International Health Regulations

Report of the First Regional Consultation of National IHR Focal Points on the Revision of International Health Regulations
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<tr>
<td>APW - Agreement for Performance of Work</td>
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<td>CD - Compact discs</td>
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<td>CSR - Communicable Diseases Surveillance and Response</td>
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<td>DG - Director-General (WHO)</td>
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<td>EB - Executive Board (WHO)</td>
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<td>EC - Expert Committee</td>
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<td>EPR - Epidemic Preparedness and Response</td>
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<td>FAO - Food and Agriculture Organization</td>
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<td>FAQ - Frequently Asked Questions</td>
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<td>FCTC - Framework Convention on Tobacco Control</td>
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<td>FETP - Field Epidemiology Training Programme</td>
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<td>HIV - Human immuno-deficiency virus</td>
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<td>IATA - International Air Transport Association</td>
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<td>IGWG - Inter Governmental Working Group</td>
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<td>IHR - International Health Regulations</td>
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<td>ILO - International Labour Organization</td>
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<td>IMO - International Maritime Organization</td>
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<td>ISR - International Sanitary Regulations</td>
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<td>MOH - Ministry of Health</td>
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<td>MS - Member States</td>
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<td>NFCP - National Focal Contact Person/s</td>
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<td>NFP - National Focal Point</td>
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<td>NGO - Nongovernmental Organization</td>
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<td>NICD - National Institute for Communicable Diseases</td>
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<td>NW - National (IHR) Workshop</td>
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<td>OIE - World Organization for Animal Health</td>
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<td>PHEIC - Public Health Emergency of International Concern</td>
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<td>RCM - Regional (IHR) Consultation Meeting</td>
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<td>RD - Regional Director</td>
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<td>SARS - Severe Acute Respiratory Syndrome</td>
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<td>SEARO - South East Asia Regional Office (WHO)</td>
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<td>WER - Weekly Epidemiological Record</td>
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<td>WHA - World Health Assembly</td>
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<td>WPRO - Western Pacific Regional Office (WHO)</td>
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<td>WR - WHO Representative</td>
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<td>WTO - World Trade Organization</td>
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1. **INTRODUCTION:** New and emerging challenges requiring new approaches and strategies

The International Sanitary Regulations (ISR), providing a framework on quarantine measures, were adopted in 1951\(^1\). These were revised and became the International Health Regulations (IHR) in 1969 with six diseases being included for notification. In 1981, IHR was further revised to include notification only for plague, yellow fever and cholera. Thus the existing IHR is limited to notification of the above three diseases, and lack mechanisms for collaboration and the capacity to take risk-specific measures directed at control of outbreaks of diseases.

While there is a need to draw on and maintain those provisions and concepts in the existing IHR that are of continued relevance, it is time to introduce new provisions and adapt existing regulations to the ever-changing health challenges faced by today’s international community. Considering these needs and emerging global threats, the Forty-eighth World Health Assembly called for a revision of the existing IHR\(^2\). Based on this, and pursuant to resolution WHA56.28 to complete technical work required to facilitate reaching agreement and to keep Member States informed about the revision of the IHR, a final draft has been officially communicated to all Member countries.

To facilitate endorsement of the revised IHR by the Intergovernmental Working Group to be held in November 2004, it is of utmost importance that the IHR be given high priority on the agenda of the Regional Offices.\(^3\) Therefore, a two-day regional consultation on the revision process of the IHR was organized by the Regional Office for South-East Asia with technical support from the IHR review team in WHO/HQ and WPRO.

2. **KEYNOTE ADDRESS:** Participation of all stakeholders, particularly at national level is essential

The meeting was inaugurated by Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region (SEARO). In his address, the Regional Director emphasized the increasing threats from emerging and re-emerging

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\(^2\) WHA48.7, 1995
\(^3\) DG memo: Ref CSR E14-439-4; 4 February 2004
diseases and the need for revision of the International Health Regulations to address these challenges. He stated that since the IHRs was adopted in 1969, “there has been a lot of changes worldwide; including epidemiological changes, changes in disease patterns and genetic changes in the pathogens. Coupled with rapid advancement in information, communication and transportation technology; the current International Health Regulations have become out of date and need urgent attention in their review and revision. This is clearly demonstrated by the recent outbreaks of diseases like SARS and avian influenza”.

Dr. Samlee Plianbangchang highlighted that developing the revised IHR was an enormous task, and emphasized that even more challenging would be its implementation. He called upon the participants to “carefully review the revised IHR and critically review and document the whole consultation process, particularly at the national level”. (for full text of the address, see Annex 3).

The List of Participants and the Programme are at Annexes 2 and 3 respectively.

3. OBJECTIVES AND EXPECTED OUTPUTS

3.1 Objectives of the Consultation

The objectives of the consultation was to thoroughly brief the country focal points on all matters related to the review of the revised draft IHR, particularly

(i) Critically review key issues for further discussions at the national level, and

(ii) Prepare a draft country action plan for arriving at a national-level consensus on the revised IHR.

3.2 Expected outputs

- Identification of potential constraints in obtaining national consensus in adopting and implementing the revised IHR as well as possible solutions
- Identification of specific issues from the country perspective and support required to address these issues
- An outline plan for the national IHR review meeting of Member countries.
4. **REVISION PROCESS OF IHR AND IMPLICATIONS:**

   **Key changes for real time needs**

4.1 **Need for IHR**

   Serious and unusual disease events are inevitable. With Globalization, the problem in one location has increasingly become a challenge beyond geographic borders. An agreed code of conduct protects against the spread of serious risks to public health and the unnecessary or excessive use of restrictions in traffic or trade for public health purposes.

4.2 **The Expectation**

   The revised IHR maintains the best of the current IHR to make it more relevant to emergencies faced today. It envisages a more flexible approach to deal with different types of Public Health Emergencies of International Concern (PHEIC) and the need for varied levels of response and aims to achieve a balance between urgency of action and transparency of the process of notification. It is a “package” of rules, guides, resources, programmes and activities that work together. While it may not meet the expectations of everyone, it is a much better compromise than the status quo.

4.3 **Legal Basis of IHR**

   The revision of IHR and its adoption by Member countries is based on legal provisions as stipulated in two important Articles. Article 21 of the WHO Constitution states that “The Health Assembly shall have the authority to adopt regulations concerning sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease”. Article 22 provides: “Regulations adopted pursuant to Article 21 shall come into force for all Members after due notice has been given of their adoption by the Health Assembly except for such Members as may notify the Director-General of rejection or reservations within the period stated in the notice”.

4.4 **Revision Process**

   The IHR revision Secretariat at WHO/HQ coordinates the process, including drafting and dissemination, incorporation of comments into the document and support to regional and national consultations. The process of revision
provides the framework for the established and successful WHO system of Global Outbreak Alert and Response Network (GOARN) needed for daily review of outbreaks, verification, risk assessment and appropriate response. The outbreak field operations presently include 26 countries with over 40 GOARN partners and 350 experts, and have carried out more than 30 outbreak investigations and responses.

The major milestones in the revision process include:

- Draft revision proposals were sent to Member countries in January 2004
- The revised draft of IHR was given the green light by EB 113 in January 2004
- Regional consultation meetings would be held from April to June 2004
- The amended draft revision proposals would be ready in October 2004 and submitted to the Intergovernmental Working Group in November 2004
- Final regulatory draft in December 2004

4.5 Five Key changes in new IHR

The notification to WHO of a case of cholera, plague or yellow fever and provision of information when the area is free from infection had a very narrow focus as these are not the only important diseases. The maximum measures applicable to international traffic which a state may require for the protection of its territory against cholera, plague and yellow fever are very limited, rigid and punitive. The SARS experience has shown that rapid transportation leads to rapid spread of disease and therefore adequate control measures need to be in place. Hence in revising the provisions of IHR there was a need to overcome the above limitations.

The primary aim of the revision of IHR is, therefore, to address the current challenges faced by the global community in timely recognizing public health risks and diseases with a potential for international emergency. To address these issues in an effective manner, some key changes were required to the existing IHR. The proposed key changes are expected to improve the capacity for detection, notification, verification and containment of these
public health emergencies. IHR will integrate with WHO’s ongoing activities in epidemic preparedness and response and GOARN.

(1) Notification

The revised IHR, unlike the existing IHR which requests notification of only three diseases, has a wider scope. Hence the term ‘Public health emergency of international concern’ (PHEIC) was coined. It requires notification of all public health emergencies of international concern, including such diseases, events and risks based on a decision matrix developed to assess and notify such events (Annex 2 of the revised IHR). However, there were discussions regarding the need to define the scope further for better compliance. Some suggested that a list of priority conditions be drawn and communicated to Member countries.

Notification in the revised IHR is linked to an established mechanism for response actions and verification of suspected public health emergencies, both official notifications and rumours from unofficial information sources.

(2) National Focal points

Designation of a national IHR focal point is a new core-component in the revised IHR. The role of the national focal points includes direct operational link of states with WHO for notification and information purposes, to provide official inputs to the revision process, and in implementing the revised regulations. This is an important step as there is a need to link or encompass both technical and political decisions about identifying public health emergencies of international concern (PHEIC), and notification of such events in a transparent and timely manner.

(3) Definition of core capacities

The third important area of change is defining core capacities required at the various levels for surveillance, early recognition, notification and response to PHEIC. The revised IHR clearly outlines the various capacities required at points of entry and exit, at central, intermediate and community levels (Annex 1 of revised IHR document). The meeting suggested that these overall requirements be further supported by more detailed guidelines which clearly provide Member countries with a target to achieve in building these core capacities.
(4) Recommended measures

The document provides temporary and standing (continuous) recommended measures to be applied by Member countries during public health emergencies of international concern. The recommendations will be based on the assessed risk and severity and recommended measures commensurate with the risk. WHO may make such temporary or standing recommended measures (Annex 3 and 10 of the revised IHR). Routine sanitary measures at ports of arrival and departure and during journeys would continue to be necessary and should be modernised.

(5) External advice regarding IHR

The revised IHR has provisions for Member States to seek external assistance as required and for WHO to offer this support. An advisory panel of experts, an IHR emergency committee (for emergency recommendations), and an IHR review committee to settle disputes that may arise among countries will be established by the Director-General, WHO. These committees will offer standing recommendations and advice on IHR functioning and recommend the necessary changes to annexes (Articles 10-12 and Annex 10 of the revised IHR).

4.6 Some key issues and controversies that may arise

(1) Scope

One important issue that may arise in IHR is whether notification should be based on a specific list of diseases or be for all PHEIC. Using disease lists makes it simple and clear, and it is congruent with most national legislation and pre-set measures. However, this list may become rapidly obsolete and cannot predetermine what will be important as it takes no account of the context and risk. Additionally, this may lead to stigmatisation where States may not be transparent and hence obscure true emergencies.

Notification of all PHEIC is dependent on Member countries definition and hence may lead to a long process. But this system has an overriding advantage to address emerging and remerging infectious diseases and risks from chemical and radio nuclear materials of concern. Hence, the revised IHR will be based on notification of all PHEIC.

(2) Specificity vs. flexibility
While specificity provides an opportunity to offer fixed measures for fixed
diseases and defines clear mandate and applicability, it is also unable to cope
with the unexpected or changing world. On the other hand, if the system is
too flexible, it contributes to uncertainty as to the interpretation of what
constitutes a public health emergency, thereby delaying notification and
interventions. The primary aim of the revised IHR is to achieve a balance
between the two and ensure that there is an acceptable and practical
notification system in Member countries.

(3) National sovereignty vs. international responsibility
The issue of defining a PHEIC, its notification, and request for external
assistance may be an issue for some Member countries. But, it is an accepted
practice that all international agreements entail some compromise of national
authority to achieve a benefit for all. To promote national and global health
security, the revised IHR seeks to achieve a balance between sovereignty and
responsibility.

(4) Incentives and compliance
The revised IHRs define the roles and responsibilities of both Member
countries and WHO. It emphasizes that notification not only gives credibility
but also an opportunity to seek external assistance for PHEIC.

(5) Rapid response vs. transparent/inclusive procedures
In the existing system, defining and responding to PHEIC, consensus and wide
consultation are not possible. Nor is a unilateral action by WHO acceptable to
a Member country. The revised IHR outlines the criteria to define the
mechanism to notify PHEIC and seek external assistance. It also has provisions
for establishing mechanisms including emergency committee, the review
committee and WHO’s governing bodies (Annex 10 of the revised IHR).

(6) Consistency with other international obligations/treaties
The IHR revision team has consulted other related international treaties to
ensure consistency. The draft was shared with stakeholders like WTO and
ILO.

(7) Developed vs. developing nation perspectives
One issue that may arise is its application and benefits for developed and developing nations. The legal document provides protection for all and offers support for those who need it.

(8) Feasibility of implementation (resources)

Development of core capacities in surveillance, notification and response at different levels is required to implement the IHR. Of particular mention is the need to develop these at the points of entry/exit. The IHR may provide opportunities to mobilize resources to develop these core competencies.

4.7. Added Values of the revised IHR

Unlike the existing IHR, the revised version offers added values to Member countries, including support to strengthen surveillance systems and protection from punitive measures.

(1) Supporting existing national systems

The best way to prevent international spread of diseases is to detect public health threats early and implement effective response actions when the problem is small. IHR reemphasizes the need for developing capacity for response (investigation, control measures) at all levels (local, regional, national, and international). It also underscores strengthening integrated disease surveillance and response systems and public health laboratories in countries. WHO will provide technical assistance to attain these by the Member countries.

(2) IHR offers protection

There is a misconception that IHR offers protection only to the developed countries against diseases of the developing countries, whereas IHR actually offers protection to the developing countries. IHR would also avoid excessive or unnecessary restrictions on countries through recommended measures from an authoritative neutral body.

(3) Incentives linked to compliance

The regulations belong to the Member countries through an inclusive and collaborative process. In addition to the above benefits, the incentives to the Member countries are that IHR:
➢ provides a roadmap to obtaining appropriate technical assistance to
protect from and effectively manage emergencies
➢ clear target and support for strengthening capacities
➢ access to verified information about internationally significant events
➢ international community - increased credibility, avoids stigmatization
➢ peer pressure - need for credibility
➢ rumours more damaging than facts
➢ regular reporting to WHA on the functioning of regulations.

(4) Other benefits of the revised IHR

IHR benefits countries in that:
➢ notification is related to the significance of the event and need for
  urgent action
➢ it is a collaborative process between States and WHO (not just being
  published in WER)
➢ it is directly linked to support actions from the international
  community
➢ there are time-limited recommended measures, appropriate to
  assessed risk
➢ there is explicit consensus on surveillance and response capacity.
➢ routine measures and certification are brought up to date.

5. LESSONS FROM EMERGING AND RE-EMERGING
   DISEASES AND IMPLICATIONS FOR IHR

5.1 Severe Acute Respiratory Syndrome (SARS)

(1) Sequence of events during SARS outbreak

On 27 November 2002, an outbreak of respiratory illness was identified in
Guandong province, China. On 11 February 2003, health workers reported
cases with atypical pneumonia with rapid progression to respiratory failure
and high mortality. On 14 February 2003, the WHO team in Beijing reported
305 cases and 5 deaths. On 26 February 2003, a businessman who had
travelled to China and Hong Kong was detected to have the same disease in
Hanoi, Vietnam. And, on 4 and 5 March 2003, 77 hospital staff in Hong Kong
and 7 in Hanoi reported with the syndrome. WHO teams were sent to these
two places to assist in the investigation of the outbreak.

The first Global Alert was issued on 12 March 2003 on atypical
pneumonia with rapid progression to respiratory failure. Cases were then
reported in Canada and Singapore and hence a second, more precise and
urgent global alert to international travellers was issued. The alert identified
the outbreak as SARS (Severe Acute Respiratory Syndrome) and also provided
the case definition.

By 17 March 2002 virtual research Networks were established to share
public health information. These included laboratory, epidemiology and
clinical networks in 9 countries.

By 26 March 2002, a third global alert providing guidance to airlines and
affected areas was released to screen passengers from affected areas to
decrease risk of international spread of SARS.

Environmental transmission was suspected on 31 March 2002 with
evidence of clustering of cases. Advice to international travellers to postpone
unnecessary travel to Hong Kong and Guangdong Province was therefore
issued on 2 April, 2003. Regional SARS team and WHO multi-disciplinary
consultants for affected countries were deployed.

(2) Measures to prevent international spread of
disease: the example of SARS

Following the global alert, a number of local and international measures
aimed at preventing further spread and reducing mortality from SARS were
instituted. Case definitions, case management, contact tracing, and infection
control guidelines were developed. Field teams and diagnostics support were
also promptly mobilized. Regular alerts and awareness messages were
dispatched through various channels. Prevention measures including exit
screening, in-flight management, and postponement of travel were established
at major ports of entry.

As a result of the concerted global effort, the fast spread of SARS was
effectively slowed. This is evident due to the fact that to date, 27 persons on
only 4 of 32 international flights carrying symptomatic persons with SARS
appear to have been infected.

The key elements for the successful control of SARS outbreak are
leadership and commitment, hard work of response teams, unprecedented
worldwide collaboration among governments and the scientific community, and the willingness of governments to take risks and put health before economy.

(3) Lessons from SARS outbreak to the revision of IHRs

SARS has once again signalled the need for collaboration and swift action in ensuring global health security. It showed that many Member countries did not have adequate surveillance mechanisms in place, and there were delays in sharing surveillance data from affected countries. Follow-up of cases across borders were often hampered by incomplete information. Control measures were not standardized. This emphasized the need to define travel advisories, screening procedures at entry and exit points and health declaration cards.

Building on these experiences and lessons, it was imperative to make changes in the draft IHR. Accordingly, IHR now covers all PHEIC. International control measures, including travel recommendations, are tailored to assessed risk, and verification includes rumours, both formal and informal sources. Moreover, pro-active management by WHO with 24-hour country focal point and global alert was emphasized. The decision by the WHO Director-General for on-site collaborative evaluation of control measures (should such evaluation be considered necessary) to ensure containment of international spread was also included in the revised IHR.

5.2. Avian Influenza A (H5N1)

(1) Sequence and summary of Avian Influenza A (H5N1) outbreak

The outbreak started in early November 2003 with Thailand reporting “chicken cholera”. In December DPR Korea reported avian influenza in chickens; this was followed by Vietnam in January 2004. On 12 January Vietnam confirmed 3 human deaths due to avian influenza. From 23 January, human influenza cases were also reported from Thailand. Up to 27 February, 33 human cases and 22 deaths have been reported in Thailand and Vietnam. Also, large numbers of chicken have been culled in these affected countries resulting in significantly high economic loss.

The increasing number of countries/areas with avian influenza and human avian influenza cases and the risk of genetic re-assortment with a
potential for the emergence of a pandemic strain is an important source of concern. The majority of the human population would lack immunity to the emerging strain.

(2) Measures to prevent international spread of disease

WHO promptly responded with measures to reduce the risk of human infection and to avoid the emergence of a new virus. These measures include the elimination of animal reservoir (in collaboration with FAO, OIE), and protection of at-risk individuals (e.g. cullers) through personal protective barriers (PPE). Moreover, surveillance among animals and human population was scaled up through collaboration with stakeholders and provision of diagnostic kits. Global reporting of suspected cases was enhanced through networks. As part of this effort, WHO support for epidemic preparedness was also boosted through development of technical guidelines, situation updates (daily update, confirmed human cases), technical advice (FAQ, fact sheets, recommendations to travellers), and laboratory specimen collection, transport and testing networks. At the same time, WHO provided on-site expertise for field investigations and coordination.

As part of the global effort to contain this outbreak, a framework for resource mobilization, including funding and supplies and equipment was devised. A pandemic preparedness plan was drafted for discussion, including training and strengthening influenza laboratory network (FluNet).

(3) Lessons from avian influenza outbreak

In a world of rapid transport and interconnectivity, an infectious disease in one country is a threat to all: infectious diseases do not respect national borders. The collaborating laboratories and public health experts, as experienced during this outbreak, can rapidly find answers that help prevent and control new and emerging infections. Similarly, transparency has an impact on international spread of outbreaks. In addition to human suffering and death, emerging infectious diseases with international spread have a negative impact on travel, tourism and trade. Thus, it is imperative that there be collaboration among Member countries in the implementation of IHR.

6. INTRODUCTION TO THE REVISED IHR

6.1 IHR Documentation Hierarchy
The document is organized to provide core text (composed of 55 articles) with ten supplemental annexes outlining technical details that are subject to change and amendment, and reference guidelines on implementation and standards which are not strictly “regulatory”.

6.2 Introduction to the contents

At these sessions, participants were briefly introduced to the contents of the revised IHR. As the session was only to provide an overview, it was highly recommended that each participant read through the document with its referenced materials for further clarifications.

(1) Definitions, Purpose and Communications

In this session, brief introduction to definitions used, the purpose of the revised IHR and required communications were made. Article 1 describes the terms and definitions used in the revised IHR. Article 2 defines the purpose of the IHR as a legal framework for providing security against international spread of disease while avoiding unnecessary interference with international traffic whereas Article 3 emphasizes on information sharing (communications), the mechanism and roles regarding PHEIC between WHO and Member countries.

(2) Surveillance, Notification, Information, Verification and Response

The main focus in this section is on setting up a framework for surveillance, notification and response to “public health emergencies of international concern”, including events and risks.

Accordingly, Article 4 details the core capacities, mechanisms, roles and responsibilities required to strengthen national surveillance systems. It also outlines the IHR principles for notification to detect early public health threats requiring effective national disease surveillance and international coordination and to respond to them.

In Article 5, the means to notify an event before public notification of the occurrence of PHEIC is described. Article 6 gives a description of Consultation during events not requiring notification and where a health administration may keep WHO advised through NFP as well as consult on appropriate measures. Article 7 provides an overview regarding sharing of Information with WHO on health risk in another state that may cause
international disease spread. In Article 8, the process of verification of rumours and information regarding public health risks and any PHEIC are detailed including the roles of health administration of Member countries. Article 9 and Annex 3 contain the procedures for temporary recommendations, and when to declare that PHEIC has ended.

Article 10 details ‘Response’ including assistance to affected state(s). It describes the need to develop and maintain capacity to promptly and effectively respond to PHEIC. This section also describes how Member countries can seek such support from WHO and, in the absence of a request, WHO still may offer assistance to the health administration to respond to PHEIC.

(3) Recommendations

The main theme of this section is on the required recommendations and procedures to undertake these in an event of PHEIC. Accordingly, Article 11 describes Temporary Recommendations that WHO shall make (as per Annex 3) to apply to a country facing PHEIC, other affected states, conveyances, containers, cargo, goods, baggage, and persons (ad hoc, time-limited, risk-specific) whereas Article 12 provides information on Standing Recommendations as per Annex 10 in such emergencies.

Following the presentation and review of this section, a number of recommendations in clarifying some of the terms used in the context of the legal framework were discussed (Refer to Section 7 plenary and Group Discussions and Recommendations)

(4) Points of Entry

This section defines the ports of entry, the required capacity at these points, and the role of health authorities in enforcing public health measures to prevent the spread of PHEIC.

Article 13 on Health Administration underscores the obligations of such authorities to ensure that core capacity exists and required designation to provide timely information during PHEIC is made. Article 14 describes airports and ports and their roles in ensuring that appropriate public health measures are instituted and certified accordingly. It states that WHO shall, at the request of the health administration concerned, provide certificates upon fulfilment of the requirements set in this article referred in Annexes 1 and 3 of
(5) Public health measures

This part provides the various provisions that the health authority may require to institute at different settings with regard to travellers, conveyances, goods and containers and the loading area. The main emphasis of Article 17 is on the General Provisions for public health purposes required with regard to travellers and inspection of conveniences and foods, etc. Article 18 describes measures that the health authorities shall take, while Article 19 has provisions to ensure unrestricted movement of Ships in transit (unless recommended by WHO or authorized pursuant).

Article 20 on Affected conveyances outlines the public health measures and provisions that need to be applied to prevent occurrence and stop spread of PHIEC. Accordingly, a conveyance that has been considered as affected shall cease to be regarded as such when WHO recommended measures have been effectively carried out, or the health authority is satisfied that there are no conditions on board that constitute a public health risk. Article 21 describes that conveyances at points of entry, unless otherwise recommended by WHO or authorized pursuant, shall have unrestricted movement, including embarking or disembarking, discharging or loading of cargo. But, if there is a suspected risk of a PHEIC, measures as recommended in Article 22 may be applied. This Article describes measures regarding Surveillance of travellers, which is further elaborated in Articles 23-25 which provide guidance on medical examination, vaccinations, and other prophylaxis and special provisions recommended for Goods in transit, containers and loading areas. Further details on the various guidelines are referred to in Annexes 4-7 of the same document.

(6) Health documents

In this section provisions on health documents including certificates of vaccination or prophylaxis, declaration of health etc. are described with reference to travellers on sea, land and air. Related models and guidelines are given in Annexes 6-9. While Article 26 provides the general provisions on the application of health documents, Article 27 defines the types of health documents applicable. Accordingly, unless recommended by WHO, a
traveller in possession of valid certificates, as specified in Annex 6 and when required as described in Annex 7, shall not be denied entry as a consequence of the disease to which the certificate refers.

Similarly, Article 28 describes the procedures and provisions in Maritime Declaration of Health. Article 29 refers to the Health part of the Aircraft General Declaration including supplying information to health authorities on health measures applied to both. Article 30 describes that Bills of health shall not be required from any conveyances.

(7) Charges
In this section, as stated in Articles 31 and 32, medical examination, vaccination, or other prophylaxis, undertaken when recommended for travellers seeking temporary or permanent residence, shall be free of charge.

(8) General Provisions
The Articles in this section, Articles 33-43, describe the general provisions in the implementation of IHR, including on excessive measures taken by states, rights of persons, diplomats and special population groups, and transport of biological specimens and infection control. In this regard, Article 39 states: “health authorities shall expedite transport of specimens, reagents, and other diagnostic tools for verification and response to a PHEIC”. It also describes the relation of IHR to special arrangements between States and on ensuring that military conveyances, goods and personnel travelling across international borders meet the requirements of IHR and WHO recommended measures.

Article 41 explains that in case of suspected intentional release of a biological, chemical or radionuclear agent, States shall immediately provide to WHO relevant public health information, materials and samples for verification.

(9) Final provisions
This part describes the role of the Director-General and the World Health Assembly on functioning of the IHR, establishment and tasks of the Review Committee, and procedures on Amendments and additional annexes to the IHR (detailed in Articles 42-46). Article 47 provides guides on Settlement of disputes concerning interpretation or application of IHR. Article 48 explains how the revised IHR relates to existing conventions, regulations and similar agreements, including multilateral and regional agreements. It states that
subject to Article 50, on Reservation of a Member State on a section of the Regulations, the revised IHR shall replace all earlier agreements cited in the same document (refer to Article). Article 51 states that a rejection of the whole or part of any reservation by a Member State may be withdrawn any time by notifying the Director-General.

As stated in Article 52, the regulations shall enter into force on the first day of January 2006. Article 53 describes the relation of States not Member of WHO in the implementation of IHR. The Director-General, as stated in Article 54, shall notify all States, Members and Associate Members to WHO, and all other parties to any conventions, regulations and similar agreements listed in Article 48 of the adoption by the World Health Assembly of these Regulations. As stated in Article 55, the original texts of the IHR in Arabic, Chinese, English, French, Russian, and Spanish are equally authoritative.

(10) Annexes

Annexes 1-10 attached to the main document, were referenced in relation to the main text as cited in each Article. The participants recommended further discussions and clarifications in the working groups. Accordingly, the groups discussed the Annexes and provided valuable comments for consideration by the IHR Review Team.

7. PLENARY AND GROUP DISCUSSIONS

7.1 Plenary Sessions

(1) Main issues and answers discussed in the plenary

(Q) How many countries had sent in their comments on the revised IHR since the draft was circulated in January 2004?

(A) So far three countries (China, New Zealand and USA) have sent formal comments on the revised IHR to WHO. Four regional/sub-regional consultation meetings also have been held and comments were received. The European commission has also given its comments.

(Q) For the FCTC process a lot of effort had been put into advocacy and it had to be passed in the WHA with the MS voting for it. How would the IHR be binding on the Member States?
The current IHR has been signed by most states. So here we are only dealing with a revision process. Member States would be free to either reject or endorse the revised IHR. If they reject the revised IHR, they would still be bound to the current IHR. They could also accept the revised IHR with reservations on particular articles. Australia, for example, is not a signatory to the current IHR. Also, India had accepted the current IHR but with reservations regarding yellow fever as they were of the opinion that the measures in it did not adequately protect their country against importation of the disease.

Media response during emergencies needs particular skills. Whether training courses for the media are envisaged in the IHR process?

WHO has been involved in training for emergencies in different countries but mainly for health personnel (e.g. NICD conducting EPR courses in India). Efforts should be towards better “risk communication” so that the health authorities are trained to release information through the media to the public in such a manner as to avoid creating panic/alarm. Operational packages could be developed towards that end.

What happens when a Member State is not convinced that an outbreak/event in their country is a public health emergency? Even after the Expert Committee (EC) reports it as a PHEIC the MS could still not accept it as a PHEIC.

If a Member State does not agree to report an outbreak, the Expert Committee (EC), which is external to WHO would give its opinion. The Director-General of WHO would then declare the emergency based on the recommendations of EC. This is a responsibility of all Member States (and not only the affected state). It is expected that this would be a rare occurrence. The draft is very clear under which circumstances information (under Article 5) would be shared with other MS. If a Member State has an outbreak, it would be difficult to suppress this information as in today’s world this information is available through reports by neighbouring countries, the media and on the web sites (public domain). If a MS is not responding to the verification process, then this unofficial information would be put out by WHO (which may be inaccurate, based on rumours and more damaging).

What would be the penalty to a MS for non-compliance?

The revised IHR has no penalty for non-compliance. WHO is in favour of a positive relationship with MS. Those that are in a better position to exert influence are neighbouring countries and trade partners. Hence this is a stronger incentive for compliance.
What are the trends in OIE, FAO and other International organizations in the related areas of IHR?

WHO is learning to work better with OIE, FAO and other international organizations after SARS and avian flu. This is particularly so in the area of importation of livestock and foodstuffs. The organizations are also in the process of redesigning their systems of notification for reporting diseases in animals and are compatible with our present notification system. OIE has come out with a long list of diseases in animals which they are closely monitoring.

How does the IHR regulate check points/porous borders between countries where no legal permits are required?

Land borders are best monitored through bilateral relationship with MS. Health services on both sides of the border would be more effective in disease control rather than through WHO.

Infected (affected) areas should be declared at national, state and district levels as this has been an effective method of control in the past. These measures were usually applied automatically and countries were not declared free later. WHO is not in favour as this leads to unnecessary stigmatization.

The imposition of some measures would be subjective and could be different in different circumstances. It was agreed that since the decisions would be made by human beings, it was bound to be subjective but under the proposed IHR these decisions would be based on the criteria and indicators given in Annex 2.

A new feature in the IHR is that WHO would be supporting MS in outbreak investigations through multi-disciplinary teams and also through transportation of laboratory samples to reference laboratories. Countries may not be willing for such support.

Countries may not wish WHO to assist them. WHO would not send teams into countries without the clearance of Member States.

Some positive recommendations by WHO should also be given when unfair or unjustified measures are applied to a country by some countries.

Positive recommendations (like no travel and trade restrictions recommended) will be made for countries experiencing unfair trade and travel restrictions.
which are not appropriate to an outbreak in the MS. WHO will be willing to give them (Annex 2).

(Q) Annexes in the IHR should be reviewed along with the general recommendations and not separately.

(A) This is imperative as the core document is more of a legal document whereas the annexes explain in detail the various provisions under IHR.

(Q) Many issues were raised regarding the national focal point (NFP). Some felt that if the focal point was not a high level official like a health minister or Director-General of Health Services, he would not be sufficiently empowered to deal directly with WHO. Other issues like logistic support for focal point, equipping properly for surveillance and resource mobilization were also raised.

(A) The NFP issue has baffled a number of MS. The focal point is required to facilitate rapid communication with WHO. A high official would be difficult to contact or would not be easily accessible. An operational mechanism could be developed by MS for easy functioning of the focal point (including political clearance). MS should therefore nominate the right focal point. Regarding support to the focal point, strengthening laboratory services and logistics, these would be tackled through the development of core capacity of countries which is also in the interest of MS. IHR and WHO would be behind this support. MS could also assist neighboring states to develop core capacities.

- IHR puts roles and responsibilities at different levels. Requires some level of commitment from both MS and WHO. This partnership is necessary for sustainability.
- Concern was expressed regarding free compulsory vaccination (for e.g. yellow fever, cholera and meningitis) as this would be a burden to some countries.

(Q) Saudi Arabia during Haj had suddenly insisted on Haj travellers getting tetravalent vaccines (which were not easily available and very expensive). Timely information of vaccine requirements by some countries should be provided.

(A) In fact, WHO would not recommend a vaccine if it is not available. Any changes in vaccine requirements are usually published in WER based on recommendations of countries. Routine requirements of vaccination by countries are published annually in the International Travellers Health.

(Q) What is the mechanism to assess if excess or inadequate measures were to be applied to a country and when to declare it is over and measures should stop?
(A) If WHO comes to know about excessive measures being applied, it would question the MS concerned as to why these measures are being implemented. WHO would then get back to the complaining country.

(Q) What are the standards or guidelines on which the expert committee would make their recommendations?

(A) It would be up to the Expert Committee to go through all the available epidemiological, operational and other information prior to making appropriate recommendations.

(Q) Define the meaning of additional health measures and whether this is in line with IHR. (e.g. migrants with HIV not allowed into some countries)

(A) It is reasonable to carry out health checks of migrants since it has long-term implications for future health care and responsibility. Also, in the case of mass exodus, refugees, and other incidents the risk of outbreaks justify additional health measures.

Article 39 - transportation of infectious material (lab samples) and Article 36 - rights of persons are important articles. These could be discussed in the deliberations at country-level meetings.

(Q) Nuclear, biological and chemical issues which potentially fit the criteria of PHEIC should also be covered by IHR

(A) These are covered under intentional PHEIC and WHO would investigate/verify and support MS to carry out appropriate response at the country level.

(Q) How will IHR apply to territories/communities who are not MS of WHO?

(A) The WHO Legal Counsel will take these situations on merit and will deal with them accordingly.

(Q) What do you think about running dummy outbreak exercises?

(A) Training for emergencies: A number of training is carried out at present, for example through FETP. May be risk communication is an area we need to provide training on.

(Q) Can MS totally reject or take exception to certain parts of regulations?

(A) Yes. Australia is not a signatory to the current regulations. MS can also take reservation to certain articles - like India on current IHR. If a large number of MS reject IHR, it loses its value.

(Q) What if a state and WHO disagree on PHEIC?
(A) The expert committee - experts of international standing, and the Director-General will determine what action to be taken in the collective interest of all MS.

(Q) A definition for infected area is not included in the draft? Why we remove infected area from IHR?
(A) Infected area leads to unnecessary stigmatization and once declared, the area is forever considered infected area.

(Q) SARS was declared late by China. What was the action taken by WHO for late reporting?
(A) The damage caused by late reporting was evident in China during SARS. No specific penalty was imposed by WHO.

(Q) During bird flu, the animal health part was found to be weak, and food safety demands a more pro-active surveillance and intervention programme. How IHR see this area in relation to outbreak management?
(A) OIE and FAO were learning to work with other agencies. EU for example stopped embargo on receiving WHO reassurance.

(2) Related issues and recommendations

- Excessive measures: Member States would like to know what measures will be considered as "excessive measures"
- Member States would also like to be aware of "standards" and "principles" to be applied when measures are recommended.
- The scaling-up of functions of health authorities at points of affected area/outbreak need to be stated/elaborated in the draft.
- PHEIC needs to be covered under definitions.
- Selection of expert committee -see annex 10 - needs elaboration.
- Points of exit are equally important as points of entry. During SARS outbreak, measures at exit points were as predominant as at entry points. So both exit and entry points must be defined and inserted in the text appropriately.
- To ensure quality of vaccination provided to the public as well as to reassure the international community regarding vaccination given to travellers during outbreaks, vaccination must be carried out by a state designated and recognized body.
- The main challenge to the implementation of IHRs is to develop and maintain effective, district-focused national surveillance system and to link this to sub-regional, regional and international surveillance
and response networks. We need to devise a mechanism to overcome these.

- The other main challenge is to establish and maintain a national notification system of PHEIC and to link it with effective and prompt response mechanism. There is a need to address this issue.

7.2 Summary from Group Session Discussions (Annex 5)

Two working groups, one to review and identify issues for further clarification and discussion, and the other for drafting a plan for national IHRs consultation workshop, were formed (Annex 4).

(1) Main issues and recommendations

- Clarify some of the definitions of terms and concepts used in the document, and apply such concepts and terms consistently throughout the document.
- Need for providing detailed guidelines on some of the recommended measures to ensure that standard procedures and norms are used for assessed risk.
- Consider inclusion of selected diseases list in addition to PHEIC to strike a balance between specific and broad scopes for notification and encourage compliance to IHR.
- Define required core capacities and type of support to be provided for this purpose.
- Articles on settlement of disputes need to be reviewed by legal authorities of Member States.
- Composition of the Review Committee needs to be reviewed to reflect senior experts in various disciplines (not necessarily only public health).
- Define the types of support for ensuring that the national focal points are functional.
- Develop an IHR kit/package with all relevant references, including an annotated version of the document.
- Explore possibility of mobilizing global funds for capacity building and strengthening EPR in resource limited states.
- Political commitment of Member States for the revision process, its adoption, and implementation are critical. Thus national advocacy,
including at national consultation workshops and communication with Permanent Missions based in Geneva, is recommended.

(2) Proposal for National IHR Consultation Workshop

- Ensure broad participation of stakeholders including from travel, trade, tourism, agriculture, international cooperation, aviation and maritime during the national consultation workshop.
- The workshop is an opportunity to create awareness and sensitize stakeholders regarding the importance and usefulness of the revised IHR, to identify issues and resources needed for implementation, and capacity required at the country level.
- Member States, through national IHR focal points, will develop a detailed workshop plan and identify and communicate to WHO country offices on technical and financial support.
- National workshops need to be conducted before 10 June 2004 to give adequate time for incorporation of issues and proposed recommendations for the regional consultation workshop.

8. NEXT STEPS IN THE REVISION PROCESS OF IHR

8.1 Participation of WHO Member States

Since the draft is based on technical consultations with experts and national authorities, the process adopted gives much greater control and responsibility to Member States. Member States should develop a government perspective of the proposal, and comment directly to WHO at a secure site ihradmin@who.int or through surface mail and participate in the regional consultations and in the IGWG in November 2004. National consultation meetings are scheduled for May-June 2004.

This participatory process, besides further refining the draft IHR, offers an opportunity to improve collaboration in responding to emergencies, target the development of key capacities, and clarify mandates and responsibilities.

8.2 Regional Consultation

Regional consultation is to exchange views/issues and to mutually get informed about the draft IHR and not to seek a regional position. A public health expert accompanied by a decision-maker from MoH and a legal expert
would be the ideal combination for the regional consultation. But there may be others who NFP can identify and intimate to the Regional Office. The team should also include people from WHO offices. The right people to attend the regional consultation could be identified at the national workshop. The second consultation is scheduled for June 2004.

8.3 Global Consultation Meeting

The “final draft” of the revised IHR will be presented to the Inter Governmental Working Group (IGWG) meeting to be held from 1 to 12 November 2004 at Palais des Nations, Geneva, which will have State delegations (not just health administrations), NGOs and Observers. Its objective would be to endorse a final draft of the revision.

9. CONCLUSIONS

The report of the meeting contains the collective views of an international group of experts, and does not necessarily represent the decisions or the stated policy of the World Health Organization. The report will be shared with all participants as expeditiously as possible through the WHO country offices.
Annex 1

TEXT OF ADDRESS BY DR SAMLEE PLIANBANGCHANG

Distinguished participants, colleagues, ladies and gentlemen

With great pleasure, I welcome you all to this First Regional Consultation on the Proposed Revision of the International Health Regulations.

As you are aware, the International Health Regulations (IHR) are the only legally binding instrument to prevent trans-boundary spread of infectious diseases. The fundamental principles of the Regulations are to provide security against international spread of diseases while avoiding unnecessary interference with international traffic, travel and trade. In recent times, the world has witnessed major outbreaks of a number of new, emerging and re-emerging infectious diseases. This has had devastating consequences on travel, trade and economy and caused widespread anxiety, panic and disruption of normal life for thousands of people around the globe. The existing International Health Regulations, which have been in force since 1969, address primarily only three diseases; namely plague, yellow fever and cholera. The Regulations concentrate on the notification of the occurrences of these diseases, in addition to certain preventive measures at ports, airports and border crossing points. From 1969 to today, there have been a lot of changes worldwide; including epidemiological changes, changes in disease patterns and genetic changes in the pathogens. Coupled with rapid advancement in information, communication and transportation technology; the current International Health Regulations have become out of date and need urgent attention in their review and revision. This is clearly demonstrated by recent outbreaks of diseases, like SARS and avian influenza. The present Regulations cannot now deal effectively with the changing health scenario and public health concerns globally. It may be recalled that in May 1995 the World Health Assembly requested the WHO Director-General to take action for the review and revision of the existing International Health Regulations. The Director-General was also requested to facilitate the involvement of all Member States in such a process in order to ensure a consensus on the revised regulations. Subsequently, the World Health Assembly established an intergovernmental group to work with Member States in the formulation of the draft revision of the regulations. Since then the working group had put a lot of efforts on such formulation. The first draft of the regulations had been prepared through extensive consultations with
experts and Member States. As far as South-East Asia Region is concerned, the draft has already been shared and discussed with ministries of health. In order to ensure agreement on the draft, the Fifty-sixth World Health Assembly in May 2003 further requested the Director-General to critically review the draft regulations through technical consultations with Member States once more, with a view to refining the text to be presented to the intergovernmental working group in November 2004. In this connection, all WHO Regions are required to hold such consultative meetings for the purpose. Therefore, this assembly of the national IHR focal points from all the Member States of the Region is organized to look into the salient issues in the draft once again. After this very meeting, national workshops involving other stakeholders such as agriculture, tourism, trade, food safety, legislative sectors, etc. need to be held in our individual countries. This process at the national level is vital since it will provide an excellent opportunity for in-depth discussions of various implications of the draft from the national perspectives. Subsequent to these national-level consultations, it is proposed to organize another regional meeting towards the end of June this year. This will provide another opportunity for Member States to collectively reflect upon specific issues that concern the Region as a whole, and arrive at a consensus on the revised draft.

Distinguished participants,

As we are all aware, the recent outbreaks of SARS and avian influenza caused unprecedented economic setbacks and disruptions in normal day-to-day life, in addition to health consciousness. In this context, we fully understand the general concerns of our Member States regarding the socio-economic implications of the disease outbreaks such as those. We trust that the revised IHR will go a long way in addressing these concerns. However, during public health emergencies at international scale, the application of measures requiring restriction of travel and trade may be necessary. To clearly address the issues in this regard, WHO has consulted relevant international agencies; such as the European Union, International Air Transport Association, International Civil Aviation Organization, International Maritime Organization, the World Tourism Organization and the World Trade Organization, amongst others. Moreover, in this connection, WHO has explored the possible synergies, particularly between IHR and the relevant provisions of WTO.

Ladies and gentlemen,

In the draft of the revised IHR which you will be reviewing, there are five key departures from the existing ones.
(1) Notification

In addition to notification of communicable diseases, the revised IHR requires notification of all public health emergencies of international concern in a transparent manner. This is very important. The word “public health emergencies” is a broad one, subject to a wide-range of understanding and interpretation, even among public health professionals. Therefore, the most suitable definition of public health emergencies must be found. This process would be linked to WHO’s established mechanisms for Epidemic Alert and Response.

(2) National Focal Points

These are operational links between WHO and the countries for notification and information purposes. The inputs of national focal points during the process of IHR revision would be very vital.

(3) Definition of core capacities

Establishment and strengthening of minimum core capacities for surveillance and response in each Member State is an integral part of IHR.

(4) Recommended measures

The revised IHR clearly sets out the roles and responsibilities of WHO as well as of individual countries in responding to disease outbreaks. It also contributes greatly to the use of uniform and effective measures to be undertaken, both on a routine basis, as well as in certain emergency situations.

(5) External advice regarding IHR

In order to provide technical guidance and support during emergencies, WHO will appoint an IHR Emergency Committee. In addition, there will be an IHR Review Committee established to deal with disputes, and make necessary recommendations for action in the process of implementation of the revised IHR. I would like you to study these changes thoroughly and understand them clearly in order to ensure our considered views on all implications of regional concerns.
Colleagues,

I would also like to ask all of us to critically review the whole consultation process, and recommend how we can proceed efficiently and effectively with full participation of all stakeholders, particularly at the national level. This process will assist the Secretariat in preparing for the coming regional consultation in June 2004, as mentioned earlier.

The in-country and regional consultations in this regard have to be completed respectively by May and June this year.

I fully realize the enormous task in the process of developing the revised IHR, and even much more challenging is the process of implementing these regulations. More and more, we will see in these processes the importance of the relationship between the provisions in IHR and certain measures in international trade agreements and international travels. Whatever, we have to keep in mind that IHR is a very important instrument for protecting global public health, including our own health. The benefits our Member States will derive from the effective implementation of the revised IHR will be very much well worth the efforts we put in.

With our invaluable inputs and the commitment of our Member States to international public health, we will succeed on our part in contributing to the achievement of the goal of this global exercise.

Finally, I wish you all success in your deliberations, and a pleasant stay in New Delhi.

Thank you.
Annex 2

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WHO-SEARO
Mr K. R. Viswanathan
Administrative Assistant
Mr Sanjeev Kashyap
Database Administrator
**Annex 3**

**PROGRAMME**

**Tuesday - 13 April 2004**

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<td>Registration</td>
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<td>0900 - 0930 hrs</td>
<td>Inauguration</td>
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<td>1000 - 1020 hrs</td>
<td>Objectives and expected outputs</td>
<td>Dr A.S. Abdullah, Coordinator, Communicable Disease Control, WHO-SEARO</td>
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<tr>
<td>1020 - 1040 hrs</td>
<td>The revision process of IHRs and its implications</td>
<td>Dr Max Hardiman, Group Leader, IHR Revision Project, WHO-Geneva</td>
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<tr>
<td>1040 - 1100 hrs</td>
<td>Lessons from emerging and re-emerging diseases and implications for IHRs</td>
<td>Dr Conchy Roses, Technical Officer, WPRO</td>
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<td>1100 - 1120 hrs</td>
<td>Introductions to the revised IHRs (Parts I-III)</td>
<td>Mr E. Jesuthasan, Technical Officer, IHR Revision Project, WHO-HQ</td>
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<tr>
<td>1120 - 1150 hrs</td>
<td>Discussions on summary presentation</td>
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<td>1150 - 1200 hrs</td>
<td>Introductions to the revised IHRs (Parts IV-VI)</td>
<td>Dr Ayana Yeneabat</td>
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<td>Dr K.K. Dutta</td>
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<td>Introduction to group work and terms of reference</td>
<td>Dr Ayana Yeneabat</td>
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**TECHNICAL SESSION 1 - Facilitator: Dr M. Hardiman**

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**TECHNICAL SESSION 2 - Facilitator: Mr E. Jesuthasan**

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**TECHNICAL SESSION 3 - Facilitator: Dr A.S. Abdullah**

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<td><strong>Individual Group Work:</strong></td>
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<tr>
<td>1600 – 1700 hrs</td>
<td>Group work continues</td>
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**Wednesday - 14 April 2004**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Group 1</th>
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<tbody>
<tr>
<td>0900 – 1030 hrs</td>
<td>Individual Group Work (continues)</td>
<td>Groups</td>
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<tr>
<td>1100 – 1200 hrs</td>
<td>Presentation of group reports and recommendations</td>
<td>Group Rapportuer</td>
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<tr>
<td>1200 – 1220 hrs</td>
<td>General discussions</td>
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<td></td>
<td>Facilitator: Dr Ayana Yeneabat</td>
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<tr>
<td>1220 – 1230 hrs</td>
<td>Closing session – CDC</td>
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<td></td>
<td>Dr A.S. Abdullah</td>
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Annex 4

TERMS OF REFERENCE OF THE WORKING GROUPS

Each group will

1. review past experiences, challenges and difficulties in the implementation of the existing IHR;
2. identify gaps for early recognition, verification and notification of risks and diseases of public importance;
3. discuss how the revised IHR addresses the gaps and needs identified above.

Group I: IHR related issues

- Discuss
  - Difference/changes from existing IHR: what is new?
  - Main areas and concepts included in the revised IHR
  - Identify issues and concepts for further clarifications.

- Identify challenges for implementation
  - Likely difficulties that may arise in compliance to IHR
  - Surveillance gaps to effectively implement IHR
  - Challenges for national coordination and collaboration
  - Suggested solutions for addressing these challenges

Group II: National IHR Review Workshop Plan

- Identify issues for national agenda
  - Review main issues and concepts for national-level discussion

- Identify key participants and stakeholders for national IHR consultation meeting

- Identify required resources
  - Technical support
  - Budget
  - Logistics
  - Timeframe
  - Reference materials
Annex 5

DISCUSSION POINTS, ISSUES AND RECOMMENDATIONS FROM THE TWO WORKING GROUPS

Group 1: IHR related issues

1.1. Definition of terms in need of clarification:

- Affected area - Should there be a definition?
- Containers - How about disposable ones?
- Frontier posts - Should there be a definition?
- Goods - How the term is defined by IATA and IMO?
- National focal point - A clear definition
- National focal contact persons - A clear definition for NFCP
- Public health emergency - More refined definition for the term?
- Quarantine - What is the most appropriate definition?

1.2. Other IHR issues raised:

- Disease list in addition to PHEIC
- Core capacities – prioritization, support for capacity building
- Disinfection/decontamination – separate measures for goods from measures for persons
- Applicable international agreements must be elaborated on
- Health authority – State authority - Clear distinction/definition of the two

Group 2: National IHR Review Workshop Plan

2.1. Objectives of the National IHR Workshop

- To create awareness and sensitize stakeholders regarding the importance and usefulness of the revised IHR.
- Identify IHR issues and problems for further clarification
- Arrive at a consensus and identify resources needed for adaptation process, implementation, and capacity required at country level
- Identify technical support required from WHO to implement IHR
- Recommend follow-up actions
2.2. Proposed agenda for the National IHR Workshop:

- Briefing on revised IHR (difference between existing versus new)
- Background presentation including SARS/avian flu to understand the need to have revised IHR
- Go through the IHR draft, article by article, discuss and critically assess, as well as gather comments from different sectors
- Tasks of country to implement IHR (Resources required etc.)
- Country issues:
  - National Focal Point, and advocacy plan for country
  - Sectorwise impact and implications on: Tourism, commerce and health

2.3. Key participants/stakeholders for the National IHR Workshop:

- Ministry of Health: Public Health, Laboratory, and Medical Services
- Other Ministries/Sector:
  - Agriculture, Fisheries, Livestocks, Forestry and Food Safety
  - Tourism, Civil Aviation, Customs and Immigration and Communication
  - Foreign and External Affairs, Home Ministry, Trade and Commerce
- Other: Information, Defence, Environment, Chemicals, UN agencies, Policy and Health related NGOs etc.

2.4 Process:

- Quarantine - What is the most appropriate definition?
- RD’s letter to the WHO Representative and Ministry of Health with a copy to the national focal point along with the report of this workshop and recommendations, indicating WHO support for holding the national workshop.
- The IHR focal point should submit the proposal as soon as possible indicating whether WHO technical support is needed. Estimated budget - US$5000 - 10,000/-
- The WHO country office follow up with the MoH and IHR Focal Point
The Regional Office ensures every country has a national IHR focal point before holding the national IHR workshop.

Identify, contact, communicate with the stakeholders with documents and get feedback by 10 June 2004 to the Regional Office.

Provide technical support from HQ/Regional Office and other WHO country offices (WHO staff, CDs, hard copies of document, standard text for press release for use of countries).

Workshop conducted as per the timeframe.

2.5. Expected outcome from national workshops

Report with country’s suggested positions, comments and suggestions on articles

Advocacy plan for the country.

2.6. Follow up action at the country level:

Informing Permanent Mission in Geneva

Communication and interaction among stakeholders and policy-makers.

Getting political commitment

Continuous support planned provided by WHO for capacity building.

2.7. Time-frame for activities leading up to IGWG:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tr>
<td>End of April 2004</td>
<td>10 proposals in the Regional Office</td>
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<tr>
<td>10 May 2004</td>
<td>Review of proposals in the Regional Office, APW signed at countries.</td>
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<tr>
<td>10 May - 10 June, 2004</td>
<td>11 country workshops</td>
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<tr>
<td>10 June, 2004</td>
<td>11 country comments in the Regional Office</td>
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<tr>
<td>29 June - 1 July 2004</td>
<td>Regional consultation (4 to 5 persons from each country)</td>
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<tr>
<td>November 2004</td>
<td>IGWG Meeting</td>
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