

**INTERNATIONAL CONSULTATION ON STRENGTHENING NATIONAL
CAPACITIES FOR EPIDEMIC PREPAREDNESS AND RESPONSE IN SUPPORT
TO THE NATIONAL IMPLEMENTATION OF THE INTERNATIONAL HEALTH
REGULATIONS (2005)**

MAY 2 – 5, 2006

**Conclusions and Recommendations of the
WORKING GROUP ON ALERT AND EARLY WARNING**

Defining PHEIC

1) Countries should make use of the definition of PHEIC in Annex 2 of the IHR (2005), and interpret it within the framework of their routine surveillance systems, and in the context of their own background epidemiology and pathogenesis as well as emerging information on new infectious diseases or outbreaks from the international context. The formal process of defining and prioritising threats will provide guidance as to how they need to monitor health events. They may choose to record specified disease events, but should not be restricted to static list of infectious diseases, but incorporating flexibility to record syndromes and to identify new and emerging conditions. Countries should be encouraged and supported to regularly undertake review of the definitions of the items and procedures for the monitoring of health events and defining potential PHEIC. Countries could also benefit from some regular exercises in the use of the tool to define potential PHEIC. Countries are encouraged to discuss an event with WHO as part of the process of notifying it as a potential PHEIC.

Design of surveillance systems

2) Systems for surveillance within a country that will support the detection of unusual events can be based on a variety of models, depending on the context. There are broadly speaking two different kinds of information that need to be collected. One is based on quantitative and routine case reporting, and could involve laboratory confirmed disease or syndromes or indirect indicators such as drug prescriptions, and linked to the corresponding data collections for animals. The other form of information is more qualitative, and involves the processing of reports of unusual health events of different kinds. Sources of such information may not be formally within the health system. The quantitative and qualitative sources of information can complement each other.

Generating Information

3) In many countries there are systems for routine data collection that currently have a limited ability to generate information that can provide early warning. The minimum requirement for surveillance at the community or primary public health response level is the ability to rapidly detect and report events of potential significance. At the next level up, there must be the capacity to analyse the reported information and recommend an appropriate public health response in a meaningful time frame, i.e. to confirm the status of the report and assess the form of response required sufficiently quickly to be able to have an impact on the course of the health event.

Guidelines

4) There are a number of documents already available that give guidance on various aspects of surveillance. Countries could benefit from the development of a document that shows how surveillance data collection and analysis must be modified in the context of an outbreak, and the need for surge capacity in data collection and analysis, based on recent practical examples. Also of potential value would be a checklist of steps required, indicating who is responsible, in implementing the surveillance aspect of the guidelines.

Assessment

5) The IHR (2005) requires that each country assess its capacity to conduct surveillance to meet the standards of the agreement within two years. Although there are assessment tools available and there has been considerable work at country level in assessing surveillance, these evaluations have tended to focus on routine systems rather than outbreak detection and reporting. Tools should be developed to focus this assessment so it is able to measure how well systems meet the IHR (2005) requirements, particularly in regard to detection and early warning of signals to provide timely information that may indicate outbreaks and allow for adequate response. The systems should permit the detection of signals related to both known and potential threats. Assessment of the system should consider the types of signals that need to be detected, who is responsible for reporting the signals, including regional and national focal points, and the time frame of reporting.

Surveillance

6) Each country will need to have a national level institutional structure authorised and capable of receiving and assessing and medical intelligence from a range of sources. There should be a close linkage between this structure and the National Focal Point (NFP), which is also an institution rather than an individual, and they may well be one and the same. This institution would also play a role in assessing the IHR (2005) capacity and implementation monitoring.

Resources and Training

7) Compliance with the IHR (2005) should be systematically incorporated into new surveillance initiatives, especially those related to outbreak and early warning, whether funded through national budgets or other funds. In practice some prioritization will be required in determining how to make use of available resources for implementation. IHR (2005) compliance should also be integrated into surveillance training activities. In particular, WHO can use support the integration of IHR into FETP-type training to increase access to resources. The ultimate goal would be to have a critical mass of health professionals sufficiently competent in surveillance and response to support the sustainable implementation of the IHR. Sub-regional approaches may be used in some areas, such as training for surveillance, to make optimal use of resources.

Monitoring and evaluation

8) Monitoring and evaluation of the IHR (2005) implementation, and identification and resolution of problems, are particularly relevant to the surveillance aspects. Although there are existing WHO documents for IHR (2005) monitoring and evaluation, some additional indicators may need to be developed. Monitoring should be linked to IHR (2005) core capacity assessment, and with capacity building more generally.

Summary of Recommendations

WHO actions

1. Establish guidelines/checklist for assessing surveillance system from perspective of IHR/ early warning, including
 - a. Specific surveillance activities and systems
 - b. Defining potential threats and priorities
 - c. IHR requirements
 - d. Indicators and performance monitoring
2. Provide support to countries through missions on
 - a. Technical aspects of developing early warning systems
 - b. Resource mobilization to enable implementation of systems
3. Develop training modules aimed at
 - a. FETP
 - b. Short courses for IHR focal points
4. Establish a mechanism of evaluation and review of progress in implementation

Country actions

1. Mobilize surveillance resources in support of IHR implementation from
 - a. National budget
 - b. Development aid programs
2. Support IHR focal points to have
 - a. An institutional rather than an individual base
 - b. Operational role in alert and response
 - c. National implementation and coordination of IHR responsibilities
3. Facilitate the assessment process
 - a. Support the assessment
 - b. Exchange of results between countries
 - c. Legal aspects