Regional Consultation on the Revised
International Health Regulations
Harare- Zimbabwe, 1-3 June 2004

Report

World Health Organization
Regional Office for Africa
Regional Consultation on the Revised International Health Regulations

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LIST OF ACRONYMS

AFRO      WHO African Regional Office
CSR       Communicable Disease Surveillance and Response
HQ        WHO Headquarters
IDSR      Integrated Disease Surveillance and Response
IHRs      International Health Regulations
IWG       Intergovernmental Working Group
MOH       Ministry of Health
PHEIC     Public Health Emergencies of International Concern
RC        Regional Committee
WHA       World Health Assembly
WHO       World Health Organization
EXECUTIVE SUMMARY

In line with the Resolution of World Health Assembly to actively involve Member States in the revision process of International Health Regulations, the World Health Organization Regional Office for Africa in collaboration with WHO Headquarters convened a regional consultation meeting in Harare, Zimbabwe from 1-3 June 2004. The general objective of the meeting was to enhance the participation of the African region in the revision of International Health Regulations. Specifically the participants discussed the contents of the draft regulations and made comments, suggestions and recommendations.

This meeting was a follow-up of the briefing of high-level Ministry of Health Officials held in Johannesburg, Republic of South Africa, from 5-6 April 2004. The Permanent Secretaries or Directors General of Health and the national focal persons for IHRs from 34 Member States and WHO senior staff from Headquarters and the Regional office attended the meeting. The participants were informed on the revision process and content of the draft revised IHRs.

Country delegates systematically reviewed the contents of the core text and the. Among other aspects, key issues such as notification of events, designation of focal points, capacity building for IHR, and communication between WHO and MOH were extensively discussed and comments and suggestions made.

This report summarizes the presentations, discussions, key conclusions and recommendations of the meeting.
1. BACKGROUND

The World Health Organization (WHO) is building national capacity to detect and respond major outbreaks and events in partnership with other parties. The role of the International Health Regulations (IHRs) is critical to accomplish this goal. Indeed, the main purpose of the IHRs is to ensure maximum security against the international spread of diseases with a minimum interference in world traffic. The current IHRs, adopted by the 22nd World Health Assembly (WHA) in 1969 are the revised and consolidated version of the International Sanitary Regulations that were adopted in 1951.

With the emergence of new communicable diseases and reemergence of those once controlled, there is a need to revise IHRs. In 1995, the WHA passed resolution WHA48.7 calling for the revision of IHRs and later reinforced through resolution WHA54.14 in 2001. In May 2003, the World Health Assembly called for active participation of all Member States in the revision process. Accordingly, a series of regional consultation meetings were proposed in each WHO Region.

In the African Region, the consultation process started by a briefing of High Level Ministry of Health (MOH) Officials held in Johannesburg, Republic of South Africa on 5-6 April 2004. At this meeting, delegates agreed to continue consultation at national level with the participation of wide range of professionals and experts from relevant sectors in the months of April and May 2004. They also recommended holding a regional consultation meeting to assemble the comments and suggestions of the Member States on the revised IHRs as a contribution of the Region.

The World Health Organization – Regional Office for Africa in collaboration of WHO – Headquarters (HQ) convened a Regional consultation meeting in Harare, Zimbabwe from June 1-3 June 2004. During this meeting, delegates from 34 countries were able to attend. The purpose of this meeting was to create a forum for delegates from all Member States to review the technical content, the legal issues and the practical implications of the revised IHRs.

2. PROCEEDINGS OF THE MEETING

Dr Antoine Kaboré, Director of Division of Prevention and Control of Communicable Diseases, in his opening speech welcomed the distinguished delegates to this historical meeting. He stated that infectious diseases respect no political and administrative borders necessitating for international disease reporting to contain spread of epidemics. The current IHR, which focuses on mandatory reporting of three diseases, is no longer responsive to the changes in infectious diseases.

Recalling the Integrated Disease Surveillance Strategy, adopted by the Regional Committee in 1998 through resolution AFR/RC48/2 in 1998, Dr Kaboré pointed out that currently 42 of the 46 countries have embarked on implementation. A documentation exercise conducted in six countries has shown that disease surveillance and response have improved significantly in the region. It is absolutely important that Member States incorporate key elements of the revised IHR into the national IDSR technical guidelines.
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In her welcoming remarks, the Permanent Secretary of the Ministry of Health of Zimbabwe, Dr Elizabeth Xaba, hailed the meeting as an historic landmark in the process of revision of the International Health Regulations. It was her hope that the meeting would produce a regional position paper for submission to the World Health Assembly. She informed participants about Zimbabwe’s national process of reviewing the IHRs, which involved participants from various ministries and other stakeholders. This meeting produced a country position paper, which had been submitted to the secretariat as input into the regional position paper. Zimbabwe hopes that the revised IHRs will provide a sound basis for this country’s review process of the relevant pieces of legislation that the country is currently working on and that this process of review of the IHR would ensure compatibility between national and international pieces of legislation. The Permanent Secretary then wished participants a successful meeting and a safe stay in Zimbabwe and she declared the meeting officially opened.

Dr P. S. Lusamba-Dikassa, Regional Advisor of Communicable Diseases Surveillance and Response (CSR), stated that the general objective of the meeting is to enhance the participation of the African region in the revision of International Health Regulations. He further elaborated that specifically the country delegates would discuss the technical content of the draft International Health Regulations and make comments and suggestions.

Dr Damase Bodzongo, Director General of Health from Congo Republic was elected as the chairperson of the meeting while Prof. S. Benson Barh, Deputy Minister and Director of Health Services of Liberia was elected as Vice-chairperson. Three rapporteurs namely Ms Daisy Mafubelu from South Africa, Dr Moussa Diakhate from Senegal and Dr Marcelino Lucas from Mozambique were elected.

2.1. Overview of revised IHRs: Content and key issues (Mr. Gonzalez Martin)

The presentation highlighted the background, legal basis and revision process, major changes in the revised document, and key issues surrounding the revision process. He stated that IHRs are the only legally binding international instrument covering measures for preventing the trans-border spread of infectious diseases. These agreed codes of conduct provide protection against the spread of serious public health risks, excessive use of restrictions in traffic or trade and use of uniform and effective protective measures.

The WHA has the legal authority to adopt regulations concerning prevention of the international spread of diseases (article 21 of WHO constitution). The limitations of the current IHR in terms of the narrow focus in the notification of diseases, the outdated health service organization at point of entry to deal with the newly emerging diseases, and the health measures applied for international traffic have necessitated the revision process.

The revision of IHR provides a framework for global epidemic alert and response operations. The revised IHRs will strengthen procedures for rapidly gathering information, for determining when a disease event constitutes an international threat, and for seeking WHO assistance. The implementation of IHR requires building core capacities and technical assistance. The second draft will be discussed in the intergovernmental working group (1-12 November 2004), which will endorse the revised IHR to be submitted to the WHA in May 2005.

The revised IHRs have five major changes compared to the existing regulations. These are: national focal points, scope of notification, definition of core capacities, recommended
measures and external advice. The presentation also highlighted the areas that emerged as issues for discussion during previous consultations with Member States. These were: (i) scope of the IHRs (ii) flexibility versus fixed approach to specific diseases; (iii) national sovereignty in contract to international responsibility; (iv) incentives and compliance versus credibility and compensation scheme; (v) rapid responsive procedures and transparency/inclusiveness, (vi) consistency with other international obligations/treaties; (viii) developed vs developing national perspectives and (ix) feasibility of implementation (resources) particularly the core capacities in surveillance, response and at points of entry.

2.2. Introduction to group work I (Dr Lusamba-Dikassa)

Dr Lusamba-Dikassa, RA /CSR, in his introduction to group work, highlighted that the group will specifically discuss on the main issues raised during the plenary and also during the briefing of the High-Level MOH Officials and examine them with the view of providing comments and suggestions to improve the IHRs. To facilitate the group discussion four working groups (2 francophone and 2 Anglophone) were organized.

- Group 1: Burkina Faso, Comoros, Congo, Cote d’Ivoire, DRC Equatorial, Guinea,
- Group 2: Cape Verde, Central African Republic, Chad, Madagascar, Mali, Niger, Senegal, Togo,
- Group 3: Cameroon, Eritrea, Ghana, Lesotho, Liberia, Mozambique, Namibia, and The Gambia
- Group 4: Mauritius, Nigeria, Seychelles, South Africa, Swaziland, Zambia, and Zimbabwe.

Since only two countries were represented from Lusophone countries, Mozambique joined the Anglophone and Cape Verde joined the Francophone working groups.

2.3. Introduction to the IHRs working paper (Mr. Gonzalez Martin)

Mr. Fernando introduced the content of the revised IHRs. He indicated that the document has three components:

(i) **Core text**: Unchanging rights and obligations, prohibitions and permissions. It contains 55 articles partitioned into 9 main parts.

(ii) **Annexes**: Regulatory but greater technical details and subject to change and amendment. This part has 10 annexes.

(iii) **Referenced guidelines**: Not strictly regulatory. Provide technical advice on implementation, require periodic updating (e.g. guidelines, early warning system in disease surveillance, IDSR)

The revised IHRs are expected: (i) to be more relevant to the emergencies, (ii) to be flexible to deal with different types of emergencies and varied level of response, (iii) to achieve a balance between urgency of action and transparency, (iv) to maintain the best of the current IHR.
Introducing Group Work II, Dr P.S. Lusamba-Dikassa indicated that the purpose was to examine the draft paper article by article along with the relevant annexes in three thematic areas. The selected themes were: (i) surveillance and reporting of public health emergencies of international concern, (ii) Role of WHO in receiving, verifying and responding to notifications and other information sources and (iii) Regulations of points of entry, travelers and conveyances operators. He assigned group 1 and group 3 to work on theme 3, group 2 to work theme 2 and group 4 to work on theme 1.

2.4. Capacity building for IHRs implementation

2.4.1. Capacity building for IHR implementation in the African region

(Dr Lusamba-Dikassa)

Dr Lusamba-Dikassa presented a framework for implementation of revised IHRs for the African region. He emphasized the need to prepare a successful implementation of revised IHRs after their adoption by the World Health Assembly in May 2005.

He recalled the goals of integrated disease surveillance and response (IDSR) and IDSR implementation framework. This strategy was conceived in 1995 and adopted by the Member States of the African region in 1998. The Regional Director created a Task Force on IDSR in 2000. The development of guidelines and tools was completed in 2001, allowing the launching of training activities the same year.

Since then countries have achieved considerable progress in IDSR implementation: 91% of them have assessed the strengths and weaknesses of existing disease surveillance systems; 85% have formulated strategic plans for IDSR implementation; 75% have developed technical guidelines and 52% of countries have launched training activities at district level. The countries that have used IDSR core indicators have recorded improvements in terms of reporting of priority diseases, data analysis at district level, and notification and investigation of disease outbreaks involving the laboratory for the confirmation of aetiological agents.

Dr Lusamba-Dikassa indicated commonalities and possible synergies between IDSR and IHRs. Indeed, both aim at improving event detection, reporting, verification and public health response. The existing IDSR infrastructure could serve implementation of IHRs and, in return, IHRs implementation could further help strengthen core capacities and improve overall disease surveillance and response by bringing additional tools, infrastructures and resources from the Global Outbreak Alert and Response Network.

He outlined the steps for IHRs implementation including sensitization of Member States, incorporation of IHRs into IDSR, adaptation of existing structures, capacity strengthening and actual implementation. He concluded that with reinforced capacities, the Member States of the African region would be ready to implement revised IHRs within the framework of integrated disease surveillance and response already being implemented.

2.4.2. Capacity building for IHR implementation: Global strategy

(Dr Chungong)

Dr Chungong from WHO/HQ presented the global strategy for building capacities for IHR implementation, as part of the national surveillance and response system strengthening. She
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discussed some of the current challenges, needs in surveillance and response, the coordination of surveillance activities, global surveillance and response strategy and implementation framework.

She also indicated the progress of implementation of the national capacity building for surveillance and response. This included development of a structured approach to support countries based on a cycle of risk assessment, prioritization, in-depth assessment, a plan of action development, implementation, monitoring and evaluation. To date, over 50 countries from 4 WHO regions have embarked on various components of this strategy.

Dr. Chungong concluded her presentation by indicating IHRs as yet another opportunity to strengthen national capacity for early warning systems.

3. SUMMARY OF COMMENTS, SUGGESTIONS ON REVISED IHRs

3.1. Summary of comments and suggestions from group Work I

The first day of the meeting concentrated on the discussion of main issues raised during the national consultation meetings and the presentation of Mr. Gonzalez. The main key issues raised during the plenary issues became the basis for the group work. The following summarizes the comments and suggestions of the plenary that followed the group work presentation.

3.1.1. Definition of terms and guidelines to avoid conflict

There is need to make the definition of terms used in IHRs less ambiguous by further clarifying the current one as necessary. For example, the terms of optional regulations, review committee, temporary residence, ship sanitation control exemption certificate need clarification. In the same line, public health emergency is not clearly defined.

3.1.2. Report of the evaluation of the implementation of the 1969 IHRs

The participants flagged the absence of the detailed report as part of the working documents. They emphasized that the lessons learned from the implementation of the 1969 IHRs could be instrumental in the implementation of revised regulations. The detailed report should be shared with Member countries as a working document. Lessons learnt included in the report should be inserted in the preamble to revised IHRs.
3.1.3. **Capacity strengthening:**

The IHR implementation should be preceded by an in-depth situational analysis on existing core capacities based on the needs assessment of the human, financial and material capacities to be addressed. The issue of communication and logistics including equipment should be properly addressed. In the African Region, IDSR has started with assessment of capacity for surveillance, epidemic preparedness and response and there is need to build on those capacities. The need should be articulated properly in contrast to simply lumping it as the implementation of IHRs.

3.1.4. **National Focal points:**

The definition of focal point should be clear. The participants propose to replace the term of center with structure in the definition of IHRs national focal point. This term is defined on page 3 and also on page 5. Only the definition appearing on page 5 that is the most complete should be kept. Its designation should take into consideration both the political and the technical aspects. The focal point should be with in the health administration (MOH). Indeed the focal person should be someone at higher level such as the Permanent Secretary or Director General for effective support to the focal point. However, the decision should be left to the country. Each Member State should decide on the focal point and focal person based on criteria provided in the IHRs.

It was expressed that a multi-sectoral committee cannot be a focal point, as this will delay the notification and verification process. On the other hand other sectors should be called in to participate in IHRs through a multi-sectoral committee chaired by the Ministry of Health. The issue should not be left to MOH only. It was also expressed that the committee that handles the surveillance, preparedness and response issues could be designated to handle the IHR issues instead of creating another committee. The participants expressed the need for Member States and partners to support the focal points by providing the required capacities for its mission. The structure is not independent of the state. It is not up to the national points to notify diseases but the Ministry of Health.

3.1.5. **Communication between WHO and focal point**

The communication between WHO and the National focal point are important. However, this is not of major concern if the focal point is also the high level official, e.g. the permanent secretary or the Director General. Nevertheless, for the day-to-day exchange of information, the focal person could directly communicate with WHO. Declaring epidemics is the duty of the MOH. But after the epidemic is declared, there is no need to seek clearance. Thereafter, the routine exchange of information between WHO and the focal point would continue for a continuous update of the situation.

Timeframe of reporting is dependent of the time it takes to confirm the pathogens. Pending the confirmation of the disease under consideration, there should be an initial alert to WHO.
3.1.6. **List of diseases and events**

The concept of PHEIC does not help in building capacity at national level. It is important to include minimum number of diseases. In addition, we can still retain the PHEIC concept and the decision-making algorithm. Some groups have suggested: cholera, plague, yellow fever, anthrax, Ebola viral hemorrhagic fever, SARS and influenza were some of the suggested infectious diseases.

3.1.7. **Notification based on unofficial sources**

In the African context, unofficial sources could be beneficial. However, WHO should verify unofficial information with concerned health authorities. Unofficial sources should be used only for information. However, it is only the health authority that should notify WHO.

3.1.8. **Land, road and air transportation**

The road and rail transport aspect is not sufficiently developed. It needs to be further developed just as the air and maritime section. There is no specific entity that works on the land/road transportation. Specific provisions for implementation of the land and rail conveyances should be made.

3.1.9. **Intercountry collaboration**

This concept should be further developed. Indeed, in the African context promoting inter-country collaboration could help strengthen response to public health alert.

3.1.10. **National sovereignty**

When responding to PHEIC, the sovereignty of the country should be respected. The regulations should clearly indicate that any external assistance from another country should only come with invitation of the host country. If Article 10 does not clearly indicate this aspect, it should be amended.

3.1.11. **Mechanisms for monitoring & evaluation of IHRs implementation**

The suggested approach is to develop/strengthen partnerships between WHO and national health structures and to involve WHO in national IHRs consultative Committees through WHO country office. A joint WHO missions to Member States to assess progress in IHR implementation and prepare regular reports (periodicity to be determined) should be undertaken.
3.1.12. Vaccination, prophylaxis and the related certificates

Recommendation was made to include model vaccination exemption certificate form.

3.1.13. Informal trade with foodstuffs across border

It was agreed that there are other international bodies whose mandate is to deal with these aspects and the decision was to leave this out from the IHRs.

3.1.14. Settlement of disputes

Concerns raised regarding a need for a dispute settlement body would be taken care of by the provisions of Article 47.

3.2. Summary of comments and suggestions from group Work II

The working groups reviewed the different sections of the working paper on revised IHRs, focusing on the content of the articles in the core text and in the annexes. They proposed changes in the following areas.

Article 4:

− A list of diseases should be included in main body or annexes
− The content of annex 1b should be incorporated in core text
− Provide operational guidelines to include aspects currently not covered in the regulations (e.g. funds)

Article 5:

− 5.1 Implies health administration report to National Focal Point. Needs to be reviewed.
− No further recommendations on 5.2 and 5.3.
− Need to develop and include in annexes recommended notification forms

Article 6

− This article referring to paragraph 2 of article 5 has no problem. However the criteria for event notification are listed in article 5. The text under this article should be reformulated for clarity in the French version, making it clear the each listed criteria is sufficient to warrant event notification

Article 9

− Determination of a Public Health Emergencies of International Concern: 9.2 should be amended to read: “inform other health administrations …”
Article 10

- In order to take into account the sovereignty of countries, the suggested amendment to the formulation of paragraph 3 is “In the absence of such request, WHO may propose…”

Article 11

- The formulation of this article should take into consideration the importance of transport by road in Africa. Therefore there is need to reinforce border posts.

Article 14

- Under point 3b “Ship sanitation control exemption certificate” should be replaced with “Ship sanitation exemption of control measures certificate”

Article 15

- This article suggests the preparation of a guide for the assessment of border posts.

Article 16

- 16.5 should include lakes because they may also be contaminated

Article 17

- Article 17 a (iii): WHO should provide a definition for "non-invasive medical examination"

Article 23

- At the end of the article, take off the phrase "except for travellers seeking temporary or permanent residence".

Article 24

- This article should be reviewed in such a way that public health reasons should not stop export and import of goods.

Article 31

- Article 31(b) should be replaced by article 82 of 1969 regulation, which is more elaborate and equitable.

Article 33

- Instead of “General provisions” the heading should read “General measures”
Article 47

- Article 47 should include provisions for settlement of disputes

Annex 1: Core Capacity Requirements for Surveillance and Response

- Need to define terms used in the annex (proposed levels)
- 24 hour timeline should be included in main body under article 5.1
- Item (g) under response capacities...“national public health emergency response plan” is the core of any response and should be at top of list

Annex 2: Decision instrument for states to access and notify events

- Include footnotes under the decision tree to introduce the illustrations that follow
- Keep the 4 scenarios in Annex 2: impact serious; unusual/unexpected; risk of spread and risk for restrictions
- Include “either” for scenario 1 and 4 for clarity: i.e. either 1,2 or 3 and or 8,9,10 or 11
- Last sentence on page 31 not relevant and should be deleted

Annex 3: Processes to be followed by WHO

- Under this annex, it is suggested to refer to the usual communication channels, especially official ones

Annex 4: Technical requirements on conveyances & conveyance operator

- After sections 1, 2 and 3, in model certificate, it is important to mention the date when the document was issued

Annex 5: Specific measures for vector-borne diseases

- Under point 4, in addition to airports, port and container terminals, road terminals should be added.

Annex 9: Health part of the aircraft general declaration

- The type of insecticide should be added onto general aircraft declaration

Capacity building for IHRs implementation

Contingency stokes should be managed at the district level instead of at national level. This is particularly important in big countries. This will contribute to the rapid response to outbreaks.

Other events that have nothing to do with diseases have not been covered in the presentation. It is important to provide clarify how to build such capacities to ensure that the capacity to verify, validate and transmit any other events and risks as they occur.
The quality of surveillance data is questionable in many instances. Wouldn’t it be possible to establish some sort of quality control to epidemiological surveillance reporting similar to the laboratory quality control methods? Secretariat responded saying implementation is difficult, but instead suggested that countries could improve the quality of surveillance data through continuous monitoring and evaluation of progress made including quality of data with the aim of improving implementation.

The WHO should continue provision of technical guidelines in relevant areas. Particularly an appeal was made for guidelines in the area of environmental health interventions. Participants appreciated the link and clarification provided with regards to the relationship between IDSR and IHR.

4. CLOSING REMARKS

Dr Asamoah-Baah, Assistant Director-General for Communicable Diseases Cluster thanked all the participants. This is a very tricky exercise for several reasons. Firstly, the call to WHO to respect the sovereignty of Member States, however diseases do not need Visas and know no borders and they cross in all forms, it is therefore not enough to only talk about national laws. Secondly even though we are talking about IHR, the other side is international trade, security, tourism and travel for a variety of reasons such as for training. Very proud that consensus was reached on many issues. Thirdly is to deal with the process of adopting the IHRs. Who has two ways of adopting them namely, a resolution, which is not legally binding and the other is a convention, which after ratification becomes legally binding.

The way the IHR will be dealt with is a middle way between the two, unless a Member States opts out of the IHRs they become legally binding. Dr Asamoah-Baah called on as many people as possible in this meeting to attend the November IGWG in Geneva. He emphasized not to focus on the health issues alone but on the wealth issues as well, taking into account that other delegations will be looking at both health and wealth. He concluded his remarked by thanking everyone that made the gathering a success.

5. RECOMMENDATIONS

1. WHO to disseminate the report on evaluation of implementation of current IHRs and lessons learnt.
2. WHO to widely sensitize Member States on content and implementation of revised IHR (after adoption by the WHA) and also support in-country sensitization of all stakeholders
3. WHO to support countries in the assessment of core capacities for implementation of IHRs
4. Member States are encouraged to participate in the inter-governmental working group to be held in November.
5. Organize another regional consultation session shortly before the IGWG in November, preferably a day or two before the beginning of IGWG.
ANNEX 1: PROGRAMME OF WORK

REGIONAL CONSULTATION MEETING ON
REVISION OF INTERNATIONAL HEALTH REGULATIONS
Meikles Hotel, Harare, Zimbabwe, 1-3 June 2004

Tuesday 1 June 2004

08:00 –09:00: Registration of participants
09:00 –09:45 Opening ceremony
\hspace{10mm} Opening of the meeting, The Permanent Secretary of MOHCW of Zimbabwe
\hspace{10mm} Opening remarks (Dr Antoine Kaboré, Director, Division of Prevention and Control of Communicable Diseases WHO/AFRO)
09:45-10:00 Presentation of the objectives of the meeting (Dr Lusamba-Dikassa, Regional Advisor, CSR)
\hspace{10mm} Selection of chairperson and rapporteurs
\hspace{10mm} Group Photo

10:00 – 10:30: COFFEE BREAK

10:30-11:00: Overview of revised IHR: Process, content and key issues (Mr. Fernando Gonzalez-Martín, IHR/CSR/WHO/HQ)
11:00-12:00: Plenary to list main areas and issues of concern identified during the national consultation meetings the revised IHRs
12:00-12:30: Introduction to Group work I (Dr Lusamba-Dikassa, RA/CSR)

12:30-14:00: LUNCH BREAK

14:00-15:45: Group work to discuss the issues and concerns identified during the plenary

15:45-16:00 COFFEE BREAK

16:00-17:30 Group work continues

Wednesday 2, June 2004

08:30 –10:00: - Group work presentation and discussion

10:00 –10:30: COFFEE BREAK
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10:30-12:30: Discussion on the group work presentation continues

12:30-14:00: LUNCH BREAK

14:00 –14:30 Introduction to the IHR working paper (Mr. Fernando Gonzalez-Martin, IHR/CSR/WHO/HQ)

14:30-15:00 Discussion

15:00-15:15 Introduction to group work II (Dr Lusamba Dikassa, RA/CSR)

15:20-17:30 Group discussion to review revised IHR in detail in the following areas.

1. Surveillance and reporting of public health emergencies of international concern
   - Relevant articles
   - Annex 1A – Core capacity requirements for surveillance and response
   - Annex 2 – Decision instrument for states to access and notify events potential constituting a public health emergency of international concern. Role of National Focal Points (see separate agenda paper)

2. Role of WHO in receiving, verifying and responding to notifications and other information sources, including:
   - Relevant article
   - Annex 3 – Processes to be followed by WHO
   - Annex 10 – The review committee

3. Regulation of points of entry, travelers and conveyance operators
   - Relevant articles
   - Annex 1B – Core requirements for designated airports, sports, ground cross
   - Annex 6 – Vaccination, prophylaxis, and related certificates
   - Annex 7 – Requirements concerning vaccination or prophylaxis for specific diseases
   - Annex 4 – Technical requirements on conveyances and conveyance operator
   - Annex 5 – Specific measures for vector-borne diseases
   - Annex 8 – Model of maritime declaration of health
   - Annex 9 – Health part of the aircraft general declaration

16:00-16:20 Break

Thursday 3, June 2004

08:30 –10:00: - Group work presentation and discussion

10:00 –10:30: COFFEE BREAK
10:20-12:00 Group work presentation and discussion
12:00-12:30 Capacity building for IHR implementation
   − Capacity building for IHR implementation in the African region (Dr Lusamba-Dikassa, Regional Advisor CSR/AFRO)
   − Capacity building: Global strategy for IHR implementation (Dr S. Chungong, EPS/CSR)
12:30-13:00 Discussion

13:00-14:00: LUNCH BREAK

14:00-15:30 Free time for the rapporteurs to prepare summary of the suggestions and recommendations of the meeting
15:30-16:30 Presentation of the summary of the suggestions and recommendations
16:30 Closing of the meeting
   Closing remarks (Dr Asamoah-Baah, Assistant Director General, CDS)