

TECHNICAL ASSISTANCE COMPLETION REPORT¹

Division: SESS

TA 6305-REG: Strengthening Epidemiological Surveillance and Response for Communicable Diseases in Indonesia, Malaysia, and Philippines			Amount Approved: \$1,200,000	
			Revised Amount: N/A	
Executing Agency Asian Development Bank		Source of Funding TASF	Amount Undisbursed: \$9,697.22	Amount Utilized: \$1,190,302.78
TA Approval Date: 18 January 2006	TA Signing Date: 18 January 2006	Fielding of First Consultant: 19 September 2006	TA Completion Date Original: 31 August 2007 Actual: 31 March 2009 Account Closing Date Original: 31 August 2007 Actual: 26 May 2009	

Description

Emerging infectious diseases (EID) cause major human and economic impacts in the region, and require regional and global cooperation to bring them under control. Recent outbreaks of EIDs have shown weaknesses in emergency surveillance and response (ESR) systems. In accordance with provisions of the International Health Regulations (IHR) of 2005 of the World Health Organization (WHO), all member countries of WHO are to strengthen their ESR systems by 2009. The Southeast Asia and Western Pacific Regional Offices of WHO (WHO/SEARO and WHO/WPRO) developed the *Asia Pacific Strategy for Emerging Infectious Diseases (APSED)* to strengthen national and regional capacity for early detection, rapid response, and preparedness for EIDs. ADB is well placed to support regional public goods, and gives high priority to implementing APSED. Accordingly, ADB agreed to support a subregional initiative with the Ministry of Health (MOH), Government of Indonesia; MOH, Government of Malaysia; and the Department of Health (DOH), Government of the Philippines.

Expected Impact, Outcome and Outputs

The expected impact of the TA was to strengthen the human and institutional capacities of the three countries to properly perform ESR. Improvements in the performance of ESR would help the three countries respond in an effective manner to threats of EIDs within and across the three countries, and also help reduce morbidity and mortality due to communicable diseases and achieve related MDGs. The outcomes include (i) strengthened ESR systems for early detection and response to undesirable changes in the occurrence of communicable diseases, (ii) improved national capacity to respond to an epidemic outbreak of communicable disease (including the capacity to use laboratory-supported analytical epidemiological methods in investigating and addressing the causes of outbreaks), and (iii) harmonized national efforts to promote a subregional collaboration mechanism for communicable disease control and the monitoring, containment, and prevention of outbreaks.

The TA had three outputs: (i) Output A required the preparation of country epidemiological profiles and their consolidation into a subregional profile, which can be posted and accessed through a website; (ii) Output B involved the conduct of exercises and activities that will measure the functionality of existing ESR systems; and (iii) Output C consisted of interventions designed to address the ESR weaknesses identified under Output B. Based on the recommendations of the participants at the subregional planning workshop in Jakarta in November 2006, the TA scope was revised to reflect local needs and priorities. Output A was re-focused on ESR system analysis and plan formulation; Output B on systems development; and Output C on capacity building to enhance ESR systems.

Delivery of Inputs and Conduct of Activities

The TA commenced in June 2006 and was extended to August 2008, upon the request of the ministries of health of Indonesia and Malaysia to complete activities. The performance of the implementing agencies of Indonesia and Malaysia was satisfactory, and highly satisfactory in the case of DOH, Philippines. After an initial slow start, the three Governments demonstrated strong ownership. ADB performance was satisfactory, but required very detailed information in order to release funds. With limited initial consultation, the cooperation with WHO had a slow start but thereafter WHO/WPRO and country offices supported the TA. WHO Geneva also participated in the planning workshop. The performance of the consultant was highly satisfactory. ADB contracted PRIMEX, Philippines; in partnership with PT Trans Intra Asia (TIA) in Indonesia; Singapore Health Services PTE Ltd in Singapore; and the Health Solutions Group in Malaysia; to help implement the TA. Under the TA, PRIMEX provided strong management and technical support, training, and subcontracted services under Outputs B and C. A cash advance mechanism and sound activity monitoring and financial tracking system was established to ensure timely funding of planned activities. Three tripartite meetings were conducted. The Consultant provided timely quarterly progress reports and other documents.

TA formulation was partly satisfactory. The original TA design was overambitious and inadequately reflected country setting and implementation constraints. Consultation of Governments and WHO at TA formulation was insufficient. Subsequent consultations and revision of the TA scope resulted in strong country ownership and WHO support. The

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time frame was short for this kind of TA. The success of the TA resulted largely from strong consulting firms that also secured support of Governments. With limited TA funding, critical initiatives could not be sustained in Indonesia. The Government of the Philippines committed \$2 million to help finance the ESR plan prepared with TA support.

Evaluation of Outputs and Achievement of Outcome

Output A: ESR Systems Analysis and Plan Formulation: The ESR assessment utilized the WHO's ESR Evaluation Guidelines, ESR Performance Standards, Laboratory Assessment Tool, and Outbreak Communications Guidelines, which helped improve the consistency and comparability of the results across the three countries. The assessments were able to uncover critical gaps and issues that helped identify priorities for urgent action. The strategic plans served as a strong basis for long-term ESR development. The information generated by the comprehensive ESR assessments led to ESR capacity-building.

Output B: ESR Systems Development: Under this output, the three countries developed guidelines and procedures that strengthened compliance with, and implementation of, the IHR of 2005. Drawing on the information generated by the country ESR assessments and with the technical guidance provided by WHO and other experts, the health ministries of the three countries designed and established systems that will strengthen their capacity to conduct ESR and comply with IHR requirements.

Output C: Capacity-Building to Enhance ESR Systems: This output consisted of specific activities that addressed weaknesses in the ESR system or constraints that hampered the country's ability to support IHR. To facilitate the conduct of these innovative measures, each country was provided with a budgetary allocation of \$200,000 through a cash advance facility provided by ADB and managed by PRIMEX. Despite the limited funding available to the three countries under this output, the accomplishments in the three countries far exceeded expectations.

Sub-regional Accomplishments: At the sub-regional level, the TA (i) generated momentum and support among the three participating countries and other countries and institutions to establish coordination mechanisms in the area of applied epidemiology training; (ii) created awareness on the need to share epidemiological information and resources; (iii) generated interest in the establishment of common standards and guidelines in ports of entry especially for countries that share common borders. Four workshops were conducted, on TA planning, ESR design, applied epidemiology training, and TA concluding workshop. Subregional objectives were only partly met. There was some collaboration: the consultants from the Philippines were asked to support the ESR assessment and national focal point in Indonesia. The collaboration did facilitate regional networking, but this was not tested or systematized.

In terms of outcomes, the TA resulted in overall strengthening of the ESR system in the Philippines, specific ESR strengthening in Malaysia, and increased capacity and acceleration of the process for ESR strengthening in Indonesia. Subregional collaboration improved but remained limited to exchanges of information and technology.

Overall Assessment and Rating

The TA is considered successful. The TA objectives were, and still are, highly relevant to the needs of the countries, and the Governments appreciated the assistance provided by the TA and gave their commitment to pursue and sustain efforts to enhance their ESR capabilities. The original TA design was overambitious, inadequately reflecting country priorities and implementation constraints. Insufficient consultation took place during TA formulation. Subsequent consultations and revision of the TA scope resulted in strong country ownership and WHO support. The Strong consulting firms helped secure Government support and the success of the TA.

Major Lessons

Regional TAs are complex and require sufficient advance consultation and preparation, time, and funding. Full cooperation of Governments and partners needs to be secured in advance. Both ADB and the consulting firm were able to respond to the request of partners in a flexible manner, and this responsiveness, in turn, helped build trust and generated much country appreciation and effort. The IHR of 2005 and the Asia-Pacific Strategy for Emerging Infectious Diseases provided an excellent framework and anchor for building the countries' ESR systems. While national objectives were by and large achieved, the level of subregional activities remains limited. Governments are still trying to improve their own national ESRs before moving on to subregional collaboration. The value of engaging experienced local firms to provide administrative support cannot be overemphasized. A cash advance mechanism is key to fast-tracking TA implementation.

Recommendations and Follow-Up Actions

There are still challenges that need to be overcome for the ESR system to be fully functional in the three participating countries: (i) development of appropriate training approaches for sub-national applied epidemiology training; (ii) generation and mobilization of resources for ESR capacity-building; and (iii) effective mechanisms for regional and sub-regional coordination and collaboration.