

## **AIDSTAR-Two – Trip Report Thailand –July 10-15, 2011**

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May 2011

5 key words:

1. AIDSTAR-TWO
2. Country Health System Surveillance (CHeSS) Workshop
3. Institutional Capacity
4. Health Progress and Performance Reviews, Analysis Methods and Tools Workshop
5. Organizational Capacity Building

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## AIDSTAR-Two Project Trip Report

### 1. Scope of Work:

Destination and Client(s)/ Partner(s)	Bangkok, Thailand
Traveler(s) Name, Role	Judith Seltzer, Director, Technical Strategy and Quality Assurance Yadira Almodóvar-Díaz, Senior Program Officer
Date of travel on Trip	July 10-15, 2011
Purpose of trip	To facilitate two sessions on institutional strengthening at the Country Health System Surveillance (CHeSS) Workshop focused on <i>Health Progress and Performance Reviews, Analysis Methods and Tools</i> .
Objectives/Activities/ Deliverables	<p>Day 1 Presentation (30 minutes):</p> <ul style="list-style-type: none"> <li>Review key institutional capacity terms and the anatomy of an institution, taking into account the following components: mission, values, strategies, structure and systems, and link them to the National Platform for CHeSS</li> <li>Explore which components present the greatest barriers to the operationalization of the Platform and impede improvements to availability, quality and use of data to inform country health sector reviews; collaboration across institutions and sectors</li> <li>Coordinated planning processes; and systematic monitoring of health progress and system performance</li> </ul> <p>Day 5 Presentation (3.5 hours):</p> <ul style="list-style-type: none"> <li>Re-visit briefly the anatomy of an institution, taking into account the following components: mission, values, strategies, structure and systems from session</li> <li>Review and apply the systems thinking model, using a case vignette to explore root causes of poor coordination and collaboration across institutions, and unclear roles and responsibilities within institutions</li> <li>Brainstorm ways in which the participants might further involve themselves in breaking down barriers to data availability, quality and use, once the root cause of under performance is known</li> </ul>
Background/Context, if appropriate.	The <i>Health Progress and Performance Reviews, Analysis Methods and Tools Workshop</i> , hosted by the WHO, in partnership with GAVI, the Global Fund, World Bank, USAID, Rockefeller Foundation, and ICF Macro was held July 11-15, 2011 in Bangkok, Thailand. The aim of this event was to introduce participants to the existing tools, concepts and methods available across the Country Health System Surveillance (CHeSS) framework, and to demonstrate how these tools and methods can be used to improve the capacity of countries to conduct comprehensive health progress and performance reviews in the context of national health plans and related global health goals.

## **AIDSTAR-Two Project Trip Report**

Eighty (80) participants from 13 countries from the South-East Asia, Western Pacific and African region attended this event. These included senior analysts from the Ministry of Health, Bureau of Statistics, academic institutions and others that play important roles in preparing the analytical background to the health sector reviews. The countries represented were: Bangladesh, Cambodia, Fiji, Lao, Indonesia, Malaysia, Mauritius, Mongolia, Nepal, Philippines, Sri Lanka, Thailand and Viet Nam.

This is the third regional workshops scheduled for FY11 and 12. The first workshop took place in Kenya (April 2010) and brought together representatives from countries in Eastern Africa. The second workshop took place in South Africa (October 2010) and brought together 13 countries from Southern and Western Africa.

Many countries have made considerable progress in using data to inform decision-making processes such as annual health sector reviews, mid-term reviews and evaluations. National authorities have expressed the need to enhance their own analytical capacities to carry out comprehensive assessments of progress and performance. In the context of the MDGs and health systems strengthening, there is increased demand for results that demonstrate the impact of investments. This has led to considerable reporting demands on countries. Therefore, strengthening the analytical capacity of countries should contribute to one sound national platform for monitoring progress and performance, from which global reporting will draw. Country annual and other health reviews should also form the basis for all global reporting requirements. Similarly, to improve the availability, quality and use of the data needed to inform country health sector reviews and planning processes, and to monitor health progress and system performance is important that the organizations responsible for these functions count with the appropriate structures and systems to fulfill their vision and values. During the two sessions of capacity building, participants explored the many components and functions of an institution that must work in unison for optimal performance. They were also introduced to a systems thinking approach to identify performance gaps. Performance gaps can manifest as undesired events or unsatisfactory outputs or outcomes; however, their causes are often rooted deeply in an institution's value system. Through the application of an exercise, participants learned a simple methodology for identifying root causes of poor coordination and collaboration across institutions, and unclear roles and responsibilities within institutions. Such improvements should be supported in a way that strengthens global monitoring, including reporting of global goals and results of health investments, while minimizing the reporting burden for countries.

## AIDSTAR-Two Project Trip Report

**2. Major Trip Accomplishments:** Should include the major programmatic goals realized, relevant metrics, and stories of impact from the trip.

- Successfully delivered the presentations at both sessions.
- Distributed electronic and hard copies of the AIDSTAR-Two Technical Brief on the Organizational Capacity Building Framework and the Institutional Readiness Toolkit developed by USAID and the World Bank. Electronic copies of the Systems Thinking for Health System Strengthening were also shared with participants.
- Discussed with the conference coordinators possible ways in which AIDSTAR-Two/MSH could collaborate with the WHO follow-up on the outcomes of this workshop (e.g., hosting a leadernet seminar, providing in country support to one or two participating teams).

**3. Next steps:** Key actions to continue and/or complete work from trip.

Description of task	Responsible staff	Due date
Discuss with Pamela Rao and other relevant USAID staff regarding follow-up support after the conference.	Sarah Johnson, Ummuro Adano, Judith Seltzer and Yadira Almodovar	July, 2011
WHO asked that AIDSTAR-Two participate in the French CHESS workshop, scheduled for either Senegal or Geneva. One suggestion is that Willow participates in the next conference and present the sessions we conducted.	Sarah Johnson, Ummuro Adano, Judith Seltzer and Yadira Almodovar	September, 2011
WHO would also like to collaborate with MSH on the development of some virtual platforms. Judy and Carly (of WHO) will be in touch regarding this activity.	Judy Seltzer	TBD

**4. Contacts:** List key individuals contacted during your trip, including the contacts' organization, all contact information, and brief notes on interactions with the person.

Name	Title and Institution	Contact information	Notes
See Annex 1			

**5. Description of Relevant Documents / Addendums:** Give the document's file name, a brief description of the relevant document's value to other staff, as well as the document's location in eRooms or the MSH network. Examples could include finalized products and/or formal presentations, TraiNet Participant List, Participant Contact sheet, and Meeting/Workshop Participant Evaluation form are examples of relevant documents.

File name	Description of file	Location of file
Annex 1: List of Participants	PDF document	Annexes & e-Room

*The contents of this report are for the use of CLM staff only and should not be shared without permission from the individual who completed the report.*

## **AIDSTAR-Two Project Trip Report**

Annex 2: PowerPoint presentations for both sessions and sessions guides	PowerPoint presentations and Word document	Annexes & e-Room
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HEALTH PROGRESS AND PERFORMANCE REVIEWS  
Analysis Methods and Tools

Workshop  
Bangkok, 11-15 July 2010

WHO / IHPP/Africa Population & Health Research Centre / ICF Macro  
with support from GAVI / Global Fund / Rockefeller Foundation / USAID

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BANGKOK, THAILAND  
JULY, 2011**

**AIDSTAR-TWO'S SESSION GUIDE  
SESSION 1**

**JUNE 24, 2011**

**SESSION 1: INSTITUTIONAL CAPACITY BUILDING: IT'S EVERYBODY'S BUSINESS**  
**SESSION 1, DAY 1**

**Purpose**

The purpose of this session is to use the National Platform for CHeSS to explore the role of institutional capacity building and the many components and functions of an institution that must work in unison for optimal performance. We will also examine factors that thwart the operationalization of the Platform and impede improvements to availability, quality and use of data to inform country health sector reviews; collaboration across institutions and sectors; coordinated planning processes; and systematic monitoring of health progress and system performance.

**Activities**

During this session, participants will:

- Review key institutional capacity terms and the anatomy of an institution, taking into account the following components: mission, values, strategies, structure and systems, and link them to the National Platform for CHeSS
- Explore which components present the greatest barriers to the operationalization of the Platform and impede improvements to availability, quality and use of data to inform country health sector reviews; collaboration across institutions and sectors; coordinated planning processes; and systematic monitoring of health progress and system performance

**Objectives**

By the end of this session, participants will be able to:

- Explain the National Platform for CHeSS in the context of institutional capacity building
- Understand institutional capacity building within the context of past capacity building initiatives Define and distinguish between the following terms: institutional capacity, capacity building, institutional capacity building
- Describe the components and functions of an institution
- Examine the inputs and processes within an institution that may pose potential barriers to operationalizing the Platform (referring back to the Framework for Monitoring and Evaluation of Health Systems Strengthening)
- Link institutional capacity building to country ownership

**Duration**      30 minutes

**Reference Materials**

- Session Guide
- PowerPoint Slides
- Technical Brief: Organizational Capacity Building Framework: A Foundation for Stronger, More Sustainable HIV/AIDS Programs, Organizations, and Networks



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# AIDSTAR-Two

**Strengthening Institutional Capacity: It's Everybody's Business!**



**HEALTH PROGRESS AND PERFORMANCE REVIEWS  
Analysis Methods and Tools  
Workshop  
Bangkok, Thailand**



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## Institutional Capacity Defined

- **Institutional Capacity:** the ability or power of an institution to apply its skills, assets and resources to achieve its goals.
- **Capacity Building:** an on-going evidence-driven process to improve the ability of an individual, team, organization, network, sector or community to create measurable and sustainable results.
- **Institutional Capacity Strengthening:** the strengthening of institutional vision, mission, strategy, structures, systems and processes, as well as management and leadership capacity to enhance institutional, team and individual performance.

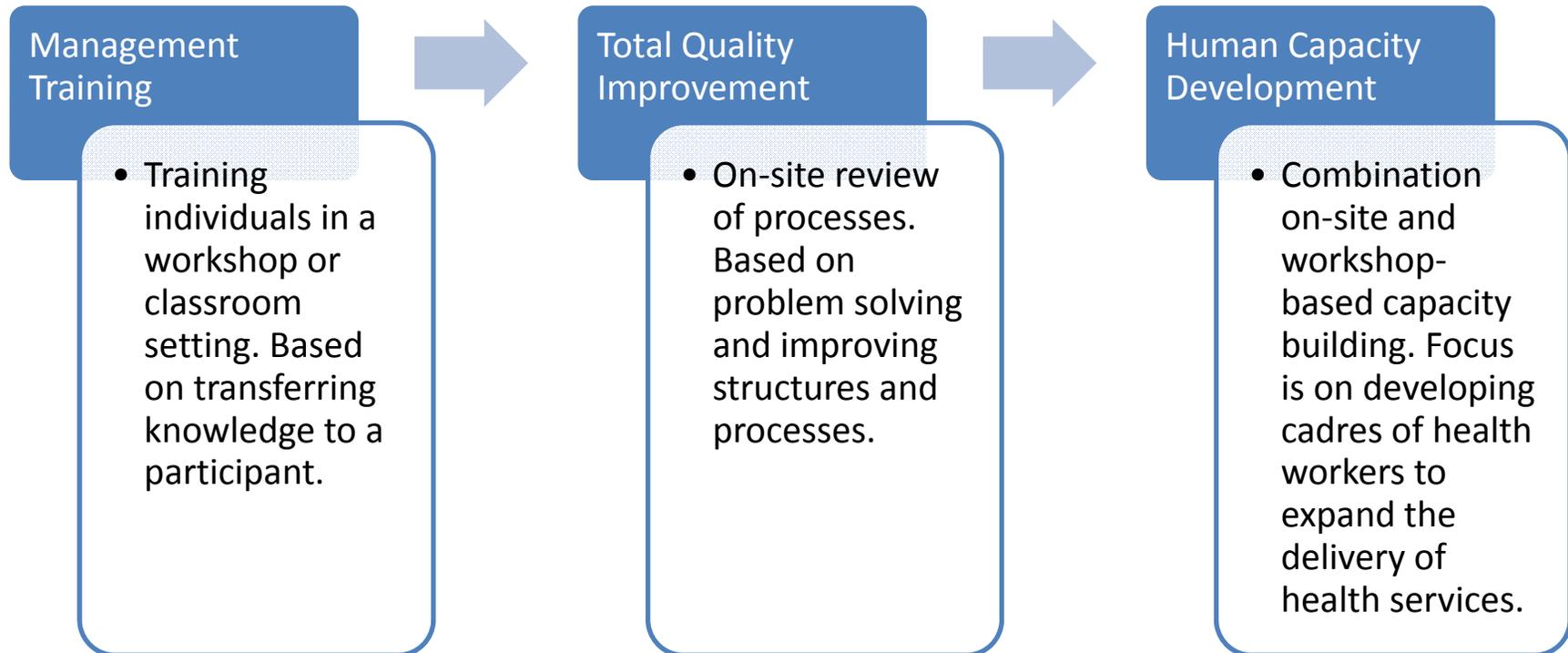


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## Institutional Capacity Strengthening: Its Predecessors





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# The Components of an Institution





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## Barriers to Success

Guided Inquiry for country teams:

1. Which components of your institution present the greatest barriers to:
  - Data availability
  - Data quality
  - Data use?
  - Collaboration across institutions and sectors?



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## Institutional Strengthening and Country Ownership

- With the right level of evidence about performance gaps and what can close them, countries can make and sustain progress towards strengthening their health systems.
- Countries can ensure plans are developed, implemented and evaluated in ways that strengthen existing structures and systems
- This country ownership reinforces commitment and long term sustainability



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## Your Role in Strengthening Institutional Capacity



...Stay tuned for the next session on using a Systems Approach to strengthening Institutional Capacity

**COUNTRY HEALTH SYSTEMS SURVEILLANCE (CHESS) WORKSHOP  
BANGKOK, THAILAND  
JULY, 2011**

**AIDSTAR-TWO'S SESSION GUIDE  
SESSION 9**

**JUNE 30, 2011**

**SESSION 9: STRENGTHENING INSTITUTIONAL CAPACITY: TAKING A SYSTEMS APPROACH TO PERFORMANCE  
IMPROVEMENT  
SESSION 9, DAY 5**

**Purpose**

The purpose of this session is to introduce the participants to a systems thinking approach to identify performance gaps. Performance gaps can manifest as undesired events or unsatisfactory outputs or outcomes; however, their causes are often rooted deeply in an institution's value system. We will apply the systems thinking model to a case vignette based on findings from a performance review of a sample of countries. Through this exercise, participants will learn a simple methodology for identifying root causes of poor coordination and collaboration across institutions, and unclear roles and responsibilities within institutions.

**Activities**

During this session, participants will:

- Re-visit briefly the anatomy of an institution, taking into account the following components: mission, values, strategies, structure and systems from session I
- Review and apply the systems thinking model, using a case vignette to explore root causes of poor coordination and collaboration across institutions, and unclear roles and responsibilities within institutions
- Brainstorm ways in which the participants might further involve themselves in breaking down barriers to data availability, quality and use, once the root cause of under performance is known

**Objectives**

By the end of this session, participants will be able to:

- Describe the components and functions of an institution
- Explain the systems thinking model and how they might apply it to their institutions to reveal root causes of performance inhibitors
- Identify things they can do to identify and eliminate barriers to coordination and collaboration across institutions, and unclear roles and responsibilities within institutions, once the root cause of underperformance is known

**Duration**      3.5 hours

**Reference Materials**

- Session Guide
- PowerPoint Slides
- Don de Savigny and Taghreed Adam (Eds). Systems thinking for health systems strengthening. Alliance for Health Policy and Systems Research, WHO, 2009
- Short Video on Red Cross' Response to Monsoons in India
- Case Vignette



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# AIDSTAR-Two

## Strengthening Institutional Capacity: Taking a Systems Approach to Performance Improvement



**HEALTH PROGRESS AND PERFORMANCE REVIEWS**  
**Analysis Methods and Tools**  
**Workshop**  
**Bangkok, Thailand**



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# The Components of an Institution: A Review





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## How to analyze institutional breakdowns: Part I

### Guided Inquiry

1. Break into country teams
2. Review the case vignette based on your work earlier in the week, which have been distributed
3. Identify an **undesirable event or outcome** in which the MOH had a role
4. Note the event on your flip chart



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## Principles of Systems Thinking

The practice of Systems Thinking is based on three principles:

1. Some ways of thinking about things are more powerful than others in creating the results we want
2. Structure influences systems
3. Systems, particularly those that generate data, influence results (or performance)
4. We're an important part of the structure we establish and the systems we install. As a worldly philosopher once said: "We have met the enemy and he is us"

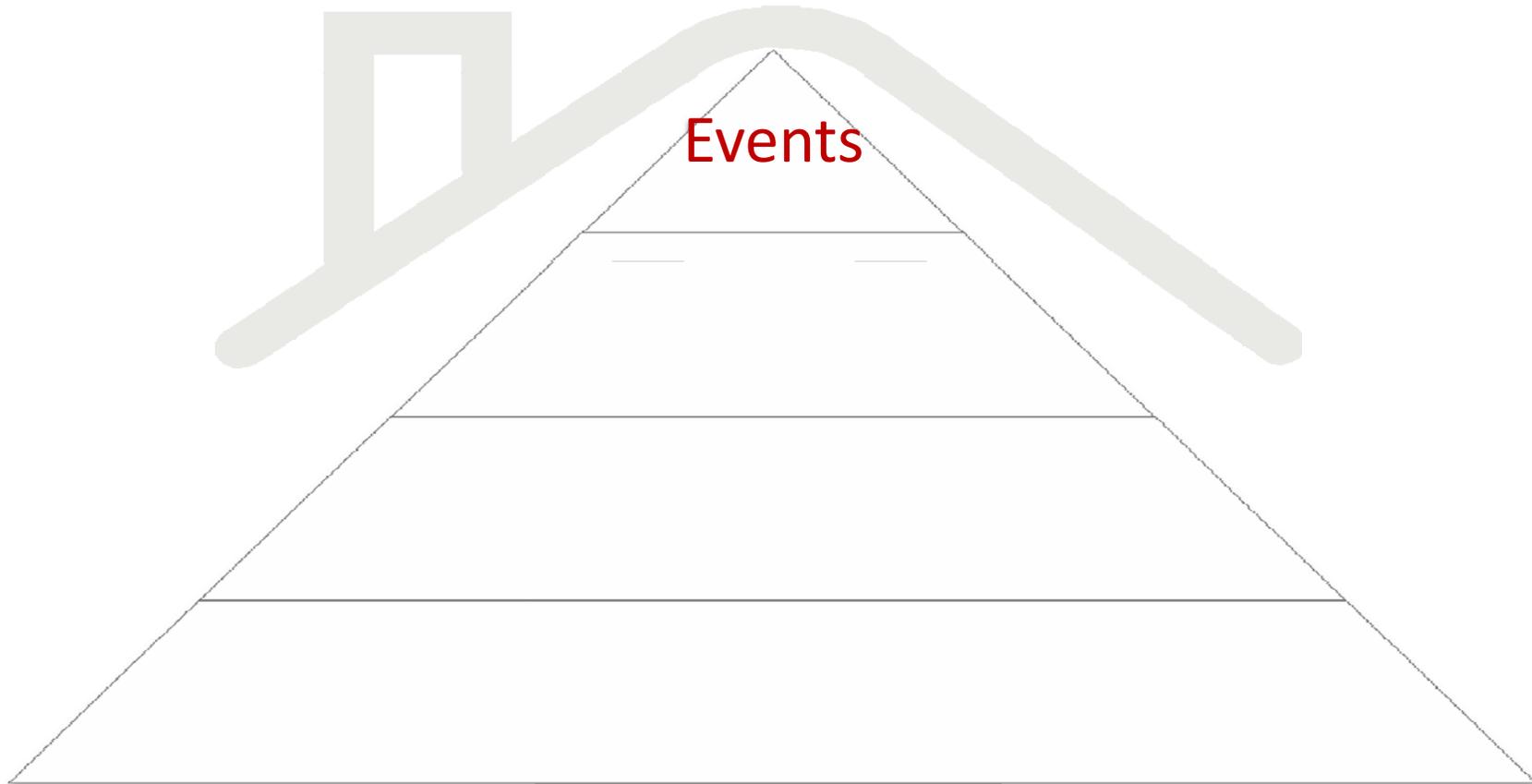


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## The Systems Thinking Model Adapted



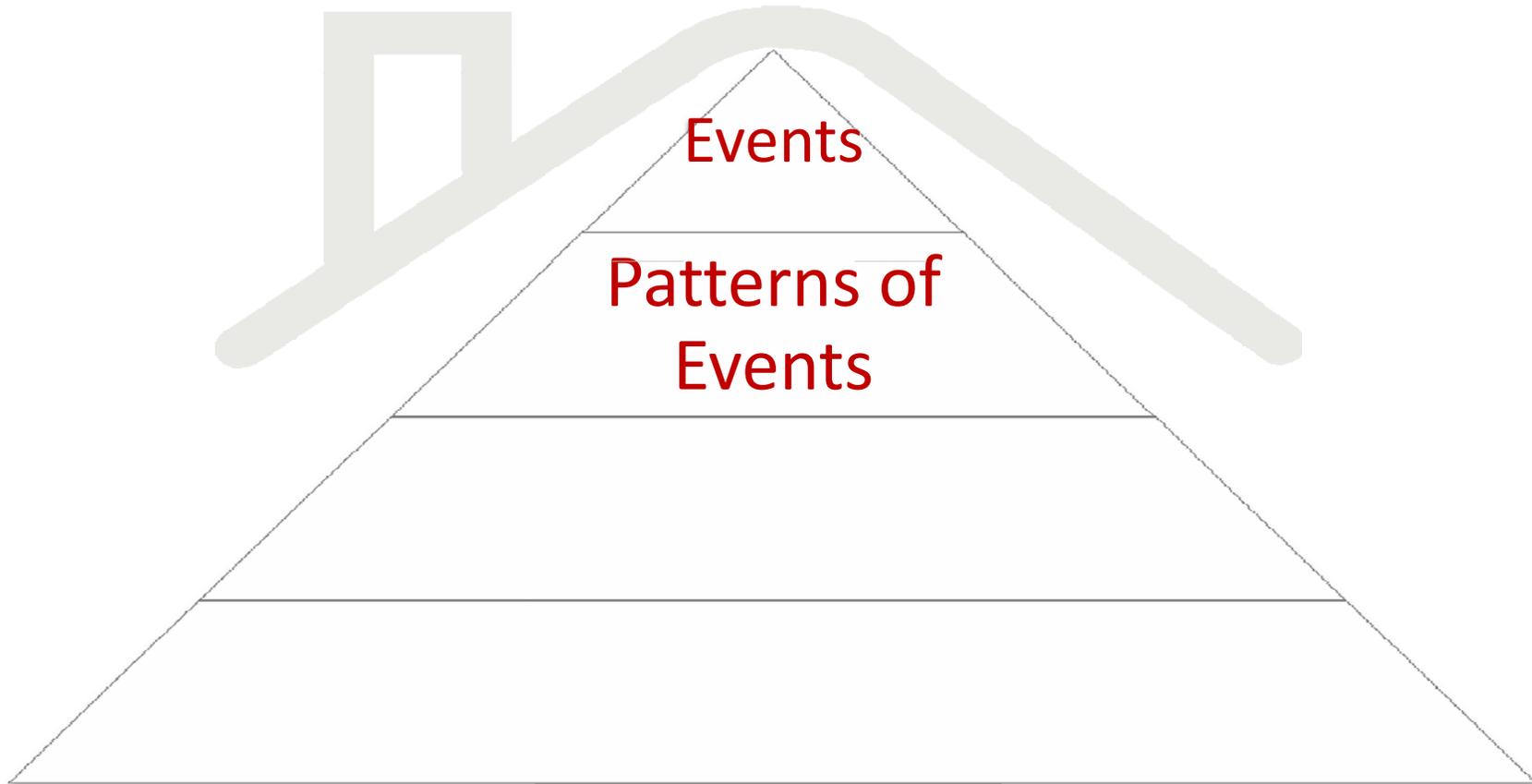


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## The Systems Thinking Model Adapted



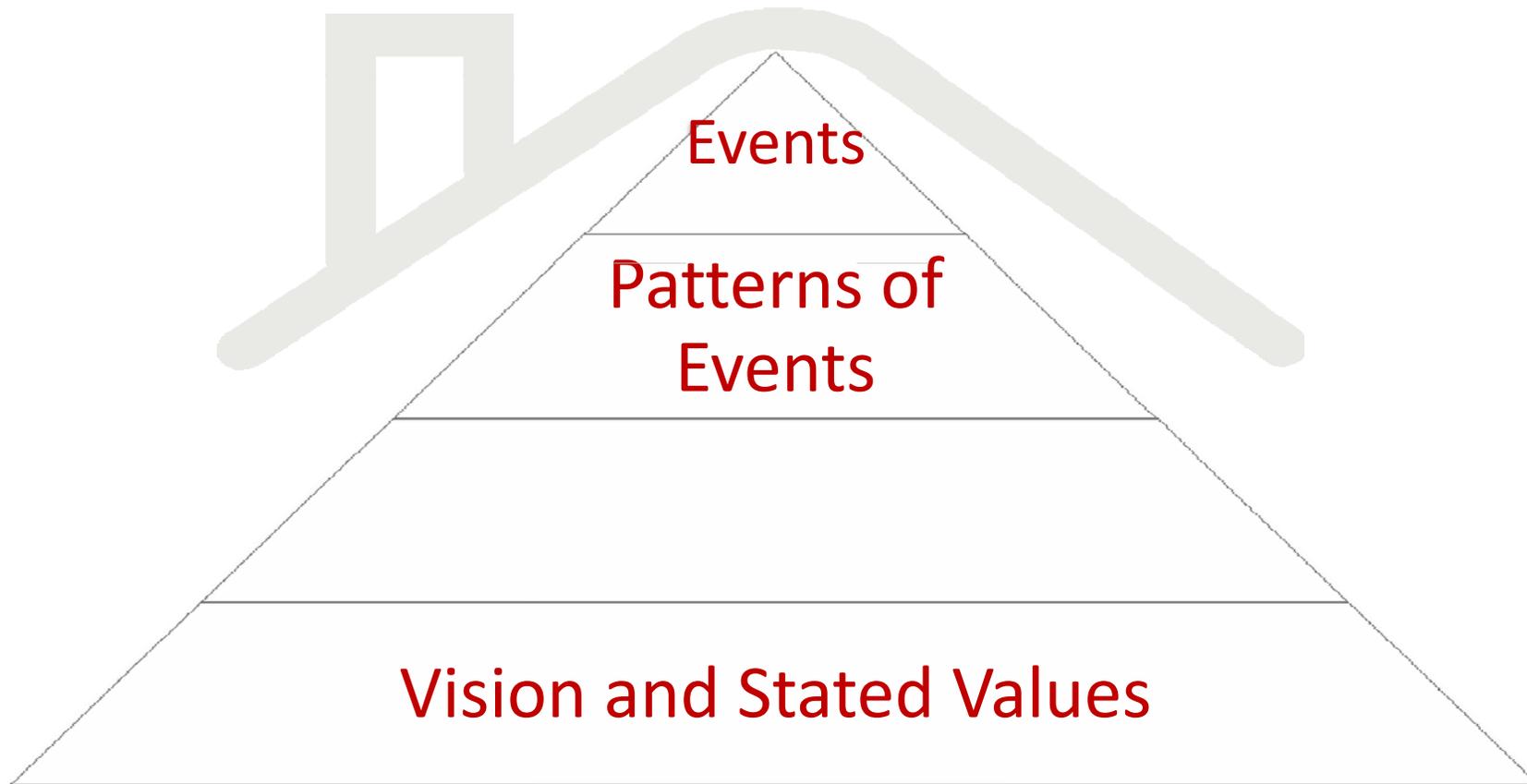


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## The Systems Thinking Model Adapted



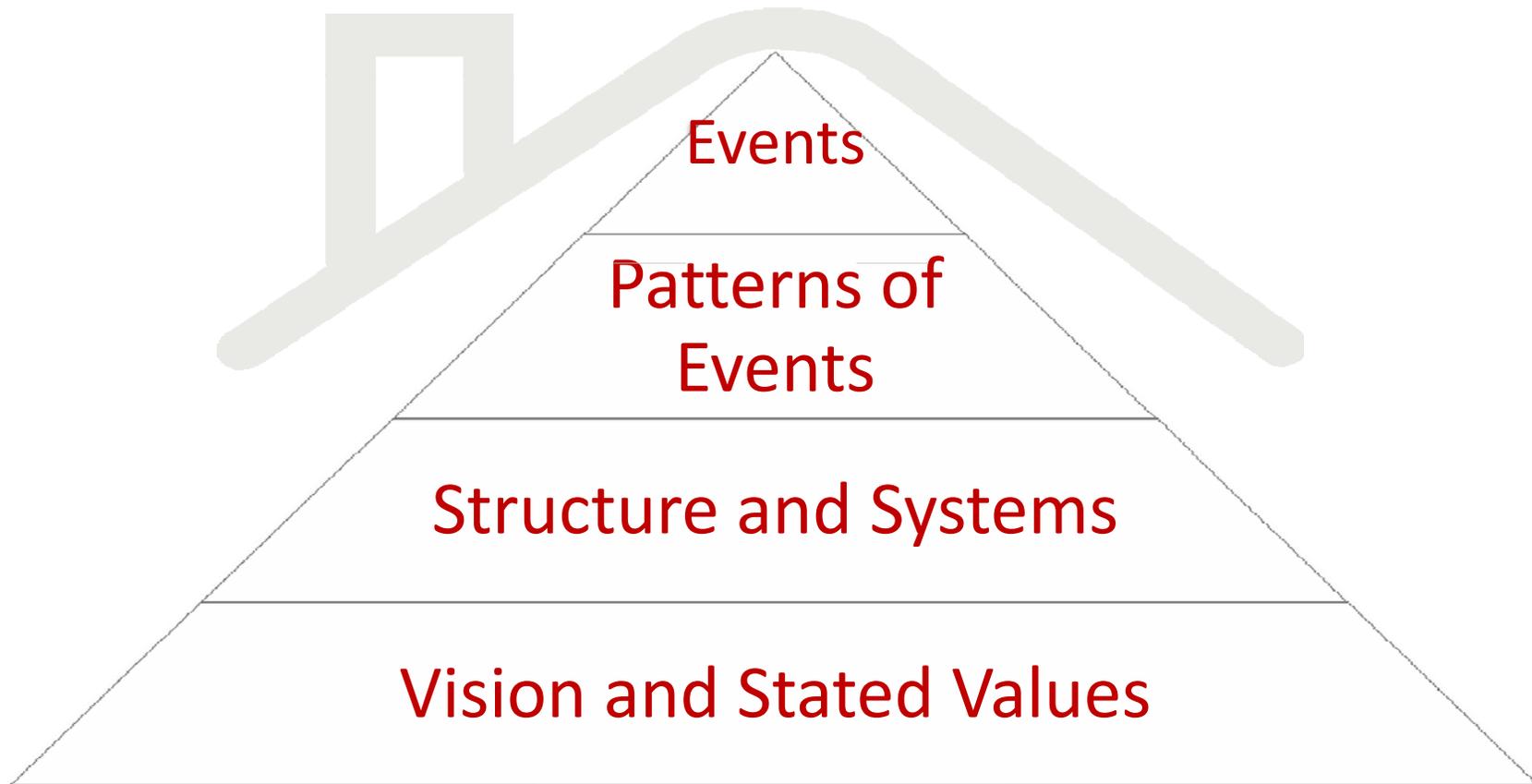


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## The Systems Thinking Model Adapted



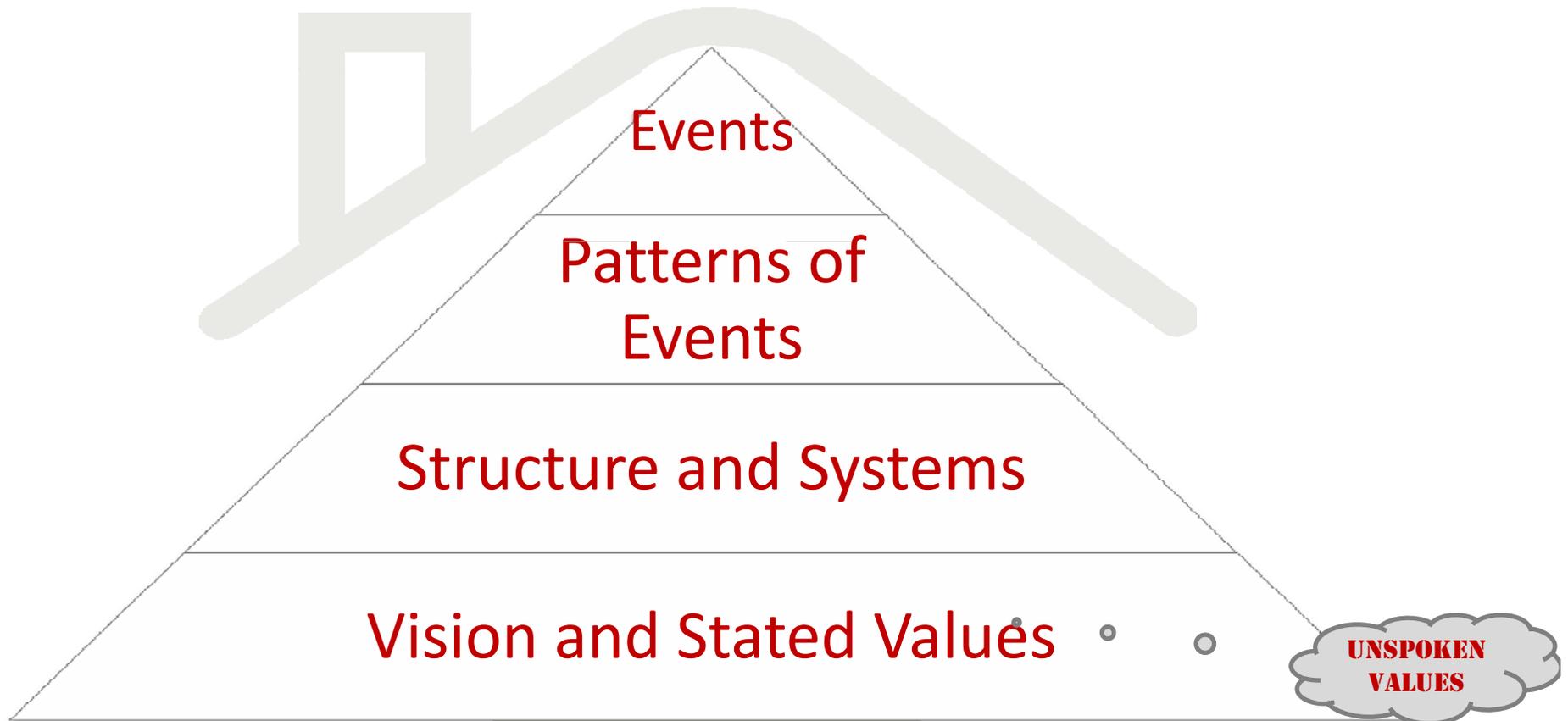


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## The Systems Thinking Model Adapted





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## Monsoon Events and their Impact

Year	Country	Impact
2003	Nepal	239 Killed 284 injured 15 575 homeless 43 395 affected
	Indonesia	241 killed 30 injured 1468 affected
	Sri Lanka	235 killed 695 000 affected US\$ 29 000 damage
2004	Bangladesh	730 killed 36 000 000 affected US\$ 2 200 000 000 damage
	Nepal	185 killed 15 injured 800 000 affected
2005	India	1200 killed 55 injured 20 000 000 affected US\$ 3 330 000 000 damage



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## Monsoon Events and their Impact

Year	Country	Impact	
2006	Thailand	116 killed 342 895 affected US\$ 25 000 000 damage	
	Indonesia	236 killed 56 injured 670 homeless	28 505 affected US\$ 55 200 000 damage
	Thailand	164 killed 2 212 413 affected US\$ 9 940 000 damage	
	Sri Lanka	25 killed 2 injured 333 000 affected US\$ 3 000 000 damage	
	India	350 killed 65 injured 4 000 000 homeless	US\$ 3 390 000 000 damage
2007	Indonesia	40 killed 1 injured 400 000 affected US\$ 695 000 000 damage	



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## Diseases Related to Flooding from Monsoons

### **Water- and food-borne**

- Cholera
- Typhoid
- Hepatitis A
- Diarrhoea
- Dysentery

### **Vector-borne**

- Malaria
- Dengue/dengue haemorrhagic fever

### **Effects on mental health**

- Sleep disorders
- Excessive grief and depression
- Exacerbation of existing illnesses

### **Due to direct contact with contaminated water**

- Dermatitis
- Conjunctivitis
- Ear, nose and throat infections
- Wound infections
- Leptospirosis

### **Due to exposure to water/rain**

- Hypothermia
- Respiratory tract infections



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## India's Response to the Pattern of Events



[Workshop\Sessions](#)



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## How to analyze institutional breakdowns: Part II

Guided Inquiry for country teams:

1. Create a pyramid for the **undesired event or outcome** in which the MOH had a role
2. Ask yourselves the following questions – in the order indicated - and post the responses on the flipchart
  1. Did the event you selected occur more than once?
  2. What are the institution's stated values?
  3. How are these values articulated in the structure and systems of the institution?
  4. What are the institutions unstated values?
  5. How did they breakdown the institution's structure and/or systems?

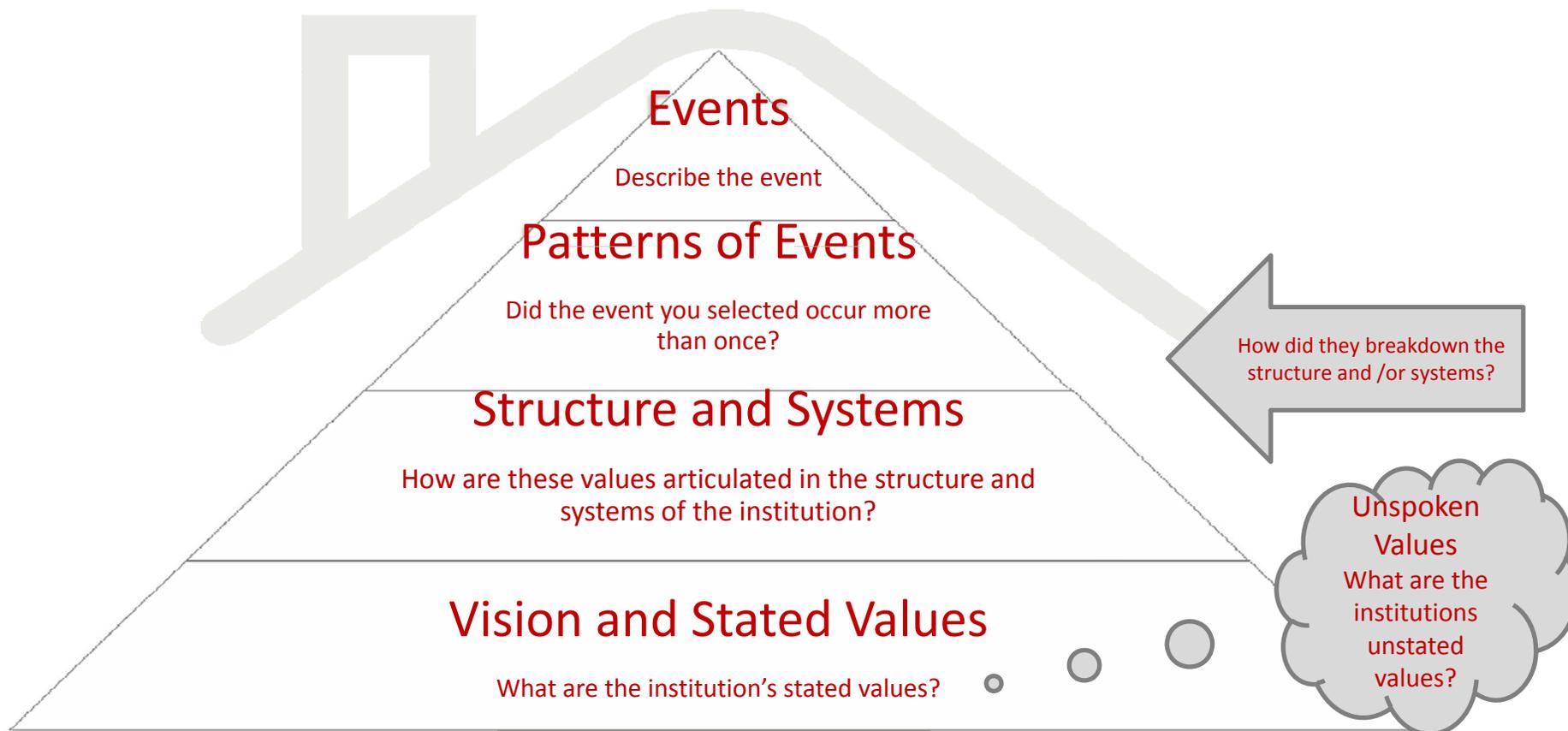


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## The Systems Thinking Model: Flipchart for Undesired Event or Outcome





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## How to apply what you have learned

Guided Inquiry for small group discussions:

1. What can you do as a responsible citizen of your institution to identify barriers to data availability, quality and use?
2. What can you do as a responsible citizen of your institution to build institutional capacity to address or avoid these barriers?
3. What is a single institutional barrier to data availability, quality or use that you feel you can address in the short-term?
4. How might you address it?

## **Abunesia: A false positive for the Country's Health Surveillance System**

Dila, Abunesia - *In 2006, an assessment of the Abunesia Epidemiological Surveillance and Response (ESR) system uncovered several gaps and weaknesses, including the lack of capacity, especially at the local level, to perform the required ESR functions; weak and ineffective surveillance support systems in terms of training, supervision, and monitoring; and inadequate funding support for equipment, travel, logistics, and other supplies essential for the optimal operation of a disease surveillance system. These gaps and weaknesses put into question the quality of the information generated from the field and the adequacy of response to epidemics.*

### **Case detection and confirmation**

The DOH has developed standard case definitions for the 17 diseases and 7 syndromes requiring notification and templates of standard reporting forms. This was supported by a department circular directing all levels of the health care system to report all cases seen on a regular basis. However, copies of the case definitions and reporting forms were not available in majority of health centers and those who have copies did not necessarily use them. There seemed to be a problem in the dissemination of these standards as not everyone received a copy of the DOH issuance and the mere act of distributing copies of the circular was not enough to ensure application of and compliance. There were also no guidelines for the collection, handling and transport of specimens for laboratory-confirmed diseases. This resulted in the inability of health centers to send specimens for laboratory confirmation. The situation was aggravated by the lack of adequate referral laboratory facilities in the field. Most specimens have to be sent to the national referral lab in Dila for confirmation. A related issue also was the cost associated with the provision of laboratory support. Cost considerations was a major factor responsible for the dearth of laboratory tests regularly performed to confirm suspected cases of communicable diseases.

### **Outbreak response and control**

Guidelines on how to respond and manage outbreaks in general did not exist. Only disease-specific case management protocols and guidelines for dengue, meningococemia and measles have



Members of the village health emergency team assist with an immunization campaign

been developed and distributed although the assessment showed that these could not be readily

located in almost all facilities visited . For all the other diseases, there are no case management protocols available. The lack of guidelines on this critical ESR function was responsible for many lapses and missed opportunities in properly and effectively responding to disease outbreaks in the field.

### **Data reporting**

The timely and regular submission of reports and immediate notification in case of suspected outbreaks is a basic requirement for effective disease surveillance and control to happen. Several means of data transmission are practiced: telephone, fax, e-mail and via the Abunesian postal system. However, the level of completeness and timeliness dropped off as one proceeds from the health facilities to the next higher levels. The same situation existed with respect to the timeliness in the submission of reports. One of the reasons cited regarding delays in the submission of reports was that surveillance officers at the provincial level usually wait until all health facilities have completed their submissions before the reports are consolidated and forwarded to the next higher level (e.g. regional health offices).

### **Data analysis**

The capability for data analysis was highly centralized. Most of the regional surveillance

units were capable of doing time-place-person analysis, trend analysis, and some action threshold analysis. However, these analytic procedures were performed minimally at the provincial and municipal/city health facility levels. It is worthwhile mentioning that in areas where local capacity was present, the surveillance officers responsible for doing the analytic work is either a graduate of the Field Epidemiology Training Program (initially a USAID-funded training program in collaboration with the CDC-Atlanta) or has been trained in a Public Health Surveillance Course.

### **Outbreak investigation**

Similar to the ESR core function of data analysis the capacity to perform outbreak investigation was highly centralized. The lack of capacity to do outbreak investigation at the sub-national and local levels was complicated by the inability of the surveillance systems to detect disease outbreaks and by the lack of data analysis performed at lower levels. Without adequate analysis there will be no disease outbreaks detected and consequently no outbreak investigations conducted. Furthermore, the responsibilities of the different levels involved in outbreak investigations were not clearly defined. The lack of policy guidance in this area has created confusion in the minds of surveillance officers and health managers with respect to the delineation of outbreak investigation responsibilities.

### **Epidemic preparedness**

There was uneven demonstration of epidemic preparedness across all levels of the health system. At the central level, the country has established a Health Emergency Management Service (HEMS) that was responsible for the management of health emergencies including epidemics. National and regional stocks of emergency medicines, vaccines and supplies are available. However, there was no DOH plan for epidemic preparedness and response. There was no epidemic committee and rapid response teams at the national level and in most regional, provincial, and community levels. Likewise, there were no budgets for epidemic response in the central, provincial, city and municipal levels. At best, preparedness was highly reactive.

### **Epidemic response**

The capacity to respond to disease outbreaks was very high at the regional and central levels. While timeliness to respond to reported outbreaks follow this centralized pattern, the case-fatality ratios in reported outbreaks at all levels were high. The lack of outbreak response capacity at the local level was critical. Because of geographic distance, it takes time for regional and central office outbreak response teams to get to the field. Such delays may account for the high case-fatality ratios seen in some of the investigated outbreaks. The lack of guidelines in the conduct of outbreak response activities and the absence of case management protocols for some diseases contributed to this problem.

### **Feedback**

Only the DOH central office provided regular feedback through the issuance of a surveillance bulletin from the National Epidemiology Center. This feedback mechanism was provided mainly to the other offices at the central DOH as well as other national government agencies and media practitioners. The issuance and dissemination of a similar type of surveillance bulletin at the regional, provincial and municipal offices visited have not been done on a regular basis. Many of the surveillance reports from regional and provincial levels were on an ad hoc basis, especially in high-media profile reports like dengue and meningococemia. Only 50% of regional health offices received feedback from the central office and only 12% of provincial health offices received feedback from the regional health offices on reports submitted. No such feedback was received by the municipal or city levels.

### **Abonesia's response: Better structures and systems**

WHO, under International Health Regulations-2005, required all its member states to strengthen their core capacities for disease surveillance and response. IHR-2005 has a greatly expanded scope, which applies to diseases, including those with new and unknown causes that present significant harm to humans irrespective of origin or source.

With the inadequacies of the disease surveillance systems and the need to comply with the IHR-2005 call for the urgent adoption of an integrated approach towards the strengthening of the ESR system, the Abunesia DOH established the Abunesia Integrated Disease Surveillance and Response (AIDSAR) system. The system integrated the existing parallel disease reporting systems, transformed the weekly notifiable disease reporting into a case-based system, updated clinical protocols and guidelines, built sub-national capacity for ESR, and strengthened ESR support systems. A manual of operations for AIDSAR was also developed to serve as reference for communicable disease program managers and expanded program for immunization (EPI) managers at the national and local levels, members of epidemic investigation and control teams, epidemic management committees at the provincial and regional levels, health emergency management staff, medical doctors and nursing personnel, and even community health volunteers. The AIDSAR has been established at the national and regional levels and is now moving progressively towards full implementation at the provincial and city/municipality levels.

### **Abunesia is put to the test**

In 2009, Abunesia was in the throes of an Influenza A/H1N1 pandemic. The central level (DOH) management committee on prevention and control of emerging and re-emerging infectious diseases (EIDS) was activated. Health surveillance was enhanced in hospitals, seaports, and airports, including thermal scanning of arriving passengers from affected countries. A DOH hotline was activated for immediate reporting of suspected Influenza (H1N1), flu-like illness, and atypical pneumonia by DOH regional offices, local government units (LGUs), hospitals, and the general public. Referral centers for EIDs were readied and the national personal protective equipment (PPE) stockpile and the anti-viral drug (Oseltamivir) and other logistics were firmed up, with priority given to high-risk exposure groups consisting of frontline health workers and surveillance teams. Information, education, and communication (IEC) materials were prepared public health advisories were done to provide information on Influenza A/H1N1.

At the regional level, the DOH Centers for Health Development (CHDs) activated their respective committees for the prevention and control of Re-EIDs together with enhanced surveillance in all points of entry (airports, seaports) and hospitals, including coordination with quarantine and airport officials.

Lectures on Influenza A(H1N1) were conducted for multi-sectoral groups (local chief executives, representatives of government line agencies, local health workers, private hospital personnel, medical societies, non-medical hospital personnel, private sector groups, etc.).

At the local level, a memorandum circular from the Department of Interior and Local Government mandated local governments that village health emergency teams must be organized and will serve as community-based partners of national and local government in the campaign (prevention, containment, and control) of emerging and re-emerging diseases. Each team was to be the eyes and ears on the ground for unusual events like sudden poultry/animal deaths, clustering of febrile cases, etc. These teams were also tapped to assist in pre-, during, and post-disaster situations like floods, volcanic eruptions, etc. that results in temporary displacement of population and possible outbreak of diseases.

In the end, despite a high-level policy support and a national/local system for coordinating preparedness planning and response against emerging and re-emerging diseases, there was still a need for more clearly defined policy and administrative arrangements for collaborative effort and partnership between DOH and other sectors like agriculture (in charge of animal health), education, etc. The relationship among various sectors to address human and animal health was not sufficiently formalized, including the integration of rapid response teams at national and local levels. Also, the problems of keeping village health emergency teams “alive” when no imminent threat (of disease or disaster) exist is a challenge that must be addressed. In areas with low perception of threat, these teams quickly disappeared in the wood work.

## Breakdowns

**Central level:** Within the central DOH, there seems to be differences in opinion on how diseases are to be reported and managed. For example, the program office (e.g. dengue or malaria program) and the National Epidemiology Center (NEC) have different systems of collecting information for the same disease. There is also the issue of “media jealousy” regarding who deals with the media in times of outbreaks and feedback. Moreover, there is the question of who takes the lead in responding to an outbreak. Should it be the Health Emergency Management Staff (HEMS) or NEC?

**Sub-national level (provincial/city/municipal levels):** Despite decentralization of Abonesia’s health system, the issue of who declares an epidemic is also a problem. Provinces/local governments are wary in declaring epidemics or outbreaks because of possible economic repercussions (tourism, export, etc.) of an epidemic issuance, even if the central level deems it necessary not only because of its commitment to the IHR-2005, but also if the situation has reached national/international concern.

There is also a case of a pseudo-epidemic (non-existent typhoid) being reported by a few local governments, so they can declare an emergency situation and be able to use their calamity funds.

Furthermore, there is a tendency of some health managers not to report outbreaks since these are sometimes viewed as a form of “non-performance” by their superiors.

## Abonesia’s Minister of Health speaks out

“In my opinion, policy support for the establishment of surveillance system does not necessarily provide for the creation of new structures and systems but, instead, imposes it on a pre-existing and overworked machinery like the DOH and other agencies. At the same time, it is necessary but sometimes difficult to fit systems to existing structures or vice-versa. Although collaboration within and between the human and animal health sectors exist, there is a lack of a defined mechanism to link the efforts of all sectors involved in the prevention and control of

emerging and re-emerging communicable diseases. Formal arrangements must be established for better collaboration between their Agriculture and Health Ministries for early detection and response. E.g. - in cases of Zoonosis, there are instances wherein sudden poultry or animal deaths are detected by /reported to / investigated by the Department of Agriculture but this information is not shared to the Department of Health.

While a system of community-based detection and response systems (e.g. BHERTS) has been established, this has been done on a limited scale and with limited accompanying resources. These initiatives should be continued and expanded but efforts should be made to ensure their sustainability especially when risk perception becomes low. Local governments must realize that it is within their responsibility to support and provide resources in maintaining the surveillance and response activities at their level.”



Minister of Health, Dr. Lucy Magboo meets with her CHeSS team