Implementation of International Health Regulations (2005)

Report of the Second Regional Meeting of the National IHR Focal Points
Colombo, Sri Lanka, 23-25 June 2008

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Acronyms

AI	Avian Influenza
CSR	Communicable Diseases Surveillance and Response
DG	Director-General (WHO)
FAO	Food and Agriculture Organization
FETP	Field Epidemiology Training Programme
GOARN	Global Outbreak Alert and Response Network
HQ	Headquarters (WHO)
IATA	International Air Transport Association
IHR	International Health Regulations
ILO	International Labour Organization
MS	Member States
MOH	Ministry of Health
NFPs	National Focal Points (IHR)
NIC	National Influenza Centre
OIE	World Organization for Animal Health
PH	Public Health
PHEIC	Public health Emergency of International Concern
PoE	Ports of entry/exit
RD	Regional Director
RRTs	Rapid Response Teams
SEAR	South-East Asia Region
SEARO	Regional Office for South-East Asia (WHO)
SHOC	Strategic Health Operations Center
SIDAS	SEARO Integrated Data Analysis System
WHO	World Health Organization
WCO	WHO Country Office

1. Background

The revised International Health Regulations-IHR (2005) came into effect on 15 June 2007.[1] In accordance with the Regulations, Member States have committed to develop and maintain public health core capacities as defined by IHR (2005).

The purpose and scope of the International Health Regulations (IHR) are "to prevent, protect against, control and provide a public health response to public health risks that may pose significant risk to international spread of disease or unnecessary international trade or travel restrictions". The new Regulations are significantly broader in their scope than the earlier versions. They include obligations for Member States to strengthen their health systems and core capacities for implementation of the Regulations. The core capacities required include: building national capacity for surveillance and response at all levels including points of entry; being able to detect and assess events; and having reporting and response mechanisms in place to effectively deal with potential public health emergencies of international concern (PHEIC). Also, Member States have agreed to promptly report to WHO any event which may need a coordinated international public health assessment and response. While every Member State is responsible for implementing the Regulations at the national level, WHO will collaborate with and support States to meet these requirements and to provide assistance, as and when required.

Recent outbreaks of avian influenza, dengue, nipah, scrub typhus and chikungunya fever in South-East Asia have demonstrated the vulnerability of the Region to emerging and re-emerging diseases.[2] The majority of worldwide cases and deaths due to human avian influenza (H5N1) in the first half of 2008 were reported from Indonesia, a Member country in the South-East Asia Region. Also, Myanmar and Bangladesh reported their first cases of human avian influenza (H5N1) in late 2007 and early 2008 respectively. In view of the vulnerability of the Region, it is imperative that

[1] See http://www.who.int/csr/ihr

[2] See document SEA-CD-145 (2007)

Member States enhance ongoing efforts to strengthen surveillance and response systems. Furthermore, it is of paramount importance to scale-up existing inter-sectoral collaboration between various sectors for a well-coordinated and effective response to public health emergencies.

Recognizing the invaluable contribution of sharing experiences and lessons among Member States, WHO organized the First Regional Workshop on Implementation of IHR in April 2007. The participants of this workshop underscored the importance of the forum and recommended that WHO coordinate an annual workshop to review progress towards IHR implementation and identify follow-up actions. Accordingly, WHO in collaboration with the Ministry of Healthcare and Nutrition of Sri Lanka organized the Second Regional Workshop during 23-25 July 2008 in Colombo.

2. Objectives of the meeting

The general objective was to review progress towards IHR implementation in Member States of the South-East Asia Region between June 2007-2008. The specific objectives were:

- to review the status of IHR (2005) implementation including the progress made since the last meeting held in April 2007;
- to identify constraints and challenges faced by countries to implement the Regulations;
- to propose strategies and interventions to overcome the challenges faced; and
- to develop follow-up actions for IHR (2005) implementation for each member country and WHO.

3. Opening Session

Dr Athula Kahandaliyanage Secretary, Ministry of Healthcare and Nutrition, Sri Lanka, in his opening address highlighted the increased threat from infectious diseases and the subsequent revisions made to the IHR to adequately deal with such threats. He stressed the importance of transparency, international

partnerships and collaboration between and among various sectors in fulfilling the IHR obligations (Annex 1 for full text of speech).

The message of the WHO Regional Director for South-East Asia, Dr Samlee Plianbangchang, was delivered by Dr Agostino Borra, WHO Representative to Sri Lanka, who also welcomed the participants. In his message, the Regional Director underscored the need to strengthen core capacities required for implementation of IHR (2005) and noted the progress made by Member countries in the past year.

The Regional Director reiterated that the IHR encompasses, in addition to infectious diseases, a range of events including those related to food and chemical safety, as well as toxicological events, and any event with the potential to cause a Public Health Emergency of International Concern (PHEIC). Furthermore, he noted that the South-East Asia Region faces considerable threat not only from emerging and re-emerging diseases such as dengue and avian influenza (H5N1) but also from frequent natural disasters including floods and cyclones. In this regard, he cited the recent cyclones in Bangladesh and Myanmar; earthquakes in Indonesia; and the 2004 tsunami that caused huge devastation and destruction.

In conclusion, the Regional Director emphasized the central role of partnerships and noted the excellent collaboration from Member countries towards IHR implementation. (Annex 2 for full text of Regional Director's Message).

4. Progress in implementation of IHR (2005)

The programme of the meeting is at Annex 3. The participants included national IHR focal persons, WHO Country Office focal persons as well as staff from WHO/HQ and from the Regional Office (Annex 4 for list of participants).

4.1 Progress in implementation of IHR (2005) – global perspective

A presentation was made on the global progress achieved in the seven strategic actions developed to guide implementation and monitoring of IHR

(2005). These are to: (i) foster global partnerships; (ii) strengthen national surveillance, prevention, control and response systems; (iii) strengthen public health security in travel and transport; (iv) strengthen WHO's global alert and response system; (v) strengthen the management of specific risks; (vi) sustain rights, obligations and procedures; and vii) conduct studies and monitor progress. (See Figure 1).

Figure 1. ***Strategic actions to guide IHR (2005) implementation***

	Strategic action	Goal
Global Partnership		
1	Foster global partnership	WHO, all countries and all relevant sectors(e.g. health, agriculture, travel, trade, education, defence) are aware of the new rules and collaborate to provide the best available technical support and, where needed, mobilize the necessary resources for the effective implementation of IHR (2005)
Strengthen National Capacity		
2	Strengthen national diseases surveillance, prevention, control and response systems	Each country assesses its national resources in disease surveillance and response and develop national action plans to implement and meet IHR (2005) requirements thus permitting rapid detection and response to the risk of the spread of international diseases.
3	Strengthen public health security in travel and transport	The risk of international spread is minimized through effective and permanent public health measures and response capacity at designated airports, ports and ground crossings in all countries.
Prevent and Respond to International Public Health Emergencies		
4	Strengthen WHO global alert and response systems	Timely and effective coordinated response to international public health risks and public health emergencies of international concern
5	Strengthen the management of specific risks	Systematic international and national management of the risk known to threaten international health security, such as influenza ,meningitis, yellow fever, SARS, poliomyelitis, food contamination, chemical and radioactive substances.

	Strategic action	Goal
Legal Issues and Monitoring		
6	Sustain rights, obligations and procedures	New legal mechanism as set out in the Regulations are fully developed and upheld; all professionals involved in implementing IHR (2005) have a clear understanding of, and sustain, the new rights, obligations and procedures laid out in the Regulations.
7	Conduct studies and monitor progress	Indicators are identified and collected regularly to monitor and evaluate IHR (2005) implementation at the national and international levels. The WHO Secretarial reports on progress to the World Health Assembly. Specific studies are proposed to facilitate and improve implementation of the Regulations

The presentation focused on specific required elements under IHR such as emphasizing the designation and role of National Focal Points (NFPs) and WHO contact points who should be accessible at all times for communication with WHO to notify, report, consult and verify events. The speaker noted that certain rules and procedures should be followed e.g. confidentiality and criteria for posting events on the IHR website.

Global partnerships were discussed in the context of IHR implementation. The speaker highlighted that implementation of the IHR requires participation of many stakeholders including Member States, WHO, GOARN, IATA, ILO, FAO, OIE and other national, regional, and global partners. It was underscored that the main role of WHO is to assist Member States in strengthening their capacity to implement the Regulations including the production of guidelines and tools to facilitate Member States to reach implementation goals and objectives. In this regard, WHO has developed several documents and guidelines which are available on the web (http://www.who.int/csr/ihr). Others are being developed and finalized. Finally, the IHR roster of experts was highlighted as one area where worldwide progress has been made with a list of 200 expert names submitted to WHO by Member States. SEAR Member countries submitted eight names. Further follow-up is required to get more representation from experts in countries of the South-East Asia Region.

4.2 Progress in implementation of IHR in the Region

A second presentation reviewed regional progress made in IHR implementation in the past year with reference to the seven strategic areas of work. It was encouraging to note the progress in all the strategic areas made since the last meeting. All Member States have designated national IHR focal points with 24/7 access and availability. Three countries have nominated an expert for the IHR roster of experts. Eight countries have assessed their laws for compliance with IHR training in field epidemiology and rapid response is being undertaken throughout the Region systematically and some countries are already implementing sub- national level training in order to strengthen national capacity in surveillance and response. Four countries have organized risk communication training for health and media personnel. All the Member countries are strengthening their laboratory capacity and there are now seven National Influenza Centres in the Region. In the past year, WHO provided support to Member countries by producing guidelines and tools for the clinical management and laboratory diagnosis of Influenza A (H5N1), and produced a guide on early warning, alert and response. The Regional Office also developed a strategy for zoonoses prevention and control.

The presentation identified gaps and constraints that need further follow-up by WHO and Member States. These included the need to: enhance timely communication between IHR focal persons and the Regional Office focal person; identify resources for implementation, and develop a few sound indicators to monitor and measure IHR implementation. WHO SEARO is in the process of developing such indicators.

4.3 Event management and Global Outbreak Alert and Response Network (GOARN)

Under IHR (2005) WHO is committed to support Member States to build capacity to detect, monitor and manage PHEIC. Member States have an obligation to notify such events to WHO. In turn, WHO will assist to ensure a prompt and coordinated international assessment and response.

In the last year, WHO has taken steps to strengthen its event management system and to enhance the Gobal Outbreak Alert and Response Network. It has developed guidelines on standard operating procedures and tools for event management (which is in its final stages), and actively participated in verification and response to public health events of national,

regional and global importance. The process involves daily tracking of media and other information sources on public health risks, and verification of rumours of outbreaks and other events. When requested, WHO will assist Member States in responding to public health emergencies through the mobilization of human resources, supplies and logistic support.

GOARN was established in 2000 as a response component. . WHO/HQ facilitates the coordination of GOARN partner response when countries request assistance and the country capacity is insufficient to mount a response. Upon receipt of a request from a country, GOARN partners are alerted and experts sought. The Network currently has about 150 institutions worldwide. Among these, there are 15 institutions which are GOARN members from seven countries in the Region (Table 1). Table 2 shows events where experts were mobilized through GOARN.

Table 1. *GOARN partners in SEAR*

S. no.	Name	Country
1	ICDDRB: Centre for Health and Population Research	Bangladesh
2	Institute of Epidemiology, Disease Control and Research (IEDCR)	Bangladesh
3	National Institute of Preventive and Social Medicine (NIPSOM)	Bangladesh
4	Department of Public Health, Ministry of Health	Bhutan
5	Indian Council of Medical Research (ICMR)	India
6	National Institute of Communicable Diseases (NICD)	India
7	Field Epidemiology Training Programme (FETP)	India
8	GEIS - US Naval Medical Research Unit No. 2 (NAMRU-2)	Indonesia
9	Mekong Basin Disease Surveillance Network (MBDS)	MBDS, Myanmar
10	Epidemiology Unit, Ministry of Healthcare and Nutrition	Sri Lanka
11	Bureau of Epidemiology	Thailand
12	Mekong Basin Disease Surveillance Network (MBDS)	Thailand
13	Queen Sirikit National Institute of Child Health, Department of Medical Services, Ministry of Public Health	Thailand
14	Global Disease Detection Centre, Thai- MoPH – US-CDC collaboration (TUC)	Thailand
15	Field Epidemiology Training Programme	Thailand

Table 2. *GOARN operations in the South-East Asia Region, 2004-2007*

Year	Disease / Event	Country
2006	Earthquake	Indonesia
	Avian Influenza	Indonesia
2005	Acute Myocarditis	Sri Lanka
	Dengue/DHF	East Timor
	Tsunami Communicable Disease Response	Thailand
	Tsunami Communicable Disease Response	India
	Tsunami Communicable Disease Response	Sri Lanka
	Tsunami Communicable Disease Response	Indonesia
2004	Nipah Virus	Bangladesh
	Avian Influenza	Indonesia
	Avian Influenza	Thailand

The Regional Office has taken steps to strengthen partnerships, including networking of IHR Focal Points, to enhance outbreak verification, alert and response operations in the Region. Furthermore, efforts to identify and establish a database of institutions of excellence in areas such as emerging infectious diseases and epidemiology training are ongoing. The Regional Office has also established the Strategic Health Operations Centre (SHOC) which coordinates day-to-day outbreak verification, alert and response activities in close collaboration with country offices, HQ and regional and global partners. It is also proposed to establish a regional outbreak alert and response network by engaging national and regional partners working in disease surveillance, response and capacity building activities.

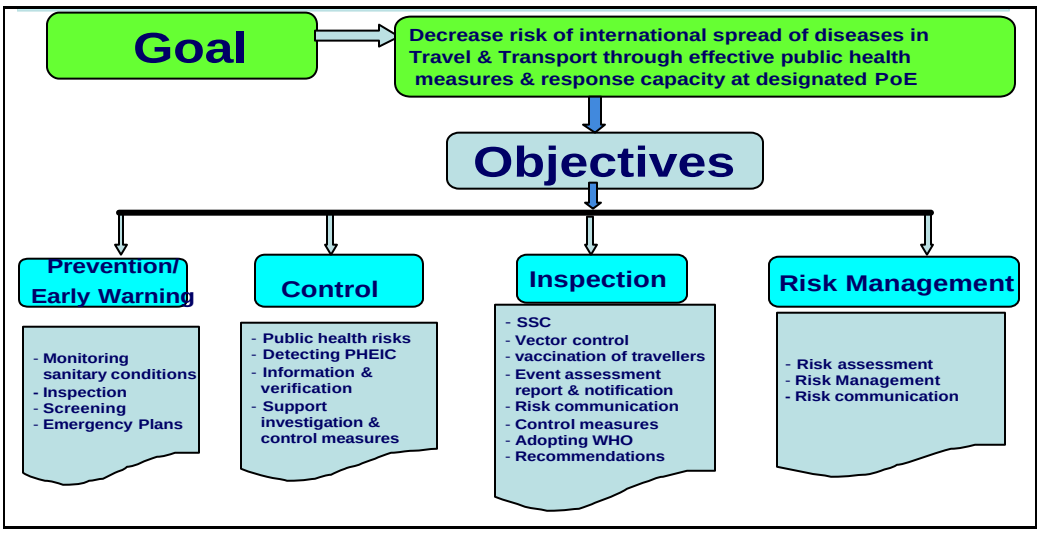
4.4 Capacities of points of entry

One of the obligations of Member States and a requirement under IHR (2005) is to develop, implement and maintain core capacities at designated ports of entry/exit (airports, ports and ground-crossings, as appropriate). The presentation on PoE described the required capacities at points of entry and the need for partnership and collaboration. The speaker noted that over 90% of world trade is carried by international shipping. He mentioned that there were over 3,000 airlines worldwide, flying to approximately 3,700 airports with nearly 24,000 aircraft and 29 million departures in 2007.

Strengthening capacities at points of entry falls under strategic actions 2 and 3 in this regard it was important to strengthen national disease surveillance, prevention, control and response systems and to strengthen public health security in travel and transport.

The speaker indicated that the overall aim of capacity strengthening at points of entry is to decrease risk of international spread of diseases in travel and transport through effective public health measures and response capacity at points of entry. To this end, designated points of entry/exist must develop the required core capacities for prevention, early warning, control, inspection, risk assessment and management (Figure 2).

Figure 2. ***Key objectives for management of potential PHEIC at PoE***



Member States should assess and designate PoE for core capacity building. At each designated PoE a competent authority should be identified and plans for implementation of core capacities developed. The plans should include promotion of multi-sectoral collaboration and coordination for prevention, surveillance and response. The speaker informed the participants about the latest guidance and tools available on travel and transport.

4.5 Best practices of IHR implementation in countries

Countries presented reports on progress toward IHR implementation and the gaps and challenges faced in the past year. Countries are working diligently to strengthen capacities and progress has been made in several areas in particular in strengthening national capacities for surveillance and response. The following list provides examples of best practices by country.

- **Bangladesh** – Training of RRTs on case management of AI mobilization and orientation of community volunteers.
- **India** – Development of interactive training on recognizing PHEIC.
- **Indonesia** – Simulation exercise.
- **Maldives** – Establishment of SIDAS-web-based data analysis system.
- **Myanmar** – Training of RRTs on avian influenza.
- **Sri Lanka** – Training of port health officers.
- **Thailand** – Development of IHR implementation plan 2008-2012 with approved budget.

The above examples of best practices can be adapted by other Member countries to strengthen core capacities required for implementation of IHR (2005). Many of these practices and their benefits were further elaborated during the discussion sessions.

SIDAS: from the experience of Maldives, a computer-based surveillance system has an advantage for compiling real-time and reliable data that is useful for detection of unusual trends. The system incorporates daily internet, telephone, fax and SMS communication in order to ensure daily reporting from the atolls and inlands. Countries currently using a paper-based system for reporting and transmitting data may consider whether it is feasible to implement SIDAS or some other web-based system depending on availability of computers and internet access throughout the country. This would help in reducing delays and duplication of data compilation at all levels and allowing more analysis to be undertaken.

RRTs: These can be established at different levels, whether at the district, township, or atoll level as the case may be in each country. Experiences shared by Member States on RRT composition, training, roles

and responsibilities and how they are utilized to maximize effectiveness were valuable.

Community volunteers: from the experience shared by Myanmar and Indonesia it was learnt that community volunteers can be useful to create awareness on AI. Member States shared their experience on how community volunteers are chosen and trained, and what is expected of them.

Port health officers: Sri Lanka shared its experience in training port health officers. Their training curriculum is a good resource that can be shared with other Member States.

Simulation exercise: the conclusion from Indonesia's simulation exercise is that simulation is a good way to test plans and procedures. The greatest benefit came not from the actual simulation but from the months of planning for the exercise. Countries could share with each other the planning process for conducting an exercise.

5. Challenges faced by countries in IHR implementation

All countries are facing challenges with implementation of IHR. The common challenges expressed were as follows:

There is a high turnover of Ministry of Health medical personnel. This undermines the training programmes as those trained are moved to other sections within the health service. Involvement of private sector physicians is limited. This is another major challenge which countries have recognized and are trying to address.

Multi-sectoral collaboration is limited. This is a key component for successful IHR implementation. For instance, collaboration between the health sector and the customs and immigration sector is important to ensure proper screening of arriving and departing passengers at airports.

Porous ground crossings pose a challenge for neighbouring countries in terms of having adequate staffing and facilities to address the issues.

Remote and difficult to reach areas, may pose special problems related to logistics and transport for RRTs and specimens, referral, and cross-border issues.

Raising awareness among the public and the health care providers is yet another challenge which countries must address to support early warning systems.

6. Needs and priorities identified by countries

Several presentations and the discussions which followed, identified key needs and priorities grouped under the following four broad areas:

6.1 Global partnerships

The presentations and discussions showed that there has been encouraging improvement in the timely verification and response of rumours of outbreaks in the Region. However, the development and maintenance of core capacities among Member countries for early detection, reporting and response needs more funding and sustained investment. To achieve this, there is a need to mobilize resources within countries and globally for implementation of IHR (2005). Thus, it is necessary for WHO to continue to advocate for and engage donor support.

6.2 Legal issues

Most countries have reviewed their public health laws, regulations and acts, and have made amendments where necessary, in-line with IHR (2005). Some countries need to review their laws and develop a legal framework, policies and administrative arrangements for implementation of IHR. It is important to ensure that there is inter-and intra-sectoral collaboration for this cross-cutting area.

6.3 Monitoring

Another priority need identified was for Member countries to develop benchmarks to monitor progress in implementation of IHR (2005). One

approach would be for countries to develop an IHR plan either as a stand-alone plan or to modify their AI plan to include the additional elements of IHR. Indicators would be developed under the plan

6.4 Strengthening national capacity

Countries indicated a need for further strengthening surveillance and response capacity at all levels of the health system, particularly at points of entry. These include undertaking needs assessment, refurbishment of port health services, adequate staffing and appropriate training. Furthermore, countries expressed a need to explore mechanisms to promote involvement of the private sector; to scale-up training of laboratory staff in epidemiology and laboratory quality assurance and quality control issues; and to organize joint training of veterinary and public health personnel including development of a short course in field epidemiology for veterinary public health.

6.5 Prevention and response to international public health emergencies

Global experience shows that there is a wide variation in the capacity of Member countries to detect potential public health emergencies of international concern. Delay in the timely recognition and consequently the process of verification and response of events that may constitute potential PHEIC could threaten public health security. Thus, it is essential to organize training for health workers in recognizing a PHEIC and establish a mechanism for early and direct reporting of any potential PHEIC to the IHR focal point who will, in turn, contact the WHO contact person. The materials which were developed for this purpose and piloted in India were shared at the meeting for further adaptation and use, as appropriate, by Member countries.

7. Recommendations

The focus of the meeting was on building capacity at points of entry and on improving event management systems. The recommendations therefore, reflect this focus.

7.1 Recommendations for Member States

All Member States will have an IHR implementation plan by June 2009.

Member States will develop public health emergency plans at points of entry/exit that will include rapid cross-border (if necessary) communication for reporting events that pose a public health risk at borders.

An in-depth external assessment of IHR core capacity at randomly selected designated points of entry/exit will be conducted in at least four Member States of the region by June 2009. Sites should be representative of large and smaller designated ports.

Member States will identify relevant competent national authorities at points of entry/exit who will oversee coordination and implementation of IHR requirements.

Member States will review existing surveillance systems to ensure that there is an early warning and response function for immediate reporting of unusual events to the national IHR focal point.

7.2 Recommendations for WHO

- The WHO Regional Office for South-East Asia will: send an official communication to Member States requesting names of experts/institutions with specific expertise to assist Member States with technical assessment/implementation of IHR.
- Will continue to develop/adapt training materials for Member States to train various functionaries to meet IHR requirements at points of entry/exit.
- Will Compile an inventory of existing field epidemiology training (FET) and make available to all Member States.
- Provide support to MS to conduct selected FET courses.
- Conduct training in rapid containment in all MS; training should include all health sectors.
- Conduct training in surveillance and rapid response aimed at district levels to also include veterinary personnel.
- Ensure a consistent system for event management (recording and reporting) throughout the Region.

8. Conclusions and next steps

The meeting of IHR focal points deliberated on the progress made at national, regional and global level with regard to the implementation of IHR. It was noted that encouraging progress has been made in the areas of development of guides and tools, strengthening core capacities, and in review of legislation. The participants commended the experiences from Member countries in the development of a detailed implementation plan (Thailand), use of computerized surveillance data management (Maldives), capacity building of RRTs (Bangladesh, India, Indonesia and Myanmar), and in the development of training tools (India) which can further be replicated in Member countries. The networking among IHR focal points and its role in rumour and event verification and sharing of timely information on related issues of public health importance was another example of good practice.

While the overall objectives of the meeting were fulfilled, it was noted that most activities last year seemed to be focused on strengthening national capacity; and hence it was suggested that more attention be paid to other strategic action areas. For example, strategic action areas 4 and 5 need to be strengthened i.e., the global event management system which ensures a consistent systematic process for recording and reporting events will greatly facilitate communication in the event of a (potential) PHEIC if implemented by countries. Having experts to call upon during an emergency is another area that requires attention both with regard to the IHR roster of experts and for responding to regional outbreaks/events. Capacity at points of entry has been on the agenda for a while now and hopefully this meeting will encourage WHO and Member States to focus more on this aspect. The Regional office will follow-up on actions emanating from this meeting and will organize the third meeting in 2010.

9. Closing

The meeting was concluded by noting that while encouraging progress has been made in the last one year by all Member States, a lot more is required to establish and maintain essential core capacities required for implementation of IHR (2005).

The participants underscored the need for sharing of best practices and experiences among Member countries, enhancing networking and

partnerships in verification and response; and in training of health workers at various levels. The meeting suggested that WHO facilitate this process, including through inter-country visits and exchange of expertise.

10. Acknowledgements

The Second Regional Meeting of IHR focal point was jointly organized with the Epidemiology Unit of the Ministry of Health and Nutrition, Government of Sri Lanka, and WHO representative's office. The support provided by all officials of the Ministry, particularly the IHR focal point, and WHO country office staff was invaluable for organizing the meeting.

Annex 1

Address by Dr Athula Kahandaliyanage, Secretary, Ministry of Healthcare & Nutrition, Sri Lanka

Distinguished Guests, Invitees, Participants, Ladies and Gentlemen with great pleasure I welcome you all to this Second Regional Meeting on Implementation of International Health Regulations 2005 here in Sri Lanka.

As you are aware, the threat from infectious diseases has, over the past few years increased, mainly due to their emergence and reemergence and increased International travel and trade. Severe Acute Respiratory Syndrome and Avian Influenza are just two recent examples of such threats with serious public health and socioeconomic implications. The earlier version of the International Health Regulations which dates back to 1969, required Member States to notify the World Health Organization of only three infectious diseases, namely cholera, plague and yellow fever. This, however, was felt to be inadequate to address the growing risk from infectious diseases and other public health emergencies. Therefore, WHO Member States adopted the Revised International Health Regulations on 25 May 2005.

The revised International Health Regulations which came into force on June 15, 2007 represent an important milestone in the global efforts to build and reinforce at the national and international levels. This Meeting, I am sure is going to contribute greatly to this goal. It is essential that every country fully implement these regulations, which are based on transparency, international partnership and collaboration. Effective communication strategies and collaboration among different sectors such as ports of entry, customs and tourism authorities are important for efficient application of the Regulations.

We, in Sri Lanka, are fully committed to the implementation of the Regulations with the highest level of political commitment.

I hope the deliberations of this meeting will address these challenging issues faced by countries in implementing these regulations.

I sincerely hope that this meeting will help us to know the status of country preparedness for implementing IHR (2005) and the present status of IHR implementation in the countries of the Region.

I also wish to thank WHO and the Regional Office, in particular, for hosting this workshop in Sri Lanka. I also thank the officers who have contributed to make this workshop a reality.

Thank you.

Annex 2

Message from Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region at the Second Meeting of National IHR Focal Points, 23-25 June 2008

(Delivered by WHO Representative to Sri Lanka)

I welcome you all to the second meeting of national IHR focal points. The first of these annual meetings took place in April 2007 prior to entry into force of the International Health Regulations (IHR) in June last year.

As you all know, the IHR are a legal framework for ensuring global health security – for preventing, protecting and providing a public health response to the international spread of diseases without interfering with international traffic and trade.

The IHR encompass, in addition to infectious diseases, a range of events including those related to food and chemical safety, as well as toxicological events, and any event with the potential to cause a Public Health Emergency of International Concern (PHEIC).

The requirements under IHR place great responsibility on Member countries to ensure that they can detect such events in a timely manner in order to protect their populations' health. Critical steps include having the ability to detect early warning signs and to monitor events at points of entry to limit morbidity and mortality and thus national and international spread of disease.

Under the IHR, Member countries are required to ensure that they have the capacity to detect and respond to a PHEIC i.e. robust systems for human and animal surveillance and response, capacity in laboratories and mechanisms for reporting. Risk communication, as well as capacities at points of entry should be in place and operational.

The South-East Asia Region faces considerable threat from emerging and re-emerging diseases. The Region is also susceptible to natural events,

such as the recent cyclones in Bangladesh and Myanmar; earthquakes in Indonesia; and the 2004 tsunami that caused huge devastation and destruction. Some of these are due to a number of factors including the effects of climate change, and the interplay of socioeconomic and cultural factors in parts of the Region.

Changes in climate in our Region are impacting the patterns of communicable diseases. Warmer temperatures are facilitating the transmission of vector-borne diseases, while limited water supplies are resulting in waterborne and diarrhoeal diseases. Dengue and chikungunya fever outbreaks are occurring throughout the Region. Chikungunya fever causes high morbidity with substantial economic loss.

The close human-animal interface observed in backyards in rural communities in countries in this Region facilitates the continued poultry outbreaks of avian influenza H5N1, especially in Indonesia. Transmission to humans increases the chances of mutation and reassortment of virus genetic material and thus a pandemic.

Distinguished participants,

The overall objective of this meeting is to review the progress in IHR implementation in the South-East Asia Region and to identify follow-up actions needed by Member countries to achieve the requirements according to the prescribed timeline. Although countries have until 2012 to implement activities, we can work together to achieve our goal ahead of time.

This meeting follows from the first IHR meeting held in April 2007 in Maldives. That meeting oriented participants to the obligations of WHO and it's Member States under the revised IHR which came into force on 15 June 2007. Since then, we have developed a good common understanding regarding this issue. In fact, the Regional Office and country offices have received excellent collaboration from Member countries towards IHR implementation.

In this meeting we will take the opportunity of the first anniversary of the coming into force of IHR to review the progress made during this period; to learn from each other on ways to implement the requirements and to avoid any pitfalls. WHO will continue to serve as facilitator for information-sharing and providing technical support, where required.

WHO has established a taskforce on IHR at the Regional Office to assist Member countries in formulating policies, strategies and activities

essential for IHR implementation and pandemic preparedness, and to provide them with technical assistance to develop their core capacities.

Ladies and gentlemen,

As you can see, much work is being carried out in the Region. However, we need to keep track of the progress, as well as share our experiences regarding IHR implementation. We need to work together, especially in respect of cross-border movement, because effective surveillance and sanitation systems at ports and crossings are critical to prevent the spread of disease. This is one agenda item that needs to be covered in this meeting, in addition to "early warning systems" and "legal issues related to communicable disease control".

WHO recommends and emphasizes the need for all countries and sectors to collaborate with one another in order to increase the collective capacity and infrastructure to respond to potential international health emergencies and other public health risks. However, measures to be adopted should be tailored to local conditions and take into account socioeconomic, environmental and ecological factors.

Strengthening existing systems and developing good linkages within and between countries to ensure a consistent and coordinated approach to deal with any Public Health Emergency of International Concern will help safeguard the health and well-being of our Member countries. It will, at the same time, help ensure global health security.

If the objectives of this meeting are achieved it would help towards enhancing our capacity as countries and as a Region for effectively managing public health emergencies and events of international concern".

Ladies and Gentlemen,

I will, of course, apprise the Regional Director of the outcome of this meeting.

I wish you fruitful deliberations and every success in achieving the objectives of this important meeting.

Annex 3

Programme

23 June 2008

08:30 – 09:00	Registration	
09:00 – 9:45	Inaugural Function	

Chair: Prof. Moazzem Hossain, BAN
Co-chair: Dr Andi Muhadir, INO

10:30 – 11:15	International Health Regulations – The global situation	Mr Emmanuel Jesuthasan IHR, WHO/HQ
11:15 – 12:00	Progress in IHR implementation in the Region	Dr Khanchit Limpakarnjanarat Regional Advisor CSR/SEARO
12:00 – 13:00	Country presentations on progress with IHR implementation:	
	Bangladesh	Prof Dr Moazzem Hossain
	Bhutan	Mr Namgyel Wangchuk

Chair: Dr A M J W Walalawela, SRL
Co-chair: Mr Namgyel Wangchuk, BHU

14.00 – 15:00	***India***	Dr Sujeet Singh
	Demonstration of interactive tool for PHEIC identification	Dr Sampath Krishnan
15:30 – 17:00	***Indonesia***	Dr Andi Muhadir
	Simulation Exercise	Dr Graham Tallis
	Maldives	Ms Geela Ali
	SIDAS – data analysis system	
	Myanmar	Ms Kanokporn Coninx
	RRT for AI	

24 June 2008

Chair: Dr Kumnuan Ungchusak, THA
Co-chair: Dr (Mrs) Paba Palihawadana, SRL

09.00	Summary of previous day's proceedings (not including country presentations)	Chair Co-chair

09.15 – 10:45	Country presentations on IHR implementation.(continued)	
	Nepal	Dr Laxmi Bikram Thapa
	Sri Lanka	Dr Paba Palihawadana
	Training of Port Health Officers	Dr A M J W Walalawela
	Thailand	Dr Kumnuan Ungchusak
11:15 – 11:30	Summary of country presentations	Chair Co-chair
11.30 – 12.45	WHO's Event Management System	Dr Thomas Grein
	Global Outbreak Alert and Response Network (GOARN)	Coordinator, Alert and Response Operations WHO/HQ

Chair: Ms Geela Ali, MAV
Co-chair: Dr Sujeet Singh, IND

13.45 – 15.00	Capacities at Points of Entry	Mr Emmanuel Jesuthasan IHR, WHO/HQ
15.30 – 17.00	Methods and approach to developing core capacity in key work areas	All - group work 1

25 June 2008

Chair: Dr Laxmi Bikram Thapa, NEP
Co-chair: Ms Ahamed Riyasa Ahamed, SRL

08:30 – 9:30	Feedback from group work 1	Group representatives
09:30 – 10:30	Next steps – goals and objectives for the next year (2008-09)	All - group work 2
11.00 –12:00	Feedback from group work 2	Group representatives
12:00 – 12:45	Recommendations	All
12:45 – 13:00	Remarks by Regional Advisor, CSR/SEARO	Dr Khanchit Limpakarnjanarat
	Closing remarks	Chairperson

Annex 4

List of participants

Bangladesh

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In accordance with International Health Regulations (2005), Member States have committed to develop and maintain public health core capacities as defined by the Regulations. Recognizing the contribution of sharing experiences and lessons among Member States, WHO organized the first Regional Workshop on Implementation of IHR in April 2007. This report is a compilation of the Second Workshop organized by WHO in collaboration with the Ministry of Healthcare and Nutrition of Sri Lanka during 23-25 July 2008.

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