



# Are we “PRET” for the next pandemic?

*Diversity, equity, and inclusion in pandemic planning and our role as field epidemiologists*

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**World Health  
Organization**

RESEARCH

Open Access



# Field epidemiology training programs contribute to COVID-19 preparedness and response globally

Audrey E. Hu<sup>1,2</sup>, Robert Fontaine<sup>1</sup>, Reina Turcios-Ruiz<sup>1</sup>, Aisha A. Abedi<sup>1</sup>, Seymour Williams<sup>1</sup>, Angela Hilmers<sup>3</sup>, Eni Njoh<sup>1</sup>, Elizabeth Bell<sup>1</sup>, Carl Reddy<sup>3</sup>, Kashef Ijaz<sup>1,4†</sup> and Henry C. Baggett<sup>1†</sup>

## Abstract

**Background:** Field epidemiology training programs (FETPs) have trained field epidemiologists who strengthen global capacities for surveillance and response to public health threats. We describe how FETP residents and graduates have contributed to COVID-19 preparedness and response globally.

**Methods:** We conducted a cross-sectional survey of FETPs between March 13 and April 15, 2020 to understand how FETP residents or graduates were contributing to COVID-19 response activities. The survey tool was structured around the eight Pillars of the World Health Organization's (WHO) Strategic Preparedness and Response Plan for COVID-19. We used descriptive statistics to summarize quantitative results and content analysis for qualitative data.

**Results:** Among 88 invited programs, 65 (74%) responded and indicated that FETP residents and graduates have engaged in the COVID-19 response across all six WHO regions. Response efforts focused on country-level coordination (98%), surveillance, rapid response teams, case investigations (97%), activities at points of entry (92%), and risk communication and community engagement (82%). Descriptions of FETP contributions to COVID-19 preparedness and response are categorized into seven main themes: conducting epidemiological activities, managing logistics and coordination, leading risk communication efforts, providing guidance, supporting surveillance activities, training and developing the workforce, and holding leadership positions.

**Conclusions:** Our findings demonstrate the value of FETPs in responding to public health threats like COVID-19. This program provides critical assistance to countries' COVID-19 response efforts but also enhances epidemiologic workforce capacity, public health emergency infrastructure and helps ensure global health security as prescribed in the WHO's International Health Regulations.

# Contribution of the Australian field epidemiology training workforce to the COVID-19 response, 2020

Amy Elizabeth Parry,<sup>a</sup> Charlee Law,<sup>a</sup> Davoud Pourmarzi,<sup>a</sup> Florian Vogt,<sup>a,b</sup> Emma Field<sup>a</sup> and Samantha Colquhoun<sup>a</sup>

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The range of public health emergencies that occurred in Australia during 2020 illustrates the complexity of contemporary acute public health issues. In 2020 alone, Australia mounted responses to bush-fires, storms, drought, floods and rodent plagues, as well as the coronavirus disease (COVID-19) pandemic. Such events have highlighted not just the vital role played by the field epidemiology workforce in rapidly and effectively managing a wide range of public health emergencies but also the need to continually train and invest in this workforce to ensure high levels of public health emergency preparedness.<sup>1–5</sup>

Health workforce strengthening is essential to achieving the International Health Regulations (IHR 2005) core capacities.<sup>6</sup> The Asia Pacific Strategy for Emerging Diseases and Public Health Emergencies (APSED III) also makes specific reference to the need for a skilled and experienced local public health workforce for preventing the escalation of public health emergencies.<sup>7</sup>

Australian FETP alumni work in senior roles in health departments at local, state, national and international levels, in Aboriginal and Torres Strait Islander health services and organizations, in United Nations agencies, as well as in research institutions and academia. Alumni and students have been consistently involved in national and international epidemic responses, including severe acute respiratory syndrome (SARS) (2002–2003), H1N1 influenza (2009), Middle East respiratory syndrome coronavirus (MERS-CoV) (2012–) and Ebola virus disease in West Africa (2014–2016). The experiences of alumni and students have been used to modify the programme to make it more relevant, adaptive and “pandemic ready”.

The aim of this study was to describe the level and scope of Australian FETP alumni and student contributions to the COVID-19 response during the first 10 months of the pandemic so that these experiences could inform programme learning priorities going forward.

# Involvement and readiness of fellows from Papua New Guinea's Field Epidemiology Training Programme in the COVID-19 response, 2020–2021

James A Flint,<sup>a,b</sup> Joanne Taylor,<sup>a,b</sup> Tambri Housen,<sup>b</sup> Barry Ropa,<sup>c</sup> Bernie Smaghi,<sup>d</sup> Laura Macfarlane-Berry,<sup>b</sup> Celeste Marsh,<sup>b</sup> Alois Pukienei,<sup>e</sup> Mathias Bauri<sup>f</sup> and David N Durrheim<sup>a,b</sup>

Correspondence to James A Flint (email: james.flint@health.nsw.gov.au)

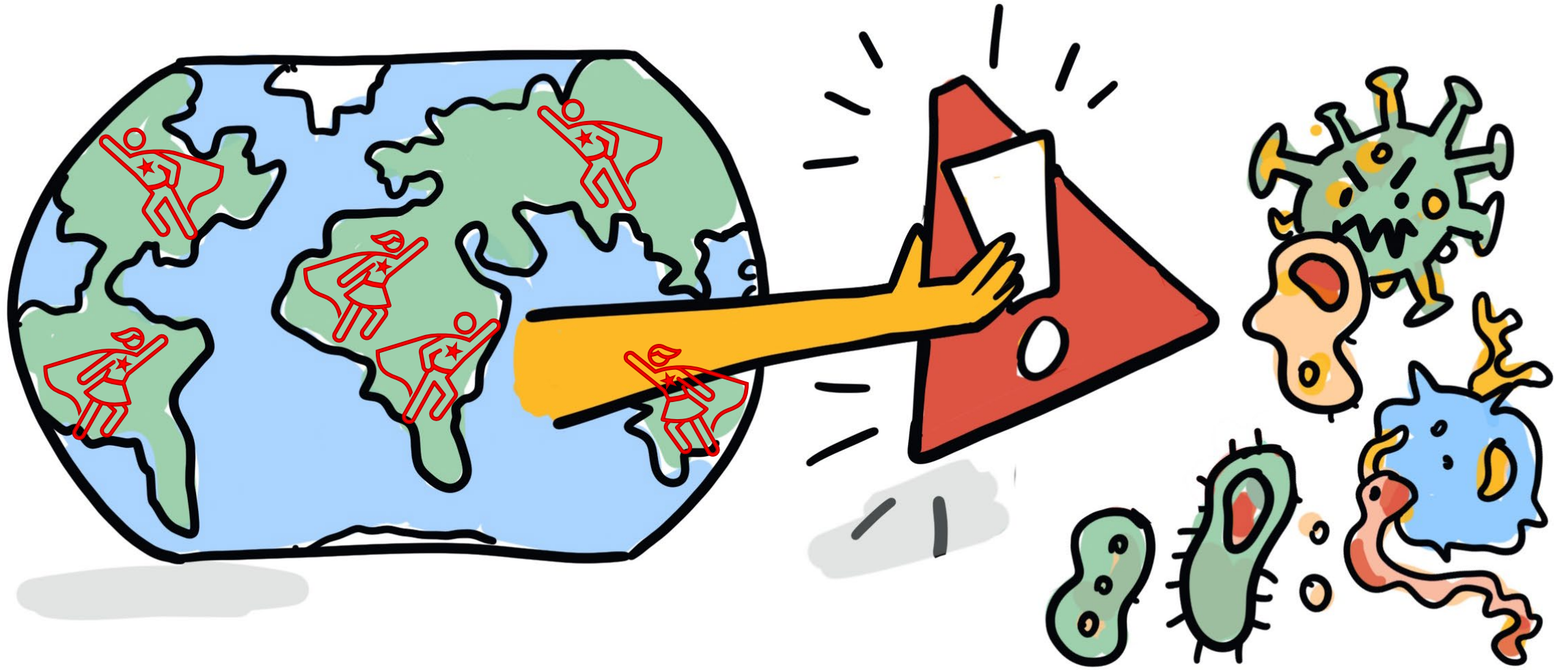
**Problem:** Fellows of the Papua New Guinea Field Epidemiology Training Programme (FETP) were part of the national coronavirus disease (COVID-19) response. However, the specific activities and challenges experienced by fellows in the field were unknown.

**Context:** The advanced FETP cohort commenced just prior to the COVID-19 pandemic and all fellows were involved in the response. The advanced fellows participating in this review represented a cross-section of the country's public health workforce.

**Action:** A review was conducted to better understand the scope of activities undertaken by FETP fellows, identify the challenges experienced and assess how well the programme prepared fellows for their COVID-19 response roles. A facilitated discussion based on the World Health Organization COVID-19 intra-action review methodology and an online survey was conducted with advanced FETP fellows.

**Outcome:** The fellows made important contributions to the national COVID-19 response by assuming leadership positions at all levels of government, leading training activities and applying core field epidemiology competencies in surveillance and response activities. The programme had prepared them well for the response, giving them the confidence and skills to undertake a diverse range of response roles.

**Discussion:** The FETP review of the COVID-19 response in Papua New Guinea highlighted the role and influence of the fellows during the pandemic response. Fellows were able to apply core field epidemiology competencies across a range of roles. The recommendations derived from this review will be instructive for the FETP specifically and the COVID-19 response generally.



**This presentation has two key messages.**

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**EMERGENCY  
COORDINATION**

**But, before we go further, let's learn more about who is in the room!**

# slido



**I am a...**

**i** Start presenting to display the poll results on this slide.

slido



**Were you involved in the COVID-19 response?**

ⓘ Start presenting to display the poll results on this slide.



slido



**In 1-3 words, what is a key lesson from the COVID-19 pandemic?**

ⓘ Start presenting to display the poll results on this slide.

**slido**



**In 1-3 words, what is equity in pandemic response?**

**i** Start presenting to display the poll results on this slide.

## **Equity in pandemics...**

**Timely access to interventions  
based on public health need**

**so that everyone can reach  
their full potential for health  
and well-being.**



# Determinants of Vaccination Status among Mortality Patients with Omicron Variant COVID-19 in Riau Province, Indonesia: A Cross-sectional Study, February–April 2022

Tuesday, 12th September - 16:15: (Manning Clark Hall) - Long Oral

*Mr. Rajunitrigo Rajunitrigo*<sup>1</sup>, *Dr. Irwan Muryanto*<sup>2</sup>, *Mrs. Renti Mahkota*<sup>2</sup>, *Mr. Fajri Marindra*<sup>3</sup>, *Mrs. Nina Elvita*<sup>4</sup>, *Mrs. Eka Malfasari*<sup>5</sup>, *Ms. Mega Utami Basra*<sup>6</sup>, *Ms. Marwanty Marwanty*<sup>1</sup>

1. FETP Universitas Indonesia, 2. Department of Epidemiology, Faculty of Public Health, Universitas Indonesia, 3. Faculty of Medicine, Universitas Riau, 4. State Islamic University of Sultan Syarif Kasim Riau, 5. Faculty of Nursing, Universitas Indonesia, 6. Faculty of Public Health, Andalas University

## Background

The increasing mortality rate due to COVID-19 is a high-priority public health issue in developing countries such as Indonesia. Since the Omicron variant of COVID-19 was first detected in Indonesia in mid-December 2021, this variant quickly spread to different provinces, one of which is Riau Province. This study aimed to identify the determinants of vaccination status among Omicron variant COVID-19 patient deaths in Riau Province, Indonesia, from February to April 2022.

## Methods

This cross-sectional study used secondary data. Inclusion criteria were all patients who died with confirmed COVID-19, and Omicron variant by SGTF and or sequencing, and were treated in referral hospitals of Riau Province in two months (February 8 – April 4, 2022). We used 158 patients' data as the sample. The distribution of patient deaths was analysed by univariate and bivariate analyses.

## Results

We found that 106 (67.1%) of cases were unvaccinated. The variable age group of  $\leq 20$  years (PR: 2.25, 95% CI: 0.98-5.15), age  $\geq 61$  years (PR: 1.92, 95% CI: 0.87-4.27), living on the mainland (PR: 3.04, 95% CI: 0.89-10.4), and coastal (PR: 3.35, 95% CI: 0.97-11.5) had a significant relationship with COVID-19 vaccination status among the death of Omicron variant patients. The highest time of death was on February 8-12, 2022 (40 cases). The highest comorbidity among dead patients are diabetes mellitus (35.9%) and cardiovascular disease (28.9%).

## Conclusions

We found that the children under 20 years, the elderly, location of residences in coastal and mainland are the determinants of the death of Omicron variant COVID-19 patients. Accelerating full vaccination and increasing coverage by using any vaccine available, particularly among children and the elderly is an important strategy to optimize protection of COVID-19. Improved comprehensive treatment of comorbidities in omicron patients is urgently needed.

Among COVID-19 fatal cases, a greater proportion of unvaccinated individuals lived in coastal areas who had **lower access** to health services.

**This study showed local inequity**

# SINCE THE PANDEMIC BEGAN, GENDER INEQUALITIES HAVE DEEPENED



By 2021, there were still **19.7M** FEWER JOBS FOR WOMEN, compared to **10.2M** fewer for men.



In 2020, **WOMEN DID 29% MORE** CHILDCARE per week than **men**, based on data from 16 countries

**This analysis showed national inequity**

## AS GOVERNMENTS RESPONDED, WOMEN'S NEEDS WERE RARELY AT THE CENTRE



**196 OUT OF 226** countries and territories adopted **at least one** gender-sensitive measure



of COVID-19 task forces across 130 countries were **dominated by men**

**In April 2021, five months after COVID-19 vaccines became available, 500 million doses were administered:**

- **86% in high-income countries**
- **0.1% in low-income countries**

**This monitoring showed global inequity**

*Low-income countries would add \$38 billion to their GDP forecast for 2021 if they had the same vaccination rate as high-income countries. Global economic recovery is at risk if vaccines are not equitably scaled up and distributed.*

[Health equity and its determinants \(who.int\)](https://www.who.int)

[Vaccine inequity undermining global economic recovery \(who.int\)](https://www.who.int)



**RISKS AHEAD.**  
**PREPARE NOW!**

# Learning from COVID-19

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## 1. Preparedness works

Invest in functional capacities, interoperable systems and critical infrastructure

## 2. Health is everyone's business

Take whole-of-government and whole-of-society action

## 3. No one is safe until everyone is safe

Serve vulnerable groups locally and globally

## 4. Response must be agile and adaptive

Adapt as the situation evolves



**90+**  
country intra-  
action reviews

**300+**  
recommendations

**20+**  
international  
reviews





**Involving different sectors**  
in preparing for the next pandemic will  
**save lives, protect livelihoods and**  
**speed up recovery**





# PRET

Preparedness and Resilience  
for Emerging Threats



World Health  
Organization

**WHO's new approach to improve pandemic preparedness for groups of pathogens based on their mode of transmission**

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**PRET**

Preparedness and Resilience  
for Emerging Threats

# PRET global launch and call to action: April 2023



EPIDEMIC  
& PANDEMIC  
PREPAREDNESS  
& PREVENTION



## CALL TO ACTION

WHO, Member States, and partners are working together to identify and implement priority actions to strengthen national, regional, and global preparedness for pandemics and emerging infectious disease threats. We recognize the role of communities and all sectors, and the need for harmonized and sustained momentum to end the cycle of panic and neglect that is all too common in pandemic preparedness and response.

We recall lessons from previous epidemics and pandemics, especially those caused by respiratory pathogens. These pathogens have and will continue to pose a significant global threat with the potential to cause tremendous morbidity and mortality, overwhelm health systems, de-stabilize the global economy, and exacerbate inequities, which exist in the access to both the tools to prevent pandemics and health care for all people.

This is a Call to Action to accelerate preparedness for pandemics and emerging threats globally. Effective preparedness relies on robust planning and coordinated action. A collective commitment on the following actions will see progress achieved by December 2025 as will be described in the (Preparedness and Resilience for Emerging Threats (PRET) monitoring framework:

(1)

**Update preparedness plans that affirm priority actions** and that have considered learnings from past events. Recognizing the risk posed by respiratory pathogens, planning for a respiratory pathogen pandemic based on the themes identified in the *PRET Module #1: Planning for Respiratory Pathogen Pandemics* is a priority.

(2)

**Increase connectivity among stakeholders in pandemic preparedness planning through systematic coordination and cooperation.** This includes building equitable systems; conducting joint exercises; and sharing information on good practices, challenges, and opportunities.

(3)

**Dedicate sustained investments, financing and monitoring of pandemic preparedness** with a particular focus on addressing the gaps identified during past pandemics and epidemics.

The COVID-19 pandemic response has demonstrated what can be achieved with political commitment, community engagement and funding. At the heart of this work is to ensure equity to be ready for the next pandemic together. Whole-of-society action is needed to make the progress outlined in this Call to Action. Implementation should therefore strengthen the resilience of communities; maintain, sustain, and build on routine systems; and leverage broader capacities for emergency preparedness and response.

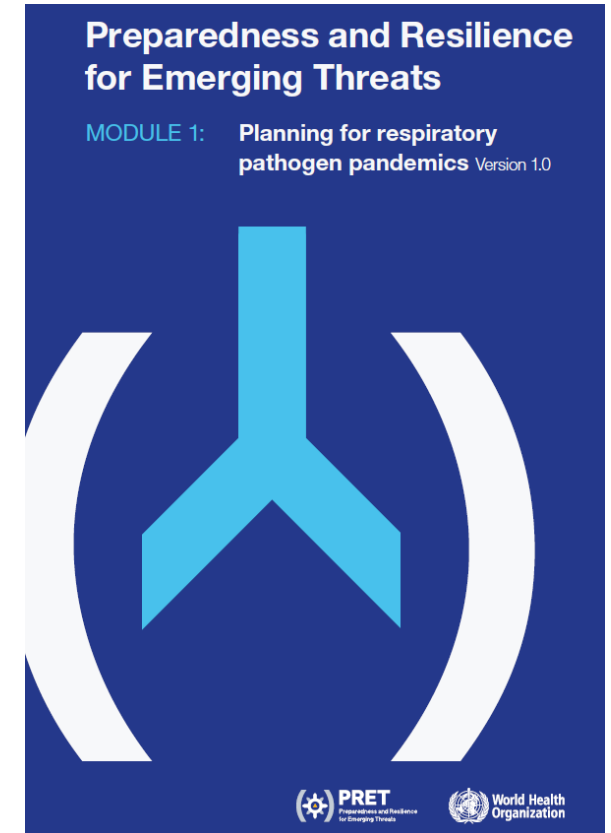
This Call to Action was released at the Preparedness and Resilience for Emerging Threats (PRET): Global Meeting for Future Respiratory Pathogen Pandemics held on 24-26 April 2023 in Geneva, Switzerland.

[Call to action \(who.int\)](https://www.who.int)

# PRET Module #1 Respiratory Pathogens: an overview

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- **PRET Initiative** = let's improve pandemic preparedness for groups of pathogens **based on their mode of transmission**
- Module #1 focuses on **respiratory pathogens**
- New **organizing framework** with operational stages (prevent/prepare - respond – recover)
- Provides principles, assumptions and key actions **to strengthen** pandemic preparedness
- Outlines ways to take a **whole-of-society approach**
- **Tools, simulations & collaborative platforms** to support planning



[Preparedness and Resilience for Emerging Threats \(PRET\) \(who.int\)](https://www.who.int/premit)

**(Part A)**  
Introduction

- a Country context
- b Purpose and scope of document
- c Objectives of the plan
- d Target audience
- e Risk of respiratory pathogen pandemics

**(Part B)**  
Planning considerations and assumptions

- a Principles and ethical considerations
- b Legal and policy considerations
- c Methods for plan development
- d Approach for planning
- e Pandemic preparedness and response periods and operational stages
- f Planning assumptions
- g Funding for multisector preparedness and response
- h Other considerations

**(Part C)**  
Country systems and capacities

- a Emergency coordination
- b Collaborative surveillance
- c Community protection
- d Clinical care systems
- e Access to countermeasures

**(Part D)**  
Plan activation / triggers for shifting between operational stages

- a Activation of plan
- b Triggers for shifting between operational stages
- c Procedures for assessing and adjusting response measures at the country and sub-national levels

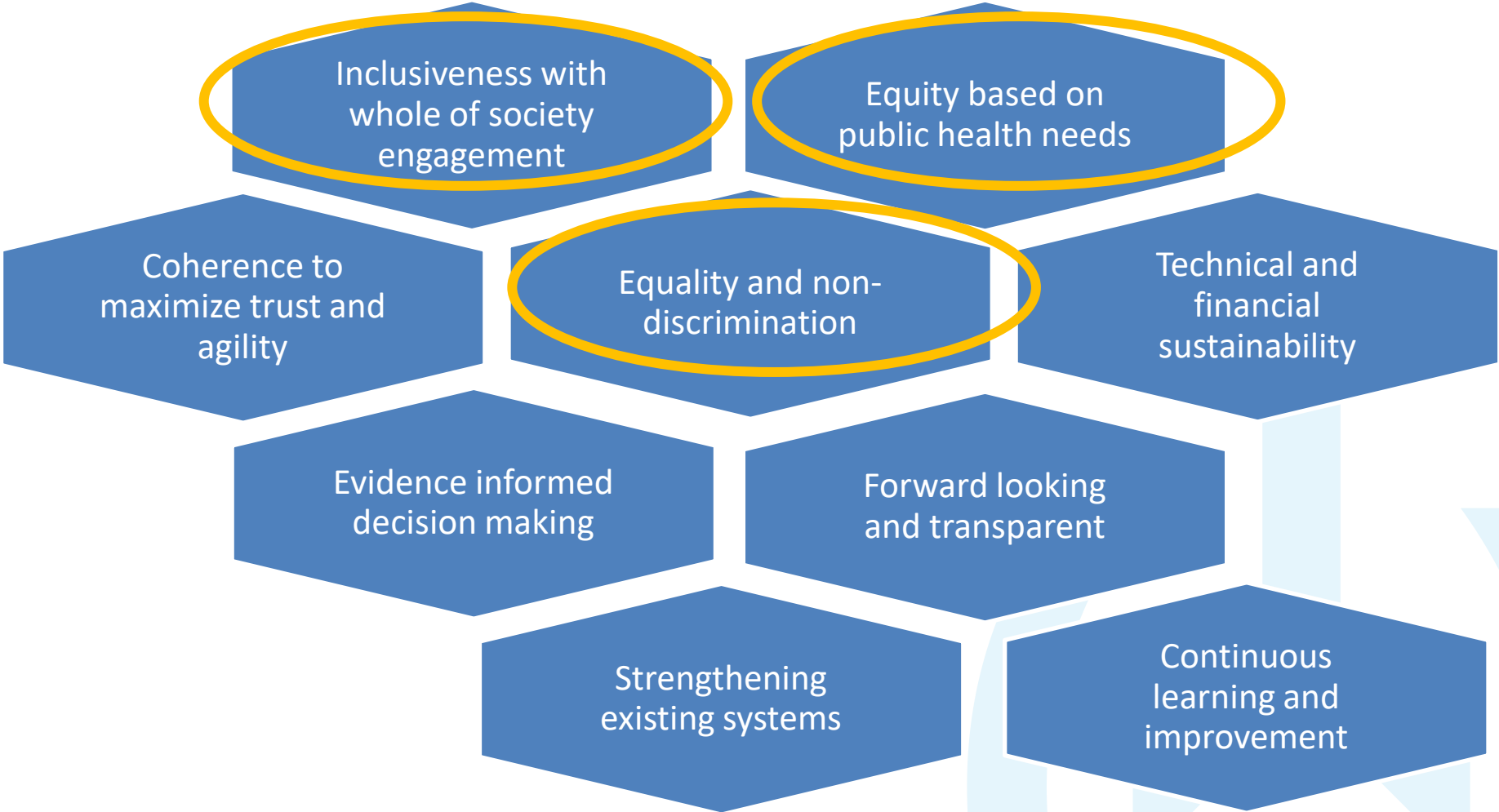
**(Part E)**  
Actions during operational stages

- a Actions for each operational stage

**(Part F)**  
Annexes

# PRET's pandemic planning guiding principles

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## **Equity in pandemics...**

**Timely access to interventions  
based on public health need**

**so that everyone can reach  
their full potential for health  
and well-being.**





# Public health need

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Some groups may be more heavily impacted during future pandemics

## 1. People with a weak immune system:

- Children (especially young children)
- Older persons
- People with immunosuppression, including HIV
- Pregnant women

## 2. People with underlying medical conditions

- E.g. cardiovascular diseases for COVID-19 and Influenza

## 3. People living/working in crowded, confined places

- People living and working in institutions such as long-term care facilities, prisons, nursing, retirement or residential homes for older people, or children's homes
- People experiencing homelessness or inadequate/overcrowded housing conditions
- Refugees, migrants, internally displaced persons

## 4. Vulnerable groups needing special support during crisis

- People with disabilities
- People living in informal settlements or slums

- People without access to health services or who cannot afford health services
- Socially or geographically marginalized and isolated groups
- People with language limitations or other barriers to information People with mental health conditions and/or in need of psychosocial support
- Indigenous communities

## 5. People at higher risk of becoming infected due to greater exposure to sick people

- All categories of health workers
- Home care givers
- Women and girls, who often take caregiving roles which expose them further to disease

## 6. Groups essential to economies and social cohesiveness during crisis

- People who are essential for business continuity to deliver essential products or services
- People dependent on the informal economy

# Operationalizing the principles

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Take a stepwise approach to plan and deliver an equitable pandemic response based on public health need

Source: [PRET Module 1](#) based on WHO's [Innov8](#) approach to leave no one behind

## Determine

who was left behind and why, by analysing data and assessing barriers to improve health outcomes during the COVID-19 pandemic

## Develop

approaches and implement initiatives to address barriers and build back better

## Build

in accountability and monitor progress

## Conduct

research to assess inequities and to identify effective programmes or remedial actions

## Strengthen

technical and operational capacity across the intersectoral pandemic planning workforce so that they have the know-how to deliver quality programmes

## Dedicate

resources specifically to promote whole-of-government and whole-of-society programmes that focus on equality, equity and human rights

## Engage

communities especially through civil society from the outset to maximize trust, co-design and co-achieve.

# Addressing public health need: an exemplar from COVID-19

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## Indigenous Australians at increased risk of COVID-19 due to existing health and socioeconomic inequities

Aryati Yashadhana   • [Nellie Pollard-Wharton](#) • [Anthony B. Zwi](#) • [Brett Biles](#)

[Open Access](#) • Published: July 24, 2020 • DOI: <https://doi.org/10.1016/j.lanwpc.2020.100007>

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# New South Wales

Data as at:  
30 Aug 2021

Australia's COVID-19  
Vaccine Roadmap

State	Statistical Area 4	Indigenous people aged 15 and over with at least one dose	Indigenous people aged 15 and over fully vaccinated	AIR Indigenous Population	Indigenous people aged 15 and over with at least one dose %	% Indigenous people aged 15 and over fully vaccinated
New South Wales	Capital Region	2,695	1,229	5,775	46.67%	21.28%
New South Wales	Central Coast	3,720	1,991	8,529	43.62%	23.34%
New South Wales	Central West	4,208	1,701	9,565	43.99%	17.78%
New South Wales	Coffs Harbour - Grafton	2,050	1,012	5,681	36.09%	17.81%
New South Wales	Far West and Orana	7,030	2,042	14,829	47.41%	13.77%
New South Wales	Hunter Valley exc Newcastle	4,186	1,818	10,783	38.82%	16.86%
New South Wales	Illawarra	2,571	1,423	6,054	42.47%	23.51%
New South Wales	Mid North Coast	4,503	2,305	11,661	38.62%	19.77%
New South Wales	Murray	1,262	653	3,447	36.61%	18.94%
New South Wales	New England and North West	5,480	2,154	14,178	38.65%	15.19%
New South Wales	Newcastle and Lake Macquarie	3,936	2,091	9,773	40.27%	21.40%
New South Wales	Richmond - Tweed	2,367	1,165	7,563	31.30%	15.40%
New South Wales	Riverina	2,637	1,296	6,379	41.34%	20.32%
New South Wales	Southern Highlands and Shoalhaven	1,929	965	4,718	40.89%	20.45%
New South Wales	Sydney - Baulkham Hills and Hawkesbury	813	429	1,285	63.27%	33.39%
New South Wales	Sydney - Blacktown	3,683	1,441	6,984	52.73%	20.63%

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> [BMJ Glob Health](#). 2022 Jul;7(7):e008815. doi: 10.1136/bmjgh-2022-008815.

# Aboriginal peoples' perspectives about COVID-19 vaccines and motivations to seek vaccination: a qualitative study

Simon Graham<sup>1</sup>, Megan Blaxland<sup>2</sup>, Reuben Bolt<sup>3</sup>, Mitchell Beadman<sup>4</sup>, Kristy Gardner<sup>4</sup>, Kacey Martin<sup>4</sup>, Michael Doyle<sup>5</sup>, Karen Beetson<sup>6</sup>, Dean Murphy<sup>7</sup>, Stephen Bell<sup>2 8 9</sup>, Christy E Newman<sup>4</sup>, Joanne Bryant<sup>4</sup>

Affiliations + expand

PMID: 35858705 PMCID: PMC9304971 DOI: 10.1136/bmjgh-2022-008815

[Free PMC article](#)

Concluded: Achieving high vaccination rates in Aboriginal communities is possible if vaccination programmes are delivered through trusted general practitioners or Aboriginal Health Services.

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# Embedding Aboriginal cultural governance, capacity, perspectives and leadership into a local Public Health Unit Incident Command System during COVID-19 in New South Wales, Australia

Kristy Crooks <sup>1,2</sup>, Charlee Law,<sup>2</sup> Kylie Taylor,<sup>3</sup> Katie Brett,<sup>3</sup> Peter Murray,<sup>2</sup> Julie Kohlhagen,<sup>2</sup> Kirsty Hope,<sup>2</sup> David N Durrheim<sup>2,4</sup>

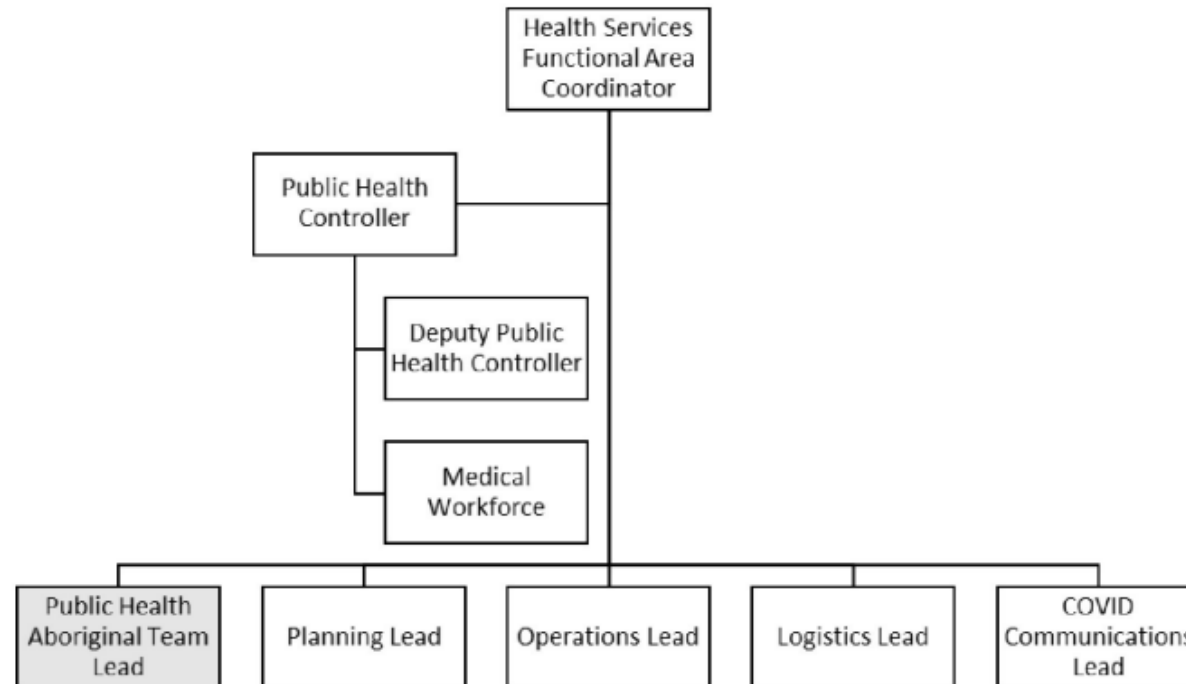


Figure 1 Hunter New England public health Incident Command System for COVID-9.

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In September 2021, 8 months after the Australian COVID-19 vaccine rollout began, a HNE Aboriginal Vaccination Steering Committee was established to identify, inform and implement local vaccination activities.

Targeted, tailored and culturally appropriate communication was delivered as driven by the Steering Committee.

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Estimated Aboriginal population in Hunter New England region (HNE): 72,000

Increased COVID-19 vaccinations: **within 5 weeks of establishing the HNE Aboriginal Vaccination Steering Committee, 29751 vaccines were administered to Aboriginal peoples across the HNE region.**

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**(Part A)**  
Introduction

- a Country context
- b Purpose and scope of document
- c Objectives of the plan
- d Target audience
- e Risk of respiratory pathogen pandemics

**(Part B)**  
Planning considerations and assumptions

- a Principles and ethical considerations
- b Legal and policy considerations
- c Methods for plan development
- d Approach for planning
- e Pandemic preparedness and response periods and operational stages
- f Planning assumptions
- g Funding for multisector preparedness and response
- h Other considerations

**(Part C)**  
Country systems and capacities

- a Emergency coordination
- b Collaborative surveillance
- c Community protection
- d Clinical care systems
- e Access to countermeasures

**(Part D)**  
Plan activation / triggers for shifting between operational stages

- a Activation of plan
- b Triggers for shifting between operational stages
- c Procedures for assessing and adjusting response measures at the country and sub-national levels

**(Part E)**  
Actions during operational stages

- a Actions for each operational stage

**(Part F)**  
Annexes

# As a field epidemiologist planning for future pandemics, consider diversity, equity and inclusion...

- **Analyze your data and stratify** by age, sex, income, race, rurality and other socio-economic factors to detect inequalities & inequities
- **Consider the interventions** that you have now and may have at the time of the emergency: how can everyone who needs those interventions get them in a timely way
- **Consult with stakeholders** on how to best deliver interventions and what preparedness actions need to be taken now to be “PRET”
- **Document in pandemic plans**, monitor implementation of those preparedness actions, periodically test and review your plan

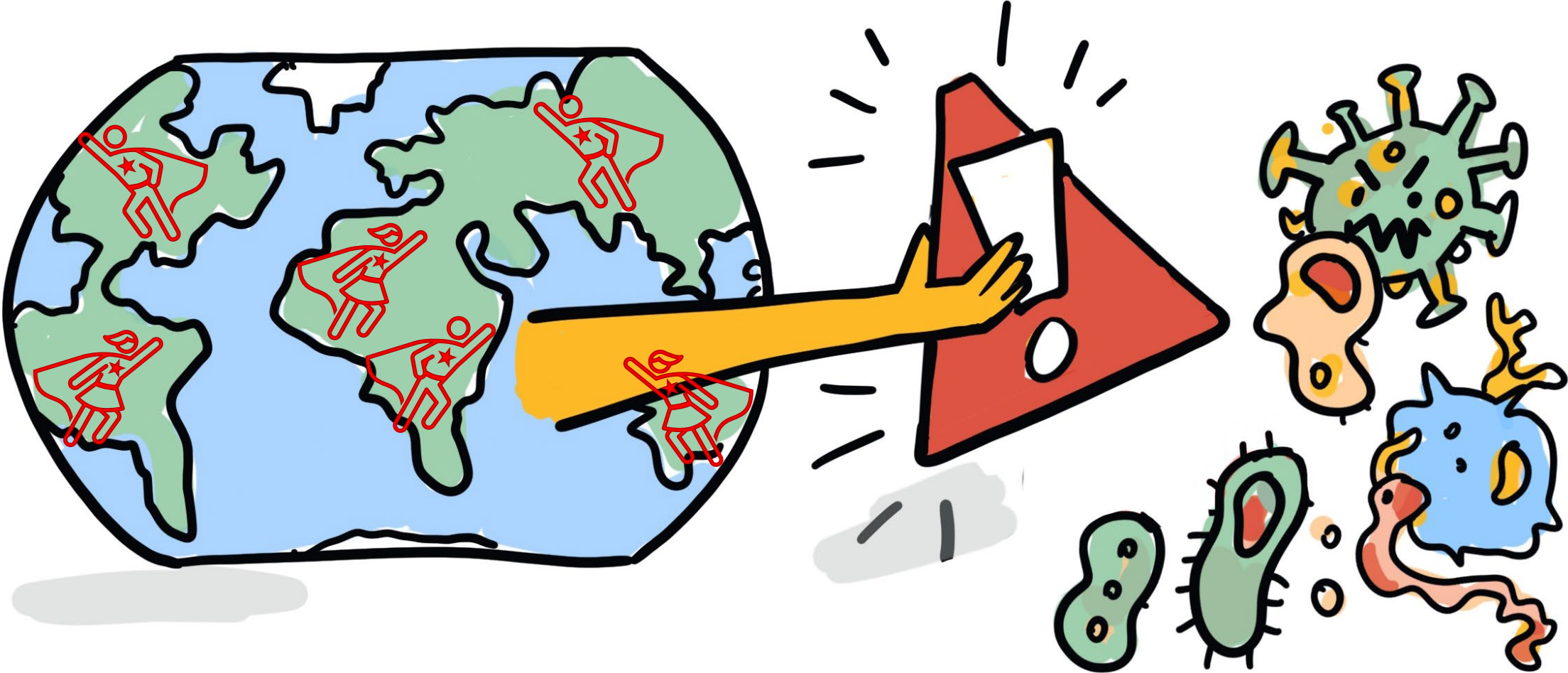


## Equity in pandemics...

**Timely access to interventions based on public health need**

**so that everyone can reach their full potential for health and well-being.**

**Pandemic planning: critical in a field epidemiologist's toolkit**



**And we can address equity, diversity and inclusion systematically in our work**



# Thank you!

## Acknowledging:

- Special thanks to Rajunitrigo and Charlee Law for sharing experiences and examples that spoke to how equity can be addressed in pandemic preparedness and response
  - Countries: Ministries of Health and other sectors and levels engaged in pandemic preparedness
  - Partners: involved in pandemic preparedness
  - WHO: PRET three-level steering committee & technical units providing inputs
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