technology as options for strengthening surveillance and response activities in the region.

16. Dr Thane Hancock (CDC) mentioned the importance of sustainable funding and strong mechanisms for ongoing management transparency.

17. Ms Amy Simpson (SPC) endorsed the recommendations for PPHSN governance.

18. Dr Nuha Mahmoud (WHO) endorsed the recommendations and advised that WHO, SPC and others have begun discussions on how to include all partners on One Health to strengthen this network.

19. Dr Sarah Jefferies (ESR) endorsed the recommendation for the governance. Indicators will facilitate ESR to seek funding and other mechanisms to more formally support sub-regional surveillance activities in the Pacific region.

20. Dr Gillian Dunn (PIHOA) endorsed the recommendations.

PacNet / PSSS

21. PPHSN plays an important role in communication, needs to meet current approaches

22. Strengths of PacNet
    a. Facilitate information sharing
    b. Diverse range of communication tools

23. Weaknesses of PacNet
    a. Dissatisfaction with PacNet's email-based format
    b. Need to modernise communication methods
    c. Language barrier

24. Recommendations for PacNet
    a. Consider how to increase impact in providing communication and coordination mechanism
    b. Greater focus on real-time relay of information
    c. Use visualisation dashboard on PPHSN website, online communities of practice or forums
    d. Surveillance needs to meet outbreak detection objectives

25. Strengths of PSSS
    a. Improving early warning disease surveillance
    b. Implementing standardised system to track diseases and syndromes
    c. PSSS designed to be simple to conduct routine surveillance
    d. PSSS close tie with PacNet and SHIP-DDM

26. Weaknesses of PSSS
    a. Limited efforts to review currency and performance
    b. PSSS model unchanged despite limitations
    c. Not effectively meeting outbreak detection objectives
    d. Inconsistent reporting practices
    e. Timeliness of event reporting

27. Recommendations for PSSS
    a. Review syndromes under surveillance, reporting mechanisms and methods for signal generation
    b. Need multi-source surveillance and collaborative surveillance
    c. Link organisations across different sectors to bring together data from various types of surveillance

PacNet / PSSS Discussions

28. Dr Thane Hancock (US CDC) suggested to integrate multi-source surveillance into the existing PSSS and consider renaming the network to reflect multi-source surveillance.

29. Ms Sara Demas (WHO) endorsed recommendations for PacNet and PSSS, especially multi-source surveillance at the regional level. She noted the need to update the guidelines for syndromic surveillance, which haven't been revised since 2010. This will strengthen country collaboration and provide clear guidance on expectations for timely reporting of outbreaks and surveillance data.

30. Ms Tmong Udui (Palau) stated that data sharing is key to taking a One Health approach Updated guidelines for PSSS are needed, and the system could expand beyond just syndromic data. She also suggested to modernise public health surveillance systems, especially in remote regions, by adopting electronic health record systems.
31. Ms Meru Sheel (USyd) suggested that timely data sharing, especially from PICTs into PSSS, could be added into the roles and responsibilities.

32. Mr Jojo Merilles (SPC) reminded that developing a multi-source surveillance system (proposed to be called SurvNet) has been endorsed since 2019 PPHSN regional meeting.

33. Dr Nuha Mahmoud (WHO) recommended that data sharing agreements should be added into the PPHSN TORs to facilitate better sharing and collaboration between member states and partners. The need for data sharing agreements has already been presented to the Pacific Heads of Health in April 2024 and should be taken to the next Pacific Health Ministers Meeting in 2025. This may also include strengthening Health Information Systems in PICTs – having patient electronic records which are compatible for extracting surveillance data.

34. Ms Mele Mose-Tanielu (Samoa) recommended that there be multisource surveillance and collaborative surveillance, with data sharing from all PICTs. As data sharing is important for decision making and public interventions at all levels, she requested there be continuous support and capacity building for member countries to improve timeliness and quality of data reporting.

LabNet

35. Key strengths of LabNet
    a. Supporting lab referral systems
    b. Development and establishment of quality laboratory systems

36. Weaknesses of LabNet
    a. More diagnostic oriented than surveillance
    b. Issues with laboratory result turnaround times
    c. Lack standardised procedures and data on referral times
    d. Infrastructure challenges
    e. Assessment metrics only sporadically available

37. Recommendations for LabNet
    a. Establish list of priority diseases and clear protocols for surveillance
    b. Need effective laboratory surveillance for timely detection and response
    c. Consider establishment of interoperable LIMS in all PICTs

LabNet Discussions

38. Dr Darwin Operario (WHO) stated priority diseases and laboratory protocols need to be established to shift from clinical focus to surveillance. LabNet will require support for advocacy for surveillance testing to become an integral part of laboratory testing. This may include sensitising clinicians and reviewing community clinics for what diagnostic capabilities are available locally and improving referral pathways for sample testing at hospitals.

39. Dr Eka Buadromo (SPC) supported the first two LabNet recommendations. She concurred with Dr Operario and mentioned that in the Pacific most of the laboratories are conducting tests from clinical laboratories as they don't have public health laboratories. The PICTs require linkages between the epidemiologists and surveillance officers to support establishment of public health laboratories.

40. Dr Eka Buadromo further states LIMS are weak in the PICTs, but the countries will need to agree to establish interoperable LIMS if SPC is to support.

PICNet

41. Key strengths of PICNet
    a. Renewed commitment to IPC efforts
    b. 81% reported PICNet as moderately to very effective for building capacity for IPC professionals
    c. IPC staff capacity development, with 75% of PICNet respondents reported IPC staff available in their organisation
    d. Improvement in IPC practices and policies
    e. Establishment of regional definitions and methodologies

42. Weaknesses of PICNet
    a. Limited human resources and infrastructure, particularly in remote and outer islands
    b. Need for comprehensive evaluation
    c. Difficulty in maintaining adherence to IPC practices over time
    d. Ensuring IPC standardised across different health facilities

43. Recommendation for PICNet:
    a. Need comprehensive mechanism for end-to-end surveillance for IPC
    b. Need development of guidelines
    c. Need systematic approach to collecting, analysing, and reporting of Healthcare Associated infections.

EpiNet

44. Key strengths of EpiNet
    a. 91% of respondents reported having designated teams
    b. Many teams have expertise that are being met
    c. Multi-disciplinary team effective at preparing for and responding to outbreaks

45. Weaknesses of EpiNet
    a. Some expertise still lacking in some teams
    b. Lack of standard reporting procedures
    c. Members not always feeling equipped to respond to outbreaks
    d. Lack of practical experience in outbreak investigation and/or response
    e. 74% reported team being deployed less than 10 times in the last 5 years

46. Recommendation for EpiNet: Professional development and systematic training of EpiNet teams.

PICNet and EpiNet Discussions

47. Ms Amy Simpson (SPC) endorsed the recommendations for PICNet and EpiNet and informed that some of the recommended actions are already underway by technical working groups for each service network.

SHIP-DDM

48. Key strengths of SHIP-DDM
    a. Capacity building facilitated through PPHSN
    b. Bolster and empower workforce for readiness and response

49. Weaknesses of SHIP-DDM
    a. Comprehensive list of graduates and contact details absent
    b. Recruiting and retaining skilled personnel difficult

50. Recommendation for SHIP-DDM: Review SHIP-DDM programme for relevance.

SHIP-DDM Discussions

51. Dr Ramneek Goundar (FNU) commented that FNU reviews most programmes every 3-5 years. The SHIP-DDM programme (PGCFE Programme) is due for review next year and recommendations from this PPHSN review can be considered. Programme documentation could be updated within this review period.

52. Ms Amy Simpson (SPC) mentioned that reviews of SHIP-DDM have been undertaken by PIHOA and SPC since the external review was done, which will be presented later in this meeting.

53. Ms Sara Demas (WHO) noted that global resources are available, monitoring and evaluation framework has been developed for FETPs and could be contextualized for the Pacific.

Updating the PPHSN Strategic Plan

Dr Thane Hancock, Career Epidemiology Field Officer-Us-Affiliated Pacific Islands, PIHOA/CDC and Dr Salanieta Saketa, Senior Epidemiologist, Surveillance, Preparedness and Response Programme, SPC Suva

54. Dr Thane Hancock presented on importance of having a current strategic plan through a metaphor of navigation: knowing the mission and goals of the Public Health Surveillance Network (PPHSN), understanding the current position, history, and members of PPHSN. and how to navigate the future.

55. Proposal for updating the PPHSN strategic framework using expert facilitation and broad consultation.

56. Suggested process to include:
    a. Recruiting a strategic planning facilitator in October 2024
    b. Holding a strategic planning workshop and finalise the plan/framework in February 2025.
    c. Present the strategic plan at the next CB meeting (tentatively March 2025)

Discussion

57. Dr Salanieta Saketa (SPC) reminded everyone that there is working paper to support the presentation. The working paper contains terms of reference (TORs) of what could be done and asked for feedback from everyone.

58. Dr Gillian Dunn (PIHOA) agreed with approach to engage a facilitator who will help in an objective manner and strongly recommends the strategic planning process described by Dr Thane Hancock.

59. Dr Sarah Jefferies (ESR) fully endorsed the process recommended, stating the timing is perfect. A national public health surveillance strategic plan for New Zealand has been developed for the first time and supporting regional and public health response activities in the region is important component of it. ESR can support with expertise and will seek other ways how they can support this plan.

60. Dr Nemia Bainivalu (Solomon Islands) endorsed the recommendation to have an updated strategic plan, which incorporates the recommendations from the review. He asked who will be involved in the strategic framework planning workshops, if it will be the Coordinating Body with a broader group of country representatives?

61. Dr Thane Hancock (CDC) answered all PICTs should be invited to participate in the workshop, with a smaller group to refine and finalise. For the strategic plan it is important to have the engagement of people who work in the network

62. Dr Nemia Bainivalu (Solomon Islands) asked once the strategic framework is in place will the Heads of Health/Ministers of Health be notified for endorsement or will it be only the Coordinating Body to endorse.

63. Ms Amy Simpson (SPC) stated that the Coordinating Body has the authority to endorse the process of updating the PPHSN Strategic Plan through a workshop with wide stakeholders. The final product, the updated strategic plan, will be presented to the Heads of Health for their endorsement.

64. Dr Nuha Mahmoud (WHO) reiterated that all the countries need to be engaged in the strategic planning instead of only the 7 countries representing the Coordinating Body. She endorsed progressing with the update of the strategic plan.

65. Dr Meru Sheel (USyd) stated they would be happy to continue assisting PPHSN with the strategic plan on the back of the review. She questioned whether there will be a separate operationalisation plan or it would be part of the strategic plan?

66. Dr Thane Hancock (CDC) said the scope of the plan was still to be determined at this stage. A smaller working group could be stood up to consider the scope of the plan and the timelines before organising the workshop with the facilitator.

67. Mr Jojo Merilles (SPC) commented:
   a. he hoped that the PPHSN review would give a detailed scanning of the issues, challenges and trends in the Pacific across the work of PPHSN. The results should allow the Coordinating Body to conduct segmentation analysis, to identify if the services provided to the countries are sufficient or not. The recommendations of the review pertain to conducting further assessment and review.
   b. will the progression of updating the strategic plan be contingent on completing further assessments of the services, or can the two processes occur in parallel?

68. Dr Thane Hancock (CDC) suggested that the strategic plan update should continue in parallel to any further evaluations. The network should remain nimble and flexible, the recommendation is to create a strategic plan that can adapt to any additional information which becomes available from evaluations, or outbreaks or environmental changes.

69. Dr Salanieta Saketa (SPC) commented that developing an operationalisation plan could be done in tandem with updating the strategic framework. There could be a 3-5 yearly costed action plan aligned to a longer-term framework.

PPHSN Membership

Mrs Elise Benyon-Kamisan, Data Processing Officer, Surveillance, Preparedness and Response Programme, Public Health Division, SPC Noumea

70. Presentation on PPHSN membership; application from prospective members and a review of current members.

71. PPHSN institutional framework includes 22 core members, primarily from the Ministries or Departments of Health, alongside allied members.

72. Training institutions, networks, international agencies, laboratories, project donors and others can apply to become an allied member of PPHSN.

73. Current PPHSN allied members are listed in Image 1, with blue text members being currently active and black text members indicating inactivity in last 5-10 years.

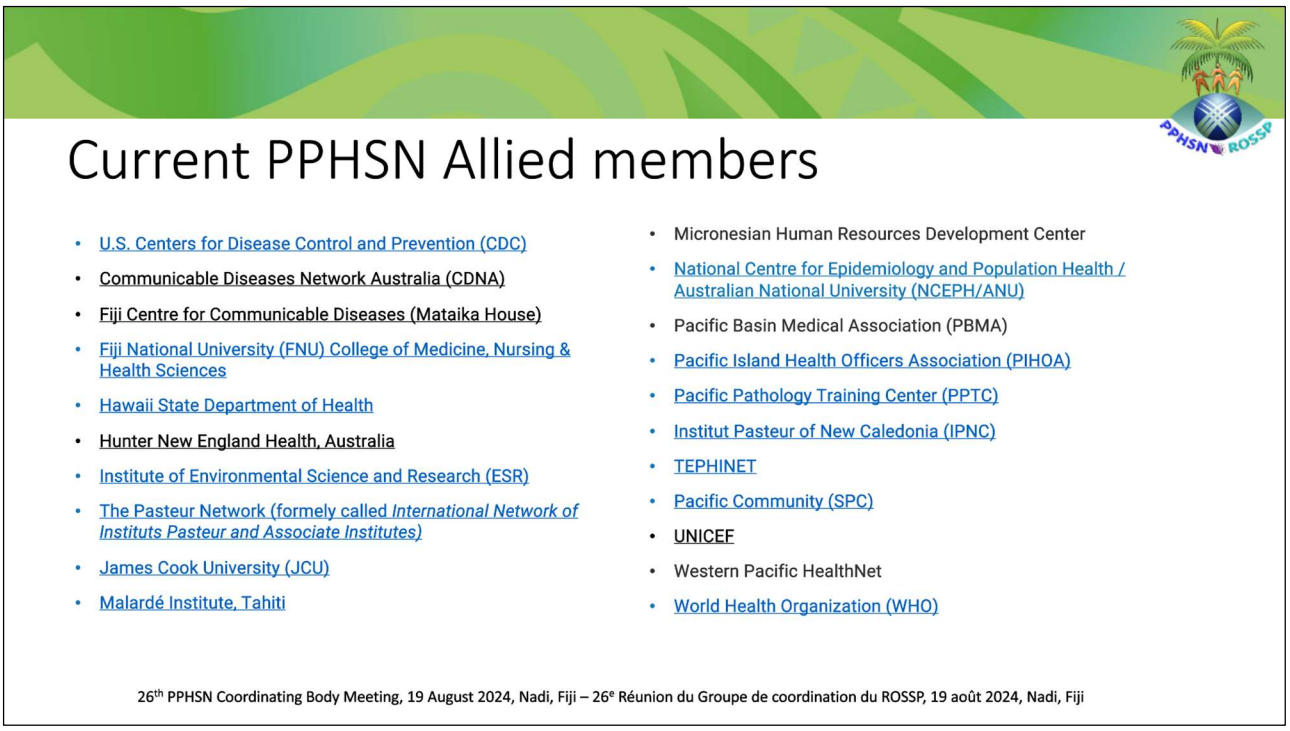

Figure 1 – Current PPHSN Allied members, August 2024

74. The process to apply to be a PPHSN allied member is;
    a. Partner fills out an application form detailing their mission, services, and motivation etc,
    b. Existing members consider and endorse or reject applications,
    c. Membership is successful if 50% + 1 of respondents endorse the application.

75. There is currently no guidance for the role of allied members nor process for periodic evaluation of allied members engagement and contributions.

76. Two recent applications have been received: South Asia Field Epidemiology and Technology Network, Inc (SAFETYNET) and The Peter Doherty Institute for Infection and Immunity (Doherty Institute).

77. SAFETYNET offers:
    a. Digitalization of Human Resource for Health (HRH) training via e-learning management system (eLMS) - ELMS deployment, onboarding, Training of Trainers, technical and user supports.
    b. Alumni / Talent Management Platform (TMS) to digitize the remote management & human resources deployment & collaboration of PPHSN members across the pan-pacific region.
    c. E-Office Platform [EMX] - deployment, onboarding, Training of Trainers, technical and user supports – to digitize operational capacity of PPHSN across its member states.
    d. Technical training on Digital Epidemiology - Big Data Analysis & Machine Learning Predictive Analysis application in Epidemiology
    e. Interactive E-Learning One Health Training.
    f. Digitisation of health management, e-learning, technical support, and collaboration with PPHSN.

78. Doherty Institution offers:
    a. Education and professional development, epidemiology and data science, public health laboratory services, capacity and capability building, placements
    b. Existing staff who would assist depending on need and requirements in the Asia-Pacific

Discussion

79. Consideration was given to the two applications by CB members, with discussion then votes held for each.

80. Both applications were unanimously endorsed by the group.

81. Ms Amy Simpson (SPC) suggested developing TORs for the role of allied members and initiating a process for reapplication or periodic evaluation of the allied members and what they are contributing to the network.

82. Dr Sarah Jefferies (ESR) endorses Amy's suggestion for a review of allied member, as well as having up to date focal point contacts within each allied member.

83. Dr Thane Hancock (CDC) suggested a 3-year review timeframe for members to stay engaged and opt to remain part of the network, ensuring it is not an arduous process.

84. Dr Nemia Bainivalu (Solomon Islands) mentioned that from the presentation there are at least 20 allied-members and asked why there are only 4 + 2 allied members seating at the CB.

85. Ms Amy Simpson (SPC) responded that there are many allied partners for PPHSN, and explained how the Coordinating Body operates as a subset of the full PPHSN. The 13-seat CB contains: 7 seats for PICTs who serve 3 years on a rotating basis; 4 seats for permanent allied members: SPC, WHO, FNU, PIHOA; and 2 seats for non-permanent allied members, currently CDC and ESR. The two applications received are not for seats in the CB but are applications to become PPHSN allied members. The process to be seated in the CB is different.

86. Ms Tmong Udui (Palau) welcomed the two new applications. She agreed for a review process and questioned whether the cycle for application will be advertised via PacNet? A further suggestion is that requests for updates, such as the annual update for the EpiNet team details from SPC, should be done for the allied members to make sure of the engagement.

87. Ms Christelle Lepers (SPC) reminded that we had a PPHSN Resources Directory, and it can be revived, and all allied members can be asked to provide updates on what assistance they can offer to countries and focal point contact details.

88. Dr Nemia Bainivalu (Solomon Islands) referred to the CB ToRs and asked what are the processes of inclusions and exclusions of members at the CB, could there be another seat for an allied member at the CB?

89. Ms Amy Simpson (SPC) answered that the rational of 7 countries and 6 allied members is that the countries have the majority vote for PPHSN matters.

90. Ms Christelle Lepers (SPC) advised that before there were 7 countries and 5 allied members in the CB, but the number of permanent members have been extended from 2 to 4 so the number of allied members in the CB increased to 6. In the past the CB took the decision to expand the list, and this could be done again.

Pacific Outbreak Manual

Dr Nuha Mahmoud, Team Coordinator, Pacific Support for Health Security and Communicable Diseases, Division of Pacific Technical Support, WHO Suva

91. The 2016 Pacific Outbreak Manual (POM) is used by most of the PICTs as the main reference for public health surveillance and response recommendations.

92. Updates are needed to simplify the manual while updating with new evidence. This includes:
    a. Additional public health priority diseases for the Pacific (including COVID-19 and mpox)
    b. New scientific evidence and international recommendations
    c. Information on clinical descriptions and progression of illness
    d. Case definitions for suspected & confirmed cases
    e. Misalignment thresholds/alerts with PSSS
    f. Limited guidance on laboratory testing available in Pacific countries' settings.
    g. Emphasis on enhanced surveillance.
    h. No recommendations on a reporting process and informing the end of outbreak

93. WHO engaged a consultant in November 2023 and teams have been working on revisions through 2024. A second revision is ongoing, to contextualise it to the Pacific situation.

94. Sections updated:
    a. Section 1. Emergency Management Structure
    b. Section 2. Public Health Surveillance and Response
    c. Section 3. Response Guidelines for Core Syndromes
    d. Section 4. Vector Borne Diseases / water- food- borne diseases / Vaccine Preventable Diseases. Incorporating epidemiology, alert/action thresholds, laboratory testing algorithms, public health management and Risk Communication and Community Engagement (RCCE).

95. Monthly Coordination meetings and feedback processes ongoing.

96. Final revisions anticipated by April 2025 with publishing by July 2025.

Discussions

97. Dr Gillian Dunn (PIHOA) suggested that electronic versions of the POM be available, including apps, for easier access and updates.

98. Ms Sara Demas (WHO) said that there is collaboration on maintaining updated guidelines and resources. The POM will have algorithms as annexes.

99. Mr Jojo Merilles (SPC) informed that SPC has a regional health guidelines application and links will be shared.

100. Dr Thane Hancock (CDC) offered assistance for technical inputs into the review and updates of the POM.

101. Dr Nemia Bainivalu (Solomon Islands) asked whether there will be RCCE guidance for specific diseases?

102. Ms Sara Demas (WHO) replied that yes, RCCE will be expanded for specific diseases.

103. Ms Christelle Lepers (SPC) suggested that to keep the POM concise and a live document, it should have links to other documents.

Regional EpiNet TORs and rapid response capacity training curriculum

Mr Jojo Merilles, Epidemiologist-Project Coordinator, Surveillance, Preparedness and Response Programme, Public Health Division, SPC Noumea and Mr Steven Ssendagire, Division of Pacific Technical Support, WHO Suva

104. Presentation divided into two parts: EpiNet TORs and training curricula for Rapid Response for EpiNet teams.

105. EpiNet (Rapid Response Team (RRT) network) was created in 2001 as the outbreak response arm of PPHSN, and includes functions for Leadership, Coordination and Management, as well as Field and Technical Response.

106. Key roles for EpiNet teams include:

Current EpiNet Roles	Leadership	Team Mgt	Field and tech. ops
1. To be the, or be part of any, official national (or subnational) surveillance and response team,	✓	✓	✓
2. To be prepared to mobilize in response to outbreaks or epidemics,			✓
3. To organize the multisectoral Task Force in order to respond to an outbreak or to advise the appropriate authorities on the proper composition of such a Task Force, and to be the technical body in such a Task Force,	✓		
4. To advocate for political support for communicable and other disease control activities,	✓		
5. To participate in and support a Pacific network of health professionals who communicate regularly, preferably by email and in a confidential forum, regarding surveillance and response to outbreak-prone CDs: PacNet and PacNet-restricted		✓	
6. Whenever needed, to define clear communication channels to be used in-country, inter-state/country and with the other PPHSN members,	✓		

Current EpiNet Roles	Leadership	Team Mgt	Field and tech. ops
7. To properly report outbreaks immediately to other health professionals in the PICT and to the other PPHSN members, using PacNet or PacNet-restricted for the latter,		✓	
8. Maintaining surveillance and response protocols for PPHSN target diseases, and all technical and resource-related aspects of all operations		✓	✓
9. To develop, adapt and implement PPHSN guidelines, recommendations and strategic framework for the surveillance and response to PPHSN target CDs,		✓	
10. To immediately investigate suspected outbreaks,			✓
11. To organize the public health measures to respond in a timely way to the outbreak,			✓
12. To seek appropriate advice and technical support through PPHSN whenever needed.		✓	✓
13. Attend meetings related to the surveillance and response to outbreak-prone CDs.		✓	
14. Be among those considered by government, should opportunities arise, for further training in surveillance/response.		✓	✓
15. A Primary Focal Point should be designated in each EpiNet team		✓	

107. Epidemic capacity is required at subnational, national, and regional levels to respond to outbreaks and public health events.

108. Identification of gaps and needs in public health rapid response capacity in PICTs has led to the development of a competency based modular generic curriculum for RRTs, targeting subnational level teams.

109. PICTs can utilise any or all the 10 drafted modules according to their needs. Modules have been utilised for outbreak preparedness and response training in RMI, Tonga and Samoa for mass gathering events

110. Proposal for going forward, is to:

a. Engage and support interested PICTs to adapt and implement the RRT training curriculum
b. Engage stakeholders to support country level adaptation and implementation of the RRT curriculum
c. Engage training programs in the region on how the developed materials can be integrated in their curricula and how the materials can be used to inform other stakeholder supported activities like development of simulation exercises (SimEx) aimed at improving outbreak management.

Discussions

111. Dr Thane Hancock (US CDC) suggested making RRT modules accessible for trainers across the Pacific, including EpiNet team training in the USAPIs, and showcase during the monthly EpiRounds meetings.

112. Mr Steven Ssendagire (WHO) agreed with Dr Hancock's suggestion and highlighted the need to adapt the training materials to specific country needs.

113. Dr Nuha Mahmoud (WHO) reiterated that the curriculum is generic and encompasses training for a minimum set of competencies, aimed for the lowest sub-national level. Training needs to be rolled out in conjunction with updating, roles and responsibilities, rosters etc

114. Dr Nuha Mahmoud (WHO) further stated there is a need to establish a coordinated approach to utilise EpiNet team trainees effectively and suggested to create and manage a roster of trained personnel in the region and collaborate with funding partners like DFAT or RRT programs.

115. Dr Thane Hancock (US CDC) recommended using PPHSN as a framework for sharing resources.

116. Dr Nuha Mahmoud (WHO) agreed that the training materials have been created to be utilised as PPHSN resources available to all.

117. Ms Sara Demas (WHO) proposed organising a coordination meeting to discuss competencies of EpiNet teams, Rapid Response Teams training curriculum, along with updating the Pacific Outbreak Manual.

PSSS and Early Warning, Alert and Response System (EWARS) update: Integrated Respiratory Disease Surveillance

Ms Sara Demas, Epidemiologist, Pacific Health Security, Division of Pacific Technical Support, WHO Suva

118. Integrated Respiratory Disease Surveillance (IRDS) meeting held in March 2024 had three outcomes:

a. Development of integrated respiratory surveillance guidelines
b. Building and sustaining the capacity to test for multiple respiratory pathogens.
c. Linking syndromic surveillance to laboratory surveillance for timely detection in EWARS.

119. Plan is to build a new module in EWARS for integrated respiratory surveillance, combining existing outpatient surveillance indicators (ILI, SARI, and ARI) with virological surveillance indicators (Influenza, SARS-COV-2, RSV) detected through respiratory Labs.

120. EWARS to be introduced to focal points in labs for consolidating and sharing weekly lab reports with surveillance teams.

121. PSSS and IRDS will be Pacific wide modules available in EWARS. Further plans are to expand EWARS in PICTs that lack surveillance systems for dengue labs and notifiable diseases.

122. All reports from EWARS can be utilised in weekly national surveillance reports, as well as fed automatically into weekly subregional reports such as FluID, FluNet (both part of RespiMart) and PSSS.

123. Laboratory testing capabilities have been mapped as of July.

124. Vanuatu is currently enrolled into the respiratory EWARS module, Solomon Islands planned next.

125. Next steps are to:
   a. Roll out EWARS module
   b. Support to strengthen laboratory capabilities
   c. Finalize the IRDS guideline
   d. Country-level support to building surveillance capacity towards implementing IRDS

Discussions

126. Dr Thane Hancock (US CDC) asked if there were plans to develop other arboviral modules like the respiratory module.

127. Ms Mele Mose-Tanielu (Samoa) requested to include arboviruses as they are re-emerging now in some countries. Need to build surveillance and lab capacity, including for clinicians.

128. Ms Sara Demas (WHO) said that development of modules for arboviral diseases surveillance are the next priority in 2025, after respiratory surveillance, for countries with active arboviral surveillance. Need to ensure there are also testing capabilities in PICTs, test kits available and guidelines and algorithms developed.

129. Dr Nuha Mahmoud (WHO) emphasised that IRDS builds on the gains from the COVID-19 pandemic and expanded laboratory capacity. More needs to be done to build the same models for dengue and arboviral surveillance. A significant aspect of this effort involved building the necessary capacity and fostering strong collaborative relationships with SPC, US CDC, and various reference laboratories.

130. Dr Salanieta Saketa (SPC) mentioned that vaccine preventable diseases may also be considered. Lots of resources will be required, and some countries are unable to sustain testing now. PICTs need to commit to sustaining resources for testing and reporting for enhanced surveillance.

131. Dr Joseph Takai (Tonga) agrees that country commitment is required, especially for human resources for integrating laboratory and surveillance teams, including incorporating clinicians and other public health practitioners.

132. Ms Sara Demas (WHO) said that country buy-in is very important. Guidelines may be used by surveillance, laboratory, decision-makers for resourcing and clinicals for sending samples for testing etc. Programs have already been launched in eight countries, and there have been numerous requests for further expansion. However, sustaining these efforts, will require ongoing resource allocation and participating country commitment.

One Health

Dr Eric Rafai, One Health Coordinator, Land Resources Division, SPC Suva

133. PPHSN has been advocating for a One Health approach since 2018; through including a One Health focus in the updated Strategic Plan for PPHSN, strengthening One Health partnerships in research and training, developing a One Health framework and establishing a One Health Network for the Pacific.

134. Pacific Heads of Health and Pacific Heads of Agriculture & Forestry both endorsed support for a Pacific One Health Network at their regional meetings in 2024, inclusive of plant health for food security and resilience.

135. Proposed governance framework for the Pacific One Health Network includes human, animal, environmental health Government sectors, as well as organisations for wildlife, plant protection and biosecurity.

136. A Pacific One Health Scientific Technical Working Group inception meeting is planned for 15th October 2024, and a One Health Symposium will be convened in Samoa in April 2025.

137. There is a Pacific One Health Interest Group on WhatsApp, with an open invitation to all to join our One Health community for updates on activities, events, projects, opportunities, etc.

138. Information sharing and sharing technical expertise is required across all sectors, particularly epidemiology capacity, highlighted through an example of chicken illness detected in Solomon Islands prior to the Pacific Games in late 2023.

Discussions

139. Dr Joseph Takai (Tonga) informed that Tonga is in discussion about establishing a One Health body, also including finance and human resources, to integrate the One Health aligned activities in the various sectors.

140. Ms Tmong Cheryl-Ann Udui (Palau) stated that Palau has no formal One Health working group, but the human health sector has been driving engagement with other sectors to date. There have been One Health symposiums over the last 2 years with support from the US military. They recommended forming a comprehensive body to oversee One Health initiatives on a national level. In addition to engaging regularly with relevant stakeholders to discuss One Health approaches.

141. Ms Nikarawa Karoua (Kiribati) shared Kiribati does not currently have a focal point for One Health, but relevant stakeholders were identified during completion of the IHR States Parties Self-Assessment Annual Report (SPAR) last year. Kiribati has got a draft National Outbreak Manual, and the EpiNet teams are having regular meetings with other sector stakeholders linked in.

142. Ms Raihei White (French Polynesia) informed that 3 focal points for One Health have been identified in French Polynesia, one each from the Office of Health Surveillance and Obsevation (Bureau de la Veille Sanitaire et de l'Observation), Environmental Health and Biosecurity.

143. Dr Nemia Bainivalu (Solomon Islands) stated that there is a currently an antimicrobial resistance committee for Solomon Islands, but the government is looking at formally establishing a One Health National Working Group and the highest levels. The IHR Joint External Evaluation (JEE)

process has been helpful for engaging with focal points from other sectors, ongoing engagement with other sectors important.

144. Ms Mele Mose-Tanielu (Samoa) acknowledged that a multi-sectoral One Health approach is important, as learned through the JEE process in Samoa. She shared that One Health is still a challenge as each Ministry has its own priorities, but they will push to have a focal point person in place.

145. Dr Salanieta Saketa (SPC) reiterated that utilising IHR monitoring frameworks like SPAR and JEE can help to operationalise One Health.

146. Dr Sarah Jefferies (ESR) shared that New Zealand is making multi-sectoral progress in addressing Highly pathogenic avian influenza and requested clarification on the best way to connect with the network?

147. Dr Eric Rafai (SPC) replied that requests for nominations from the human health sector will be shared through the Secretariat.

Pacific Vector Network

Dr Limb Hapairai, Regional Medical Entomologist, PIHOA

148. The Pacific Vector Network (PVN) was established in October 2022 to Increase regional action on vector management including surveillance, prevention, and control.

149. Core functions are to:
   a. Identify priorities, gaps, and strengthen capacities in vector management,
   b. Facilitate regional and global partnerships,
   c. Promote information and data sharing for evidence-based actions and innovations.

150. Actions taken during PVN's first 18 months;
   a. Selected allied members during PVN meetings,
   b. Drafted TORs, and strategic and M&E frameworks,
   c. Conduct regional vector management and outbreak response training based on country-identified topics.

151. Next steps:
   a. Finalise strategic framework 2025-2029 including clear objectives and indicators,
   b. Continue regional vector management trainings,
   c. Identify and establish potential regional labs,
   d. Convene annual PVN meetings and quarterly online meetings of the Technical Working Body,
   e. Create a PVN website under the PPHSN website,
   f. Seek endorsement to become 7th network of PPHSN at the next PPHSN regional meeting.

SHIP-DDM

SPC updates

Dr Louise Fonua, Epidemiologist-Training, Surveillance, Preparedness and Response Programme, Public Health Division, SPC Suva

152. SHIP-DDM is a capacity development program delivered in response to the call made by Pacific Ministers of Health for training programs to strengthen HIS in the region and more specifically, to support Ministries of Health in responding effectively to three key challenges in the Pacific: the prevention and control of endemic and emerging communicable diseases, the very high and rising prevalence of non-communicable diseases (NCDs) and the accelerating effects of climate change on health.

153. Since 2019, SHIP-DDM is accredited by Fiji National University (FNU) and integrated into FNU's postgraduate programs in epidemiology. The SHIP-DDM program has three levels: Postgraduate Certificate in Field Epidemiology – PGCFE (Tier 1), Postgraduate Diploma in Applied Epidemiology – PGDAE (Tier 2), and Master in Applied Epidemiology – MAE (Tier 3).

154. PGCFE's 5 modules are conducted over 1-2 years, with a mix of coursework and workplace-based projects.

155. PGDAE's 4 modules are conducted over 1-2 years, to complete operational research with the aim to publish.

156. 193 PGCFE graduates across the Pacific since 2019, 53 more students from 7 PICTs expected to graduate in December 2024.

157. Currently conducting an evaluation of SHIP-DDM.

158. Way Forward:
   a. Focus will be on the PGDAE course and progression to MAE
   b. Await results of the SPC SHIP-DDM evaluation and recommendations
   c. Continue the collaboration with partners to deliver SHIP-DDM in PICTs
   d. Await finalisation of Memorandum of Agreement (MOA) between SPC and FNU
   e. PICTs to identify a focal person for SHIP-DDM for ease of communication and follow up of documents
   f. PICTs to continue to support SHIP-DDM and strengthen internal processes to minimise attrition
   g. To develop a SHIP-DDM alumni network

PIHOA Updates

Ms Hélène Le Mouëllic Paulino, Program Manager, Strengthening Health Interventions in the Pacific, PIHOA

159. 86 certificates and diploma courses delivered in the USAPIs since 2013.

160. 144 PGCFE graduates as of December 2023 and 28 more set to graduate in December 2024.

161. 26 PICT health workers enrolled in the diploma course (PGDAE)

162. External evaluation by Georgetown University aiming to assess program effectiveness. Of the 17 recommendations from the external evaluation, 7 are prioritised for follow-up:

a. Clarify the goal of SHIP
   - Promote SHIP as a Field Epidemiology Training Program (FETP) and an HIS strengthening program
   - Refer to and market SHIP as the FETP for the Pacific
   - Continue to hold orientation meetings with United States Affiliated Pacific Islands (USAPI) health leadership and PIHOA Board members

b. Standardise naming conventions
   - Address confusion and inconsistencies with use of term "Data for Decision Making (DDM)" – Discontinue use of "DDM"
   - Use FNU's terminology: PGCFE (Certificate), PGDAE (Diploma), and MAE (Master's) consistently

c. Commit to protected space and time for the courses, through Memorandum of Understanding with PICTs to ensure understanding of the benefits of the programme, and that systems improvement projects address needs.

d. Create instructor SOPs and standardise teaching materials, through developing a faculty orientation manual and updating PGCFE and PGDAE course materials.

e. Increase supervisors' and Ministry or Department of Health officials' engagement with the Field Epi Projects

f. Supplement existing course materials by providing more materials for students to prepare and practice with before and between modules, through online offerings on Moodle platform.

g. Commit to ensuring appropriate staffing of SHIP, sustainable funding and full time Human Resources dedicated to the programme.

163. Pursuing Training Programs in Epidemiology and Public Health Interventions Network (TEPHINET) accreditation:

a. TEPHINET accreditation advantages: quality training alignment, international recognition, funding, opportunities for improvement, community of practice and outbreak response through WHO Global Outbreak and Response Network (GOARN).

b. PIHOA Board endorsement to pursue TEPHINET accreditation.

c. Seeking PPHSN endorsement to progress TEPHINET application.

FNU updates

Dr Ramneek Goundar, Assistant Professor & Programme Coordinator/ Epidemiology & Biostatistics, Fiji National University (FNU)

164. SHIP-DDM is a 3-tier programme at FNU.

165. PGCFE (Tier 1) graduates from 2019-2023 was 193 as of December 2023.

166. 3 PGCFE graduates in April 2024, 66 more expected to graduate in December 2024.

167. Geographic distribution of PGCFE graduates: Highest in RMI (45) and FSM (43).

168. Notable graduate from April 2024: Lilieta Tinae-Francis received the FNU Gold Medal.

169. MOA between FNU and SPC and PIHOA requires revisions and endorsements.

170. Way Forward
   a. Continue collaboration with partners e.g. SPC and PIHOA in the delivery of SHIP-DDM
   b. Use the Evaluation of PPHSN services including SHIP-DDM & FNU Programme review to map out plans for TEPHINET accreditation in near future
   c. To finalise MOA and renew adjunct faculty contracts

Discussions

171. Ms Tmong Udui (Palau) questioned the process of applying for TEPHINET accreditation and who would be applying.

172. Dr Ramneek Goundar (FNU) responded that FNU would apply. The process involves PIHOA, FNU, and SPC working together to map out and reach consensus and the whole program will get accredited.

173. Mr Jojo Merilles (SPC) clarified the TEPHINET accreditation has three levels: basic (for shorter frontline training programmes), intermediate (PGDAE could be eligible), and advanced. There are requirements for accreditation that SHIP-DDM does not currently meet, so FNU documentation requires revision before we could apply.

174. Dr Gillian Dunn (PIHOA) said PIHOA has started preliminary steps on behalf of PPHSN, exploring accreditation for the whole SHIP-DDM programme with a consultant. TEPHINET has indicated flexibility for accrediting our regional programme. The whole network will need to endorse exploring TEPHINET accreditation on behalf of the network, as well as the 3 partners delivering SHIP-DDM to support the leg work for the application.

175. Dr Eric Rafai (SPC) requested if One Health modules could be integrated into SHIP-DDM.

176. Dr Ramneek Goundar (FNU) stated that in 2025, FNU will be internally evaluating the 3-tiered programme, in consultation with SHIP-DDM partners. Revisions and updates can be considered at this time, including addition of One Health modules, requirements for TEPHINET application etc.

177. Ms Sara Demas (WHO) commented that some PICTs have parallel programmes with SHIP-DDM and a national FETP programme. This may need to be considered for TEPHINET application.

178. Mr Steven Ssendagire (WHO) stated that accreditation is a learning process; even if SHIP-DDM is not accredited, the program remains relevant.

179. Dr Gillian Dunn (PIHOA) replied that the national FETP programmes are separate from PPHSN and would not be covered under the SHIP-DDM accreditation. She agreed that is not a reflection on the national program's quality.

180. Dr Louise Fonua (SPC) highlighted that SHIP-DDM came to be as a directive from the Pacific Ministers of Health. They will continue to deliver SHIP-DDM based on that directive, and that it is already an accredited programme by FNU.

181. Mr Jojo Merilles (SPC) informed that SAFETYNET officers form part of the TEPHINET accreditation team which is good opportunity to engage them as a new allied partner.

182. Dr Salanieta Saketa (SPC) asked if PIHOA has resources to support progressing with the TEPHINET application.

183. Dr Gillian Dunn (PIHOA) replied that PIHOA has no specific resources or funding for progressing accreditation application, the exploration of accreditation has been done by current PIHOA staff to date. People's time would need to be resourced for the TEPHINET application process.

184. Dr Nemia Bainivalu (Solomon Islands) suggested rewording the recommendation to reflect approval for partners to progress explorations into TEPHINET accreditation at this time, noting discussions between FNU, SPC and PIHOA are required for a consensus on the approach and requirements.

Project Progress - Ongoing and upcoming projects which support PPHSN

PIHOA updates

Dr Gillian Dunn, Regional Health Information Systems and Performance Management Coordinator, PIHOA

185. Continue supporting SHIP-DDM delivery and collaborate with Georgetown University to enhance materials and alumni networking.

186. Implement and expand EPI 101 courses for Pacific Public Health Fellows.

187. Training and support for EpiNet teams, mapping of health information between lab and surveillance focal points.

188. Conduct a COVID-19 after-action review with US CDC coordination.

189. Maintain communicable disease elimination efforts in Chuuk and American Samoa.

190. Collect and analyse data from the genetically modified mosquito release for vector management improvements, support for PVN and building vector management capacity.

191. Dengue Early warning systems in use in RMI, FSM and Palau.

192. Progress climate services for dementia data projects in RMI, FSM, and Palau.

193. Ensure ongoing personnel training, protocols, quality management, certification and accreditation for laboratories. And linking laboratories with other sectors, human health, animal health etc.

194. PIHOA's funding is predominantly from US CDC, just completed year 3 in a 5-year agreement.

195. Other funders of PPHSN work are project based, including US DOS, US Department of Interior, CDC Foundation and Diagnostic Laboratory Services.

SPC updates

Ms Amy Simpson, Team Leader, Surveillance, Preparedness and Response Programme, Public Health Division, SPC Suva

196. SPC has four ongoing projects which directly support PPHSN function and implementing activities for its service networks. These grants are from the European Union, Australian DFAT and the US Department of State, with a total of over EU7.5million. There are additionally two upcoming grants from USAID and AFD which will start later in 2024.

197. SPC will continue collaboration with a wide range of partners for ongoing and new initiatives, which strengthen PPHSN as a whole, as well as SHIP-DDM, PICNet, EpiNet and LabNet.

198. Progress negotiations with the French Development Agency (AFD) for a new 4.5 million euros grant, which focuses on laboratory strengthening, enhancing surveillance and response capabilities, and addressing climate change and health

199. Finalise the agreement with USAID for a 9 million USD grant over five years, emphasising One Health Collaborations, particularly for laboratory capacity, zoonotic diseases and vector control.

200. Other proposals in the pipeline include Pandemic Funds.

WHO updates

Dr Nuha Mahmoud, Team Coordinator, Pacific Support for Health Security and Communicable Diseases, Division of Pacific Technical Support, WHO Suva

201. WHO has four ongoing funding sources.

202. COVID-19 response in the Pacific in the framework of the COVID-19 strategic preparedness and response plan from NPT, includes Water, Sanitation and Hygiene, laboratory, and surveillance, as well as installation of oxygen plants in nine targeted countries.

203. Strengthening Pacific IHR: DFAT funded project focuses on supporting Pacific Island countries in IHR strengthening of core competencies, emergency preparedness, risk mitigation for high threat pathogens and lab capacity.

204. Pacific Health Security Project under USAID is currently in its second year (of five in total), with focus on IHR assessments and coordination, updating PSSS and Event based surveillance with one health approach, capacity building for Rapid Response Teams, laboratory epidemiology and RCCE. Strategic Tool for Assessing the Risk STAR rolled out in Fiji, Vanuatu, and Tonga. Pacific Influenza preparedness and response project – US CDC funding shared from regional office. Focuses on prevention, detection and response to influenza viruses, including capacity building for laboratory surveillance.

205. Upcoming projects include Pandemic Funds, WHO has supported multi-country proposals

US CDC updates

Dr Thane Hancock, Career Epidemiology-Field Officer-US-Affiliated Pacific Islands, CDC/PIHOA and Dr Michelle McConnell, Regional Director, CDC East Asia and Pacific Regional Office

206. Support Vector Network and SHIP-DDM delivery in northern Pacific through funding provided to PIHOA.

207. Support to EpiNet and LabNet in the USAPIs through domestic programmes and hosting monthly EpiRounds.

208. Increased US CDC engagement through the new regional office in Tokyo, covering Asia and the Pacific.

209. CDC global priorities include strengthening surveillance efforts and public health workforce, through TEPHINET and FETPs, rapid response teams and GOARN, developing public health emergency management capacity among others. CDC will continue to work collaboratively with established partners and build upon needs and capacity in the region.

Institute of Environmental Science & Research (ESR) updates

Dr Sarah Jefferies, Public Health Physician, Health Intelligence &Surveillance, ESR

210. Reference testing through L3 laboratory supported by MFAT and Pacific Pathology Training Centre; sequencing of over 500 COVID-19 genomes for the PICTs with results uploaded to GISAID.

211. Support for Pacific Vector Network through a collaborative research proposal investigating mosquito movements in the Pacific.

212. Collaboration on environmental health projects, including a sustainable water quality monitoring in Kiribati, funding from MFAT.

213. Ongoing hosting of students and technical staff from PICTs for training in communicable disease surveillance and lab services. Revision of ESR's science strategy is underway to enhance regional technical capability development.

214. Contribution to epidemic and pandemic preparedness through workshops on genomic surveillance and engagement in regional meetings.

215. Transition of focal point at ESR for LabNet services to Dr Leanne Olsen.

216. Ongoing commitment to regional surveillance reporting through PacNet, acknowledging the network's importance in information sharing for risk assessments and planning, as well as PPHSN as a whole.

Meeting closure

217. Ms Amy Simpson (SPC) wrapped up the meeting with the following:
    a. All discussions and recommendations will be collated and circulated to the coordinating body members for input.
    b. Begin planning for the next PPHSN regional meeting in early 2025.
    c. Encourage partners to assist with organisational contributions for the next meeting.
    d. SPC Regional Health Guidelines App launched in March 2024, free to download with offline access to a range of guidelines.
    e. Google form shared for meeting feedback.
218. Closing prayer delivered by Dr Joseph Takai from Tonga.

Annex 1: Recommendations

1. The review recommendations on governance and the creation of indicators to evaluate PPHSN's impact are endorsed, and to be included in the updated Strategic plan.

2. PICTs to commit to regularly sharing multisource surveillance data.

3. The importance of data sharing agreements between PICTs and PPHSN to be presented to the Pacific Health Ministers Meeting in 2025 and included in the PPHSN TORs.

4. The review recommendations for individual service networks are endorsed and to be shared to Technical Working Groups or lead focal point of service network for their action.

5. Present the PPHSN Review report to the Pacific Heads of Health for endorsement and then publish the report.

6. PPHSN Strategic plan to be updated, through the process of engaging a facilitator and convening a strategic planning workshop with relevant stakeholders.

7. Allied partners to provide support (funding and expertise) for the proposed workshop.

8. SAFETYNET and Doherty Institute endorsed as allied members.

9. SPC to announce new member endorsements and update the PPHSN membership directory.

10. CB to develop a process for review of allied membership on a 3-yearly basis, with TORs to be developed for responsibilities of allied members, inclusive of contributions to network and updated focal points.

11. Agreement for the Pacific Outbreak Manual to be a living document for members to make updates and changes when necessary.

12. Establishment of a working group for validation of EpiNet team roles and responsibilities, and development of Rapid Response Team capacity training curriculum.

13. WHO to introduce an indicator-based surveillance module for respiratory diseases into EWARS to complement syndromic surveillance.

14. PICTs to commit to sustained resources for enhanced disease surveillance and testing if they opt into IRDS.

15. PICTs to nominate health focal points for the Pacific One Health Technical & Scientific Working Group.

16. Include One Health in the PPHSN framework.

17. Allied partners to provide support for Pacific One Health Network and One Health Symposium in April 2025.

18. At the next PPHSN regional meeting, present the Pacific Vector Network for endorsement to become the 7th service network.

19. Endorsement to progress explorations of requirements for SHIP-DDM to obtain TEPHINET accreditation, with thorough self-assessment and readiness initiatives.

Annex 2: List of participants

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