WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC

REPORT

CONSULTATION ON THE REVISION OF THE INTERNATIONAL HEALTH REGULATIONS (IHR) IN THE WESTERN PACIFIC REGION

Manila, Philippines
28-30 April 2004
REPORT

CONSULTATION ON THE REVISION OF THE INTERNATIONAL HEALTH REGULATIONS (IHR) IN THE WESTERN PACIFIC REGION

Convened by:

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC

Manila, Philippines
28-30 April 2004

Not for sale

Printed and distributed by:

World Health Organization
Regional Office for the Western Pacific
Manila, Philippines

June 2004
NOTE

The views expressed in this report are those of the participants of the Consultation on the Revision of the International Health Regulations (IHR) in the Western Pacific Region and do not necessarily reflect the policies of the World Health Organization.

This report has been printed by the Regional Office for the Western Pacific of the World Health Organization for the participants in the Consultation on the Revision of the International Health Regulations (IHR) in the Western Pacific Region, which was held in Manila, Philippines, 28-30 April 2004.
# CONTENTS

## SUMMARY

1. INTRODUCTION ............................................................................................................. 1  
2. PROCEEDINGS .............................................................................................................. 3  
3. CONCLUSIONS AND RECOMMENDATIONS ................................................................ 16  

## ANNEXES:

ANNEX 1 - LIST OF PARTICIPANTS, CONSULTANTS, OBSERVERS/REPRESENTATIVES, AND SECRETARIAT .. 21  
ANNEX 2 - AGENDA/PROGRAMME ............................................................................ 41  
ANNEX 3 - LIST OF DOCUMENTS .............................................................................. 45  
ANNEX 4 - OPENING SPEECH .................................................................................. 47  

**Keywords:**

International health regulations, communicable disease, surveillance and response, capacity strengthening,
A Consultation on Revision of the International Health Regulations (IHR) in the Western Pacific Region was conducted in Manila, Philippines, from 28 to 30 April 2004. The meeting was convened by the World Health Organization Western Pacific Regional Office.

The objectives of the meeting were:

(1) to increase awareness of the proposed revision of the IHR and associated documents in all Member States and areas of the Western Pacific Region and among collaborating agencies and partners;

(2) to provide an opportunity for Member States and areas of the Western Pacific Region and collaborating agencies and partners to review the draft IHR and associated documents in order to provide input to the revision process; and

(3) to develop a shared understanding of the core requirements for public health surveillance and response by Member States and areas to support the IHR and resulting capacity-building needs.

The meeting was attended by 62 participants from 32 countries and areas, and a further four observers from the Region. There were two WHO consultants and 17 WHO staff members serving as the secretariat.

The meeting was in two main parts. Days one and two focused on the proposed draft of the IHR, its strengths and weaknesses, and potential improvements. Day three focused on strengthening communicable diseases surveillance and response capacity to support revised IHR implementation. The format for the days consisted of brief presentations followed by discussion group sessions that were reported back by rapporteurs appointed by the groups. There was a final plenary session to review key IHR issues and recommendations.

The main conclusions from the meeting were summarized by rapporteurs from each discussion group and the two rapporteurs for the meeting as a whole, with assistance from the meeting consultants. In summary, key themes included the following:

- **Strong support for the general intent of the proposed IHR.** Member States believe that once adopted, the revised regulations will contribute to: early effective detection and notification of threats to international health; improved response and management of these threats; and an effective framework for working with other agencies to contain the international spread of disease.

- **Strong support for the international networking potential of the IHR.** The IHR should acknowledge and affirm existing regional surveillance and response arrangements. The National IHR Focal Points could also provide a basis for improved regional networking and communication.
• **Need to clarify the role of National IHR Focal Points.** The NFP role is central to the successful implementation and operation of the IHR and needs to be more clearly defined in the IHR, annexes and supporting documents, particularly as this function is related to the health administration of each Member State.

• **Support for supplementing the decision instrument with a list.** The decision instrument is supported as it allows the IHR to adapt to emerging and unforeseen hazards. Most participants think this should be supplemented with a disease list to add certainty to the reporting of events that are known to have high potential to cause public health emergencies of international concern.

• **Divided views on the scope of the IHR.** The scope of the IHR as it relates to nonbiological hazards (chemical and radiological) needs further development and consultation. Some participants favour an all-risks approach whereas others believe the scope should be limited to infectious diseases and diseases of unknown etiology. There was also discussion over the scope of the IHR as it relates to intentional releases of biological agents.

• **Clarifying the intent and wording of articles dealing with team deployment.** The IHR should facilitate effective and collaborative on-site investigations between WHO and Member States. Participants support a specific change in the text for Article 10(3), as detailed in the body of this report.

• **Achieving a suitable balance on sovereignty concerns.** International law, by its very nature, impinges on country sovereignty. Some participants consider the proposed IHR needs to be modified to shift the balance more towards the rights of Member States. As well as the question of team deployment, some participants wish to retain the right to impose measures in excess of those recommended by WHO, where there is an appropriate rationale. Most participants feel that the issue of charging for patient services should be left to their own discretion, especially with regards to medical examination, vaccination and prophylaxis.

• **Need for consistency with other international agreements.** Member States request an analysis of IHR consistency with other related international agreements and regulations.

• **Need to expand emphasis on prevention.** Participants support the article requiring Member States to develop and maintain effective infection control practices. There was discussion as to whether other aspects of infectious disease prevention could be further developed in the regulations.

• **Need to refine details of some articles and annexes.** Member States had views and suggestions on many specific parts of the proposed IHR. These views have been passed to the IHR revision team for further consideration during the drafting process. All Member States in the region have also been encouraged to provide written comment on the proposed IHR.

• **Need for phased implementation of IHR.** Most, if not all, Member States will need to strengthen their surveillance and response capacities to meet IHR requirements. This process will have budget and resource implications. Many will have to change their national legislation to bring the revised IHR into effect. These requirements may mean phased implementation for the IHR.
• **Need to assess surveillance and response capacity.** Participants support the need for systematic assessment of their surveillance and response capacity for carrying out their responsibilities under the IHR. There is support for the use of the proposed IHR capacity inventory to provide a rapid assessment of capacity in Member States across the Region. Participants also expressed interest in undertaking in-depth assessments of their surveillance and response capacity.

• **Need for WHO to strengthen its capacity in the Region to support introduction of the IHR.** WHO must have the capacity to support the responsibilities specified in the proposed IHR. These include both assessing and strengthening the capacity of Member States in the Region, and providing the capacity in WHO in the Region to respond to notifications and carry out the other functions described in the IHR. To facilitate this process, the WHO Western Pacific Regional Office should develop a regional IHR implementation plan. WHO will also need to produce a range of detailed information resources to support IHR implementation.

The following recommendations emerged from the meeting:

1. WHO is urged to consider the views expressed at the meeting and use them to assist preparation of the draft IHR proposal for the Inter-Governmental Working Group that is to meet in the second half of 2004.

2. Member States of the Western Pacific Region are encouraged to review the IHR proposal in detail and send specific written responses to WHO before the end of June 2004.

3. WHO was asked by participants to develop a regional IHR adoption plan. This should cover the steps needed for ongoing consultation with Member States and WHO Headquarters to facilitate adoption of the revised IHR at the World Health Assembly in 2005.

4. The WHO Western Pacific Region Office should develop a regional capacity-strengthening plan, to include:
   - a national capacity-strengthening plan - containing strategies to support capacity strengthening in Member States over the short to medium term, and
   - a WHO capacity-strengthening plan - containing strategies to strengthen WHO capacity in the Region to support operations of the IHR.
A Consultation on Revision of the International Health Regulations (IHR) in the Western Pacific Region was conducted in Manila, Philippines, from 28 to 30 April 2004. The meeting was convened by the World Health Organization Western Pacific Regional Office.

1.1 **Background information**

The meeting was part of the consultation process that will lead to a final draft of the revised International Health Regulations (IHR) being presented to the 56th World Health Assembly (WHA) in 2005.

There is a strong consensus that the IHR need to be revised to provide an effective basis for preventing the international spread of infectious diseases. The present regulations were issued 35 years ago in 1969. Increasing globalization and the emergence of new diseases, such as severe acute respiratory syndrome (SARS), have highlighted the importance of establishing a more effective basis for coordinating the response to international human health threats.

To help refine the draft IHR, WHO regional offices have convened meetings to consult member countries on the proposed revisions to the IHR and associated documents. These meetings have also provided an opportunity to review the core requirements for public health surveillance and response that countries and areas need to support IHR introduction.

Expected outcomes of the regional meeting included: effective consultation on the proposed IHR by all Member States, collaborating agencies and partners; clear identification of any concerns or issues arising from the IHR; and an agreed process for assessing and strengthening surveillance and response capacity in the Western Pacific Region.

1.2 **Objectives**

(1) To increase awareness of the proposed revision of the IHR and associated documents in all Member States and areas of the Western Pacific Region and among collaborating agencies and partners;

(2) to provide an opportunity for Member States and areas of the Western Pacific Region and collaborating agencies and partners to review the draft IHR and associated documents in order to provide input to the revision process; and

(3) to develop a shared understanding of the core requirements for public health surveillance and response by Member States and areas to support the IHR and resulting capacity-building needs.
1.3 **Participants**

The meeting was attended by 62 participants from 32 countries and areas: American Samoa, Australia, Brunei Darussalam, Cambodia, China, Hong Kong (China), Macao (China), Cook Islands, Fiji, Guam, Japan, Kiribati, the Lao People's Democratic Republic, Malaysia, the Marshall Islands, the Federated States of Micronesia, Mongolia, New Caledonia, New Zealand, Niue, the Commonwealth of Northern Mariana Islands, Palau, Papua New Guinea, the Philippines, the Republic of Korea, Samoa, Singapore, Solomon Islands, Tonga, the United States of America, Vanuatu and Viet Nam. There were four observers from the Asian Development Bank and the Secretariat of the Pacific Community.

There were two WHO consultants and 17 WHO staff members serving as the secretariat.

A list of participants, observers, consultants and secretariat members is provided in Annex 1.

1.4 **Organization**

The meeting programme is attached as Annex 2, and a list of documents distributed during the workshop as Annex 3. The documents included the IHR working paper (the proposed draft), initial comments from countries, draft role of the IHR focal point, provisional list of IHR National Focal Points and presentation materials by WHO secretariat members. Documents also included a number of WHA papers from previous meetings, which were added as reference materials. Copies of these papers can be obtained upon request from the WHO Regional Office for the Western Pacific.

Dr Mahomed Patel was appointed as Chairperson, Dr Ma. Concepcion Roces of the WHO Secretariat as Vice-Chairperson, and Dr Douglas Lush of New Zealand and Dr Balachandran Satiamurti of Malaysia as Rapporteurs.

The meeting was in two main parts. Days one and two focused on the proposed IHR, its strengths and weaknesses, and potential improvements. Day three focused on strengthening communicable diseases surveillance and response capacity to support IHR implementation. The format for the days consisted of brief presentations followed by discussion group sessions that were reported back by rapporteurs appointed by the groups. There was a final plenary session to review key IHR issues and recommendations.

1.5 **Technical inputs**

Two consultants were appointed to assist with planning and facilitate the meeting and its follow-up.

Dr Michael Baker, a senior lecturer from the Wellington School of Medicine and Health Science, New Zealand, acted as convenor for the meeting. He developed the detailed meeting plan, organized the agenda papers, assisted the rapporteurs in reporting back, and drafted the final meeting report.

Dr Mahomed Patel, a senior lecturer from the Australian National University in Canberra, Australia, acted as facilitator and chairperson for the meeting. He assisted with planning the meeting, assisted the rapporteurs in reporting back, and helped draft the final meeting report.
1.6 Opening remarks

Dr Shigeru Omi, WHO Regional Director for the Western Pacific, delivered an opening speech (see Annex 4). He welcomed participants and emphasized the importance of the task ahead. His address briefly summarized the historical development of the IHR and the current revision process. He concluded with four points he wished to emphasize: (1) The stakes are high, referring to the increasing level of risk from emerging infections diseases; (2) We need to sharpen our axe, meaning that the public health workforce needs effective information-sharing methods to stay relevant in the electronic age; (3) You need to be ambassadors for these regulations within your own countries, because the regulations can only be adopted and implemented by Member States, and require multisector involvement; and (4) There will be considerable interest in these discussions because this is the first full regional consultation meeting on the IHR and the Western Pacific Region has been at the forefront in responding to public health emergencies such as SARS and avian influenza.

2. PROCEEDINGS

2.1 Workshop objectives and agenda

Dr Michael Baker presented the workshop objectives and agenda. These were adopted.

2.2 Presentations on the IHR

Dr Hitoshi Oshitani, Regional Adviser in Communicable Diseases Surveillance and Response (CSR), WHO Western Pacific Regional Office, gave a presentation on the future of disease surveillance and response in the Western Pacific Region under the new IHR. He outlined the major communicable disease outbreaks in the Western Pacific Region and the lessons learned from SARS and avian influenza. He also explained how the scope of the IHR was only intended to capture the small subset of public health events of international concern. As SARS illustrates, such events will usually start as local events. For that reason, countries will need to improve their surveillance capacity at all levels to support successful implementation of the new IHR. Similarly, countries need to develop the breadth of their surveillance capacity, including animal, hospital-based, laboratory, and rumour surveillance, as well as the more familiar notifiable disease systems. IHR development also has implications for response capacity. Many countries do not have sufficient surge capacity and will, therefore, occasionally need to draw on international resources. Delivery of such resources may be coordinated by subregional, regional and global networks. The Western Pacific Regional Office has strengthened its capacity by recruitment of additional long-term staff, as well as increasing its ability to quickly mobilize specialized short-term staff. Regional and subregional networks will have an important role in improving the response to public health events of international concern, including those that are below the threshold to constitute events of true global concern.
Dr Max Hardiman, Project Leader, International Health Regulations, CSR/CDS, WHO Headquarters, presented an overview of the IHR process. He began with an outline of why the IHR were being revised and explained that the process was being driven by the need to respond in a responsible, effective and credible way to the sudden development of public health events that threaten to spread, as illustrated by the SARS experience. Further serious and unusual disease events are inevitable, and globalization means the effects are felt everywhere.

Dr Hardiman described the legal basis for the IHR and the limitations of the 1969 version currently in force. He discussed the aims of the revision and the benefits that will flow from it. Benefits include an improved base for WHO’s successful global alert and response operations. He then described the revision process, including the contribution of regional consultation meetings, which need to complete their input by June 2004. Dr Hardiman outlined key issues and controversies, including scope, national sovereignty, compliance, speed of response, consistency with other international obligations/treaties, implications for developed and developing countries, and feasibility of implementation. He concluded by emphasizing the important opportunity provided by the proposed IHR revision.

2.3 Plenary discussion of context for the IHR and main strengths and weaknesses

A wide range of IHR issues were discussed. Many were questions seeking clarification of aspects of the proposal and its implications. There were also statements regarding particular concerns with the proposal. These issues are described in the next section under strengths and weaknesses.

2.4 Discussion groups to review context and need for IHR and identify main strengths and weaknesses of the proposal

The meeting separated into discussion groups, followed by reporting back by group rapporteurs. The aims were:

(1) to increase shared understanding of the IHR and how it can assist in managing important public health threats in the region; and

(2) to identify key strengths and weaknesses of the proposed IHR revision for more detailed discussion on day 2.

The groups were:

- Pacific countries and areas
- ASEAN countries (Brunei Darussalam, Cambodia, the Lao People’s Democratic Republic, Malaysia, the Philippines, Singapore, Viet Nam) and Mongolia
- Other countries and areas (Australia, China, Hong Kong (China), Macao (China), Japan, New Zealand, Republic of Korea)

In reporting back, the groups identified issues under a number of key topics:

Main strengths

- **Supports public health advocacy** – As international law, the IHR will provide a powerful base for advocacy within countries, and with other sectors, for measures to protect public health.

- **Makes reporting requirements more transparent** – The IHR will encourage greater transparency of reporting, e.g. some countries in the Pacific will not report typhoid
outbreaks because of concerns about the potential impact on tourism. Under the IHR, countries would be expected to notify WHO of such events.

- **Provides a framework for responding to public health threats** – The IHR will oblige Member States and WHO to address identified public health threats. This process sets the stage for greater preparedness.

- **Facilitates communication and networking** – The IHR will facilitate discussion, negotiation, collaboration and networking. It will promote integration of existing systems, committees, taskforces and other processes within countries and within the Region, e.g. role of Pacific Public Health Surveillance Network (PPHSN) as a collaborator with WHO.

- **Provides a basis for capacity-building in Member States** – The IHR will specify an internationally agreed minimum set of standards and criteria for surveillance and response capacity.

- **Clarifies roles of Member States and WHO** – The IHR will clarify the roles, responsibilities and obligations of Member States and WHO for surveillance, investigation and response.

- **Provides more flexibility and consistency of responses** – The IHR framework is sufficiently versatile that it can respond to a range of events, including outbreaks caused by microbiological and unknown agents, while at the same time specifying a consistent response based on level of risk and effectiveness of control measures.

- **Produces greater consistency for travellers, conveyance operators and points of entry** – The IHR provisions will update and improve the consistency of measures for travellers, conveyance operators and points of entry, e.g. clarify exit and entry screening measures, such as arrival cards and temperature screening.

**Main potential weaknesses of the proposed IHR**

- **Role of National IHR Focal Points not sufficiently clear** – The roles of the National Focal Points and Health Administrations/Authorities, and their relationship to each other, is not particularly clear.

- **Scope of events covered by proposed IHR may be too broad** – The proposed scope of the IHR raises a number of issues and potential difficulties, particularly (1) whether to include chemical, radiological and physical hazards, and (2) inclusion of deliberate / intentional releases. Some participants supported an "all-risks" approach to the regulations, whereas others believed the proposed IHR articles and associated capacity were largely oriented towards halting the spread of infectious diseases. Those favouring a narrower scope argued that the IHR appeared oriented towards the spread of infectious diseases so may not have the infrastructure for other types of hazards. It may also be faster to implement if it is focused on infectious diseases. The alternative "all-risks" approach argues that a more generic approach to public health emergencies of international concern is far more in keeping with the intent of the IHR. This more facilitative approach would allow the IHR to adapt to new emerging hazards that cannot currently be anticipated.
• **Decision instrument on its own would not provide sufficient certainty** – On its own, the decision instrument would not provide sufficient certainty that public health emergencies of international concern would be reported swiftly and consistently by all Member States. Participants raised the potential for inconsistent interpretation of the criteria, delayed reporting and trivial notifications. Some emerging infectious diseases are of such importance that they should always be reported. There are questions of how a disease list would complement a decision instrument, and how such a list could be developed and included in an easily revisable form, e.g. guideline. Such a list would also raise the need for standardized and well accepted case definitions that would be useable in both developed countries and developing countries that may lack laboratory resources.

• **IHR needs to facilitate existing networks where these are effective** – The IHR should clarify requirements for situations where Member States establish bilateral and regional solutions to public health emergencies. Some participants felt that the IHR reporting requirement might duplicate existing subregional surveillance processes. The IHR and its operational aspects should try to facilitate these arrangements so as to minimize the strain on limited resources within Member States.

• **Need for confidentiality** – There was concern over the balance of confidentiality of information versus the need for transparency in assessing risk. Some participants felt that a country should be informed before information was distributed further.

• **Some specific sovereignty issues may interfere with acceptance of the overall IHR** - A number of national sovereignty issues were raised, including: potential concerns about WHO use of non-official surveillance information to identify potential public health emergencies of international concern (PHEIC); implications of reporting events in other countries; the ability of WHO to deploy teams for on-site investigations in Member States without an official request; limitations on measures exceeding those recommended by WHO; and the policy on charges (medical exams, vaccination and prophylaxis).

• **Need to review some issues around recommendations** – Participants raised a number of issues, including: the need for WHO to specify the basis of recommendations; the need for an agreed mechanism whereby countries could introduce measures that exceeded those recommended by WHO for points of entry; procedures for termination of health intervention (e.g. screening, travel advisories).

• **The need to clarify some definitions** – Some important terms are not defined and definitions for others need to be reviewed. These include the definition of travellers (crew members, transit passengers); temporary residents; borders, e.g. status of European Union; invasive/non-invasive medical examination; inland ports and borders, e.g. Mekong River.

• **The need to review the scope of the IHR as it relates to baggage and other goods** – Participants considered that extending the IHR scope to include baggage would be very difficult to implement. They also requested clarification of the scope in terms of transport of biological materials, hazardous materials, and contaminated goods.

• **Measures that can be applied to travellers need to be more specific** - Some participants considered that the annexes should list the measures that Member States could lawfully apply to travellers, as they do for conveyances (see Annexe 4). There appeared to be some uncertainty about the relative role of exit and entry measures and the ability to validate them. Participants were also unclear on the optimal approach to standardizing arrival cards and the recording of information on travellers’ destinations.
• **Potential resource implications for Member States** – Many developing, as well as developed, countries will need to strengthen their surveillance and response capacity to reach the levels described in the IHR. These capacities include expanded surveillance requirements, e.g. rumour verification, and resources for surge capacity and emergency measures. Some Member States will need assistance to reach a minimum basic level of capacity. One example raised was the situation where a country in the Region did not have the capacity for laboratory confirmation of avian influenza and neighbouring countries did not have the surplus capacity to assist them. Several forms of assistance were suggested, including a regional implementation plan, teams to assist, and international resource mobilization.

• **Potential legislative implications for Member States** - Implementing the IHR has legislative implications for Member States. In some cases, it may even conflict with existing health policies and legislation. It may take considerable time for Member States to review the legal implications and amend or introduce new legislation. This barrier could potentially mean that their adoption of the IHR would be delayed or phased over a period.

• **Potential conflict with other international agreements** – Participants were not aware of specific conflicts between the IHR and other international agreements. However, they were concerned that potential conflicts should be identified and resolved.

• **Role of quarantine needs further development** – Given the important role that quarantine still plays in controlling infectious disease outbreaks, some participants felt that it needed more development in the IHR.

2.5 **Presentations on the structure of the IHR and key proposals**

Dr Max Hardiman, Project Leader, International Health Regulations, CSR/CDS, WHO Headquarters, gave a presentation on the structure of the working paper and key proposals. He described the IHR document hierarchy from core text, through annexes to referenced guidelines. He outlined key proposals, including: notification and verification; how WHO will use the information it receives to determine PHEIC; the role of national focal points; definition of core capacities; recommended measures and the role of the IHR Emergency and IHR Review Committees; and proposals for points of entry, conveyances and persons.

2.6 **Detailed review of the proposed IHR and Annexes**

The meeting separated into discussion groups, followed by reporting back by group rapporteurs. The aim was to review in detail the issues identified on the first day of the meeting and the articles and annexes of the IHR to identify specific changes, including clarification, modification, additions and deletions, this information to be used by WHO Headquarters during final drafting of the IHR and discussions by the Inter-Governmental Working Group.

The groups were divided according to groups of articles and annexes:

1. Responsibilities of states for surveillance, reporting and other provisions under the IHR;

2. Responsibilities of WHO for responding to notifications and carrying out other functions under the IHR; and

3. Regulation of points of entry, conveyance operators, travellers and other groups under the IHR.
The reports from the groups identified issues under articles, annexes and general topics. The main points are summarized in the Conclusions section. Articles of the IHR that resulted in particularly strong points are listed below:

**Article 1 Definitions**

Some important terms are not defined and definitions for others need to be reviewed.

**Article 2 Purpose**

This was supported.

**Article 3 Communication and the role of the IHR national focal point (NFP)**

Participants thought the articles should make the communication roles of the NFP and health administration clearer. The role of the NFP seems so important that it could justify a description in the annexes to the regulations (either as a distinct annex or as part of Annex 1). This description could perhaps make it clear that the NFP is not necessarily expected to deal with all the technical aspects of the IHR.

**Article 4 Surveillance and Annex 1**

The surveillance capacity of Member States was identified as critical to the successful implementation of the IHR. Considerable capacity building will be needed to reach the level specified in Annex 1 across all Member States. Some of these requirements appeared unrealistic to some participants, notably the requirement to assess all reports of urgent events within 24 hours.

Participants also discussed whether an analogous list of capacity requirements should be prepared for WHO to specify core capacities and response expectations.

**Article 5 Notification and Annex 2**

The notification requirement and decision instrument were both supported in principle as central to effective operation of the IHR. However, participants differed over several important aspects of this article and annex.

In terms of scope, there was complete support for these provisions being applied to diseases of microbiological origin or where the etiology is unknown. However, some participants did not think they should apply to chemical and radio-nuclear contaminant events. There was also discussion as to whether they should cover events known or suspected to be the result of an intentional or accidental release of chemical, radio-nuclear or biological agents.

Participants generally supported having a disease list to supplement the decision instrument. This position was backed by a number of theoretical and practical arguments. The two approaches appear highly complementary. A list provides certainty that can help with decisions to notify events that are known to have high potential to cause PHEIC. Sometimes such events will only be apparent when notifications from widely distributed countries are integrated by WHO. The Instrument can provide flexibility for dealing with new or unanticipated threats. The decision instrument includes an element of judgement and needs to be used and refined over time. Use of the instrument may generate a dialogue (e.g. a consultation) between the Member State and WHO, which may itself be beneficial.
There was some discussion about the extent to which the IHR scope and decision instrument is intended to cover public health threats that are confined to a single Member State, but pose a risk to tourists and other travellers visiting that country. Even although such events might not pose a significant risk of international spread, would they be notifiable because of their potential for travel restrictions to the affected area?

A clear and concise definition of PHEIC is needed. It will also be necessary to define key components of this definition. For example, if an outbreak crosses the border of one country into a second, is it an “international” event by definition?

Article 7 Information

The authority of WHO to disseminate information about events occurring in a Member State without the consent of that Member State raised some concerns. Similarly, the potential implications of reporting health events in neighbouring countries.

Article 9 Determination of a public health emergency of international concern and Annex 3

The Article and Annex were supported by participants.

Article 10 Response and Annex 1

There was considerable discussion over the wording of clause 10(3) and the power it appears to give WHO to provide on-the-spot studies in Member States. Some participants were concerned about the sovereignty implications of this clause and the need to clarify the intent and wording.

Article 11 Temporary recommendations and Annex 3

WHO should be transparent in the process of developing recommendations and release details of the rationale for these. Temporary recommendations should include an expiry date.

There was discussion as to whether temporary recommendations could also be made for potential threats for prevention purposes. This could include a wording change to the first sentence of Article 11(1) to add “…or has reasonable grounds to consider that a PHEIC is likely to occur…”.

Article 13 Health administration and Annex 1B

Several of the capacities listed in Annex 1B will need to be more fully defined e.g. “organized medical service”

Article 14 Airports and ports and Annex 4

The form in Annex 4, as with the other forms contained in the annexes, needs to be reviewed in terms of content and layout. For example, the Model Ship Sanitation Control Exemption Certificate/Ship Sanitation Control Certificate should presumably include the name of the port that issued the certificate, the name of the vessel, and the place and date of issue of previous certificates.

Article 16 Health authority

The term “Health authority” has potential to cause confusion, particularly if this section is read in isolation from Article 13. Should these be defined as “Designated health authorities” or some other term that makes their status and role clearer?
Article 17

This article requires a suitable description e.g. “General provisions for information, examination and inspection”. Implementing these measures, such as exit screening and inspection of baggage, has large logistic and resource implications.

The intent of Article 17(a)(i) and (ii) appears to be to obtain sufficient information from travellers to assess their risk of infection and to enable them to be contacted if required. The wording of this article needs to be reviewed to make the intent clear, possibly with the detailed information requirements specified in an Annex.

The term “non-invasive medical examination” needs to be defined.

Should the appropriate annex list measures that may be recommended with respect to travellers as has been done for conveyances, containers, goods and cargo (as in Section 5 of Annex 4)? This approach might allow for the important role of measures such as isolation and quarantine to be better defined.

Article 18 General provisions for conveyances and conveyance operators, Annex 5

It is not clear whether the provisions of Annex 5 only apply to entry points that are receiving conveyances arriving from affected areas designated by WHO. For example, does paragraph 4, relating to vector control around airports, ports and container terminals, only apply in such circumstances?

Article 19 Ships in transit

Some participants were concerned that this article limits the ability of Member States to implement measures in excess of those recommended by WHO.

Article 21 Conveyances at points of entry

See comment under Article 19.

Article 22 Surveillance of travellers

The phrase “placed under surveillance” needs to be defined. There was some discussion about elaborating the actions that a Member State can take to ensure effective surveillance of travelers, e.g. defining a more active role for the health authority in meeting or following-up the suspect traveller at the destination.

Article 23 Medical examination, vaccination or other prophylaxis

See comment under Article 19.

Article 24 Goods in transit

See comment under Article 19.

Article 25 Container and container loading areas

This article needs to specify who is responsible for these provisions. Containers are presumably the responsibility of the health authority at the point of origin and arrival. The wording of 25(3) needs to be more precise.
Article 26 General provisions for health documents

See comment under Article 19.

Article 27 Certificates of vaccination or other prophylaxis, Annex 6, Annex 7

See comment under Article 19.

Could Annexes 6 and 7 be merged, streamlined and made more complete? For example, by including a list of approved vaccines that may be required for international travellers and PHEIC.

Article 29 Health part of the aircraft general declaration and Annex 9

This article and Annex 9 should give the health administration the power to obtain a list of all passengers and crew on a flight if an infected person is suspected to have been on the flight to enable contact tracing or other investigation.

Article 30 Bills of health

Participants could not see the need for this article in its present form.

Article 31 Charges for medical examination, vaccination or other prophylaxis

Participants considered that Member States should be able to decide their own policy on charges for medical examination, vaccination or other prophylaxis, provided these changes are fair and reasonable.

Article 33 General provisions

Should this article also refer to the obligation on WHO to facilitate implementation of relevant activities under the IHR?

Article 34 Excessive measures

Some participants expressed the view that there are situations where Member States may wish to impose measures exceeding those recommended by WHO under the IHR. The wording of this article needs to be reviewed to achieve a better balance between the intent of the regulations and national sovereignty concerns.

Article 35 Cessation of full implementation of measures

See comments under Article 34.

Article 36 Rights of persons

There was discussion about the need for Member States to impose some measures on travellers and other persons during PHEIC, e.g. isolation, quarantine and even treatment in some circumstances. This article needs to be reviewed with this requirement in mind.

Article 39 Transport of biological materials

The safe transport of biological materials is an important issue that should be covered by the IHR. As it is written, this article only relates to a very specific component of this area.
Article 40 Infection control

Participants supported the importance of effective infection control practices being in place in Member States. There was some discussion about the wording and placement of this article in the IHR. This article also raised questions about the role of other important infectious disease prevention measures and whether these should also be included in the IHR.

Article 41 Information sharing during a suspected intentional release

Participants felt this article needed to be reviewed in the context of a decision about the scope of the regulations as they relate to intentional releases. In such events, police or security agencies may have jurisdiction over evidence and a range of issues may complicate the provision of information and samples for verification and response purposes. The wording could be amended to "...verification and public health response purposes" to make it clear that WHO will not be involved in the direct response to the event as a whole.

Article 42 Arrangements between states

The wording of the text needs to take into account existing bilateral and regional arrangements. The meaning of the word “territories” compared with “states” needs clarification.

Article 47 Settlement of disputes

This article covers disputes between states. Should it be extended to cover disputes between states and WHO? The Framework Convention on Tobacco Control could be reviewed as a potential model.

Article 48 Existing conventions, regulations and similar agreements, Article 49 Period for rejection or reservations, Article 50 Reservations, Article 51 Withdrawal or rejection or reservation, Article 52 Entry into force

All the Member States have to some degree domestic constraints that will delay effective implementation of the IHR. These constraints particularly apply to the timeframe for reviewing and enacting changes to existing domestic legislation. The period for entry into force may have to be adjusted or phased to reflect these constraints.

2.7 Presentations on assessing and strengthening surveillance and response capacity

Dato Dr Tee Ah Sian, Director, Combating Communicable Diseases (DCC), WHO Western Pacific Regional Office, gave a presentation on strengthening communicable disease surveillance and response capacity in the Western Pacific Region to support IHR implementation. The overview began by reviewing the lessons learned from SARS and avian influenza. It stated the clear need for a capacity-building programme to strengthen communicable disease surveillance and response at the regional and national levels. It outlined the strategic areas for development: human resources; organization and systems; resource generation and allocation; and partnership and networking. A specific example of partnership and networking is the Regional Outbreak Alert and Response Network (ROARN). This resource includes an operational support team at the WHO Western Pacific Regional Office, surveillance partners and technical partners. The presentation outlined the guiding principles and management structure that will shape the capacity-building programme. Implementation will begin with an inventory of capacity in Member States to support IHR implementation.
Dr Stella Chungong, Medical Officer, DG/CDS/LYO, WHO Headquarters, presented an overview on assessing national diseases surveillance and response capacity. The presentation began by outlining the communicable disease surveillance and response challenges faced by many countries, notably gaps and poor coordination. The WHO CSR has a two pronged approach - the Global Alert and Response system and Country Capacity Strengthening (CCS). A component of CCS is the National Surveillance Systems Strengthening Strategy which is a structured approach to epidemiological and laboratory surveillance and response strengthening. It begins with a risk assessment and prioritization of communicable diseases for surveillance. This is followed by an in-depth assessment and nation plan of action to develop capacity. The in-depth assessments include structure and organization; core surveillance functions; laboratories; human resources; and integration /coordination. CCS provides other support for development and implementation of the national surveillance plan of action: standards and guidelines; software tools; and training. It also assists with the monitoring and evaluation of national plans of action.

2.8 Discussion of approaches for assessing and strengthening communicable disease surveillance and response capacity in the Western Pacific Region to support full operation of the IHR

The meeting participants separated into discussion groups, followed by reporting back by group rapporteurs. The aims were:

(1) to agree on approaches for assessing surveillance and response capacity of countries and areas in the WHO Western Pacific Region (This will include reviewing the draft Inventory of Capacity in Member States of the WHO Western Pacific Region to support implementation of the International Health Regulations.); and

(2) to identify areas where WHO could support strengthening of communicable disease surveillance and response capacity in the Western Pacific Region to facilitate full operation of the IHR

The groups were:

- Pacific countries and areas
- ASEAN countries (Brunei Darussalam, Cambodia, the Lao People’s Democratic Republic, Malaysia, the Philippines, Singapore, Viet Nam) and Mongolia
- Other countries and areas (Australia, China, Hong Kong (China), Macao (China), Japan, New Zealand, the Republic of Korea)

In reporting back, the groups identified issues under the main themes of capacity assessment and strengthening.

**Capacity assessment**

Systematic data on current IHR surveillance and response capacity of countries and areas:

Participants recognized the value of reviewing their own capacities for implementing the proposed IHR. In particular, the importance of timeliness has become more apparent.

Any assessment of capacity needs to consider the fact that countries often have several monitoring and surveillance systems. For example, some countries are currently integrating several systems to improve their effectiveness and efficiency. There is a need to refer to existing surveillance and response systems and utilize them to help implement the IHR.
Such an evaluation would have other benefits in terms of clarifying the scope of information required from the Member State. It could also consider trade-offs between different data quality issues, such as completeness vs. timeliness.

Pacific island countries and territories (PICT) emphasized the importance of involving subregional networks, such as the Pacific Public Health Surveillance Network (PPHSN), in the capacity-building process. At least in the Pacific, there could be advantages in carrying out the capacity-building process at subregional level. This approach recognizes the fact that many small countries share subregional capacities.

Use of the proposed Inventory of IHR capacity:

The capacity inventory was generally support by participants. Although completing the inventory will pose some challenges to Member States, it was considered that the information would assist countries in a number of ways, including generating a baseline stocktake of their capacities.

Completing the inventory will require the health administration (presumably the agency which will take the lead in this process) to discuss aspects of the inventory with other government agencies. This process may help to raise the profile of these capacity issues within the government of the Member State. However, it may also delay completion of the inventory.

Participants had some specific comments on the draft tool:

- WHO should have the capacity and resources to organize immediate solutions to address important gaps that are identified. For example, is there a plan to use the findings to help link countries to funding sources, such as donor agencies?

- The discussion emphasized that the inventory was a quick 'entry-point' stocktake to precede an in-depth assessment. The in-depth assessment will provide Member States with more specific guidance.

- The 5-point scale response will be a subjective and in some cases aggregate indication of the "degree of development". Perhaps some further criteria could be developed to guide interpretation and consistency.

- The results of the inventory should not be used for intercountry comparisons or construction of a 'league table'.

- WHO will need to provide guidelines to help Member States complete the inventory in a consistent way.

- WHO may need to consult Member States further to clarify some of the content before it is sent out.

- The wording of the inventory will need to be reviewed. For example, it refers to Member States having 24-hour assessment capability – participants suggested this criterion be changed to one that is more realistic.

Use of in-depth assessments:

Such assessments aim to acquire data on existing capacities, identify specific needs and gaps, develop tailored interventions, and involve stakeholders at all levels. They go well beyond meeting IHR Requirements.
There was considerable support for in-depth country assessment. Participants had some general comments:

- For large or populous countries undertaking an in-depth national assessment might be a very large task, and it may be more helpful to look at particular sub-national regions or a particular component of the surveillance/response infrastructure.
- These assessments need a multi-disciplinary team, including for example, laboratory scientist, environment health expert, statistician, and an epidemiologist.

**Capacity strengthening**

IHR capacities needing the most strengthening:

Groups noted that the proposed capacity-assessment processes aims to answer this question. Specific comments:

- This may need to occur at a provincial or other subnational level rather than just at a national level.
- Both routine and emergencies capacity will need to be considered.
- The process will be affected by decisions about the scope of the IHR, e.g. does it include chemical and radio-nuclear capacity.
- There is a need to consider multi-agency response capacity, e.g. animal health capacity, port and airport capacity.
- Communication within countries and among countries will assist the process.

Support needed at a country level to help strengthen these capacities:

The following points emerged from the discussions:

- The WHO Western Pacific Regional Office has an overview role with adoption and implementation of the IHR. To support this role, the Regional Office could develop, in consultation with NFP, a regional IHR adoption plan.
- Support for capacity strengthening could include components for training; advocacy; resource mobilization; political commitment; integration of vertical programmes; global fund/regional fund for health emergency; IHR Focal Person at regional level; and appropriate programme management structures.
- As for the Framework Convention on Tobacco Control, could WHO develop a model legal framework to assist countries and promote consistency?

**Regional / subregional infrastructure expected from WHO:**

Groups identified the following points:

- National focal points will be vital for state-to-WHO communications, but they will also be potentially very valuable for state-to-state communications. To this end, could WHO maintain an up-to-date list of all NFP contact points, and facilitate regional networking, training and meetings of the contact people at these centres.
During SARS, Member States in the Region reported to both WHO Headquarters and the Western Pacific Regional Office. Could the roles of WHO Headquarters and the regional offices be clarified, including reporting requirements?

Can WHO specify response times for itself when implementing the IHR from 2006 onwards, as Members States are being asked to do in the IHR? For example, performance targets for responding to both urgent and routine requests.

2.9 Closing ceremony

Dr Shigeru Omi, WHO Regional Director for the Western Pacific, thanked participants and the secretariat for their contribution to the meeting.

3. CONCLUSIONS AND RECOMMENDATIONS

3.1 Conclusions on the proposed IHR

The following conclusions, derived from the meeting discussions, were presented by the rapporteurs at the final plenary meeting. These conclusions were reviewed and adopted by the meeting participants.

**Overall view** The meeting participants strongly support the general intent of the proposed IHR. Participants believe that, once adopted, the revised regulations will contribute to:

- early effective detection of threats to international health;
- improved response and management of these threats; and
- an effective framework for working with other agencies to contain the international spread of disease.

**Regional networks** The IHR should acknowledge and affirm existing regional surveillance and response arrangements.

**Role of the national IHR focal point** This role is key to the successful implementation and operation of the IHR. It needs to be more clearly defined in the IHR, annexes and supporting documents.

**Decision instrument** The decision instrument is generally supported, but consideration should be given to supplementing it with one or more lists (e.g., specified diseases, or diseases which are only of concern in particular circumstances).

**Scope** The scope of the IHR as it relates to nonbiological hazards (chemical and radiological) needs further development and consultation. However, some participants believe the scope should be limited to infectious diseases and diseases of unknown etiology.
Team deployment The IHR should facilitate effective and collaborative on-site investigations between WHO and Member States. Participants request clarification of the intent and wording of Articles 8 and 10 in regards to when WHO may provide on-site assistance. Proposed alternative wording for this article was presented at the meeting (see footnote 1)

Infection control The development and maintenance of robust infection control practices in health care settings are a vital element of a Member State’s capacity to respond to public health emergencies.

Confidentiality Participants stress the importance of confidentiality in sharing information with WHO. A country should be informed before information is distributed further.

WHO implementation handbook Participants request a handbook to assist with implementation of IHR. This should include description of minimum surveillance capacities that support local, subnational, and national assessments and response decisions.

Emergency Plans (Annex 1) WHO is requested to provide guidance on the content and scope of public health emergency plans (i.e. objectives and principles).

Excessive measures Participants believe Member States should retain the right to impose measures in excess of those recommended by WHO, where there is an appropriate rationale (e.g., while WHO may only recommend screening of outgoing passengers, Member States may impose screening of incoming passengers).

Temporary recommendations Participants request transparency on the basis for WHO recommendations, and suggest that consideration be given to mandatory expiry dates for temporary recommendations.

Charges Participants feel that the issue of charges should be left to their own discretion, especially with regards to medical examination, vaccination and prophylaxis.

Definitions WHO should revise the draft IHR to include more definitions to cover Member State needs including a concise definition of Public Health Emergency of International Concern and amending the definition of ‘traveller’ to include transit passengers and crew.

Provisions relating to transport of goods Participants request clarity about the scope of IHR controls on baggage, animals and biological specimens.

Consistency with other regulations Participants request an analysis of IHR consistency with other related international agreements and regulations.

---

1 Modified text for Article 10(3) In the absence of such a request, WHO may offer assistance to the health administration of a Member State in responding to the public health emergency of international concern and may offer to collaborate with the health administration in assessing the severity of the threat and the adequacy of control measures including, when necessary, by offering to conduct on-the-spot studies for the purpose of ensuring that appropriate control measures are being employed. In such a case, WHO shall provide to the health administration concerned the information it has received and the assessment it has reached on the basis of that information. In case the health administration concerned does not accept that offer of assistance, WHO may make publicly available the information it has received and the assessment it has reached, as well as the nature of the assistance which has been offered, and may call upon the health administration to reconsider accepting the offer of assistance.
**Flexibility in timing of implementation** Many Member States will have to change their national legislation to bring the revised IHR into effect. Consideration should be given to extending the relevant deadlines or to phased implementation.

**Member States’ budget concerns** Recognizing that introduction may have budget and resource implications, Member States should begin estimating needs and identifying potential funding sources.

**WHO capacity** Member States must have confidence in WHO to deliver on the IHR mandate. WHO must have the capacity to support the responsibilities specified in the proposed IHR.

### 3.2 Conclusions on capacity strengthening

The following conclusions were drawn from the discussion group summaries presented by the group rapporteurs at the final plenary session. These conclusions were reviewed by the secretariat and meeting rapporteurs.

Participants supported the need for systematic assessment of surveillance and response capacity. This has many advantages for IHR implementation and communicable disease surveillance and response more generally. The approach will need to be adapted for large countries, when it may be best applied at the provisional or state level, and small countries, where a subregional approach might be more meaningful.

Use of the *Inventory of IHR Capacity* is generally supported by participants. Before being used, it needs to be further reviewed, the scale clarified and instructions produced. Participants are also interested in undertaking in-depth assessments of their surveillance and response capacity.

The strategies and scope for country capacity strengthening needs more discussion. Capacity strengthening might need to occur at a provincial or subregional level. It needs to consider routine and emergency capacity, and situations where a multi-agency response is needed. It will also be affected by decisions about the scope of the IHR, e.g. the decision about whether to include chemical and radio-nuclear hazards.

The topic of WHO support for country capacity strengthening was briefly reviewed. WHO has an overview role in adoption and implementation of the IHR. For example, WHO could develop, in consultation with NFP, a regional IHR adoption plan. A range of other specific forms of support could emerge from the capacity-assessment process. For example, WHO could prepare a model legal framework for the IHR, as was done for the *Convention on Tobacco Control*.

WHO will need to strengthen its capacity to support introduction of the IHR. An important strategy will be to support development of the national IHR focal points as a regional network. WHO also needs to clarify its own internal processes, including reporting requirements and response times.

### 3.3 Recommendations

The following recommendations emerged from the meeting:

1. WHO is urged to consider the views expressed at this meeting and use these to assist preparation of the draft IHR proposal for the Inter-Governmental Working Group that is to meet in the second half of 2004.

2. Member States of the Western Pacific Region are encouraged to review the IHR proposal in detail and send specific written responses to WHO before the end of June 2004.
WHO was asked by participants to develop a regional IHR adoption plan. This plan should cover the steps needed for ongoing consultation with Member States and WHO Headquarters to facilitate adoption of the revised IHR at the World Health Assembly in 2005.

The WHO Western Pacific Region Office should develop a regional capacity-strengthening plan, to include:

- a national capacity-strengthening plan - containing strategies to support capacity strengthening in Member States over the short to medium term; and
- a WHO capacity-strengthening plan - containing strategies to strengthen WHO capacity in the Region to support operations of the IHR.
AGENDA

1. Opening ceremony, introductions and group photograph
2. Presentation and adoption of workshop objectives and agenda
3. Presentation: Future of disease surveillance and response under the new IHR
4. Presentation: Background and overview of the new IHR
5. General comments on the IHR Working Paper from participants
6. Discussion groups to review context and need for IHR and identify main strengths and weaknesses of proposal
7. Presentation: Structure of working paper and key proposals
8. Discussion groups for detailed review of proposed IHR and annexes in broad functional areas
9. Discussion groups to review the key identified issues and summarize views of participants
10. Presentation: Strengthening communicable disease surveillance and response capacity in the Western Pacific Region to support IHR implementation
11. Presentation: Assessing national disease surveillance and response capacity
12. Discussion of approaches for assessing and strengthening communicable disease surveillance and response capacity in the Western Pacific Region to support full operation of the IHR
13. Agree process for capacity assessment and strengthening
14. Agree key IHR issues and recommendations to refer to Intergovernmental Working Group (IGWG)
15. Closing ceremony
CONSULTATION ON THE REVISION OF
INTERNATIONAL HEALTH REGULATIONS (IHR)
IN THE WESTERN PACIFIC REGION

Manila, Philippines
28-30 April 2004

ENGLISH ONLY

PROGRAMME OF ACTIVITIES

Day 1 – Wednesday, 28 April, WHO Conference Hall

08:00 – 08:30 Registration
08:30 – 09:00 Opening ceremony and introductions
  - Dr Shigeru Omi, Regional Director, WHO/WPRO
09:00 – 09:15 Group photograph
09:15 – 09:45 Coffee break
09:45 – 10:00 Presentation and adoption of workshop objectives and agenda
  - Dr Michael Baker, Short Term Consultant, WHO/WPRO
10:00 – 12:00 Overview of IHR and discussion of strengths and weakness of proposal
  Presentation: Future of disease surveillance and response under the new IHR
  - Dr Hitoshi Oshitani, Regional Adviser, CSR/WHO/WPRO
  Presentation: Background and overview of the new IHR
  - Dr Max Hardiman, Project Leader, IHR, CSR/WHO/HQ
  Plenary discussion of context for IHR and main strengths and weaknesses of proposal
  - General comments on the IHR Working Paper from participants
12:00 – 13:00 Lunch
13:00 – 15:00 Discussion groups to review context and need for IHR and identify
  main strengths and weaknesses of proposal
1. Pacific countries and areas (18 countries and areas)
2. ASEAN countries (Brunei, Cambodia, Lao PDR, Malaysia, Philippines, Singapore, Viet Nam) and Mongolia
3. Other countries and areas (Australia, China, Hong Kong (China), Macao (China), Japan, New Zealand and Republic of Korea)

15:00 – 15:15 Coffee break
15:15 – 17:00 Plenary session
   - Report back by discussion group
   - Assigning participants to groups for Day 2
17:30 Cocktails (WHO Conference Lounge)

Day 2 – Thursday, 29 April, WHO Conference Hall

08:30 – 10:00 Detailed Review of Proposed IHR and Annexes
   Presentation: Structure of working paper and key proposals
   - Dr Max Hardiman, Project Leader, IHR, CSR/WHO/HQ
   Discussion groups for detailed review of proposed IHR & annexes in broad functional areas
   1. Responsibilities of states for surveillance, reporting and other provisions under the IHR
   2. Responsibilities of WHO for responding to notifications and carrying out other functions under the IHR
   3. Regulation of points of entry, conveyance operators, travelers and other groups under the IHR
10:00 – 10:30 Coffee break
10:30 – 12:00 Discussion groups (continued)
12:00 – 13:00 Lunch
13:00 – 14:30 Discussion groups (continued)
14:30 – 15:45 Plenary session
   - Report back by group discussions
15:45 – 16:00 Coffee break
16:00 – 17:30 Discussion groups to review the key identified issues and summarize views of participants
   1. Pacific countries and areas (18 countries and areas)
   2. ASEAN countries (Brunei, Cambodia, Lao PDR, Malaysia, Philippines, Singapore, Viet Nam) and Mongolia
   3. Other countries and areas (Australia, China, Hong Kong (China), Macao (China), Japan, New Zealand and Republic of Korea)
Annex 2

Day 3 – Friday, 30 April, WHO Conference Hall

08:30 – 10:00 Assessing and strengthening communicable disease surveillance and response capacity in the Western Pacific Region

Presentation: Strengthening communicable disease surveillance and response capacity in the Western Pacific Region to support IHR implementation
- Dato’ Dr Tee Ah Sian, Director, DCC, WHO/WPRO

Presentation: Assessing national disease surveillance and response capacity
- Dr Stella Chungong, Medical Officer, HQ/DG/CDS/CSR/LYO

Discussion of approaches for assessing and strengthening communicable disease surveillance and response capacity in the Western Pacific Region to support full operation of the IHR
1. Pacific countries and areas (18 countries and areas)
2. ASEAN countries (Brunei, Cambodia, Lao PDR, Malaysia, Philippines, Singapore, Viet Nam) and Mongolia
3. Other countries and areas (Australia, China, Hong Kong (China), Macao (China), Japan, New Zealand and Republic of Korea)

10:00 – 10:30 Coffee break

10:30 – 12:00 Discussion groups (continued)

12:00 – 13:00 Lunch

13:00 – 14:00 Plenary
- Report back by discussion groups
- Agree process for capacity assessment and strengthening

14:00-15:00 Agree key IHR issues and recommendations to refer to Intergovernmental Working Group (IGWG)
- Report back on key issues, from Thursday afternoon groups
- Recommendations

15:00-15:20 Closing ceremony
- Dr Shigeru Omi, Regional Director, WHO/WPRO
LIST OF DOCUMENTS

- WPR/ICP/CSR/1.1/001/CSR(1)/2004/IB/1: Information Bulletin No. 1
- WPR/ICP/CSR/1.1/001/CSR(1)/2004/IB/2: Information Bulletin No. 2
- WPR/ICP/CSR/1.1/001/CSR(1)/2004.1A: Agenda
- WPR/ICP/CSR/1.1/001/CSR(1)/2004.1B: Timetable
- WPR/ICP/CSR/1.1/001/CSR(1)/2004.1C: Programme of Activities
- WPR/ICP/CSR/1.1/001/CSR(1)/2004.3: Presentation giving an overview of the IHR Process
- WPR/ICP/CSR/1.1/001/CSR(1)/2004.4: Main areas of agreement and disagreement
- WPR/ICP/CSR/1.1/001/CSR(1)/2004.5: Presentation on future of disease surveillance and response under the new IHR
- WPR/ICP/CSR/1.1/001/CSR(1)/2004.6: Presentation on structure of working paper and key proposals
- WPR/ICP/CSR/1.1/001/CSR(1)/2004.7: IHR working paper for regional consultations, 12 January 2004
- WPR/ICP/CSR/1.1/001/CSR(1)/2004.8: Draft Role of IHR Focal Point
- WPR/ICP/CSR/1.1/001/CSR(1)/2004.9: Provisional list of IHR Focal Points for Western Pacific Region
Annex 3

<table>
<thead>
<tr>
<th>Document ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>WPR/ICP/CSR/1.1/001/CSR(1)/2004.10</td>
<td>Initial comments from member countries</td>
</tr>
<tr>
<td>WPR/ICP/CSR/1.1/001/CSR(1)/2004.11</td>
<td>Synthesis and review of recommendations on the IHR</td>
</tr>
<tr>
<td>WPR/ICP/CSR/1.1/001/CSR(1)/2004.12</td>
<td>Presentation on building communicable disease surveillance and response capacity in the Western Pacific Region to support IHR implementation</td>
</tr>
<tr>
<td>WPR/ICP/CSR/1.1/001/CSR(1)/2004.13</td>
<td>Presentation on assessing national disease surveillance and response capacity</td>
</tr>
<tr>
<td>WPR/ICP/CSR/1.1/001/CSR(1)/2004.14</td>
<td>Inventory of capacity in member countries of the WHO Western Pacific Region to support implementation of IHR</td>
</tr>
<tr>
<td>WPR/ICP/CSR/1.1/001/CSR(1)/2004.15</td>
<td>Guidelines for assessment teams: Protocol for the assessment of national communicable disease surveillance and response systems</td>
</tr>
<tr>
<td>WPR/ICP/CSR/1.1/001/CSR(1)/2004/INF.1</td>
<td>International Health Regulations (1969)</td>
</tr>
<tr>
<td>WPR/ICP/CSR/1.1/001/CSR(1)/2004/INF.2</td>
<td>Frequently asked questions on proposed revision of the IHR</td>
</tr>
<tr>
<td>WPR/ICP/CSR/1.1/001/CSR(1)/2004/INF.3</td>
<td>Global crisis - Global solutions: Managing public health emergencies of international concern through the revised IHR, Geneva WHO, 2002</td>
</tr>
<tr>
<td>WPR/ICP/CSR/1.1/001/CSR(1)/2004/INF.4</td>
<td>World Health Assembly papers</td>
</tr>
<tr>
<td>WPR/ICP/CSR/1.1/001/CSR(1)/2004/INF.5</td>
<td>Public health, trade and law papers</td>
</tr>
<tr>
<td>WPR/ICP/CSR/1.1/001/CSR(1)/2004/INF.6</td>
<td>IHR consultation checklist and review questionnaire</td>
</tr>
</tbody>
</table>
Opening remarks of the Regional Director at the Consultation on the Revision of International Health Regulations (IHR) in the Western Pacific Region, Manila, Philippines, 28-30 April 2004

COLLEAGUES AND FRIENDS, DISTINGUISHED GUESTS, LADIES AND GENTLEMEN,

I am pleased to welcome all of you to this consultation meeting on the International Health Regulations. I would also like to offer a special welcome to the national focal points for the International Health Regulations who are participating in this meeting. Final revisions of the regulations, as well as their future implementation, will depend heavily on your unflagging efforts and continued commitment.

These are times of threat and opportunity. You are only too aware of some of these threats. Many of you have been on the front line in the fight against severe acute respiratory syndrome (SARS), avian influenza and other emerging infectious diseases. But from these threats also come opportunities. The revision to the International Health Regulations is such an opportunity.

Health and sanitation aspects of international traffic have been of concern to WHO since its inception. The World Health Assembly, in its 4th session in 1951, recommended that all governments should "improve sanitary and environmental conditions, especially in and around ports and airports".

The current International Health regulations, adopted by the World Health Assembly in 1969, comprise the only internationally binding legislation on the report of epidemic disease, with the purpose of ensuring maximum protection against the international spread of diseases with minimum interference with world traffic.

However, these regulations relate to an era when infectious diseases were on the decline and the first passenger flight of the jumbo jet in 1970 was still a year away. These regulations undoubtedly contributed to international success in containing infectious diseases. However, in the 35 years since they were issued, these tools have become increasingly outdated.

The need for updated regulations has been recognized for many years. The revision process began in May 1995 when the World Health Assembly passed a resolution calling for revision of the IHR to ensure that they take account of current trends in the epidemiology of infectious diseases. This process has been accelerating since then with the final drafting process decided at the 56th World Health Assembly in 2003.

The consultation draft of the International Health Regulations was distributed to member countries and other interested parties in January 2004. The final revised text will be subjected to an intensive review process that includes regional consultation meetings such as this one, in all the WHO regions, followed by an intergovernmental working group to develop the final draft. The final draft IHR will be presented to the 58th World Health Assembly in 2005.

I will not go through the main features of the regulations in any detail, as you are about to hear about them from some of the architects of this new international law.

However, I would like to emphasize the importance of achieving a successful outcome from this process. There are 4 points I would like to make:
Firstly, the stakes are high. It is a cliché, but remains true, that microbes do not respect borders. The level of risk has risen significantly, driven by the well-known trinity of organism, host and environmental factors. Microbes evolve and this process is being accelerated by human activity. Human and animal populations provide many appealing ecological niches. And environmental degradation and change are accelerating the potential for epidemic diseases spread.

Secondly, we need to sharpen our axe. If we do not establish an effective basis for swift, open and honest assessment of public health risk, then the media will set the agenda. Long gone are the days when public health officials and governments could keep emerging public health threats from the public. The electronic age, telecommunications, and the Internet mean that if we don't manage the flow of surveillance information we will as a professional group become redundant. The extended public health community is ideally placed to manage the response to these events and transparent information sharing will be a key part of our work.

Thirdly, be ambassadors for these regulations within your own countries. The International Health Regulations were created for the Member States of WHO and can only be adopted and implemented by them. We need the full engagement of all Member States at a technical and political level to ensure that all important areas of agreement and disagreement are identified early so that necessary changes can be made. This is a major purpose of this meeting. It is also why we have encouraged representatives attending this meeting to consult widely within their own countries with the many agencies involved in health, transport and international relations. National consensus on the proposed revision will be an important step toward its endorsement by Member States and adoption by the World Health Assembly.

Finally, there will be considerable global interest in the views of the Member States of the Western Pacific Region. This Region was at the forefront in controlling SARS and more recently avian influenza. It is home to the most and least populated nations on earth. It is also the first region to hold a full consultation meeting on revision of the International Health Regulations.

In conclusion, I would like to thank you and to ask all of you to help ensure the utmost benefit from this meeting through sound discussions, open exchange of ideas, and positive commitment to enhancing the International Health Regulations.

I wish you all a successful meeting and a pleasant stay in Manila.