

Background

The U.S. Centers for Disease Control and Prevention's (CDC) Influenza Division has a long history of supporting the World Health Organization (WHO) and its global network of National Influenza Centers (NIC). With limited resources, most international assistance provided in the early years was through hands-on laboratory training of in-country staff, the annual provision of WHO reagent kits (produced and distributed by CDC), and technical consultations for vaccine strain selections. The Influenza Division (at that time, the Influenza Branch) also conducted epidemiologic research including vaccine studies and serologic assays and provided international outbreak investigation assistance.

In 1997, the first human cases of influenza A (H5N1) were reported in Hong Kong, and the Influenza Division played a key role in assisting with the outbreak investigations. The re-emergence of fatal human cases of avian influenza A (H5N1) in China in 2003 following the outbreak of SARS, followed by human outbreaks caused by highly pathogenic avian influenza A (H5N1) viruses in Vietnam and Thailand in 2003 and 2004 led to a growing concern that a pandemic of influenza may emerge. These outbreaks highlighted several important gaps that needed to be closed to improve the ability to rapidly identify novel influenza viruses with pandemic potential. These included:

- conspicuous geographic gaps in human influenza surveillance.
- critical gaps in information, laboratory and epidemiologic training and technology transfer for rapid identification and analysis of avian influenza viruses in many affected countries.
- longstanding obstacles and gaps in the sharing of information, resources and specimens between agriculture and human health authorities.

These events fostered the beginning of a larger international program to improve global pandemic preparedness and enhance capacity for laboratory and epidemiologic surveillance of influenza and avian influenza.

In 2004, the U.S. government (Health and Human Services (HHS)/CDC) committed resources and developed a multi-faceted approach to support global capacity for seasonal influenza and pandemic preparedness. Support was made available through cooperative agreements to enhance the existing support to WHO's Global Influenza Program (GIP) and WHO's regional offices. Substantial support was also provided to Ministries of Health in high-risk countries to enhance influenza surveillance and response capabilities. These cooperative agreements, paired with technical assistance, support the provision of training, staffing, direct assistance, supplies and reagents, formed the foundation for CDC's expanded role in international influenza control and prevention. The program accomplishes key goals by building on existing programs and infrastructure including WHO and its regional offices, CDC Global Disease Detection (GDD) sites and International Emerging Infections Program (IEIP) sites, Department of Defense (DOD) international program sites, and by utilizing the assistance of U.S. Embassies.

In April 2009, the first case of pandemic 2009 H1N1 influenza virus infection in the United States was identified. Subsequent cases were quickly identified in Mexico and other states. The influenza virus identified in these early cases was unique and contained a combination of gene segments that had not been previously reported in animals or humans. The 2009 H1N1 pandemic allowed many countries with cooperative agreements to showcase the progress they have made in the last few years. First-time investigations of influenza were conducted in response to the pandemic and labs that previously could not identify influenza virus were able to diagnose pandemic 2009 H1N1 using molecular techniques. Many countries that previously had not reported influenza routinely were able to report consistently and contribute to the global picture of influenza epidemiology during the pandemic. The global surveillance and response capacity built before the pandemic of 2009 was critical to the rapid global response and disease prevention.

Over the past nine years the program has undergone remarkable growth [see Maps] and has expanded to provide support to over 50 countries, all WHO regional offices and WHO Headquarters. Partnerships have been developed with the DOD, United States Agency for International Development (USAID), Biosecurity Engagement Program (BEP), universities, nongovernmental organizations, private industry and other entities to enhance global surveillance and preparedness. Over 20 staff have been placed in the field [see Map] to provide on-the-ground assistance and support to countries and to WHO, and to augment the GDD Program and DOD field sites.

Recognizing that needs vary by countries, the program is designed as a continuum to include: improvements to surveillance, efforts to enhance pandemic preparedness, implementation of burden of disease studies to measure the impact of influenza, and studies to determine the effectiveness of intervention measures such as vaccination. With the data generated through surveillance, each country can determine which populations are most vulnerable to influenza-related morbidity and mortality and who should receive influenza vaccine. Based on surveillance and other analyses, influenza vaccination policy and issues related to vaccine production can be approached on a country-by-country and a regional basis. In 2010, we embarked on placing more emphasis on the development of data to help countries evaluate the need and feasibility of vaccine policy. In 2011, CDC entered a partnership with WHO's Global Action Plan for Influenza Vaccine, towards expanding prevention of global disease and improving health security through greater use of influenza vaccines worldwide.

While the response to the 2009 H1N1 pandemic was an opportunity to show recent progress, avian influenza H5N1 outbreaks still pose a significant and ongoing global health threat and a threat to U.S. security. To sustain the gains made in the past years, a broad-based commitment to build and maintain influenza surveillance globally that is sustainable (and eventually self-sustainable) requires dedicated, annualized resources and staffing. It is our hope that these HHS/CDC resources and technical assistance will act as a catalyst for affected countries, neighboring countries and donor countries to commit resources to establish long-term influenza surveillance, prevention and control, and pandemic preparedness activities as high priorities. We also envision that each affected country will utilize the technical assistance and resources available to improve surveillance, develop influenza vaccination policy, make plans for the use of influenza vaccine both annually and during a pandemic, and work closely with regional and international partners to further preparedness.

This program has implications beyond influenza. The capacity being developed for laboratory and epidemiologic surveillance of severe respiratory disease has served as the basis for capacity for the diagnosis and investigation of other infectious diseases, particularly other respiratory pathogens.

Laboratory equipment and training has enabled the diagnosis and investigation of other diseases. Likewise, through the implementation of a global rapid response training program, CDC has provided training and materials for thousands of people in all WHO regions. These courses have enabled the trained teams to participate in outbreaks not only for the recent pandemic but for other respiratory diseases and many other pathogens including Rift Valley fever, dengue, cholera, Ebola and rabies. Evidence shows that the technical assistance provided by the Influenza Division is assisting countries in increasing their capacity necessary for compliance with the new International Health Regulations 2005 (IHR). The generic approach, with a focus on influenza and avian influenza, contributes greatly to global capacity for laboratory, epidemiology and overall preparedness for emerging and re-emerging infectious diseases. Efforts are underway to plan for the sustainability of the gains that have been made. This report is the fifth update on the Influenza Division's international activities and encompasses fiscal years 2012 and 2013.