MEETING SUMMARY

Global Work Group (GWG)

Advisory Committee to the Director (ACD)

Centers for Disease Control and Prevention (CDC)

9:00 AM – 3:30 PM

October 22, 2014

Meeting #9

David Fleming, GWG Chair

Tom Kenyon, Center for Global Health (CGH) Director and
GWG Designated Federal Officer (DFO)

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On October 22, 2014, the Global Work Group (GWG) of the Centers for Disease Control and Prevention (CDC) Advisory Committee to the Director (ACD) convened at the Global Communications Center on CDC's Clifton Road Campus from 9:00 am until 3:30 pm EDT. The meeting included updates from CDC's Center for Global Health (CGH); a briefing and discussion on Ebola and Global Health Security (GHS); updates and discussion on international laboratory safety initiatives; and an update and discussion regarding the President's Emergency Plan for AIDS Relief (PEPFAR) III.

I. Welcome and Introductions

Dr. David Fleming, GWG Chair, called the meeting to order. He noted that the October 2014 ACD meeting, originally scheduled for the next day, had been cancelled; however, it was important that the GWG meeting continue as planned. Attendees in person and via teleconference introduced themselves. The meeting attendance is provided with this document as Attachment A.

II. Highlights of November 2013 GWG Meeting

Dr. Fleming provided a brief history of GWG, which serves as an advisory group to CGH and makes formal recommendations to the ACD if necessary. The last GWG meeting, held in April 2014, focused on the issues of CDC's work in noncommunicable diseases (NCDs); CDC's work in creating National Public Health Institutes (NPHIs) around the world; and increasing antimicrobial resistance (AMR).

III. Center for Global Health Update

Dr. Tom Kenyon, CGH Director and GWG Designated Federal Official (DFO), said that GWG meetings are helpful to CGH and noted that the center represents only a portion of what CDC and the rest of the United States (US) government does in global health.

<u>Global Health Security Agenda (GHSA)</u>
The GHSA was launched in February 2014. The endeavor includes diplomacy and high-level leadership as the world develops a common agenda. The world has since mobilized behind it, with a meeting in Jakarta, Indonesia, resulting in 39 countries committing to Action Packages to translate political support into action and to recruit additional countries into the effort. A GHSA Steering Group has been created to sustain momentum. CDC has enjoyed a strong partnership with the US Department of Defense (DoD) to leverage resources in 14 countries to expand GHS as part of a broader timeline to achieve GHS in at least 30 countries by 2020.

<u>National Public Health Institutes</u>
Congress allocated funding to support the formation of an African Centre for Disease Control and Prevention (ACDCP). This endeavor was initiated by the African Union (AU) in July 2013 with the primary goals to share information and to build surge capacity for crises. The AU officially requested technical assistance from CDC in May 2014. CDC convened a task force with representatives from other groups and partners. This work will be conducted in the context of the International Health Regulations (IHR).

<u>Polio</u>
There have been some successes and some setbacks in global polio, but overall, there has been a near-50% reduction in the polio caseload in 2014 compared to 2013. However, there are more countries with polio and more polio outbreaks. Efforts are underway to mobilize

leadership and to establish EOCs in affected areas as well as to intensify vaccination efforts in areas where polio is actively transmitted.

Global Hypertension Demonstration Project
CDC is collaborating with the Pan-American Health Organization (PAHO) and local governments to establish a standardized approach for the treatment of hypertension, generating useful models that can be scaled up. The approach is built on core medications, standardized approaches, widespread drug availability, and improvements in delivery.

New President's Malaria Initiative (PMI) Strategic Plan
CDC is a partner in the PMI, which is led by the United States Agency for International Development (USAID). The initial strategy ended in 2014, and an updated strategy for 2015-2020 has been developed.

CDC/ World Bank Collaboration
CDC and other agencies are engaging with the World Bank (WB), particularly regarding the Ebola response. The NCD and GHS teams are also exploring possibilities and developing relationships with WB, helping to make its investments more effective.

CGH Management Updates
Dr. Ron Ballard is retiring as the Associate Director for Laboratory Sciences. Dr. Shannon Hader is the Division of Global HIV/AIDS (DGHA) director. Dr. Vik Kapil has joined CGH as the Chief Medical Officer and Associate Director for Science.

Discussion
The ongoing Ebola crisis highlights concerns about approaches that are "government-driven," when the roles of communities and civil society are less clear. The process of shaping the GHSA should involve non-governmental organizations (NGOs), civil society, and other entities. GWG suggested that CDC be proactive about ensuring that this involvement takes place in order to link national implementation efforts to the local level, and vice versa. The Ebola crisis has "fast-forwarded" the GHSA as the centers of CDC have partnered to mobilize assets to the Emergency Operations Center (EOC) and to the field. Important inter-agency partnerships have also grown in response to Ebola.

The ACDCP is meant to be additive and will not duplicate or serve as a substitute for the formation of NPHIs. There are valuable lessons to be learned from the public health agency formation in the Caribbean and Latin America. It is important to understand the processes and responsibilities of different agencies, especially the ACDCP's relationship with the World Health Organization (WHO) Regional Office for Africa (AFRO) and the WHO/ Regional Office for the Eastern Mediterranean (EMRO). The task force also emphasized creating regional collaborating centers using the existing five zones of the AU. There is already a framework for this approach through the African Society for Laboratory Medicine (ASLM). Many countries want to host the ACDCP. It will likely be built on the working model of a regional network rather than a "monolithic institution." The involvement of United Nations Educational, Scientific and Cultural Organization (UNESCO) is not known, but there is perceived value in creating an institution that transcends national borders. The Ebola response shows where there are needs for support and additional capacity, and that experience will help guide partners to invest.

It is a significant challenge to prioritize Ebola among the rest of the CGH's efforts. GWG said that the crisis period of Ebola will end, but there will be implications and repercussions for a long time. The National Center for Emerging and Zoonotic Infectious Diseases (NCEZID) is leading

CDC's response to Ebola. CGH is facilitating much of the operationalization of the response as well as preparation for the next phase of the response.

The creation of the CGH has been a positive step forward as CDC continues to be engaged in critical areas of infectious disease and NCDs. The overall approach of the center has been positive and represents "where CDC should be." The US's domestic issues are inseparable from global health issues. A great deal of global work at CDC does not take place in the center, but CGH plays an important role in ensuring that CDC has an appropriate presence where needed. Ebola will change global health at CDC permanently.

IV. Ebola and Global Health Security

Dr. Kashef Ijaz, Principal Deputy Director, Division of Global Health Protection (DGHP), CGH, explained that the vision for the GHSA is a world safe and secure from global health threats posed by infectious diseases. CDC has an important role to play in carrying out the objectives of the US government in the GHSA. The countries for GHSA expansion activities have not been finalized, but there are plans to work in central Africa and in countries bordering those affected by Ebola as well as countries that are not as physically close to the outbreaks, but which have air travel to affected countries. There are also vulnerabilities in Latin America and the Caribbean. The current Ebola outbreak is the largest in history and the first Ebola epidemic in the world. CDC's response to Ebola is the largest international outbreak response in CDC's history. A number of challenges are associated with the Ebola outbreak in West Africa. The public health and healthcare systems are overburdened and under-resourced. Stakeholders are used insufficiently. The geographic breadth of the outbreak is significant, and the affected countries have porous borders and mobile populations. There is significant stigma, distrust of outsiders, high exposure to war, and denial among populations.

The Ebola outbreak response aligns with the priority objectives of the GHSA. CDC's Ebola response has focused on monitoring and interrupting transmission by focusing on risk factors such as infection control, safe funeral and burial practices, and protection of healthcare workers. CDC is also focusing on preventing transmission in other countries and assisting countries with surveillance and other elements of response, including training. CDC has conducted Ebola preparedness and response assessment surveys in less-affected or unaffected countries. The surveys incorporate six elements of preparedness and response and are building strategies based on the countries' responses to the survey. CDC is distributing an information catalogue through its Country Offices and PEPFAR coordinators in additional countries.

<u>Discussion</u>
GWG discussed the differences in Ebola response in countries with which CDC and the US government has had long involvement. A CDC presence on the ground makes a great deal of difference.

CDC distributed preparedness guidance to all PEPFAR countries through PEPFAR offices. The Office of the Global AIDS Coordinator (OGAC) has supported leveraging these existing platforms. Ebola leads to collapse in other areas in the affected countries, so every program has a vested interest in preventing and controlling Ebola.

GWG observed that the GHSA does not include specific objectives related to communication, particularly communication with populations. There was discussion regarding how CDC's work within the GHSA incorporates the reality of politically- or medically-failed states and what the international community can do in advance to better mobilize the necessary early rapid

response. GWG suggested that the current Ebola crisis presents an opportunity to make this point to the US government and to highlight the role that CDC can and should play in ensuring that international responses are more effective in the future.

GWG noted that previous outbreaks of Ebola have not become epidemics. The current epidemic represents the first outbreak in a large, crowded urban area. There is a lack of behavior change. For instance, many people are not changing their burial practices even months into the crisis. Changing any human behavior is challenging.

Much of the epidemic has involved healthcare workers who are treating cases. Ebola is often managed outside of formal health centers. Private providers need to be well-trained in identifying, reporting, and protecting against Ebola. CDC is not involved in direct patient care on the ground. Surveillance is important so that the government sector can support and partner with the private sector.

GWG encouraged CDC to begin planning how an Ebola vaccine will be used.

There is persistent confusion and misinformation regarding case load statistics. There have been challenges associated with data compilation and under-reporting. Efforts to examine the case numbers with more granularity, even to the county level, are underway.

The credibility of governments and transparency have been issues, particularly regarding management of incoming funds. It is important to think about the politicization of the response and how the governments are perceived.

There are Ebola-related fears and hysteria in areas that are not directly affected. NGOs could contribute to risk communication in non-affected areas. Further, weak points of entry into some countries allow for illegal cross-border movement.

GWG discussed CGH's specific value-add in assisting CDC's global response to Ebola. Movement has not been as rapid in some domains where CGH has specific expertise. For instance, what epidemiologic information is needed to control the epidemic? The inclination may be to approach the Ebola epidemic with a medical care model, but realistically, many affected places do not have adequate medical capacity. Therefore, thought must be given to a culturally-competent message for communities that will allow them to do the best they can with the resources that they have, which do not likely involve medical care. CGH has experience working and coordinating within multi-government or multilateral environments.

One of CGH's current challenges is finding the programmatic "handshake" between the acute response, which is becoming a chronic response, and capacity-building to maintain the Ebola situation and to create a legacy. Another challenge of the US government is to encourage other countries to contribute or to scale up their contributions.

GWG suggested examining successes carefully, particularly cultural, educational, and coordination strategies.

GWG discussed CDC's recommendations regarding domestic healthcare workers who have been involved in the care of Ebola patients, some of which may relate to the restriction of work activities. As the consequences for volunteer healthcare workers increase upon their return to the US, there is likely to be a disincentive for people to travel to affected countries. The wording

and interpretation of the CDC guidelines on these topics will be very important as CDC can be involved in an advisory capacity or as a "voice of reason."

V. International Laboratory Safety

Dr. Michael Bell, Interim Director of Laboratory Safety, addressed GWG regarding CDC's efforts to improve laboratory safety. There are no new or different hazards or problems associated with laboratory safety. The issues remain a combination of infrastructure, training, and oversight or governance. As a constellation of smaller laboratories, CDC historically operated with in-house, self-management of infrastructure for each laboratory. That approach is no longer efficient or effective. There is also a need to systematize training for uniformity. Governance via an Institutional Biosafety Committee (IBC) is important as well. Laboratories at CDC with Clinical Laboratory Improvement Amendments (CLIA) certification are generally more consistent and clear in their procedures, and a similar certification framework is being considered for quality management of research activities. Training is frequently not conducted in-house at CDC, and there is a need to rebuild a robust training system for the agency. Further, many elements of CDC's current physical infrastructure are not conducive to safety. In international settings, staff are often sent to off-site or regional trainings. Without considering the practices, facilities, and infrastructure at a laboratory, it is difficult for training to have as much impact as it should. CDC is considering a consultative role for on-site training in which experts in biosafety evaluate existing conditions and provide location-specific guidance.

Governance and oversight of overseas CDC laboratories are challenging, as Country Directors are not laboratory experts. A system is needed to assess practices and protocols. Further, international settings have additional influences, such as NGOs and other partnerships, which bring different techniques and technologies. It is important to consider infrastructure and governance in these instances.

Dr. Ron Ballard said that following the recent biosafety and biosecurity incidents at CDC and the National Institutes of Health (NIH), the agencies have taken measures to ensure a safer and more secure working environment. Actions have focused on domestic laboratories, but it is important that overseas laboratory operations establish and maintain the same culture of safety, and it is important to consider the impact of domestic incidents on overseas operations.

Last year, a survey was conducted regarding various aspects of CDC's overseas laboratory operations. The survey instrument included questions regarding laboratory infrastructure and personnel management; occupational health and safety standards; laboratory security; and medium- and long-term plans for laboratory capacity strengthening and country ownership.

Recommendations resulting from the survey are to:

- ❑ Resolve physical security issues
- ❑ Address training needs by adopting a Quality Management System (QMS) as part of stepwise approaches toward accreditation; fund ASLM to enhance laboratory safety in Africa, including training; and support specialized safety courses organized by the Office of Safety, Security, and Asset Management (OSSAM)
- ❑ Complete the full transition to country ownership
- ❑ Conduct an inventory of all archived specimens in accordance with CDC policy in collaboration with host country partners
- ❑ Grant laboratory equipment to partners, if appropriate, so that they are responsible for ownership and maintenance

Next steps are to:

- ❑ Issue guidance on the transfer of outstanding CDC equipment to Ministries of Health (MoHs)
- ❑ Develop a specific workplan with timelines for country transition
- ❑ Work with CDC Country Directors and programs to resolve outstanding issues regarding the transfer of locally-employed staff to MoH Conditions of Service
- ❑ Issue guidance on compliance of CDC overseas laboratories with relevant domestic directives regarding laboratory safety, with input from the Laboratory Safety Improvement Work Group (LSIW)
- ❑ Discuss changes to wording in future cooperative agreements to ensure the safety standards of funded laboratory partners

Discussion

There is a movement toward international laboratory accreditation. PAHO has a system similar to the one that is promoted in PEPFAR countries. The stepwise process is laboratory improvement through various stages and is measured using checklists. The elements of due diligence associated with accreditation are not likely to be performed unless they are required. There are also resource issues involved. A timeline should be defined for engagement and movement toward accreditation.

GWG said that CDC has a role in encouraging this work at an international level. Rather than expecting an individual laboratory to do many things, each laboratory could set and build on priorities that could be routine, but very important for the area. There are opportunities within the GHSA to improve laboratory capacity, especially to detect certain priority pathogens within countries.

VII. PEPFAR III Update: Accountability, Transparency, and Sustained Epidemic Control

Dr. Shannon Hader, Director, Division of Global HIV/AIDS, CGH provided GWG with an update regarding the next phase of PEPFAR. PEPFAR has had strong results since its inception and has delivered on more targets with an upward trajectory of delivery even with budgetary constraints. It has bipartisan support. Because treatment is part of the approach, there have been broader societal benefits of antiretroviral therapy (ART). CDC PEPFAR direct field offices are located in 44 countries, where they work with MoHs and other partners on surveillance, disease reporting, response capacity, guidelines, human resource staffing and training, quality and technical work, and other capacities. Fourteen additional countries are supported through regional offices and technical support. The three guiding principles of the PEPFAR blueprint are accountability, transparency, and impact. The five agendas are impact, efficiency, sustainability, partnership, and human rights. CDC has a comparative advantage in science, evidence generation, and evidence applications. These areas are important for CDC to “step up.”

There is a narrow window of opportunity to achieve epidemiologic control of HIV. As lives are saved through treatment and combined programs, the incidence curve needs to bend so that the number of people in need of lifelong chronic treatment services does not continue to skyrocket at an unaffordable, unsustainable rate. The PEPFAR “pivot” focuses on hotspots of incidence and saturates those communities with combination prevention coverage. Countries are asked to reassess their portfolios and define activities that are core, near-core, and non-core. The near- and non-core activities are not unimportant, but they may be less critical or can be fulfilled by other players in the country. Refocusing activities can have large impacts at the country level. Each agency in PEPFAR has been allocated a new initiative. CDC will be

responsible for delivering on HIV Impact Assessments (HIA), the next generation HIV population surveys.

Discussion

GWG has discussed previously how PEPFAR can serve as a platform or model for expanding other programs. It is clear that countries with ongoing PEPFAR presence have been better able to respond to Ebola. Investments in a consistent, collaborative CDC presence on the ground will be important for whatever comes next.

CGH and DGHA's most significant challenge is limited resources: people, expertise, and the number of hours in a day. DGHA and CGH are juggling as the PEPFAR surges demand enhanced, dedicated time and attention. GWG noted that CDC's philosophy within the response is important, and those messages will translate to the field.

Kenya's AIDS Indicator Survey was an important model for the HIAs. Site-level results will come from other database activities, as sampling will not allow for site-level analysis. In some countries, it will be possible to over-sample urban hotspots to discern incidence and other nuances.

As PEPFAR activities move from lower-prevalence areas to higher-prevalence areas, there are concerns regarding areas where the funds have been used for general health strengthening purposes. The involved partners are determining how to compensate for the shifts within PEPFAR. This problem is a systems issue for global health investments.

The current epidemiologic window demands that CDC rededicate how it works with the Global Fund, which has a new funding model with a new cycle and prioritization of countries. Concentrating on countries where it is most critical for Global Fund and PEPFAR to work together will lead to more systematic, higher-level engagement.

GWG said that PEPFAR is moving toward sustainability, more indirect support, and more provision of technical assistance. Success should be measured in that context in the future. A Sustainability Index is being created that will identify a scorecard across different parameters of sustainability. A larger issue is measuring and showing the value of technical assistance.

The HIV/AIDS epidemic is not static. Healthcare financing initiatives will result in countries investing more in their own epidemics and finding new modalities. The new HIAs will lead to greater epidemiologic intelligence, pointing toward where funds should be invested, and how. They could lead to similar approaches in other areas, such as NCDs.

VIII. Summary and Recommendations

GWG commended the wide scope of CGH's activities and the center's ability to multitask its various initiatives while staying organizationally strong.

An important issue to bring to the ACD is the consideration of Ebola not just as an outbreak, but as an endemic, long-term problem with long-term consequences and responsibilities. It was suggested that GWG recommend a strong after-action review by all partners to document and analyze mistakes made and lessons learned. The analysis should include all relevant considerations, including the private sector, NGOs, and civil society. The review should also consider how leadership was provided and how leadership roles might be different in the future. The review should also focus on the role that CGH has played in working with countries.

GWG emphasized that community, communication, partnership-building, and behavior are not tangential issues, but instead are core issues that should not be eliminated when budgets are tightened. It is critical to understand the role of communities in preparedness and response. To the extent possible, CDC and CGH should have a strong voice in responding to in-country issues, particularly regarding coordination.

CGH has an important leadership role in GHS in countries. The GHSA Steering Committee should have civil society representation or advisors, and GWG could make a recommendation to this effect. With the focus on Ebola, it is possible that other parts of the GHSA are losing out. GWG could make recommendations in this area, as it is critical not to lose sight of the important work outside Ebola.

There have been shifts in priorities of how the US government appropriates funds, and advocacy for funding for CDC's changing needs and pressures should be structured and strategic, with consistent messaging.

The manner in which Ebola has escalated in Africa has revealed the weak health systems in that region. There are opportunities for different local and international agencies to support preparedness efforts in the Central and South American regions. "Global health" should be global and not only focused on Africa. Other countries and regions have weaknesses and need support as well to avert potential situations such as the ones in Africa.

GWG encouraged CGH to think about how to advance the goals of PEPFAR while leveraging PEPFAR resources to build global health capacity.

With no additional questions or comments, the meeting adjourned at 3:18 pm.

Attachment A: Meeting Attendance

GWG Members Present

Willis Akhwale, MD
Francisco Becerra, MDE, MPH, DrPH
Walter Dowdle, PhD
David Fleming, MD (ACD Member) (GWG Chair)
Alan Greenberg, MD, MPH (ACD Member)
Joseph McCormick, MD, MS
Christine Sow, PhD, MPH
Wade Warren
Mitchell Wolfe, MD

GWG Members Absent

David Brandling-Bennett, MD
Mickey Chopra, MD, PhD
Ambassador Jimmy Kolker, MPA
Herminia Palacio, MD, MPH
Yu Wang, MD, PhD
Jonathon Woodson, MD

CDC Staff Present

Arunmozhi Balajee, PhD
Ron Ballard, PhD
Michael Bell, MD
John Blandford, PhD
Julie Fishman, MPH
Shannon Hader, MD, MPH
Kathleen Holmes
Kashef Ijaz, MD, MPH
Thomas Kenyon, MD, MPH
Jim Mercy, PhD
Glenn Moore, MISM
Jenny Parker, MPA
David Shay, MD
Larry Slutsker, MD, MPH
Robert Spengler, ScD
Marsha Vanderford, PhD

General Public

Kendra Cox, MS

Attachment B: Acronyms

Acronym	Expansion
ACD	Advisory Committee to the Director
ACDCP	African Centre for Disease Control and Prevention
AFRO	(WHO) Regional Office for Africa
AMR	Antimicrobial Resistance
ART	Antiretroviral Therapy
ASLM	African Society for Laboratory Medicine
AU	African Union
BSL	Biosafety Level
CDC	Centers for Disease Control and Prevention
CGH	Center for Global Health
CLIA	Clinical Laboratory Improvement Amendments
DFO	Designated Federal Official
DGHA	Division of Global HIV/AIDS
DGHP	Division of Global Health Protection
DoD	(United States) Department of Defense
EMRO	(WHO) Regional Office for the Eastern Mediterranean
EOC	Emergency Operations Center
GHS	Global Health Security
GHSA	Global Health Security Agenda
GWG	Global Work Group
HIA	HIV Impact Assessments
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IBC	Institutional Biosafety Committee
IHR	International Health Regulations
LSIW	Laboratory Safety Improvement Work Group
MoH	Ministry of Health
NCD	Noncommunicable Disease
NCEZID	National Center for Emerging and Zoonotic Infectious Diseases
NGO	Non-Governmental Organization
NIH	National Institutes of Health
NPHI	National Public Health Institute
OGAC	Office of the Global AIDS Coordinator
OSSAM	Office of Safety, Security, and Asset Management
PAHO	Pan-American Health Organization
PEPFAR	President's Emergency Plan for AIDS Relief
PHS	Public Health Service
PMI	President's Malaria Initiative
QMS	Quality Management System
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
US	United States (of America)
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization