Meeting Report

SIXTH WORKSHOP ON FIELD EPIDEMIOLOGY TRAINING PROGRAMME IN THE WESTERN PACIFIC REGION

1 December 2016

Siem Reap, Cambodia

World Health Organization
Western Pacific Region

WORLD HEALTH ORGANIZATION

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MEETING REPORT

SIXTH WORKSHOP ON FIELD EPIDEMIOLOGY TRAINING PROGRAMMES

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NOTE

The views expressed in this report are those of the participants of the Sixth Workshop on Field Epidemiology Training Programmes and do not necessarily reflect the policies of the conveners.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for Member States in the Region and for those who participated in the Sixth Workshop on Field Epidemiology Training Programmes in Siem Reap, Cambodia on 1 December 2016.

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Keywords:

Epidemiology – education / Epidemiologic methods / Health personnel – education / Western Pacific

SUMMARY

The sixth workshop on Field Epidemiology Training (FET)/Field Epidemiology Training Programme (FETP) was held in Siem Reap, Cambodia on 1 December 2016 to review progress of the current FET/FETPs in the Western Pacific Region, to share best practices and challenges about the sustainability of the programme and to identify the priority actions to strengthen FET/FETPs using Asia Pacific Strategy for Emerging Diseases and Public Health Emergencies (APSED III) framework.

APSED III was introduced into the workshop as a core component of human resource development for surveillance, risk assessment and response in the Regions and participants agreed its direction.

Progress was achieved in several programmes in the Region. Cambodia plans to extend the programme to a year from 6 months for selected fellows in 2017. The Republic of Korea has reformed FETP to be under Korea CDC and started an Emergency Operations Centre in Korea CDC. Japan FETP is starting a 1-year course to meet local public government need for epidemiologists, in parallel with the traditional 2-year programme.

In PNG, a participant is joining the programme in the Philippines in 2016 who is expected to be a future FETP coordinator in the country. In Malaysia, some graduates joined international response activities or other oversees training which can contribute to their mentoring skills. FET/FETP fellows and graduates have been involved in nation-wide outbreak response in Lao PDR (for circulating Vaccine Derived Polio Virus type 1 in 2015) and Mongolia (for measles outbreak in 2014-5). These activities, particularly the involvement of fellows in nationwide outbreak response, demonstrate the added value of FET/FETPs, and can contribute to improving programme sustainability.

Priority actions that the workshop identified to strengthen FET/FETPs within APSED III framework are greater collaboration across FET/FETPs, strengthening links between FET/FETPs and GOARN, development of modules for key curricula, documentation of workforce capacity in field epidemiology and continuation of WPRO FETP fellowship training programme.

1. INTRODUCTION

1.1 Meeting objectives

The objectives of the meeting were:

1) to review progress of the current FET/FETPs in the Western Pacific Region;
2) to share best practices and challenges about the sustainability of the programme; and
3) to identify the priority actions for the coming year(s) to strengthen FET/FETPs within APSED III framework.

2. PROCEEDINGS

2.1 Opening session

Dr Takuya Yamagishi, Emerging Disease Surveillance and Response (ESR), WHO Western Pacific Regional Office (WPRO), opened the workshop at 8:30 am.

Dr Ly Sovann, Director, Communicable Disease Control Department, Ministry of Health (MOH), Cambodia, provided the opening remarks. He emphasized the importance of detection of the event through surveillance using multiple sources of information and response to outbreaks and public health emergencies. He also pointed out the revision of APSED III mentioning that FETP is still one of the central parts of its strategy for human resource development.

After Dr Takuya Yamagishi introduced the objectives and activities of the workshop, Dr Bounlay Phommasach, MOH, Lao People's Democratic Republic (PDR) was selected by participants to chair the workshop. And Dr Bounlay selected the chair for each session as below:

Session 1: Dr Dang Quang Tan, Deputy Director, General Department of Preventive Medicine, Ministry of Health, Viet Nam

Session 2: Dr Lu Mei, Director, National Health and Family Planning Commission of the People’s Republic of China

Session 3: Dr Tippavan Nagachinta, Medical Officer, Field Epidemiology Training Program, Workforce and Institute Development Branch, Center for Global Health, Centers for Disease Control and Prevention

Session 4: Dr Vikki Carr De Los Reyes, Medical Specialist III, Epidemiology Bureau, Department of Health

Session 5: Dr Martyn Kirk, Associate Professor, National Center for Epidemiology and Population Health, The Australian National University

2.2 Session 1: Setting the scene

Chair: Dr Dang Quang Tan, *Deputy Director, General Department of Preventive Medecine, Ministry of Health, Viet Nam*

2.2.1 Overview of Regional FET/FETPs

– Dr Takuya Yamagishi, Medical Officer, ESR, WHO/WPRO

Dr Takuya Yamagishi presented an overview of the regional FET/FETPs in WPRO using the pre-conference survey that was conducted between 24 and 29 November 2016. Four member States, Cambodia, Lao PDR, Mongolia and Papua New Guinea (PNG), had modified FETP (FET)where the duration of training was6 months or 1 year. The number of trainee varies from Member States to Member States, ranging from 1 to 30. The number of dedicated supervisors also varies ranging from 2 to 34 (ANNEX 3).

Dr Takuya Yamagishi also summarized publications in the Western Pacific Surveillance and Response Journal (WPSAR) by country. The total number of publications was 231 between April 2010 and September 2016. The majority of publications were from Member States in WPR (e.g. Australia 35, Philippines 32 and Japan 21).

Dr Takuya Yamagishi introduced the recommendations provided at the 5th workshop on FET/FETP held in Viet Nam in 2013. These recommendations were achieved by Member States and WPRO.

Finally, Dr Takuya Yamagishi touched on APSED III and stressed on the importance of FET/FETP in surveillance, risk assessment and response, and monitoring and evaluation.

2.2.2 APSED III

– Dr Chin Kei Lee, Team leader, ESR, WHO/China Country Office

Dr Chin Kei Lee started with the historical aspects of the Asia Pacific Strategy for Emerging Diseases (APSED). APSED have been developed and used for national core capacity building to implement International Health Regulations (IHR) in WPR and South East Asia Region (SEAR) between 2005 and 2015. APSED III is a revised updated APSED to guide Member States to build capacity under IHR and was endorsed into force at the Regional Committee Meeting in 2016. Under APSED III, Focus Area 2 (surveillance, risk assessment and response) and Focus Area 7 (Regional preparedness, alert and response) are closely linked to workforce development in terms of surveillance, risk assessment and response for all hazards. Good examples of the involvement of FETP fellows for the international outbreak response was their participation in the Western Pacific Ebola Support Team (WEST). This recruited some of FETP graduates from WPR along with WHO staff to support Ebolla response in West Africa.

Dr Chin Kei Lee mentioned that the WPRO FETP fellowship training programme is a good opportunity for Member States to be exposed to event-based surveillance, risk assessment and response from aregional perspective, and can contribute to APSED III Focus Area 2.

2.2.3 Experience of the Joint External Evaluation (JEE) in relation to FETP Human Resource development

– Dr Bun Sreng, Deputy Director, Cambodia

Cambodia has developed an Applied Epidemiology Training (AET) programme that has three courses, namely: (1) 6-weeks introductory course, (2) 6-months foundation course, and; (3) AET Plus which are short courses (usually a week-long course) for selected fellows. The AET was first launched as 3 month full time plus 3 months part time. From 2016 it was extended to 6 months full time course and is aiming to extend further, possibly to one year course in 2017.

Cambodia was the 1st country to conduct JEE in WPR. Dr. Bun Sreng shared the experiences on how the National IHR Focal Point, Communicable Disease Control Department, MOH took a lead to conduct JEE. The evaluation was conducted in 2 steps: (1) Self-evaluation among national experts with support of in-country partners, and; (2) JEE by 19 national and 8 international experts. JEE was acknowledged to be a very useful process for identification and revision of priorities in Cambodia. The recommended priority actions for workforce development are showed in Box1 and Cambodia is committed to further strengthen AET.

Box1: Recommended workforce development using results from the JEE

- To include public health professions in all future human resource workforce planning and set targets to ensure adequate staffing for the multidisciplinary teams that are necessary to fulfil obligations under IHR;
- To consider ways to strengthen the AET foundation course, including increasing the duration of training to one year, continuing to improve supervision and providing access to Khmer speaking mentors; and
- Ensure AET and Cambodia Applied Veterinary Epidemiology Training (CAVET) graduates are employed in positions which allow them to practice their epidemiologic skills and regularly participate in field-level responses to potential public health threats.

2.2.4 Question and clarification

Dr Fadzilah Kamaludin mentioned that the duration of FET/FETPs should depend on the country needs, but basically more than 1-year training is recommended. In case of Cambodia, the 6-month foundation course is considered too short to gain sufficient experiences of outbreak investigation, response and epidemiological skills. It was also mentioned that all of the foundation course trainees do not have to go to the next 6 months. Based on performance review of the trainees on the 6-month foundation course, AET is able to select appropriate candidates for longer course training. She also commented that how many trainees are appropriate for the programme is another point that needs to be addressed.

Dr Tippavan Nagachinta asked if the trainees are in full time training or not in Cambodia.

Dr Bun Sreng answered that it is basically full time but when they go the province they come from, they have to do routine work due to limited human resources in provinces but they have assigned tasks.

Dr Tamano Matsui congratulated the implementation of a full time training programme and mentioned that it is good to have a core group of graduates to supervise the trainees.

Dr Michael O'Reilly pointed out that the number of graduates is one of the indicators for the programme. The functionality of trainees and graduates is also important and can be measured by number of publications.

Dr Tek Bunchhoeung mentioned that the number of publications relies not only on trainees but on mentors. In Cambodia, there are more supervisors than trainees, but time allocated and commitment of these supervisors are questionable. Cambodia FETP needs to strengthen quality of mentor and supervisor.

2.3 Session 2: New approach for the training during and after FET/FETPs

Chair: Dr Lu Mei, Director, National Health and Family Planning Commission of the People's Republic of China

2.3.1 Republic of Korea

– Dr Sangyun Cho, Deputy Scientific Director, Division of Public Health and Preparedness, Korea Centers for Disease Control and Prevention (KCDC), Republic of Korea

Dr Sangyun Cho summarized the events that occurred in Korea between 2002 and 2016 (e.g. influenza A(H1N1)pdm09 in 2009, contamination of humidifier in 2009 and Middle-East Respiratory Syndrome (MERS) in 2015). After MERS event in 2015, the government revised Law of Infectious Diseases Control and Prevention, reformed KCDC, launched Emergency Operation Center (EOC) in KCDC, set up call center and increased the number of Epidemic Intelligence Officers (Korean FETP) under KCDC.

Dr Sangyun Cho mentioned that Koran FETP used to be under the military, but now under KCDC, and the number of participants has reached approximately 90. The programme is 2-years long including introductory course (3 days, 6 times in 2 years) and on the job training. Graduates are expected to work at KCDC or local governments. Due to a sudden expansion of the programme and its widened scope, major challenges are the need to maintain the quality of facilitators. Short-term goals of the programme are to build a sustainable programme to maximize the competencies of participants, to meet the requirements from local government, and to facilitate collaboration of divisions within KCDC.

2.3.2 Japan

– Dr Kazunori Oishi, Director, Infectious Diseases Surveillance Center, National Institute of Infectious Diseases, Japan

Dr Kazunori Oishi summarized the programme of Japan FETP touching on the linkage of PhD course with some universities and recent outbreak responses in the country (e.g. Enterohaemorrhagic *Eschelichia Coli* outbreaks in 2012, measles in 2013 and carbapenem-resistant *Enterobacteriaceae* event in 2014). Since the programme started in 1999, a total of 63 people graduated and 33 were unpaid, voluntary participation during the training (not from local government or Ministry of Health).

This payment issue and less popularity from local government have been challenges of the programme. Dr Kazunori Oishi stressed that one of the unique aspect of the programme is a collaboration of graduates and trainees for responses of ongoing events.

Dr Kazunori Oishi mentioned the future directions are to tailor the programme to meet the need of local government and facilitate graduate to work at local governments. To address the former direction, Japan FETP are starting a 1-year programme specific to participants from local government since one of the barriers is that local governments cannot afford to dispatch staff to FETP due to limited human resources and budgets. This 1-year programme is to start in2017, and run along with the 2-year programme. It will focus on essential epidemiological training (e.g. descriptive epidemiology).

2.3.3 Questions and clarifications

Dr Lu Mei pointed out the importance of learning from other programmes, and introduced China FETP. In China, the programme exists in three levels (2-year-national programme, 1-year provincial-programme and 3-6-month-local programme). The programme conducts annual FETP conference, provided graduates with mentor-training workshop every year. Currently, 36 fellows participate in 14 prefectures and in national programme.

Dr Michael O'Reilly asked Dr Kazunori Oishi about the training of FETP to disaster responses in Japan. Dr Kazunori Oishi mentioned that a lot of FETP trainees and graduates participated in the mission related to Tohoku earthquake including post-disaster infectious disease surveillance in 2011.

Dr Takuya Yamagishi asked Dr Sangyun Cho about how KCDC activates or coordinates FETP who are located across several divisions within KCDC when event occurs and how they conduct risk assessment. Dr Sangyun Cho answered that there are approximately 10 central investigation teams that are specialized for each disease and each team has 2-3 epidemiologists. Risk assessment group coordinates the response. He also mentioned that it is new for KCDC to conduct risk assessment, and KCDC is really keen on learning about how to conduct risk assessment from other countries and programmes.

Dr Tippavan Nagachinta mentioned that it is surprising that Japan FETP continues the programme without salary payment to participants. She also asked about how to support them to obtain PhD and make these unpaid participants to join local governments. Dr Kazunori Oishi answered that the majority of those unpaid participants were medical doctors who can earn their cost of living by working part-time.He also touched on the close link between PhD course and FETP.

Dr Nguyen Duc Khoa asked Dr Kazunori Oishi about the role and contribution of the programme to develop or revise the guidelines or for policy making. Dr Kazunori Oishi answered that Japan FETP has contributed to develop several guidelines for emerging disease response such as contact tracing.

Dr Vikki Carr De Los Reyes asked Korea and Japan if they have developed any online trainings or utilize information technology tools such as GIS in each programme. Dr Sangyun Cho answered that there are no internet-based tools. Dr Kazinori Oishi answered that there are no online tools but they are developing video programme that can be used remotely.

Dr Lu Mei introduced mentoring system in China that they invite 3-5 senior mentors of provincial programme to the national programme to improve the quality of mentoring.

2.4 Session 3: How to utilize graduates?

Chair: Dr Tippavan Nagachinta, Medical Officer, Field Epidemiology Training Program Workforce and Institute Development Branch, Center for Global Health, Centers for Disease Control and Prevention, United States of America

2.4.1 Papua New Guinea

– Mr Berry Ropa, Program Officer, Emergence Surveillance Response Unit, National Department of Health, Papua New Guinea

Mr Berry Ropa stated that Papua New Guinea started a 6-month FET course in 2013, the Field Epidemiology Training Programme in PNG (FETPNG), which focuses on interventions. Participants are from local and national levels of the health department, and also from environmental, animal department, defence force and university. There are selection criteria for them that are mainly about how they contribute to response of local government. There are 45 graduates so far. WHO, US CDC, Australian government and others have supported this programme.

Some success stories of the programme are involvement a national surveillance system, analysis of tuberculosis, and investigation of increased HIV prevalence in 2013. Participants have contributed to international conferences, including 10 presentations in TEPHINET in Cambodia, and there is one WPSAR publication. The programme also has had two WPRO scientific writing workshops.
The programme currently has one candidate in the two-year FETP course in Thailand. Challenges include: difficulty in face-to-face gatherings due to high cost of travelling in the country. The future direction includes strengthening mentoring, improving communication and networking. Next year, the programme will have a 5 year internal assessment.

2.4.2 Malaysia

– Dr Thilakah Chinnayah, Deputy Director General of Health, Ministry of Health, Malaysia

Dr Thilakah Chinnayah showed the distribution of Epidemic Intelligence Programme (EIP) graduates since the programme started in 2002, and mentioned although the graduates are concentrated in Kuala Lumpur, EIP officers can cover all areas because of the good transportation system in Malaysia. Malaysia has enough EIP officers (are EIP officer per 500 000 population), so now the programme focuses on quality of the training. Since the start of the programme, there are 8 cohorts, and now all the supervisors are EIP graduates. EIP is currently under Deputy Director General (DG) of Public Health and also links to States and District level. This system is strategically efficient because the high position of the deputy DG.

The graduates of EIP go into each subspecialty including non-communicable disease, defense force and animal sector after they graduate. The programme started a pilot trial in 2014, and post-graduate trainees can go for overseas training for a year. Dr Thilakah Chinnayah was the one selected in 2014 and dispatched to WPRO surveillance team for a year, and five were selected in 2016.

The programme also dispatched 4 people to training of trainers (TOT) programme in Thailand for 2 months, and plans to have its own TOT programme in 2018.

The graduates are all MPH holders, and registered under national specialist registry. The trainees are expected to submit 5 pieces of work at the end of the training including situational analysis of any of the regional diseases, surveillance evaluation of any of the diseases and three outbreak reports.

Each trainee has two supervisors, one is EIP graduate and the other is a local technical officer. After trainees have field work under their supervision, the trainees come back to the national EIP programme to report their activities. The programme also invites international supervisors and asks for technical inputs to the works.

MOH has simulation exercise for rapid response to an event and includes EIP officers. There is also a duty officer system that EIP graduates has monthly roster for on call for rapid response. Also there is a roster of EIP graduates available for international deployment followingrequests for international support (e.g. request from GOARN). EIP is developing educational modules, and is planning to extend the training course for public health event inspectors from 3-4 months to 6 months.

2.4.3 Questions and clarifications

Dr Chin Kei Lee asked Dr Thilakah Chinnayah about the international role of the programme.

Dr Thilakah Chinnayah commented that Malaysia EIP joined Western Pacific Ebola Support Team (WEST) in 2015. But it was the first experience of the programme to join international operation, and no specific in house experts. But WEST was adopted team approach, well organized by WPRO and good guidance from WPRO. In the end, it was a good on the job training, and should be continued. Dr Fadzilah Kamaludin supplemented that the deployment is expected and is ready to do with clearance by DG even though the decision for deployment needed to be done within three days (usually clearance by the government needs more than two weeks). After WEST, this kind of rapid deployment system was put in place in Malaysia.

Dr Boris Pavlin mentioned one of the innovative things is the involvement of FETP into disaster response. PNG FETP involved in the current responses to El Nino related events. And he commented that under the APSED III framework, increasing emphasis on M&E including outbreak reviews and joint external evaluations needs to be addressed. FETP fellows are required to monitor and develop M&E plans during interventions.

Dr Boris Pavlin asked Malaysia about which institute is GOARN partner in Malaysia, and Dr Thilakah Chinnayah answered that it is EIP itself and it is not MOH. There was a deployment from some of the networks in European countries during Ebola response, and can be deployed even though the government is not a member of GOARN.

Dr Michael O'Reilly pointed out the GOARN deployment is sometimes for out of the Region, but it should be within the Region because they are familiar with the Region. Every time FETP fellows join international response, it is better to communicate with the local FETP fellows.

Dr Martyn Kirk mentioned that there are some disadvantage of GOARN deployment such as no salary payment and inconsistent technical expertise due to small team designation. Deployment of FETP fellows with experienced people is an excellent opportunity for experience and they can support each other. It is good to advocate GOARN to work with FETPs.

Dr Tippavan Nagachinta stressed the importance of networking citing the experience in Ebola response in Liberia, and the same goes into this Region.

2.5 Session 4: New approach for the training during and after FET/FETPs

Chair: Dr Vikki Carr De Los Reyes, Medical Specialist III, Epidemiological Bureau, Department of Health, Philippines

2.5.1 Lao PDR

– Dr Bounlay Phommasack, Director General, Department of Communicable Disease Control, Ministry of Health, Lao PDR

Dr Bounlay Phommasack started to mention that Lao PDR is rich in outbreaks but has less resource. Lao FET is a modified 1-year training course, and three modules including 1 month introductory course and three months in the field. There are 8 participants in each cohort with two veterinarians. After establishment in 2009, 55 colleagues graduated from Lao FET until 2015. They were from public health and veterinary sectors and now FET fellows cover all 18 provinces. FET trainees and graduates supported important outbreak investigations and responses in the country, including dengue epidemic in 2013, avian influenza events in 2014-15 and ongoing circulating vaccine-derived polio virus type 1(cVDPV1) outbreak in 2015-16. There are too many outbreaks and little time to sit in the office. Lao FET has published 6 scientific papers from 2011-16 through WPSAR and other journals. A total of 35 abstracts accepted for academic conference from 2013-16, including 3 abstracts in the 8th TEPHINET Bi-regional Scientific Conference in Siem Reap, Cambodia 2016.

Bounlay Phommasack summarized the FET involvement in cVDPV1 outbreak by describing rapid deployment of FET to affected provinces to conduct active case finding, contact tracing, medical record review, risk communication, supplementary immunization activities and support to provincial EOC operations. Lao FET and graduates reviewed around 845,000 records in the provincial and district hospitals, and health centres. One of the challenges was that the affected people were Hmong tribe who speaks their own language and do not understand Lao language. But FETP fellows from Hmong tribe contributed a lot to the responses such as communication and supplementary immunization activities.

2.5.2 Mongolia

– Dr Badral Davgasuren, FETP coordinator, National Center for Communicable Diseases, Ministry of Health, Mongolia

Dr Badral Davgasuren introduced strategic plan of Mongolian FETP (MFETP) and internal FETP standard operating procedures with orientation manual to describe programme activities such as organization, training, and core competencies. MFETP launched in 2009 and currently there are seven cohorts. MFETP enrolled veterinarian component in 2013, and produced 47 graduates up to 2015. MFETP Trainees were involved in 33 acute health events in the past. Also, there is a training programme for public health officers who are not participating in MFETP. There are 19 peer reviewed articles published in domestic and international journals, 20 oral and 22 poster presentations at the national and international conferences, in which 3 abstracts were accepted in the 8th TEPHINET Bi-regional Scientific Conference 2016.

Dr Badral Davgasuren then moved on to measles outbreak response as an example of FETP involvement in national level outbreak response. A total of 424 medical history records were reviewed to identify risk factors for death caused by measles by FETP colleagues with US CDC. Also, operation of EOC was supported by MFETP.

Challenges of the programme remain in improving mentorship, postgraduate support and a tracking system to fully utilize the FETP network. The direction of MOH is to set up EOC at the local level and surveillance and risk assessment for decision making, and make MFETP involve these activities.

2.5.3 Questions and clarifications

Dr Vikki Carr De Los Reyes congratulated both programmes to successfully handle these national level outbreaks, and she move on the question to Lao PDR and Mongolia whether it would it be possible for FETP to involve in international events.

Dr Badral Davgasuren commented that there is a capacity and experience of several events. And Dr Bounlay Phommasack answered that Lao FET is ready to respond anytime.

Dr Michael O'Reilly asked Mongolia about the training of non-FETP for rapid response. Dr Badral Davgasuren commented that public health officers in subnational level were trained and almni of MFETP got involved in the training.

Dr Tek Bunchhoeung shared the experience in Cambodia about rapid response. When the risk assessment conducted by national level indicates that the level of risk is high, EOC is activated and AET fellows were called for participation of responses. Although it depends on the number of events and funding, at least one AET fellow goes and responds to the outbreak.

Dr Bounlay Phommasack commented that fellows in Lao FET also have at least one response during the training. Retrospective study shows that Lao FETP estimated 480 outbreaks in the last 5 years. Dr Bounlay Phommasack emphasized the importance of EOC in rapid decision making, surveillance for rapid response because APSED III put public health response as the first priority and surveillance, risk assessment and response as the second priority. He also commented that how many EOC meetings they should have is uncertain, and Lao PDR and Lao FET are in learning process for that. APSED III should be incorporated into FET/FETPs.

2.6 Session 5: Panel Discussion – Direction for the next 5 years

Chair: DrMartyn Kirk, Associate Professor, National Center for Epidemiology and Population Health, The Australian National University, Australia

Dr Martyn Kirk mentioned that the name of 'WPRO FETP fellowship training programme' is confusing and it is good to consider changing the name. Dr Takuya Yamagishi commented that if there is any good naming, it can be changed.

Dr Michael O'Reilly mentioned that documentation of the FETP activity can help to understand the workforce capacity of each programme.

Dr Tippavan Nagachinta commented whether WHO should consider accreditation of FET/FETPs that TEPHINET is proceeding. Dr Boris Pavlin mentioned that every programme should scale its own local needs and accredit their own programme rather than being accredited by what is expected externally. Dr Fadzilah Kamaludin pointed out that TEPHINET accreditation is only for 2 year standard programme. It is ok that TEPHINET proceeds accreditation by themselves, but it is also important to have our own mechanism on how to monitor the quality of programmes in the Region.

Dr Bun Sreng mentioned the importance of networking, and asked audience about the comments on ASEAN+3 FET networks (there are 10 countries in ASEAN). Dr Fadzilah Kamaludin mentioned that it is better to have networking that is not isolated.

Dr Michael O'Reilly commented that advanced degrees that link with FET/FETPs such as Australian AET programme is one incentive. Dr Boris Pavlin commented that it may be good to have a survey that each programme has this kind of system. Dr Tippavan Nagachinta mentioned that the programme in Indonesia also links with academic degrees as well as Kenya, Nigeria, Zambia and some other African countries.

Dr Badral Davgasuren mentioned that it is good to have training course on how to utilize EOC when conducting risk assessment. Dr Boris Pavlin mentioned mentoring for risk assessment is one of the key FETP modules, but joint risk assessment with regional EOC is another thing.

Dr Chin Kei-Lee mentioned that important point is how FETP/FET and APSED III has interaction with each other for mutual benefit. The capacity of WPRO is limited, and it is also good to make practical recommendation to WPRO.

Dr Thilaka Chinnayah thanked WPRO to provide scientific writing workshops, but after the works are handled during the workshop published, there are often no activities in the country. Dr Thilaka Chinnayah requested WPRO for continuous support and follow up for documentation of the FETP work. Dr Takuya Yamagishi mentioned that WPRO conducted scientific writing workshop 4 times a year, and it may be difficult to conduct more. But it may be possible to develop some online modules that can supplement the workshop. He mentioned to bring this back to WPRO and discuss further on how to follow up for documentation with WPSAR editorial office because it is also one of the focuses of APSED III Focus Area 7.

Dr Takuya Yamagishi mentioned it is good to have a bi-regional workshop with SEARO colleagues in 2017 because SEARO colleagues did not attend this workshop, and participants agreed.

3. CONCLUSIONS AND RECOMMENDATIONS

3.1 Conclusions

- FET/FETPs and their networks are a core part of surveillance, risk assessment and rapid response under the APSED III framework in their countries.

- There are challenges in international deployment of FET/FETP fellows. Possible solutions include greater collaboration across FET/FETPs and strengthened links between FET/FETPs and Global Outbreak Alert and Response Network (GOARN).

- While many FET/FETPs have well-developed curricula, there are curricular domains that require development with innovative approaches, such as intervention, newer methods in surveillance, risk assessment, disaster response, and monitoring and evaluation (M&E).

- There is expertise within the Region in some of these areas, which could be harnessed to develop curricula suitable to the local context and could be shared through regional mechanisms such as regional training centres.

- FET/FETPs and their networks are useful resources for strengthening health systems in Member States and ensuring regional health security.

- There is a need to better document workforce capacity for field epidemiology throughout the Region.

- The WPRO FETP fellowship training programme and APSED III are important mechanisms for building regional collaboration and coordination among FET/FETPs.

3.2 Recommendations

3.2.1 Recommendations for Member States

Member States are encouraged:

1. to incorporate surveillance and risk assessment in their FET/FETP curricula for timely, informed decision-making;

2. to involve FET/FETPs in national response systems and the operation of emerging operating centres;

3. to involve FET/FETPs and their networks in their response to local, national and, where possible, international events;

4. to emphasize development and implementation of evidence-based interventions and M&E in line with APSED III, such as annual reporting, after action review, exercises and Joint External Evaluation, which involve FET/FETPs;

5. to support FET/FETP graduates in securing positions that can utilize their skills for epidemiology and response, particularly in public health departments at national and subnational levels;

6. to scale the curricula and expected competencies of their graduates based on local needs; and

7. to build capacity and increase availability of FET/FETP mentors.

3.2.2 Recommendations for WHO

WHO is requested to:

1. to continue the WPRO FETP fellowship training programme as a key platform of regional activities for surveillance, risk assessment and response;

2. to review the purpose, goal and contents of the WHO FETP fellowship training programme in light of regional and country needs and report the findings;

3. to facilitate and maintain functional networks of FET/FETPs for rapid regional and global deployment in response to disease outbreaks and public health threats;

4. to coordinate with FET/FETPs in the Region to develop curricular modules for areas such as intervention, disaster response, mentoring and M&E;

5. to conduct capacity mapping and identify strengths and challenges of FET/FETPs in the Region and report the findings; and

6. to convene a follow-up meeting in approximately one year to report back on progress against these recommendations.

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REGIONAL OFFICE FOR THE WESTERN PACIFIC
BUREAU REGIONAL DU PACIFIQUE OCCIDENTAL

SIXTH WORKSHOP ON FIELD EPIDEMIOLOGY TRAINING PROGRAMME IN THE WESTERN PACIFIC REGION

WPR/DSE/ESR(05)/2016
30 November 2016

Siem Reap, Cambodia
1 December 2016

ENGLISH ONLY

PROGRAMME OF ACTIVITIES

Thursday, 1 December 2016

8:00 – 8:30 **Registration**

8:30 – 9:00 **Opening Session**

Welcome and opening remarks
- *Dr Ly Sovann, Ministry of Health, Cambodia*

Self-introduction
Overview of objectives and agenda
Nomination of Chairs and Rapporteur
Administrative announcements
Group photo

9:00 – 10:00 **Session 1: Setting the scene**

9:00 – 9:10 Overview of Regional FET/FETPs
- *Dr Takuya Yamagishi, WHO/WPRO*

9:10 – 9:20 APSED III
- *Dr Chin Kei Lee, WHO China*

9:20 – 9:30 Experience of JEE in relation to FETP HR development
- *Dr Bun Sreng, Ministry of Health, Cambodia*

9:30 – 10:00 Questions and clarifications

10:00 – 10:30 *Coffee Break*

10:30 – 11:30	**Session 2: New approach for the training during and after FET/FETPs** *- TBD*
10:30 – 10:45	Korea *– Dr Sangyun Cho, Korea Centers for Disease Control and Prevention*
10:45 – 11:00	Japan *- Dr Kazunori Oishi, National Institute of Infectious Diseases*
11:00 – 11:30	Questions and clarifications
11:30 – 13:00	***Lunch break***
13:00 – 14:00	**Session 3: How to utilize graduates?** *- TBD*
13:00 – 13:15	Papua New Guinea *- Mr Berry Ropa, National Department of Health*
13:15 – 13:30	Malaysia *- Dr Fadzilah Kamaludin, Ministry of Health Malaysia*
13:30 – 13:50	Questions and clarifications
13:50 -14:40	**Session 4: FETP involvement of the national-level outbreak responses** *- TBD*
13:50 – 14:05	Lao PDR *- Dr Bounlay Phommasack, Ministry of Health*
14:05 – 14:20	Mongolia *- Dr Badral Davgasuren, Ministry of Health*
14:20 – 14:40	Questions and clarifications
14:40 – 16:00	**Session 5: Panel Discussion: Direction for the next 5 years** *- TBD*
16:00 – 16:30	*Coffee break*
16:30 – 17:00	**Closing session** *- Cambodia MOH*

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