WORLD HEALTH ORGANIZATION
Lyon Office for National Epidemic Preparedness and Response

REPORT

INTERNATIONAL CONSULTATION ON STRENGTHENING NATIONAL CAPACITIES FOR EPIDEMIC PREPAREDNESS AND RESPONSE IN SUPPORT TO THE NATIONAL IMPLEMENTATION OF THE INTERNATIONAL HEALTH REGULATIONS (2005)

2 – 5 May 2006
Lyon, France

(DRAFT OF 12 May)
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Convened by
WORLD HEALTH ORGANIZATION
LYON OFFICE FOR NATIONAL EPIDEMIC PREPAREDNESS AND RESPONSE
DEPARTMENT OF EPIDEMIC AND PANDEMIC ALERT AND RESPONSE

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NOTE

This report has been prepared by the World Health Organization Lyon Office for National Epidemic Preparedness and Response for governments of Member States and for those persons who participated in the International Consultation on Strengthening National Capacities for Epidemic Preparedness and Response in Support to the National Implementation of the International Health Regulations (2005) from 2 to 5 May in Lyon, France. The views expressed in this report are those of the participants and do not necessarily reflect the policies of the World Health Organization.
ACKNOWLEDGMENT

Special gratitude is extended to the Governments of France and Italy for their support of this consultation.
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Keywords: (Suggested List: to be completed by Publications Indexing Service) Epidemic, International Health Regulations, SARS, Avian Flu, prevention and control, laboratory
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<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>CIEVS</td>
<td>Strategic Information Center for Health Surveillance</td>
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<tr>
<td>EB</td>
<td>Executive Board (of WHO)</td>
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<td>EPR</td>
<td>WHO Department of Epidemic and Pandemic Alert and Response</td>
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<td>EWAR</td>
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<td>FETP</td>
<td>Field Epidemiology Training Program</td>
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<td>IHR Contact Points (of WHO)</td>
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<td>LYO</td>
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<td>MBDS</td>
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<td>National Focal Point</td>
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<td>NTIC</td>
<td>New Technologies for Information and Communication</td>
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<td>PHEIC</td>
<td>Public Health Emergency of International Concern</td>
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<td>SARS</td>
<td>Severe Acute Respiratory Syndrome</td>
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<td>WHA</td>
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SUMMARY


Specific objectives of the consultation were:

1. To define the key components and elements of national epidemic preparedness and response in the context of the IHR (2005).

2. To identify needs, strategies and mechanisms for reinforcing national capacities in the context of the IHR (2005), with a focus on epidemiological and laboratory capacities for surveillance, preparedness and response to epidemics and other public health risks and emergencies;

3. To determine the role of WHO and partners in supporting the development, strengthening and maintenance of national capacities for epidemic alert, response, and monitoring and evaluation in the framework of the IHR (2005).

The consultation brought together over 100 health professionals from over 30 countries, including national staff from both government and non-governmental and academic institutions and also staff from WHO’s HQ and Regional and Country Offices.

The program for the meeting included presentations: (1) on the history and legal implications of the IHR (2005); (2) from technical experts in infectious disease epidemiology, laboratory support; and, (3) from country representatives on their local experiences with epidemic disease surveillance and outbreaks.

Additionally participants spent over a day working in one of four groups to come up with conclusions and recommendations in the areas of: (1) early warning systems, (2) laboratory support to outbreak detection and investigation, (3) national response to public health emergencies; and, (4) coordination and response during public health emergencies.

The general conclusions of the consultation included the consensus that (1) the IHR (2005) implementation should build on existing capacity in national surveillance and response systems and should support an improvement in these national systems; (2) assessments should precede major investments in strengthening capacity to implement the IHR (2005); (3) sectoral technical capacity building must pay attention to cross-cutting issues such as training, communication, coordination, mobilizing relevant resources and monitoring and evaluation; and, (4) new technologies for information and communication, laboratory services and epidemiological surveillance should be incorporated as far as possible in implementing the IHR (2005).

Many specific technical conclusions and recommendations came from the working groups and included emphasis on the need for:
1) both WHO and countries to implement as soon as possible an effective communication system between the National Focal Point (NFP) at country level and the WHO IHR Contact Points (ICPs) within WHO for reporting on and receiving information about public health emergencies of international concern (PHEIC).

2) countries to give priority to developing a plan for implementing the IHR (2005) which includes at least: (1) development of or improvements to routine surveillance systems that will support the early detection of unusual health events; (2) a system of “rapid response” to investigate and facilitate assessments of suspect events and to initiate initial measures necessary to contain the threats; and (3) the organization of a multi-disciplinary, multi-sectoral, and multi-ministerial mechanism to coordinate national responses to a PHEIC;

3) countries, with WHO assistance, to work to strengthen technical capacities in critical areas such as: (1) defining the procedures by which potential PHEICs will be identified and formally evaluated; (2) logistics for supplies and facilities that may need to be stockpiled or mobilized; (3) the functions and role of national laboratories in surveillance, detection and identification and (4) accommodating and expanding capacities (“surge needs”) that may accompany PHEICs.

WHO was especially asked to direct efforts to provide assistance to countries in the implementation of the IHR (2005) through: (1) an elaboration of the process and procedures by which ICP-NFP communications will be organized, e.g. data links, HQ vs. RO roles, reporting formats; (2) help to mobilize resources from the international community for the IHR (2005) implementation; (3) development of important training programmes (e.g. for “decision makers” and “Focal Points”); and, (4) development and dissemination of necessary technical guidelines, SOPs and check-lists, especially for the assessment of technical capacities in the area of laboratory capabilities, detection of early warning signals in surveillance systems, and response to PHEICs.
1. INTRODUCTION

1.1 Objectives


Specific objectives of the consultation were:

1. To define the key components and elements of national epidemic preparedness and response in the context of the IHR (2005).

2. To identify needs, strategies and mechanisms for reinforcing national capacities in the context of the IHR (2005), with a focus on epidemiological and laboratory capacities for surveillance, preparedness and response to epidemics and other public health risks and emergencies;

3. To determine the role of WHO and partners in supporting the development, strengthening and maintenance of national capacities for epidemic alert, response, and monitoring and evaluation in the framework of the IHR (2005)

The detailed agenda of the meeting is attached as Annex 1.

1.2 Participants and resource persons

There were over 100 participants at the meeting including temporary advisors, consultants and WHO secretariat from Headquarters, Regional and Country offices. Participants came from 33 countries including Australia, Belgium, Brazil, Cambodia, Canada, Denmark, Egypt, France, Germany, India, Iran, Israel, Italy, Japan, Kenya, Lebanon, Mali, New Caledonia, Nicaragua, Pakistan, People’s Republic of China, Philippines, Republic of Congo, Romania, Spain, Sweden, Switzerland, Thailand, Turkey, Uganda, United Kingdom, United States of America and Zimbabwe.

The list of participants, consultants, temporary advisors and secretariat staff is attached in Annex 2.

The WHO Lyon Office for National Epidemic Preparedness and Response, Department of Epidemic and Pandemic Alert and Response provided technical and operational support for the meeting.

1.3 Organization of the meeting

The meeting was held in the Conference Hall of the Sofitel Lyon Bellecour Hotel (20, quai Gaileton, 69288 Lyon Cedex 02, France) from 2 – 5 May 2006. Methods used in the meeting included presentations, small group discussions and plenary discussions.
1.4 Welcome statements

Professor J-L. Touraine, First Deputy Mayor of Lyon and Vice-President of Grand Lyon opened the meeting with a welcoming statement to all participants. He expressed understanding that in this period of history, an infectious disease epidemic outbreak anywhere in the world is a threat to everyone and that it is absolutely imperative that we have partnerships and cooperative actions for common protection. He said that Lyon is especially sensitive to this need because of its proximity to WHO’s headquarters in Geneva and also because it had been selected by the French government as an area for special investment in the area of biomedical research and vaccine development and manufacture. Lyon is also especially sensitive to the threat of Avian Flu because infected animals had been discovered in closely neighbouring areas. He recognized that the IHR (2005) has many challenges for countries and international partners and he was confident that this meeting would contribute to finding solutions to these challenges. He said his office was looking forward to studying the results of the meeting and stressed the pleasure of the Mayor’s Office of Lyon in being involved in this important meeting. Finally, he especially invited participants to also take advantage of the historic, cultural and gastronomic pleasures of the city.

Dr M. Ryan, Director, Department of Epidemic and Pandemic Alert and Response, WHO also joined in welcoming participants to the meeting. He stressed that the meeting had the opportunity to help shape the future of global health security through improved infectious disease surveillance, analysis and response. The IHR (2005) now gave us a road map for action and it is our duty to set out on that path. He thanked the participants for their contribution of time and effort at the meeting and expressed the interest of his unit in the results that would be forthcoming.

Dr S. Lazzari, Director, WHO Lyon Office for National Epidemic Preparedness and Response also expressed gratitude to the participants for coming to share their experience. He noted that this was an especially important meeting in that it has been basically one year since the IHR (2005) was adopted by the World Health Assembly and that was also about one year to go when it could be formally in force at country level. In this regard he reminded the participants that the WHO Executive Board had recommended in its January meeting that countries should try to accelerate achievement of selected goals of the IHR (2005). The upcoming World Health Assembly was likely to adopt this recommendation and thus we must all move ahead rapidly to identify the minimum requirements for countries as well as a strategy for WHO actions. He reminded the group that recommendations should not be too complicated and demanding so as to unrealistically surpass the capacity of national public health systems in many countries. On the other hand if they are too simple and inexpensive they stand the chance of not achieving the goals of the IHR (2005). He saw this meeting as the beginning of a long journey together and assured the participants that the results of this meeting would be carefully studied and considered by his unit.

1.5 Opening of the meeting

Dr G. Poumerol, Coordinator, National Systems Strengthening for IHR, WHO formally opened the meeting. Participants at the meeting were introduced by regional representatives: Dr A. Yada, CSR Regional Focal Point/Regional Advisor, AFRO introduced participants from the African Region; Dr M Libel, CSR Regional Focal Point, PAHO/AMRO introduced participants from the American Region; Dr H. El Bushra, CSR Regional Focal Point / Regional
Advisor EMRO introduced participants from the Eastern Mediterranean Region; Dr R. Bhatia, Regional Advisor for Blood Safety and Clinical Technology, SEARO, introduced participants from the South East Asian Region; Dr A. Li, Medical officer for IHR, WPRO introduced participants from the Western Pacific Region; and, Dr G. Poumerol introduced participants from the European Region and the WHO Secretariat.

It was decided by unanimous consent that the chairperson for the four-day meeting would be Dr J-B Brunet, Director, Unit for European and International Affairs, Office of the Director General for Health, Ministry of Health and Solidarity, France. Dr R. D. Fischer, Consultant, WHO, was selected Rapporteur for the meeting.

At the invitation of Dr Brunet, Dr Poumerol presented an outline of the expectations that had been developed for the International Consultation. He stated the principle objective for the meeting: “the identification of strategic approaches to improving national capacities for epidemic alert and response in the context of the IHR (2005).” It was planned that the consultation would identify key components and essential elements of a national response in addition to national strategies and mechanisms and WHO strategies to support development of national capacities. Background papers and presentations had been organized and over one day of the meeting would be devoted to group work. Four groups had been organized: (1) Early Warning Systems; (2) Laboratory Support to Outbreak Detection and Investigation; (3) Coordination and Communication during Public Health Emergencies; and, (4) National Response to Public Health Emergencies.

2. PROCEEDINGS

2.1 Presentation of the IHR (2005)

(a) General Review of the IHR (2005)

Dr M. Hardiman, Project Leader IHR, Epidemic and Pandemic Alert and Response, WHO, presented a general background on the IHR (2005) noting especially that, when compared to the IHR (1969) which it replaced, this new approach was more focused on developing national capacities and supporting the States to address the great breadth of real life epidemic experiences rather than a mechanical system of reporting on selected infectious diseases. The IHR (2005) was also a fairly unique international agreement because it is legally binding on all member states unless they specifically express reservations or reject the regulations. The IHR (2005), of which the annexes are an integral part, has laid out specific required time frames for implementation, the kinds of support that the WHO and other countries are obliged to give to its implementation and the core capacities that are required for both routine and emergency epidemic control measures. Importantly, he pointed out that the IHR (2005) has principally established “functional outputs” rather than prescribing the precise institutional systems that should be in place. How each State accomplishes these outputs remain to be defined though Dr Hardiman reminded the participants that there are minimum objectives that need to be achieved. He encouraged participants to refer to the specific paragraphs of the IHR (2005) for the terms of these requirements. Finally, Dr Hardiman noted that there was an Executive Board resolution that would be considered by the upcoming World Health Assembly encouraging states to voluntarily speed up their compliance to the terms of the IHR (2005) especially as they relate to responses to the threat of pandemic influenza.
In response to several questions following his presentation, Dr Hardiman explained further that there were no formal sanctions for non-compliance with the IHR (2005). He also discussed again the formal timetable in the IHR (2005), distinguishing between the date when the regulations themselves “take legal force” in the country and the longer and more flexible timetable for when different core functions should be in place.

2.2 Systems of Early Alert

(a) Experience at Country Level

Dr M. K Oo, Ministry of Public Health, Thailand made a presentation on the Mekong Basin Disease Surveillance (MBDS) system that has been developed to facilitate early warning and response for transmissible disease threats along the relevant borders of Cambodia, Thailand, Vietnam, Myanmar, and Lao PDR. He reviewed the infectious disease reporting systems and public health structures of each country individually and then showed how communication links had been established along parallel levels at national, provincial, district, community and village levels. A system of periodic reports (daily, weekly, monthly and quarterly) has been developed for countries to share information on different specific diseases. This system has not only facilitated the rapid exchange of information about impending epidemic disease threats but has resulted in more confidence and trust between all parties. Remaining challenges in the functioning of the system continue to be the lack of funding and trained manpower in outlying areas.

Dr Oo also reported on the early warning and response (EWAR) system that has been established in Cambodia. This system is making extensive use of computerized information technology (IT) that is greatly facilitating early analysis and greatly improving cross-border communications between the neighbouring partners. Both the MBDS and Cambodian EWAR system are scheduled to have an external evaluation soon which was expected to stimulate more widespread support for expanding effective elements of both systems.

(b) Strengthening Early Warning Systems and Surveillance for Public Health Events of International Concern

Professor J. Chin, Clinical Professor of Epidemiology School of Public Health, University of California at Berkeley, USA, observed that traditional public health reporting systems have been “passive systems” and “free systems” that have generally been very insensitive and unreliable for early detection of epidemic disease events. It was Professor Chin’s belief that a more sensitive surveillance system is necessary for the implementation of the IHR (2005), specifically one that will rely on both the concept of surveillance at sentinel sites and will seek to detect “early signals” of an epidemic event rather than a definitive diagnosis in the first instance. With regard to the efficacy of sentinel surveillance, it was observed that this has long been used in diseases such as HIV/AIDS and influenza. Although different diseases have different “surveillance profiles”, Professor Chin noted that there are invariably a number of early “signals,” like work or school absenteeism, increased drug sales, and anecdotal reports from local clinical staff of unusual clinical presentations, that precede formal recognition of an increase in disease burden in a community. Importantly, Professor Chin stressed that, to be effective, surveillance of early signals of epidemic events in a community must be an organized and formalized system that diligently tracks the targeted signals. Finally, Professor Chin ran through a number of general recommendations for WHO to strengthen early warning and response systems including the development of an IHR (2005) Surveillance Manual that would give detailed procedures for investigating any suspicious “signal” increase.
2.3 Laboratory Support to Outbreak Detection and Investigation

(a) Country Experience: South East Asian Region

Dr. R. Bhatia, Regional Advisor, SEARO/WHO began a presentation on outbreak detection and investigation stressing the fact that, in the final analysis, the government has an obligation to try to demonstrate unequivocally the cause of an epidemic. Epidemic diseases like Plague, Nipah viral diseases, Dengue Fever, Chikungunya and Japanese Encephalitis, sometimes coupled in dual concurrent outbreaks, still occur in the South East Asian Region with challenging frequency. Despite these challenges, many countries remain unclear where the laboratory fits into the public health infrastructure or if it is truly a critical component in public health programming. He stated that national laboratory policies and a focal point for laboratory issues in the national structure are almost universally missing among countries in the SEARO region. Shortfalls in laboratory biosafety are also prevalent. In the context of epidemic situations of concern to the IHR (2005), the quality of laboratory results and the confidence that the public has in these results will be especially critical. To achieve this end, Dr Bhatia stressed that the central role for laboratories in the implementation of the IHR (2000) needs to be advocated and followed by commitments to assure that the resource requirements of laboratories are met.

(b) Critical Elements of Laboratory Support

Dr. R. Williams, Consultant, WHO, began her presentation with the observation that the Annex 1 of the IHR (2005) specifically identifies the capacity to provide “laboratory analysis of samples …” as a core need. She stressed three fundamental points in her presentation: laboratory services are essential to confirm the cause of outbreaks; it is understandable that some specialized laboratory services could be organized outside of the country; and, laboratories cannot be “switched on” during outbreak investigations but need to be an ongoing established institution in the public health structure if they are to be reliable at times of urgent need. Dr Williams also discussed the critical issues of laboratory support to outbreak response such as maintaining close communications between laboratories and the outbreak investigation teams so there can be determinations about the specimens to be collected and transported and the suspect pathogens can be identified. Notwithstanding the need to sometimes draw on supranational laboratory services for specialized investigations, Dr Williams expressed the opinion that all countries should commit the resources and management structure to have at least one laboratory with capacity to rapidly and reliably identify common causes of outbreaks. She concluded that there are still a number of important issues to resolve in order to achieve adequate laboratory services in most countries; these include the lack of national strategic plans and budgets.

2.4 Coordination / Communication during Public Health Emergencies

(a) H5N1 Outbreak in Egypt: Lessons Learned in Communication

Dr. A. G. Abdel Nasser, Director of Communicable Disease Surveillance, Ministry of Health and Population, Cairo, Egypt, explained in detail how an effective public communication program played a critical role in allaying public fears and providing vital information in the face of reported cases of Avian Flu in Egypt. Authorities started early with the establishment of a Supreme National Committee to coordinate all activities, including the selection of a single focal point to coordinate all official messages from the Egyptian
Government. This resulted in a consistency of information that helped to build trust and establish an image of good transparency by national authorities. In addition to the preparation of pamphlets, brochures and TV spots, the government established a large (40 toll-free lines) 24-hour call centre staffed by trained professionals. Though the call centre received in excess of 120,000 calls in the first week, public anxiety dropped precipitously after a short time. Egyptian authorities also maintained close communication links with WHO and other international and bilateral partners. Egypt is currently looking into the potentials to formalize an organizational structure for outbreak communications that was recently recommended by a WHO consultant.

(b) Strengthening Epidemic Response – A Canadian Perspective

Dr H. Njoo, Associate Director General, Centre for Emergency Preparedness, Public Health Agency of Canada, made a wide-ranging presentation on the experience of Canada in organizing for epidemic preparedness. He also drew extensively on both the positive and troublesome aspects of the Canadian experience stemming from the diagnosis of SARS in two cities in Canada. In looking to the core requirements of the IHR (2005), Canada feels fortunate in already having a fairly well-organized emergency preparedness and communications infrastructure to draw upon though Dr Njoo also drew attention to many challenges that yet remain, including but not limited to: the need for standardized “universal precautions” for respiratory infections; closer coordination with other professional groups like private physicians and pharmacists; the kinds of material contingencies that need to be stockpiled in advance of emergencies; and, policies and training for staff as it may relate to biological or chemical terrorist attacks, environmental contamination disasters and nosocomial outbreaks. Canada’s federal system of government also presents special challenges in coordination where central and provincial legal responsibilities may be divided. Overall, Canada is very much looking forward to supporting the implementation of the IHR (2005).

2.5 National Responses to Public Health Emergencies

(a) Country Experience: Brazil

Dr J B da Silva, Secretary of Surveillance, Ministry of Health, Brazil provided an overview of Brazil’s national health system, the system for health surveillance and the national information system for notifiable diseases. A Strategic Information Center for Health Surveillance (CIEVS) plays a critical role in Brazil in identifying and monitoring responses to suspected outbreak events. Strategic mapping of aspects such as event locations, selected infectious disease reservoirs and public health facilities have also been a critical part of the Brazilian infrastructure for dealing with epidemic outbreaks. Although Dr da Silva outlined a number of challenges that yet remain in Brazil, he was optimistic that an extensive program of short- and long-term training of staff for response to public health emergencies and a current project underway to construct Level 3 laboratories in the country will contribute greatly to the national capacity to respond to public health emergencies.

(b) A Developing Country Perspective: Uganda

Dr A. O. Talisuna, Assistant Commissioner for Epidemiology and Surveillance, Ministry of Health, Uganda, highlighted the need for systematic implementation of the IHR (2005). For a developing country however, he felt strongly that the most important barrier to implementing the regulations was weaknesses the systems of epidemic surveillance and epidemic alert. Other core capacities that Dr Talisuna felt were in particular need of strengthening in developing countries included: guidelines for dealing with clinical case management; financing for stock piling essential supplies; patient transport; simplified standardized procedures for protecting the
public as well as health care staff (e.g. barriers and hand washing), capacities for handling human remains; biosafety for laboratory staff; capacities for disposal of medical waste; and guidelines for infection control measures at the home and community level.

2.6 Multisectoral and Legal Issues

(a) Capacity Development at Points of Entry

Mr E. Jesuthasan, IHR Project, WHO reported on the results of a recent technical meeting of the “Transportation Working Group” in Montreal, Canada. He outlined the changes that are in the IHR (2005) regarding a country’s core capacity responsibilities at land, sea and air points of entry at all times and during health emergencies. Also included is an expanded role for WHO to provide guidance and tools to support countries. The technical working group looked at such issues as updating and installing an electronic list of designated international points of entry, carrying out capacity assessments and certification procedures. There was also a review of existing ‘Standard Operating Procedures’ (SOPs) at points of entry, a proposal by IATA to have “passenger locator cards” and general guidelines for aviation authorities and airlines. Among the outcomes of the meeting was the preliminary identification of 23 relevant SOPs, an agreed standardized format for SOPs and plans to identify the critical SOPs that need revision to facilitate early implementation of the IHR (2005). A timetable for these activities, including field testing of revised SOPs has been developed with the target of having finished products by May 2007.

(b) State-Party Legal Capacity and the IHR (2005)

Mr B. Plotkin, Technical Officer (Legal), IHR Project, WHO emphasized in his presentation that the IHR (2005) are “different” than most other WHO instruments in that they are “legally binding” on all WHO Member States under the terms of Articles 21 and 22 of the WHO constitution. Unless these States specifically notify the WHO Director General that they "reject" the revised Regulations as a whole, or have “reservations” to part of the Regulations, in a prescribed time frame, they become legally bound under the IHR (2005). If a State makes a reservation that is compatible with the "object and purpose" of the Regulations, and is not objected to by a certain number of Member States, the IHR (2005) enter into force for the reserving State but subject to the reservation. How each State Party incorporates or reflects the new Regulations legally within their own systems is likely to vary depending upon their particular legal, administrative and policy environments. The IHR (2005) contain a variety of provisions, including some more or less specific, some more or less mandatory, and some more general principles that govern or guide implementation. Important also in these regulations is an obligation for States Parties, in addition to WHO, to collaborate with and help other countries in their implementation, including in IHR legal capacity-building. For its part, WHO has a team (and others) in its headquarters that includes health law expertise, and is also working to establish arrangements with outside legal experts, to assist States Parties in legal capacity-building in order to implement IHR (2005). It is also developing written materials to support States Parties in this area. Mr. Plotkin emphasized that, as in other areas of capacity-building, it is important in the legal capacity area to prioritize and focus on addressing specifically legal capacity development which is necessary for effective IHR implementation.
2.7 Reports of Working Groups

Participants were divided into four working groups with the task of identifying key components, elements and strategies for implementing the IHR (2005) within four major areas. See Table 1 below.

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<th>Group Area</th>
<th>Chairperson</th>
<th>Rapporteur</th>
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<tr>
<td>I Early Warning Systems</td>
<td>Dr M. O’Leary WHO, Cambodia</td>
<td>Dr J. Kaldor University of New South Wales, Australia</td>
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<td>Dr T Kiedrzynski SPC, New Caledonia</td>
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<tr>
<td>II Laboratory Support</td>
<td>Prof C. Heuck Institute of Laboratory Medicine Germany</td>
<td>Dr J. Carter African Medical and Research Foundation, Kenya</td>
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<td>III National Response</td>
<td>Dr A. Leventhal Ministry of Health Israel</td>
<td>Ms C. Poncé WHO, Switzerland</td>
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<td>Dr A. Talisuna Ministry of Health, Uganda</td>
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<tr>
<td>IV Coordination &amp; Communication</td>
<td>Mr D. L. Menucci Ministry of Health, Brazil</td>
<td>Mr. D. Rutz Centers for Disease Control and Prevention; USA</td>
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The groups each approached their responsibilities by first identifying the relevant requirements of the IHR (2005), especially Annex 1 of that document as well as WHA58.3. The results of their work was then presented in a plenary session and general discussions followed.

See Annex 3 for the list of group participants and copies of the groups' Power Point reports. See Section 3 below for a summary of the conclusions and recommendations from the groups and plenary discussions.

2.8 IHR National Implementation “Road Map”

Dr S. Lazzari, Director, WHO Lyon office for National Epidemic Preparedness and Response, presented a suggested outline for a 3 phase “road map” to guide WHO’s activities in
IHR implementation between May 2006 and 2012. In the proposed Phase 1, between May 2006 –2007, he outlined a number of critical planning and programme design activities including but not limited to the adaptation of existing assessment tools to IHR national core requirements, development of core capacity guidance materials, development of an IHR Monitoring and Evaluation framework and the initiation of training of national and international experts to support national assessments of IHR core capacities. During Phase 2, between 2007-2009, support will be given to national assessments of IHR core capacities, the development of additional guidelines and training materials and supporting countries in implementation. Phase 3 through 2012 will continue predominately in the areas of supporting countries and monitoring progress. Following the presentation there was a general discussion of the proposed strategy with widespread recognition that budgets and trained staffing support for such a strategy would be limited in the initial stages.

2.9 Chairperson’s Closing Observations

The chair of the consultation, Dr J-B Bunet, thanked the working groups for their efforts and valuable contributions to the consultation. He shared with participants a number of personal reflections that he felt sure were also widely shared by other participants. Noting that “helping each other” is an integral part of the IHR (2005), he hoped that countries too would take note of the meetings’ conclusions and recommendations with a view to how they too can contribute to the implementation of the new regulations in other countries. He also stressed the terms of both the IHR (2005) and conclusions of the groups that an appropriate level of assessment of capacities should precede any substantial investment to address assumed problems. He observed that implementation of the IHR (2005) should not lead to a parallel or separate structure but should be organized in such a way as to contribute to the overall strengthening of national health systems. Finally, Dr. Brunet highlighted a number of the cross-cutting issues that need to be addressed in the IHR (2005) implementation and he encouraged participants to be attentive to addressing these issues in a way that capitalizes on synergies and avoids duplication. He concluded by again thanking all participants for their work and for his great satisfaction in chairing this important meeting.

2.10 Closing Ceremony

In recognition of the significance of the meeting and the importance of WHO’s work with the IHR (2005), local and national government officials joined participants and organizers in the formal closure of the consultation.

Prof D. Houssin, Director General of Health, France, used the occasion to note that epidemic disease control was still a pressing international problem and he especially thanked WHO for its assistance with the Chikungunya epidemic in the French territory of Reunion. He also observed that proper training of national focal points would be important to the success of the IHR (2005) implementation and he suggested that Lyon and the Lyon Office of WHO would be an excellent place to organize such IHR specialized training programs.

Mr J.-M Ripert, Ambassador of France to the United Nations, generally recognized the historic role that France has played in international infectious disease regulations and also the great respect and support that the Government of France accords to the WHO. He recounted several accomplishments of a recent visit by the French Foreign Minister to the WHO Headquarters in Geneva. He expressed the strong commitment of the French Government to multilateralism generally and also to continue its support for the work of the WHO Lyon Office.
Mr B. Fialaire, Vice President, Counsel General of Rhone, expressed recognition that the health security of the people of the Rhone Department was intimately linked with global health conditions. For this reason the Department was proud to work closely with the Government of France and Greater Lyon in an effort to make the area into a centre of excellence for biotechnology. He felt too that the Department’s support to the Lyon Office of WHO was entirely consistent with promoting the health of the people of the area.

Mr G. Collomb, Senator Mayor of Lyon and President of Grand Lyon, elaborated more on the plans of the Government of France to support the development of infectious disease biotechnology in the area of Lyon. He felt WHO’s presence in Lyon was fully consistent with this effort and indeed made for “good neighbours” with the many pharmaceutical firms now engaged in vaccine research and development in greater Lyon. He was confident too that the quality of the civil and cultural environment of Lyon would contribute to this work.

Dr M. Chan, WHO Assistant Director General for Communicable Diseases thanked the Mayor of Lyon for providing such a beautiful city in which to host the consultation and she too expressed confidence that the presence of the Lyon Office would contribute to its becoming a centre of excellence. She associated herself with the previous speakers’ comments on the important role that multilateral organizations play in the world today and to recognising that “no health issue is only a local issue.” Dr Chan said that the IHR (2005) was a landmark step forward in global health security but that “the devil is in the details” and that now countries and WHO were faced with the great task of implementing the regulations effectively. She expressed the commitment of WHO to do all that it could to support member states in this implementation and looked forward to their support of WHO so that it can accomplish this mission.

3. CONCLUSIONS AND RECOMMENDATIONS

3.1 General Conclusions

In addition to specific detailed technical recommendations that came from the four working groups, there were a number of general and cross-cutting conclusions that were implicated in the work of each group and revealed in the general discussions during the consultation. These include:

a) Activities to strengthen national capacities to respond to the IHR (2005) in the areas of surveillance and alert, laboratory, response and coordination / communication should be organized and implemented in such a way as to strengthen ongoing national health systems generally.

There was recognition that implementation of the IHR(2005) should not be pursued through a vertical program or structure parallel to the existing public health system. Often repeated throughout the consultation was the idea that “we are not starting from zero” and “we must build on existing ongoing systems.” At the same time, virtually all working-groups recognized that there were fundamental deficiencies and constraints in the function and structure of many national health systems that presented formidable challenges to implementing the terms of the IHR (2005). Apart from the obligations of the IHR (2005), there are great and legitimate needs within countries in the areas of surveillance, laboratory, response and coordination / communication that should be
supported in their own right. While support for improvement in public health capacity is to be encouraged, participants also recognized that there is urgent need to give priority to those activities that relate most directly to the implementation of the IHR (2005).

b) A clear assessment of needs should precede major investments by WHO and countries in developing or strengthening capacity to implement the IHR (2005).

Paragraph 2 of Annex 1 clearly stipulates that State Parties should assess the ability of national structures and resources to meet the minimum requirements of implementing core requirements of the Regulations. There was some breadth of opinion among the different groups as to how much information already exists at national and international levels on core capacities, how extensive and time-consuming should be any effort at assessments, and/or how this information should be collated and evaluated. Notwithstanding these questions, there was a fundamental understanding in all groups that some appropriate level of assessment needs to be at the foundation of any IHR (2005) capacity building.

c) Sectoral technical capacity building must pay attention to cross-cutting issues in the implementation of the IHR (2005).

All working groups recognized that there were a number of cross-cutting issues that should be addressed in ways that capitalize on synergies and avoid duplication. Areas of special attention in this regard included:

- Training;
- Communication;
- Coordination;
- Mobilizing Resources; and,
- Monitoring and Evaluation

d) Infectious disease PHEICs are clearly an immediate priority concern of the IHR (2005) although planning and implementing activities must be cognizant too of other potential non-infectious disease related emergencies.

Notwithstanding the most recent global infectious epidemic disease emergencies, the language of the IHR (2005) appears clear that the terms of this regulation include other non-infectious threats such as environmental disasters, industrial accidents and even terrorist actions where such events give rise to the potentials for a public health threat to spread internationally. Capacity to respond to these other non-infectious PHEICs must be an integral part of national and international plans to implement the IHR (2005).

e) New technologies for information and communications (NTIC) and other new technologies related to epidemic surveillance, assessment and response should be an integral part of the national and international implementation of the IHR (2005).
Although not an explicit part of the language of the IHR (2005), working group participants recognized that there was great advantage that many new technologies offer in implementing these regulations. Examples of such technologies include but is not limited to satellite and GPS mapping of epidemic outbreak and evolution, satellite, radio or other telecommunication networking, long-distance training, program planning, management, monitoring and evaluation software, innovative systems for sign and symptom surveillance, mobile laboratories and rapid presumptive diagnostic tests for pathogens at peripheral level. It was recommended overall that WHO and country planners must pay particular attention to opportunities to engage new technologies in the implementation of the IHR (2005).

3.2. Conclusions from the Working Groups

Working group reports contained a number of specific conclusions and recommendations related to the focus area of the group (see Annex 3). There were many areas of complementary overlap in the group reports that led basically to the following conclusions and recommendations.

1. Countries should develop a plan for confronting public health emergencies in the context of the IHR (2005) … such as a “National IHR (2005) Implementation Plan” … that will assure there are adequate legal authorities in place to address PHEICs (e.g. notification/reporting authority, public health control measures). The plan should provide for the creation of new or reorientation of existing national capacity critical to the implementation if the IHR (2005) including:

   • designation of a National Focal Point (NFP) with the understanding that this is not an “individual” but an “institutional capacity” (e.g., a “National Centre”) to serve primarily as the single focus for communications between WHO and all relevant national authorities related to PHEIC and the implementation of the IHR (2005).

   • organization of contingencies for a multi-disciplinary / multi-sectoral / multi-ministerial organizations and mechanisms (likely to include such sectors as police, border control, immigration and animal health) for coordinating the response to PHEICs.

   • identification of organizational components responsible for epidemic disease surveillance and response that will include:

      o development and implementation of surveillance systems that will support the early detection of unusual health events; and,

      o capacity for rapid response teams (or “rapid investigation teams”) to investigate and initiate an evaluation of public health outbreaks and any needed immediate control measures.

   • description and periodic review of the steps by which potential PHEICs will be identified and formally evaluated (e.g. using guidelines in Annex 2 of the IHR (2005) and including such issues as case definitions, check-lists, guidelines and SOPs;
• communication infrastructure and systems to be operationally linked for identifying and assessing PHEICs and communicating relevant information to the public and press;

• physical and logistical needs such as:
  o isolation rooms/facilities;
  o essential pharmaceuticals, vaccines and supplies, including consumables for specimen collection and transport, and reagents for presumptive diagnostic tests, especially those that will need to be stockpiled;
  o disinfecting equipment and supplies;
  o IEC materials; and,
  o patient and material transport

• selection of key persons, units or “focal points” who will be responsible for selected critical areas such as:
  o a “communication focal point” to be responsible for coordinating all public information and press relations;
  o a “laboratory focal point” to be responsible for the planning and implementation of activities related to necessary laboratory capabilities and services;

• functions and roles that the national public health laboratory system will play in public health emergency planning and response especially including:
  o a proactive role for the laboratory in surveillance including the central and district levels of the national laboratory network as part of the “early warning system”;;
  o appropriate mechanisms for specimen collection, transport and storage;
  o identification of laboratory indicators needed for detection, identification and investigation of outbreaks;
  o standardized internal and external quality assessment;
  o biosafety and biosecurity; and,
  o networks with reference laboratories at national and supranational levels.

• accommodation of needs for “surge capacity” in all aspects of managing a PHEIC;

• identification of a plan to monitor and evaluate implementation of the IHR (2005) and response to any particular PHEIC;

• critical training needs for staff
2. There are a number of areas in which WHO should direct or expand its efforts. These include:

- The organization should designate IHR Contact Points (ICPs) at the earliest possible time and should also develop guidance on such issues as:
  - Types of linkage infrastructure: e.g., telephone, hotline, fax, IHR website;
  - Roles of Regional vs. Headquarters;
  - Reporting template: e.g. indispensable information needed;
  - Language Issues: e.g. different contact procedures for different languages
  - Custody of Information: confidentiality vs. public access; and
  - Intellectual Property Issues

- Develop and/or disseminate technical documents (guidelines, SOPs, check-lists) relevant to assisting countries in the implementation of the IHR 2005. These include:
  - The “Outbreak Communications Guidelines” should be widely disseminated and incorporated into countries’ PHEIC communications strategy, including but not limited to news media relations;
  - Health Laboratory Facilities in Emergency and Disaster Situations” (WHO EMRO Publication Series No.6, WHO-EMRO Cairo)
  - Assessment guidelines to be used as tools to assist countries to measure how well current national systems and capacities are able to meet the IHR (2005) requirements especially in such areas as:
    - Laboratory capabilities nationally and/or how they may be linked systemically to supranational laboratory facilities;
    - Detection and early warning of signals to provide timely information that may indicate outbreaks;
    - Assessing signals, laboratory data or other medical intelligence for its potential to suggest a PHEIC;
    - Response capacity.
  - New or modified existing guidelines on monitoring and evaluation to assure that there are reliable and sensitive indicators for evaluating IHR implementation.

- Develop and implement training programs to include:
training for NFPs so as to assure they can link effectively with the ICPs and also to facilitate effective coordination within the national emergency epidemic structure;

support for the integration of the IHR (2005) into university and professional curricula for all health professions, especially into FETP-type training, to assure that there is a critical mass of health professionals sufficiently competent in PHEIC for implementation of the IHR (2005); and,

training programs for “decision makers” so that they better understand the requirements of the IHR (2005) and the critical national capabilities that will be necessary for their implementation.

3) Both WHO and countries must confront the important issue of financial resources necessary for the implementation of the IHR (2005):

- countries should have defined or “earmarked” budgets dedicated to disease surveillance and response relevant to early alert for potential PHEICs;

- WHO should increase efforts to help mobilize financial and technical resources from donor countries and the international community to support implementation of the IHR (2005).