Joint Monitoring Workshop between Indonesia and Timor-Leste

CIDA APSED

Dili, Timor-Leste, 15-16 March 2010

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Contents

1. Introduction

In her opening remarks, the WHO Representative to Timor-Leste, Dr Paramita Sudharto, welcomed the participants and stated that it was indeed an honour to host the meeting in Timor-Leste.

She highlighted that the overall objective of the APSED strategy was to have in place minimum core capacities for combating infectious diseases by 2010 in the five programme areas: surveillance and response, laboratory, zoonoses, infection control and risk communication.

The CIDA project covers Indonesia and Timor-Leste in the South-East Asia Region and she remarked that Timor-Leste had achieved very good implementation. Two factors may have been the relatively small amount of funds awarded compared to Indonesia and importantly, Timor-Leste's seriousness in implementing the project.

This workshop, the second monitoring workshop followed the first one which was held in Bali, Indonesia in 2009. It provides an opportunity to review the progress and also to continue discussion and develop a plan of action for collaborative working between Indonesia and Timor-Leste.

Dr Milena Lay dos Santos, Head of the Department of Communicable Diseases and national IHR focal point, Ministry of Health (MoH) welcomed everyone on behalf of the Ministry of Health, Democratic Republic of Timor-Leste and reiterated Dr Sudharto's comments. She thanked CIDA for their generous support through WHO and appreciated the assistance received so far in laboratory strengthening and in surveillance and response support to FETP.

She went on to detail how important port health and the establishment of these services were to the Ministry of Health. She looked forward to being able to collaborate with colleagues in Indonesia on port health and saw this workshop as a good opportunity for an important exchange and learning.

The meeting objectives were:

- to review the progress of the CIDA workplan activities;
- to discuss collaboration issues including those related to cross-border activities between Indonesia and Timor-Leste; and
- to discuss challenges, if any, faced with implementation in both countries.

2. Perspective from CIDA

The CIDA donor representative, Mr Larry Bennett, First Secretary (Development) Canadian Embassy Jakarta, Indonesia, expressed his appreciation for being invited to the workshop. He thought this was a good opportunity to get a sense of what had been happening with this project. He also wished to discuss realistic workplans for the remaining nine months of the project and for which most implementation should ideally be in place by October 2010.

He briefly informed the group of previous CIDA projects in the Region: a US$ 5.0 million programme in Indonesia for avian influenza, which ended in 2009, and a project with UNICEF (US$ 3.8 million) for information and community mobilization, which also ended in December 2009.

3. Progress with implementation: an overview

This presentation gave the background to the CIDA APSED project, which was originally part of the CAREID initiative. The project is a biregional CIDA initiative for Canadian $ 10 million. SEARO received Canadian $ 3.4 million of the total sum. From this, Indonesia received the majority of the funds, followed by SEARO, followed by Timor-Leste. Table 1 shows the breakdown of funds by project work area.

Table 1: ***Breakdown of CIDA funds by programme area for the project in SEA Region***

Programme areas	Funds (US$)
Surveillance and response	350 000
Laboratory strengthening with supplies	570 000
Health promotion and risk communication	220 000
Gender-related issues	120 000
Human resources	875 000
Monitoring and Evaluation	200 000
Subtotal	2 335 000

The remainder of the presentation focused on project implementation. In 2007, implementation was very low (21%) but this increased over the next two years. However, overall implementation for the first three years of the project still is around 47%. A major factor accounting for this scenario is the lower than anticipated implementation by Indonesia. As per the project workplan, a large proportion of Indonesian funding was for a clinical management post for the four years of this project (US$ 200 000 per year). Singapore, however, provided a secondee to this post, which meant Indonesia did not need to utilize the funds for this purpose as per the workplan. Indonesia also cites several sources of funds as another factor affecting their ability to implement the workplan.

On the positive side, all activities undertaken through this project fulfilled APSED objectives. Measurable outcomes from the CIDA project include two staff in Timor-Leste being trained in FETP; a gender assessment and guideline development in Indonesia; a gender assessment in Timor-Leste; rabies prevention and control activities in Indonesia; an infection control assessment in Timor-Leste; assessment and strengthening of four laboratories in Indonesia; and provision of laboratory equipment and supplies and training in Timor-Leste and Indonesia. In the Regional Office, the Strategic Health Operations Centre has been strengthened and funds were used to support technical collaborations such as the APSED annual review meeting, H1N1 technical consultations and staff costs.

4. Progress with implementation: Indonesia

This presentation reviewed progress by programme area. The majority of donor funds were utilized for rabies prevention and control from late 2008 to the present. There have been two case management trainings for healthcare workers in four districts–Badung, Denpasar, Gianyar and Tabanan. There was an advocacy meeting for multisectoral mobilization and commitment building, and vaccine and immunoglobulin courses were procured.

An assessment of four laboratories was undertaken with recommendations for procurement of equipment, training and participation in quality assurance schemes.

The issues cited for low implementation were funds held at SEARO, no staff being dedicated to this project and competing donor funds.

In terms of gender issues, a situational analysis was undertaken followed by tool development and plans for implementing a gender-sensitive approach to infectious diseases. Table 2 summarizes progress in Indonesia.

Table 2: ***Progress with gender component in Indonesia***

Tool development and implementation of gender-sensitive analysis	Completed
Assessment of health-care facilities in relation to gender-sensitive health care for Avian Influenza and dengue	Completed
Situation analysis for gender-sensitive health care	Completed
Policy guidelines for gender-sensitive approach in Infectious Diseases control	In progress
Pilot area (Bali and Banten provinces)	Planned
Final review	Planned

5. Progress with Implementation: Timor-Leste

Timor-Leste has 13 districts and 65 sub-districts, each with a community health centre where primary health care is delivered. There are 185 health posts. There is one international airport and four seaports with a number of land crossings. There are six hospitals.

CIDA is a major source of funding for APSED and IHR (2005) implementation and has over the years been used to support H5N1 and H1N1 activities, etc. AusAID has supported the staff costs of a WHO Timor-Leste Epidemiologist.

Implementation to date by programme area is as follows:

Surveillance and response

Two national staff attended FETP at Gadjah Mada University in Indonesia in an effort to build a critical mass of epidemiologists in Timor-Leste. A vehicle was purchased for outbreak investigations.

Laboratory

Procurement of equipment and supplies was achieved (reagents -20 C freezers, and a biohazard fume cupboard for TB lab work); a staff member was also supported to attend a laboratory morphology course in New Zealand.

Gender

A situational analysis was undertaken and several of the 11 recommendations made have already been implemented, including:

- EPI bulletin disaggregates data by age and sex
- MoH is encouraging data-collecting agencies and departments to disaggregate all data
- MoH is strengthening its capacity to undertake and analyze qualitative data

Infection control

This is a big area of concern for Timor-Leste. Although an assessment was undertaken, there is no specific infection control staff to take the work forward. There is a need to support the development of an infection control programme at the national and regional levels. There were previous plans for an expert from Indonesia to come to Dili to mentor an infection control nurse at the National Hospital.

The infection control audit conducted in 2008 found hand cleaning/washing practices (hand hygiene) were lacking in hospitals. There was no standardized practice for

- rubbish separation
- decontamination
- clean-up activities

The utilization of PPE was not maximized and there were problems with medical waste disposal. Of note and concern, health personnel and patients' relatives smoke in the hospital.

Infection control practices are not optimal in the National Health Laboratory and cleaners have limited knowledge. WHO currently supports a programme for vaccinating health-care workers and cleaners against hepatitis B.

Infection control guidelines have been printed and distributed in Bahasa Indonesia and English. There are plans in place for addressing medical waste disposal and an isolation facility has been established.

Timor-Leste Plans for 2010 in relation to IHR (2005) and APSED capacity building include:

- Support for MoH focal point for zoonotic diseases
- Strengthening of AEFI Surveillance system for H1N1 vaccine
- Improving the recording and reporting system
- Capacity building of surveillance system at the sub-national level (district and sub-district).
- Assessment of port health facilities/services at Dili International Airport and development of guidelines and forms for port health procedures
- Rapid response team refresher training
- Developing an early warning system (informal reporting) for epidemic-prone diseases
- Support the development of an infection control programme at national and regional hospitals

6. FETP–experience of Timor-Leste nationals in Gadjah Mada University

This project has supported the attendance of two Timor-Leste national staff at the Gadjah Mada University for FETP. The advantages of this placement include the participants having a similar cultural background and language as the host country. The classroom teaching and field components provide knowledge and skills and their practical application, and the faculty has competent and experienced staff members. In addition there are good facilities (e.g. library access and Internet access). The programme is a member of Training Program in Epidemiology and Public Health Interventions Network (TEPHINET) providing an opportunity for students to communicate with FETP students and epidemiologists from other countries.

On the less positive side, it appears that Timor-Leste students require more intense supervision. Undertaking field projects in Timor-Leste can be difficult as the system is new and under development, with facilities in certain areas (e.g. laboratory) still lacking.

In summary, the link with Gadjah Mada University should be maintained to strengthen field epidemiology capacity within Timor-Leste, noting the need for supervision and additional academic support for Timorese. In addition, students should avail of projects based in Indonesia rather than Timor-Leste for the time being to gain full benefit from the programme.

7. Port health

The system for ensuring the safety of travelers in Indonesia is organized into 48 port health offices and 294 branch quarantine stations. There are over 2000 staff working in this area. There is coordination with local provincial and district health authorities and all report to the national IHR focal point. There are 25 international airports and over 200 seaports, 47 of which have been designated to issue ship sanitation certificates. There are eight official land crossings. Many people enter Indonesia daily–26000 at international airports, 2000 at international seaports–with a lot of movement of people internally (113 000 through domestic airports). The competent authority has been designated to build capacity at points of entry, existing laws comply, and there is capacity for surveillance and response. There is the capacity to communicate with all PoE using rapid communication and there are adequate human resources.

8. H1N1 preparedness and response in Timor-Leste

In 2005, a national plan for pandemic influenza was approved by the (then) National committee. There have been no reported cases of H5N1; however, there is no animal surveillance system in place.

A disease surveillance system was established in 2005. In 2007, combined health and agriculture rapid response teams were trained. In practical terms prior to the current pandemic there was a low level of preparedness. There was no national stockpile of antiviral medicine; no command and control structure was in place; no isolation facilities existed in hospitals; and no port of entry surveillance nor laboratory testing was available.

On 27 May 2009, the Government of Timor-Leste established a National Emergency Preparedness Team for Influenza A H1N1. This was led by the Minister of Health, who took immediate command of the five major components:

- Surveillance
- Medical (clinical management)
- Laboratory
- Drugs and medical supply
- Information and Communication

The MoH implemented H1N1 surveillance in early May 2009 to detect the circulation of H1N1. SOPs were developed for all health facilities. These were disseminated to District Health Service managers, Community Health Centre managers and the private sector. The surveillance unit is developing Influenza-Like Illness (ILI) surveillance to increase the sensitivity of H1N1 surveillance. All health facilities are required to report ILI on a weekly basis.

An eight bed isolation room and a medical team on 24-hour standby was established at the National Hospital, Dili. A telephone hotline was also established for the public. Guidelines for case management and infection were developed to cater to the country context. Supplies such as PPE and a ventilator were procured/donated.

Initial rapid diagnostic test kits were donated by Australia and subsequent test kits procured through WHO. Staff were trained on how to

use the rapid test kits. The national lab has performed >60 tests to date. WHO facilitated IATA training for all lab staff. Prior to this, no staff were able to ship specimens.

To date, 28 suspect cases were reported and 7 of these were positive and confirmed at the WHO Collaborative Laboratory in Melbourne. Australia. All cases lived in Dili; ages ranged from 25-37 years. Four were travel-related; the remaining three were secondary cases without a travel history.

This presentation demonstrated the rapid scale-up of services and systems in response to H1N1.

9. Collaboration between Indonesia and Timor-Leste

Indonesia and Timor-Leste have been discussing collaborative working since 2007. The umbrella memorandum of understanding (MoU) mentioned in the Bali meeting in 2009 is due to be signed by both governments on 26 March, 2010. This MoU would allow processes to be formalized between the two countries. There are a number of areas that would benefit from joint working such as synchronizing disease control at border areas; for example, malaria treatment protocols currently vary.

Once the MoU is signed technical units in both countries will need to work together. Potential areas for joint work include those discussed at the last meeting in Bali (SEA CD 195) – i.e., information sharing; capacities at points of entry; surveillance and response and health promotion, with Indonesia adopting a more mentoring role.

WHO could catalyze the process by facilitating the technical collaborations across various work areas to agree on time-bound action plans.

10. Overview of the Third Regional Meeting of National IHR Focal Points

For the benefit of the participants the main points from the February 2010 regional meeting for national IHR (2005) focal points were presented. IHR

(2005) has been in force for three years and Member States are in the implementation phase, having until 2012 to fulfill core capacity requirements. At the meeting countries presented on their progress. Capacities for surveillance and response to infectious diseases have been the main focus for the past 4–5 years in all Member States. The meeting highlighted the need for countries to focus on developing capacities for detecting and responding to all public health threats, including chemical threats and radionuclear hazards (i.e. the all-hazards approach). In addition, the need for more experts and expert institutions to strengthen regional capacity to detect and respond to all types of PH events was raised.

Member States were reminded to nominate an expert for the IHR roster of experts from which the WHO DG chooses members for the Emergency Committee and for the first IHR Review Committee this year. Such experts may also be used in regional outbreak investigation. There are about ten expert institutions in the Region and SEARO plans to increase the number by engaging with more institutions.

Legal aspects of IHR (2005) implementation was a major topic for discussion. Most Member States have looked into this and are either planning to assess, or are in the process of review, and some (eg. Myanmar) have already adopted new legislation. It was remarked that this is a lengthy, complex process–India commenced assessment and review in 2001 and is hoping that a particular bill will be passed in 2010.

Capacity strengthening at points of entry has received little attention, not just in the SEA Region but globally. Although considerable capacity has been built in the area of laboratory strengthening, more needs to be done. The recommendations emerging from this meeting are listed in Annex 3.

11. Plans to develop a second APSED strategy

The Asia Pacific Strategy for Emerging Diseases (APSED) is a five-year strategy to assist Member States to combat emerging infectious diseases. The strategy ends in 2010. At the APSED meeting in 2009, there was a recommendation to develop a further strategy for beyond 2010, to be presented at the fifth APSED meeting in July 2010. The new APSED strategy would run from 2011 to 2015 and it will remain a biregional strategy.

To determine what will go into the second phase strategy, information will be obtained from a number of sources: such as countries' progress with implementation and their views on the APSED approach, which will be obtained via survey results and via in-country assessments. The focus would remain on emerging diseases, but would include developing capacities for an all-hazards approach and capacities at points of entry to align more with IHR (2005). Areas such as PH emergency preparedness and bioterrorism will also be considered for inclusion, as will cross-cutting themes such as social determinants of health and climate change.

There will be a biregional consultation in May 2010 where findings from all the various sources will be considered and a consensus reached on what should be the content of the new strategy. A draft strategy will be prepared in time for the fifth annual APSED meeting in July 2010.

12. Issues and challenges faced in CIDA APSED implementation

Overall project implementation has improved yearly since 2007. Timor-Leste clearly demonstrated a good use of the funds. Indonesia, however, has not demonstrated the same degree of success with implementation.

From the donor's perspective, CIDA needs to be assured that the figures provided are indeed correct. In addition, they need to be assured that what countries say they plan to do with the funds they will; in essence, they need confidence that the money will be spent. With Indonesia, this has not been the case so far. Apart from using the funds for rabies prevention and control activities, Indonesia has implemented the workplan poorly.

Information-sharing between WHO and the Ministry of Health and between SEARO and WHO country offices may not have been optimal in the early stages of the project; however, this has improved.

13. Conclusions

In conclusion, there has been a yearly improvement in project workplan implementation since 2007 and all activities have been in line with APSED

objectives. Therefore, the CIDA project has led to demonstrable improvements in the area of emerging diseases in Indonesia and Timor-Leste. The skills obtained by FETP graduates are transferable and therefore will also apply to noncommunicable diseases. Based on the proceedings and discussions during the workshop, the group agreed on the following recommendations.

14. Recommendations

(1) In view of the fast approaching end to the CIDA APSED project, Indonesia and Timor-Leste should provide detailed 2010 workplans (narrative and budget) to SEARO and CIDA as well as actively follow up their implementation.

(2) SEARO should consider requesting a one-year no-cost extension from CIDA.

(3) A review of progress should be undertaken in July 2010 by teleconference.

(4) In terms of cross-border collaborative efforts, once the MoU between the governments of Indonesia and Timor-Leste is signed, WHO Indonesia and WHO Timor-Leste should facilitate technical collaboration between relevant sectors in their respective countries to drive forward the collaborative activities.

(5) Timor-Leste should urgently mobilize resources with assistance from WHO to ensure continued APSED and IHR (2005) implementation.

15. Closing

In the closing remarks by Dr Megan Counahan, on behalf of WHO, it was noted that the workshop was a productive one with clear, achievable recommendations. Dr Milena Lay dos Santos thanked all the participants on behalf of the Ministry of Health, Timor-Leste. She was hopeful that the MoU between Timor-Leste and Indonesia would improve sharing of information and collaboration, thereby facilitating joint cross border activities and IHR (2005) implementation. She also thanked WHO and the donor for their support to APSED and IHR (2005) implementation and hoped that support would continue.

Annex 1

Programme

Monday 15th March

9.00 – 9.10	Welcome and Opening Remarks
9.10 – 9.20	Welcome and Opening Remarks
9.20 – 9.30	Meeting Objectives
9.30 – 9.35	CIDA-APSED Project - brief background
9.40 – 10.00	CIDA-APSED project implementation: an overview
10.30 – 11.00	Progress with implementation in Timor-Leste and plans for 2010
11.00 – 1.00	Progress with implementation in Indonesia and plans for 2010 • Assessment and Implementation of gender based health care • Implementation of activities from INO – rabies control activities • Implementation of Port Health activities
2.00 – 2.30	Implementation of activities from TLS (FETP from Gadjah Mada University)
2.30 – 3.30	Issues and challenges faced with implementation
3.30 – 4.00	Pandemic response/issues including H1N1 vaccine: Timor-Leste
4.00 – 5.00	Round Table Discussion: Cross border issues including umbrella MoH between Timor-Leste and Indonesia

Tuesday 16th March

9.00 – 9.30	Summary of Day 1 Discussion on collaboration between Indonesia and Timor-Leste
9.30 – 10.15	• Overview of the Third Regional meeting of national IHR focal points and planned regional (IHR) activities for 2010;

	and • The plans for developing a second bi-regional APSED strategy
10.30 – 11.00	To agree on areas for collaboration/joint activity between Indonesia and Timor-Leste under the CIDA funded APSED framework
11.00 – 11.30	Group to agree recommendations for the way forward
11.30 – 12.00	Open Discussion
12.00 – 2. 30	Closing remarks

Annex 2

List of participants

Indonesia Ministry of Health

Dr. H. Azimal
Head of Jakarta Port Health Office

Dr. Sinurtina Sihombing
Sub Directorate of Zoonosis

Ms. Ririn Ramadhany
Staff of Virology Lab
National Institute for Health Research and Development (NIHRD) MoH

Timor-Leste Ministry of Health

Dr Milena Lay dos Santos
Head of Department of Communicable Diseases

Mr Carlito Freitas
Head Health Promotion

Ms Orfelia do Cormo
IHR/Zoonosis Officer

CIDA representative

Mr Larry Bennett
First Secretary (Development)
CIDA

WHO Indonesia

Dr. Hariadi Wibisono
IHR /Port Health

WHO Timor-Leste

Dr Paramita Sudharto
WHO Representative to Timor-Leste

Dr Yuwono Sidharto
Epidemiologist

Dr Megan Counahan
Epidemiologist

Mr Salvador Amaral
IHR officer

Ms Nelia Gomes
Laboratory Focal Point

WHO-SEARO

Dr Shalini Pooransingh
Epidemiologist
Disease Surveillance and Epidemiology Unit

Annex 3

Recommendations

To Member States

(1) Member States should dedicate resources, technical and financial, for strengthening core capacities for effective IHR implementation

(2) Member States should have the IHR committee/taskforce and ensure other relevant agencies e.g. those concerned with food safety, chemical, radiological and nuclear hazards are represented

(3) Member States should mobilize appropriate legal expertise to review the existing legislation in context of IHR (2005) and ensure appropriate legislation are in place

(4) Member States should further strengthen inter-country collaboration

(5) Member States should nominate an expert for the global IHR roster of experts if they have not already done so

To WHO

(1) WHO should continue to advocate at the highest level for the implementation of IHR (2005)

(2) WHO should assist Member States in mobilizing resources for IHR (2005) implementation

(3) WHO should facilitate the review existing legislation in the context of IHR (2005) and ensure appropriate legislation are in place by providing technical support to countries as needed

(4) A regional roster of experts and institutions should be developed in consultation with Member States

(5) WHO should continue to facilitate interaction of national IHR focal points to enhance inter country collaboration

(6) WHO should ensure that the revised Asia Pacific Strategy for Emerging Diseases addresses all programme areas relevant to fulfilling IHR (2005) requirements

The Asia Pacific Strategy for Emerging Diseases (APSED) has been used as a regional strategic framework for core capacity building required under the International Health Regulations 2005. The goal of the APSED workplan is for all countries and areas of the Asia Pacific Region to have the minimum capacity for epidemic alert and response by 2010 in the five programme areas of work. These five programme areas are: surveillance and response, laboratory strengthening, infection control, zoonoses and risk communication.

The Canadian International Development Agency (CIDA) agreed to fund the implementation of APSED in Indonesia and Timor-Leste in the South-East Asia Region for a four-year period from 2007 – 2010. Indonesia's progress with implementation is slow in comparison to that of Timor-Leste. This second workshop was held to review progress with recommendations made at the last workshop in 2009, monitor progress in project implementation and to agree the next steps for the remainder of the project.

World Health Organization
Regional Office for South-East Asia
World Health House
Indraprastha Estate,
Mahatma Gandhi Marg,
New Delhi-110002, India

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