

Implementation of the International Health Regulations (2005)

Report of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation

Report by the Director-General

1. The Director-General has the honour to transmit to the Executive Board the report of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation, which reflects its deliberations during the meeting in November 2014 (see Annex 1, which includes Appendix I on the Review Committee members; Appendix II on the agenda of the Review Committee meeting (Geneva, Switzerland, 13–14 November 2014); Appendix III on the disclosures made in accordance with the policy on Declaration of Interests (WHO Experts); and Appendix IV on the biographies of the members of the Review Committee).

ACTION BY THE EXECUTIVE BOARD

2. The Executive Board is invited to consider this report. The Board is further requested to consider the draft resolution on the recommendations of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation prepared by the Secretariat (see Annex 2), as well as the report on financial and administrative implications for the Secretariat of the draft resolution (see Annex 3).

ANNEX 1

**REPORT TO THE DIRECTOR-GENERAL OF THE REVIEW COMMITTEE ON
SECOND EXTENSIONS FOR ESTABLISHING NATIONAL PUBLIC HEALTH
CAPACITIES AND ON IHR IMPLEMENTATION**

13–14 November 2014, Geneva, Switzerland

BACKGROUND

1. The International Health Regulations (2005) (the “IHR” or the “Regulations”) were adopted by the World Health Assembly in 2005.
2. This is the second IHR Review Committee to be convened. The first IHR Review Committee was convened in 2010 to assess the functioning of the Regulations; assess the ongoing global response to the pandemic influenza A (H1N1) 2009 (including the role of WHO); and identify lessons learned for strengthening preparedness and response for future pandemics and public-health emergencies.¹
3. One of the most important provisions in the IHR is the obligation for all States Parties to establish core capacities to detect, assess, notify and report events, and to respond to public health risks and emergencies. The initial target date for establishment of these capacities was June 2012. At that time, 42 of 193 States Parties declared that they had met their core capacity requirements. As provided in the Regulations, 118 States Parties requested and were granted a two-year extension of the deadline up to June 2014.
4. Articles 5(2) and 13(2) of the Regulations provide that, in exceptional circumstances, and supported by a new implementation plan, States Parties may request a second extension, not to exceed two years. The decision to grant a further extension shall be made by the Director-General, taking into account the technical advice of a Review Committee.
5. At the time of this second Review Committee meeting, 64 States Parties had indicated that they met the minimum core capacity standards; 81 States Parties had requested an additional two-year extension of the implementation deadline; and 48 had not communicated their intentions to WHO.²
6. The end of the second extension period will mark an important milestone in the implementation of the Regulations since they came into force in June 2007. This milestone will be a reminder that the work of developing, strengthening and maintaining the IHR’s essential public health capacities is continuous and requires ongoing attention from all States Parties. The diversity and increasing frequency of events involving infectious disease and other hazards affecting public health are potent reminders that the IHR remain foundational to global health security.

¹ See http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_10-en.pdf?ua=1.

² An additional three States became Parties to the IHR after June 2007 and have different time frames for implementation of core capacities.

APPOINTMENT OF THE REVIEW COMMITTEE

7. The Director-General appointed 13 members to the Review Committee from the IHR Roster of Experts in accordance with the IHR and the WHO Regulations for Expert Advisory Panels and Committees. A list of members may be found in Appendix I.

8. The purpose of the Review Committee was to: (1) advise the Director-General on requests from States Parties on second extensions (2014 – 2016) for establishing the core capacities to detect and respond to events as specified by Annex 1 of the IHR; and (2) advise the Director-General on how to better strengthen and assess IHR core capacities in the short- and long-term.

ORGANIZATION AND PROCESS OF THE MEETING

9. The meeting of the Committee took place at WHO headquarters in Geneva, 13–14 November 2014. The agenda can be found in Appendix II.

10. The Director-General thanked the Review Committee for its time and expertise, and noted that Ebola and other public health events continued to demonstrate the importance of having strong International Health Regulations. However, she mentioned that the world was still far from where it needs to be, with more States Parties having formally requested second extensions than had fully implemented IHR core capacities, and that advice on ways to improve the current situation was sought.

11. The Acting Legal Counsel reviewed the procedural arrangements for the Review Committee. The Legal Counsel reminded the Committee that all members should act independently and provide their personal expertise as scientists and/or public health experts and that Committee members were expected to maintain confidentiality on the non-public information that was disclosed during the course of the meeting. Appendix III of this report contains information from members' Declarations of Interests that was disclosed.

12. The Chair (Professor Didier Houssin), Vice-Chair (Dr Ximena Aguilera) and Rapporteur (Mr Andrew Forsyth) were elected. The Chair made a number of introductory remarks. The Review Committee adopted the proposed agenda.

13. The Chair noted that representatives of States Parties to the IHR, the United Nations (UN) and its specialized agencies and other international organizations were invited to attend the morning plenary session and to then return on the second day of the meeting at which time an oral summary of the Committee's deliberations would be presented.

14. The Director, Global Capacities, Alert and Response (Dr Isabelle Nuttall) made a background presentation on the IHR, including an overview of the Regulations, core capacity requirements, and associated time frames and extensions.

15. A number of States Parties and invited organizations made statements. All recognized the importance of IHR and the progress made so far. Some States Parties gave justifications for their request for extension related to the small size of their country, the circumstances of specific overseas territories or the natural disasters that affected their health systems. General comments included progress noted by countries in implementing the IHR, efforts to build surveillance systems and the importance of lessons learnt over recent years. A call for solidarity, with reference to article 44 of IHR, was clearly expressed by many States Parties, suggesting that twinning and networking would

provide opportunities to assist. In their interventions, the international organizations noted the importance of a multisectoral approach and in particular the need to strengthen the collaboration with the animal health sector through, for example, a “One Health” approach. It was also noted that more attention should be paid to the occupational health requirements of front-line health care workers.

IHR IMPLEMENTATION

Progress and challenges

16. The Review Committee noted that considerable progress has been made in implementation of the IHR and reflected on the conclusions and recommendations of the report from the Review Committee on the functioning of the IHR and on pandemic influenza A (H1N1) 2009. The Committee noted that key achievements include: establishment and functionality of National IHR Focal Point entities (NFPs); increased transparency in reporting events, using early warning systems more systematically; better communication and collaboration between animal and human health sectors; coordinated collective efforts of countries and partners to build capacities (e.g. the Asia Pacific Strategy for Emerging Diseases (2010), Integrated Disease Surveillance and Response); establishment of emergency response coordination structures; and better international mechanisms to share information for rapid response. These achievements are the result of significant efforts made by States Parties, WHO, and donor programmes. Core capacities at central, intermediate and local levels are essential public health functions that are beneficial not only to the individual country, but to the global community.

17. Though progress had been made in many areas, the Review Committee emphasized that countries in every Region still face significant challenges to fully implement the IHR. Key impediments to IHR implementation include: insufficient authority/capacity of NFPs; the misconception that implementation of the IHR is the sole responsibility of ministries of health; limited involvement/awareness of sectors other than human health; limited investment of national financial and human resources; high staff turnover; ongoing complex emergencies/conflict; the specific needs of small island states and States Parties with overseas territories; the focus on IHR extensions of the deadlines rather than on an expansion of capacities; a perception that implementation is a rigid, legal process with less emphasis on operational implications and learning from experience; and limited international solidarity to support the weakest countries in building capacities. States Parties’ self-assessment of their implementation of the IHR is limited by the variable quality and reliability of information that is provided.

Requests for second extensions

18. The Review Committee was provided detailed country-level requests and implementation plans in advance of the meeting for their review. The Secretariat also provided aggregated analyses of the requests for second extensions; States Parties were grouped based on the completeness of the implementation plan which accompanied their second extension request and on their monitoring framework scores. The Review Committee heard the analysis and thoughts expressed by WHO regional offices representatives.

19. The Review Committee considered the variability between the different extension requests; e.g. the number of core capacities requested for extension, the reasons for doing so, and the completeness of proposed implementation plans. Some of the exceptional circumstances and obstacles to full implementation of the IHR cited by States Parties in their requests, included: the need for more time; financial, economic or public health issues (e.g., “*mass vaccination campaigns competing for*

resources, and various ongoing outbreaks”); the lack of human resources; long-running emergencies (e.g., “due to protracted emergencies caused by conflicts over three decades”, “significant gaps in infrastructure, human resources, human development, education and health continue to exist”); internal or external political issues (e.g., “unprecedented military and political crisis that has disrupted the socio-economic plan, the operation of the administration, and disorganized the healthcare system at all levels for the implementation of activities”); and natural disasters.

Conclusion 1

20. The work to develop, strengthen and maintain the core capacities under the IHR should be viewed as a continuing process for all countries.

21. The current Ebola virus disease (EVD) outbreak has underscored the importance of having strong national and local capacities in place to rapidly detect, respond and take preventative measures to contain a serious public health threat. At the same time, it has highlighted the fragile nature of health systems in some countries, as well as the importance of a multi-sectoral approach. It is therefore of concern that only approximately one-third of States Parties have indicated that they have met the minimum core capacity requirements.

22. In formulating its advice to the Director-General, the Review Committee felt it was essential to consider the implementation status of all States Parties and not just those Parties that have requested a second extension. The Review Committee recommends the following for the Director-General’s consideration:

Recommendation 1

23. ***States Parties that have indicated they have met the minimum core capacity requirements should be commended for their considerable efforts. At the same time, they should be reminded that implementation of the IHR is a dynamic, ongoing process that must be continually assessed, maintained and strengthened as needed. These countries should be urged to continue their efforts to maintain and strengthen their core capacities, and to consider providing support to other States Parties that face technical, financial, political or other obstacles in establishing core capacities.***

Recommendation 2

24. ***All States Parties that have requested a second extension (or do so at a future date) should be granted the extension for 2014–2016. In granting this extension, the Director-General should note if the request was accompanied by an implementation plan and if so, whether or not the plan adequately addressed the criteria for the extensions noted by the Sixty-sixth World Health Assembly. In communicating with the State Party, the Director-General may also take into account other relevant information that relates to the core capacities for that country. The Director-General’s communication with the State Party could also be used by WHO regional and country offices to engage with the State Party and where appropriate, serve as a basis for priority setting, establishing next steps, and resource mobilization. WHO (at headquarters, regional and country levels) should continue to support these countries, as needed, in their efforts to implement core capacities.***

Recommendation 3

25. *States Parties that have not communicated their intentions to WHO should be reminded of the importance of transparency in relation to both the letter and the spirit of the IHR. These States Parties likely represent a diverse group ranging from those that may have met the requirements for core capacities but not reported to that effect, to those that have made limited progress. WHO should make further attempts to contact these States Parties, offer assistance, and provide them with the opportunity to: request an extension if it is needed; or indicate that they have met the minimum requirements under IHR Annex 1 and that, therefore, no extension is necessary.*

Recommendation 4

26. *States Parties, stakeholders, and donor programmes should be encouraged to provide technical and financial assistance as needed. States Parties should be encouraged to use guidelines and tools that WHO has developed, or may in the future develop, to support implementation of the IHR.*

Short-term action to accelerate IHR implementation

27. The Committee discussed ways in which additional improvements could be made during the extension period. It was felt that not all NFPs are sufficiently empowered; they needed to be well positioned within the public health system with appropriate seniority and close to where decisions are taken, particularly during emergencies.

28. Laboratory services and surveillance systems should be better linked to improve integrated surveillance. A lesson learnt from EVD and other events is the value of having and using existing public health capacities and networks during emergencies. The diagnostic capacity of national and intermediate level laboratories should be enhanced by connecting them to surveillance networks including those connected to health centres and clinics, and through quality assurance, quality control programmes, and biological risk management.

29. There is a need to strengthen and build multisectoral surveillance capabilities at local and community levels, with trained staff working with clinicians, and to promote integration of surveillance systems for both communicable diseases and other hazards and to establish early warning alert and response systems where needed.

30. More can be done to strengthen data management as applied to both laboratories and epidemiological surveillance. The challenges in data management include: difficulties handling multiple inputs from different sources; lack of reporting from some areas; lack of data management standards; and lack of linkages between data sets. Data collection at community level is weak in many outbreaks. Outbreak reviews at the local and national level should be encouraged and WHO should facilitate meta-evaluations of the last 20 major outbreaks to help provide evidence-based guidance.

31. One of the major challenges to IHR implementation is building up core capacities at points of entry, particularly in terms of surveillance, preparedness and response capacities. EVD has demonstrated the importance of adequate core capacity implementation at designated airports, ports and ground-crossings. Approaches or tools which integrate demography, migration, health burden, animal-human interface, transport hubs, volume of air traffic and the like into web-based applications, could assist risk assessment. Identification of high-risk international points of entry for the spread of

diseases could facilitate prioritized capacity implementation at points of entry on a more scientific basis. In the context of EVD, exit screening can be used for security, and entry screening can be used as an opportunity for education, awareness raising and monitoring. It was emphasized that cross-border cooperation for the development of risk mapping, surveillance and coordinated responses to diseases and events is critical.

32. In the context of the current EVD epidemic, public health measures that have consequential implications for travel and trade raise complex and difficult issues that require very careful consideration; a review, possibly by an ad hoc technical group and/or formal evaluative analysis, is needed to identify lessons from recent experience, and assess from a public health perspective, and the wider social and economic effects, what works, what does not and why. At the technical and political level, additional measures taken by countries that vary from Temporary Recommendations made by the WHO Director-General in public health emergencies of international concern pose special challenges (e.g. in the context of EVD, blanket travel bans are measures which exceed the Temporary Recommendations). States Parties can apply such additional measures, but only under the conditions laid out in Article 43 of the Regulations. A State Party affected by an additional measure may request consultations with the implementing State Party in order to find a mutually acceptable solution (Article 43 paragraph 7 of the Regulations). WHO also can, and should, seek to obtain the public health rationale for additional measures, and share this with other countries. Where no rationale is forthcoming, this too may be disclosed for example, via the event information site.

33. The health and safety of frontline health care workers in outbreak situations or other public health events was considered to be critical. One key approach to their protection is training; recent outbreaks have shown that, where healthcare workers were well trained, fewer became infected. It is also important to build health workers' confidence and to ensure adequate numbers by providing appropriate support; e.g., through health insurance and regular salary payments. In the current Ebola epidemic, the Review Committee acknowledged the heroism shown by many frontline health care workers, often under the most difficult of circumstances, and in many cases, at the cost of their own lives.

Recommendation 5

34. ***The Committee recommends States Parties to:***

- (a) *Review, and where appropriate, strengthen and empower NFPs to enable effective performance of key IHR functions, facilitate decision making and ensure high level support for multi-sectoral communication and cooperation*
- (b) *Support the formation of multidisciplinary outbreak investigation and response teams, including animal health expertise where appropriate*
- (c) *Foster an operational approach in which cooperation between countries, results in practical and sustainable solutions to surveillance, laboratory, and other capacities in small islands and other small States*
- (d) *Use a risk assessment approach to prioritise public health threats, capacity gaps and to identify priority points of entry for designation and capacity building*
- (e) *Build the confidence of health care workers through policy measures that promote protection of and respect for health care workers' rights.*

Recommendation 6

35. *The Committee also recommends to the Director-General to consider establishing technical working groups to:*

- (a) *Strengthen data management capacities and practices; and*
- (b) *Review the lessons learned from current and past experience with public health measures that have had negative implications for travel, transport and trade.*

Longer-term commitment to the IHR to prevent the international spread of public health threats

36. The IHR (2005) have been tested repeatedly in recent years by the continued emergence and re-emergence of infectious disease, such as influenza, polio, MERS-CoV, and EVD, the majority of them zoonotic (i.e. infecting both humans and animals), underscoring the usefulness of a “One Health” approach. The possibility of harm from radiological and chemical hazards is also of concern, contributing to an increasingly complex world in which the global community will continue to face an array of diverse threats to its health and well-being. It is critical, therefore, that the IHR are seen, and used, as an essential tool in contributing to global health security.

37. States Parties envisioned a long life for the IHR (2005): “By not limiting the application of the IHR (2005) to specific diseases, it is intended that the Regulations will maintain their relevance and applicability for many years to come even in the face of the continued evolution of diseases and the factors determining their emergence and transmission.”¹

38. Against this backdrop, the Review Committee considered the longer-term development of and commitment to the IHR core capacities. The Review Committee noted that the principles and key themes of the IHR provide an important foundation upon which to construct a long-term approach:

- The IHR recognize the interdependence between countries with respect to both threats to public health and the respective capacities of countries to manage those threats.
- The IHR provide a risk-based framework that recognizes the different nature of various threats and of the measures needed to address them.
- Proportionality is an important consideration that can be applied to capacity building (e.g. capacities of small developing island States will never match those of large countries) as well as to response measures, which should be commensurate with and restricted to public health risks.
- Implementation of the Regulations should be “... guided by the goal of their universal application for the protection of all people of the world from the international spread of disease ...”.²

¹ See Foreword to the International Health Regulations (2005), Second Edition.

² See Article 3, paragraph 3, of the IHR.

Methodologies for the shorter- and longer-term development of IHR capacities

39. To move countries towards greater IHR functionality, it is essential to have better information on the robustness of States Parties' core capacities. States Parties currently report on their progress in implementing the Regulations through a self-assessment approach that is facilitated by WHO data collection instruments and supporting tools. The Review Committee discussed the advantages and challenges to approaches that would build upon a basic "checklist" approach to methodologies that can better assess quality and functional performance. Options discussed included assisted self-assessments, voluntary independent evaluations, peer reviews and certifications.

40. Systematic reviews of States Parties' or regions' responses to disease outbreaks and other public health events is another way of assessing capacities in a more integrated and arguably useful fashion. It was noted that there are no processes or systems currently in place to institutionalize collection and dissemination of observations and "lessons learned".

Conclusion 2

41. Implementation of the IHR should now advance beyond simple "implementation checklists" to a more action-oriented approach to periodic evaluation of functional capacities.

42. The Review Committee noted that implementation of the "theoretical construct" of the IHR has now been tested against the realities of public health threats and the varying capacities and resources of States Parties to address them. In light of this experience, implementation of the IHR should now advance beyond simple "implementation checklists" so there is a more action-oriented approach to periodic evaluation of functional capacities. This will require a carefully prepared "roadmap" including regional engagement with States Parties for improvement.

Recommendation 7

43. The Review Committee recommends that the Director-General consider a variety of approaches for the shorter- and longer-term assessment and development of IHR core capacities as follows:

States Parties should urgently: (i) strengthen the current self-assessment system (e.g., if not already done, the annual self-assessment reports and planning processes should be enhanced through multi-sectoral and multi-stakeholder discussions); and (ii) implement in-depth reviews of significant disease outbreaks and public health events. This should promote a more science or evidence-based approach to assessing effective core capacities under "real-life" situations. Simultaneously, the Secretariat should promote a series of regional formal evaluations or meta-evaluations of the outbreak reviews, managed by the regional offices, to facilitate cross-region learning and to distil lessons learnt for future IHR programming.

In parallel, and with a longer term vision, the Secretariat should develop through regional consultative mechanisms options to move from exclusive self-evaluation to approaches that combine self-evaluation, peer review and voluntary external evaluations involving a combination of domestic and independent experts. These additional approaches should consider, amongst other things, strategic and operational aspects of the IHR, such as the need for high level political commitment, and whole of government / multi-sectoral engagement. Any new monitoring and evaluation scheme should be developed with the active involvement of WHO regional offices and subsequently proposed to all States Parties through the WHO governing bodies' process.

44. This performance oriented information needs to be supplemented by information of an advocacy nature that demonstrates to States Parties, especially potential donors, the value of providing additional support to IHR post 2016. One example of this potential advocacy material would be economic analysis of the costs of international public health events, such as, SARS, Avian Influenza, MERS CoV, Ebola Viral Disease etc. and the benefits of maintaining and enhancing core IHR capacities.

Recommendation 8

45. *A comprehensive, time-phased, prioritized plan for continued implementation and maintenance of the IHR to guide longer-term capacity development for the IHR should be developed based on the outcomes of the consultative process, analytic reviews and analyses mentioned above. Such a plan should be both realistic and with aspirational components, taking into account the wide disparities in States Parties' capacities and resources. Consideration should be given to delineating the basic core capacities that should be in place for all countries.*

Resource requirements

46. The development and maintenance of core capacities require extensive and sustained financial and personnel resources for States Parties. Of particular concern, as noted by the IHR Emergency Committee for EVD, is the fragile nature of health systems and other relevant sectors needed for a multisectoral response in some countries “with significant deficits in human, financial and material resources, resulting in a compromised ability to mount an adequate ... outbreak control response.”¹

47. In some cases, States Parties alone cannot supply the resources to develop and maintain core capacities, as well as mount a surge response for potential public health emergencies of international concern. The private sector has an important supporting role. The Review Committee emphasized that it is in the interest of the private sector to contribute resources for public health preparedness and response. Infectious and other public health events can have considerable direct and indirect economic ramifications for the private sector (e.g. commerce, travel, tourism, entertainment, sports), as well as the directly affected countries.

48. Well-resourced countries and intergovernmental and non-governmental entities have made significant contributions (e.g. financial, technical, supplies/materials, and personnel) in response to the EVD outbreak. Mobilization of these resources, however, has taken considerable time and effort. In this connection, it was noted that the Review Committee on the Functioning of the IHR (2005) in relation to Pandemic (H1N1) 2009 made two relevant recommendations: (1) the establishment of a more extensive global, public health reserve work force; and (2) the creation of a contingency fund for public health emergencies.² Progress in implementing these recommendations has been limited to the creation of the African Public Health Emergency Fund. Urgent support by States Parties, including through WHO governing bodies, is required.

¹ Statement on the 1st meeting of the IHR Emergency Committee on the 2014 Ebola outbreak in West Africa, available at <http://www.who.int/mediacentre/news/statements/2014/ebola-20140808/en/>.

² See http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_10-en.pdf?ua=1.

49. The Committee re-emphasized the findings of the Review Committee on the Functioning of the IHR and on Pandemic Influenza A (H1N1) in May 2011, namely that “WHO’s capacity to prepare and respond in a sustained way to any public health emergency is severely limited by chronic funding shortfalls, compounded by restrictions on the use of funds from Member States, partners and donors.”¹

Recommendation 9

50. ***The Review Committee recommends that the Director-General encourage dialogue among States Parties and public and private partners, including large NGOs, to improve cooperation and assistance:***

- (a) *Obtain support for the sustained development and maintenance of national capacities over the long-term, with particular attention to countries requesting extensions/countries with significant capacity gaps;*
- (b) *Create a response fund, as recommended by the first Review Committee, for use in public health emergencies of international concern that can be readily available for future events; and*
- (c) *Create a more extensive global, public-health reserve work force that can be mobilized as part of a sustained response to a public health emergency of international concern.*

Recommendation 10

51. ***The Review Committee encourages the States Parties to support WHO through financial and staffing resources in preparation for, and during, public health emergencies of international concern.***

¹ Ibid.

Appendix I

**IHR Review Committee on Second Extension for
Establishing National Public Health Capacities and on IHR Implementation**

13–14 November 2014

REVIEW COMMITTEE MEMBERS

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Appendix II

Agenda**IHR Review Committee (RC) on Second Extension for Establishing National Public Health Capacities and on IHR Implementation****WHO Executive Board Room****13 November 2014**

- 09:00 – 09:30 Welcome introduction and opening remarks
Director-General
Assistant Director-General
- 09:30 – 09:40 Presentation on RC mandate, independence, confidentiality
Office of the Legal Counsel
- 09:40 – 10:00 Election of Chair, Vice-Chair, and Rapporteur
Assistant Director-General
Introductory Remarks by the Chair and adoption of the agenda
Review Committee work arrangement
Chair Review Committee
- 10:00 – 10:20 Presentation: Overview of IHR, core capacity requirements, time frame, extensions
Director Global Capacities, Alert and Response department
- 10:20 – 12:30 Statements to the Review Committee by States Parties and invited organizations
- 12:30 – 13:30 **Lunch break**
- 13:30 – 15:45 Working session on second extension, short-term action to accelerate progress of IHR implementation, IHR after 2016
- 15:45 – 16:00 **Afternoon Tea**
- 16.00 – 18:30 Working session on second extension, short-term action to accelerate progress of IHR implementation, IHR after 2016
- 19:00 – 20:00 **Reception: WHO HQ Main cafeteria**

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- 09.00 – 11:00 Working session: deliberation on granting the second extensions, short-term action to accelerate progress of IHR implementation, IHR after 2016
- 11:00 – 11:20 **Morning tea**
- 11:20 – 12.30 Summary of the deliberations for States Parties and invited organizations

Appendix III

Disclosures made in accordance with the policy on Declaration of Interests (WHO Experts)

Professor Kuku VOYI

Professor Voyi has declared that she trains WHO fellows on IHR in-country implementation. She does so at the University of Pretoria continuing education centre and receives an income in this regard that WHO's Declaration of Interest Policy for Experts regards as potentially significant (i.e. in excess of US\$ 5000).

Professor Petri RUUTU

Professor Ruutu has declared that he does consultancy work in the area of Finnish communicable diseases law development, the Global Health Security Agenda, and in the area of candidate EU Member States' communicable diseases control assessment. He receives an income in this regard that WHO's Declaration of Interest Policy for Experts regards as potentially significant, i.e. in excess of US\$ 5000.

WHO regards it as appropriate to disclose this information for the sake of transparency, but in the view of the Secretariat, these interests do not give rise to a conflict of interest because they are sufficiently addressed by disclosure.

Appendix IV

**BIOGRAPHIES OF THE MEMBERS OF THE REVIEW COMMITTEE
ON SECOND EXTENSIONS FOR ESTABLISHING NATIONAL PUBLIC
HEALTH CAPACITIES AND ON IHR IMPLEMENTATION¹****Chair****Professor Didier HOUSSIN, President of the French Agency for the Evaluation Agency
for Research and Higher Education, Paris, France**

Professor Didier Houssin is President of the French Agency for the Evaluation of Research and Higher Education (AERES) in Paris, France. He is also Professor of surgery at University of Paris Descartes since 1988.

Professor Houssin was formerly the Director General for Health at the French Ministry of Health and interministerial delegate regarding pandemic influenza. From 2003 until 2005, he served as the Greater Paris University Hospitals' Medical Policy Director, following eight years as Director General of the French transplantation agency (l'Établissement français des Greffes (EfG)).

Professor Houssin devoted most of his recent career to the fields of health security, public health, health professional education, and higher education and research evaluation. He is also currently engaged as the chairman of the Board of Administrators of the French Agency for Food, Environmental and Occupational Health & Safety (ANSES).

Professor Houssin was the delegate of France to the World Health Assembly and member of the Executive Board between 2005 and 2011. In 2013–2014, he served as the President of the WHO Technical Expert Working Group on genetic sequence data for pandemic influenza preparedness. From 2011 until 2013, he has been the President of the Pandemic Influenza Preparedness Framework Advisory Group and he is still a member of this group. In 2014, he served the WHO Regional Office for the Eastern Mediterranean as an individual consultant regarding the assessment of essential public health functions at country level.

Vice-Chair**Dr Ximena AGUILERA, Director Center of Epidemiology and Health Policy, Faculty of
Medicine, Universidad del Desarrollo, Santiago, Chile**

Dr Ximena Aguilera is currently the Director Center of Epidemiology and Public Health Policies at the Faculty of Medicine, Universidad del Desarrollo, Chile. She is also Vice-president of the Chilean Society of Public Health and Member of the Chilean Society of Infectious Diseases and the Chilean Society of Epidemiology.

¹ The content and publication of these biographies have been approved by Review Committee members.

Dr Aguilera, whose background is in public health, epidemiology and global health, was previously Senior Advisor on Communicable Diseases in the Pan American Health Organization (PAHO). Before that, she was head of the Division of Health Planning and head of the department of Epidemiology for the Chilean Ministry of Health, Ministry of Health Chile (1999–2008). She was also responsible for implementing the IHR in Chile.

Dr Aguilera's previous engagement with WHO includes consultancies and active participation as a WHO expert in a number of international meetings and forums on SARS, pandemic influenza preparedness, communicable diseases eradication and elimination as well as the implementation of the IHR (2005).

Rapporteur

Mr Andrew FORSYTH, Team Leader, Public Health Group, Ministry of Health, Wellington, New Zealand

Andrew Forsyth, BA (Hons), Diploma of Public Health, is Team Leader, Public Health Legislation and Policy, New Zealand Ministry of Health. As part of this role, he is currently leading the development of the proposed Radiation Safety Bill and the Health (Protection) Amendment Bill, introduced to Parliament in July 2014.

Mr Forsyth has more than 20 years of experience with the New Zealand Ministry of Health in the areas of workforce development and environmental health. More recently, he has led the development of legislation for drinking-water, the national cervical screening programme, and a major review of New Zealand's core public health statute, the Health Act 1956.

Mr Forsyth's current role focuses on the development and implementation of public health law. He has also been involved in government level responses to a range of acute public health threats, including SARS in 2003, pandemic influenza in 2009, the Canterbury earthquake in 2011 and New Zealand's current readiness activities for Ebola virus disease.

Mr Forsyth was involved in the intergovernmental negotiations on the development of the International Health Regulations during 2004 and 2005. Since that time he has served as an adviser and consultant to WHO in various capacities relating to the implementation of the IHR and also the Asia Pacific Strategy for Emerging Diseases, principally in the Western Pacific region. In 2010, he served on the Review Committee established to review the performance of the IHR 2005 and the global response to pandemic influenza A (H1N1).

Members

Dr Idris AL-ABAIDANI, Director, Department of Communicable Disease, Directorate General of Disease Surveillance and Control, Ministry of Health (HQ), Muscat, Oman

Dr Idris Al-Abaidani is Director of Communicable Disease Surveillance and Control of the Omani Ministry of Health.

In this capacity, he is responsible for the expanded programme of immunization, the national polio eradication and the Measles and Rubella elimination program. Dr Al-Abaidani is also head of the National IHR Focal Point and responsible for implementing the IHR in Oman. Dr Al-Abaidani's fields

of professional concentration include the training of outbreak management at the regional and national level. He was involved in some epidemiological and operational studies.

He is reporter of the National Communicable Disease Committee and National Immunization Technical Advisory Group, co-chair of the polio national expert committee and member of the national Pandemic (H1N1) 2009, MERS-CoV and Ebola committees.

Dr Al-Abaidani was involved in publishing the Oman Communicable Disease vision 2050, the communicable disease strategic plan, the epidemic preparedness plan, the MERS-CoV, Ebola preparedness and response plan, the influenza pandemic preparedness and deployment plan and WHO's event based surveillance guidelines.

Dr Al-Abaidani has actively participated in a number of international meetings and trainings organized by WHO as advisor, including training workshops on H7N9 emergency preparedness and response. He is a member of the national zoonotic committee and national medical and public health and IHR implementation committee. Currently, he serves as a member of the national Ebola preparedness and response team.

Dr Martin CETRON, Director, Division of Global Migration and Quarantine, National Center for Emerging and Zoonotic Infectious Diseases, Centers for Disease Control and Prevention, Atlanta, United States of America

Dr Martin Cetron is the Director for the Division of Global Migration and Quarantine (DGMQ) at the United States Centers for Disease Control and Prevention (CDC).

Before joining DGMQ, he served in CDC's Division of Parasitic Diseases and Bacterial Respiratory Diseases. Dr Cetron is a Commissioned Officer in the U.S. Public Health Service and holds faculty appointments in the Division of Infectious Disease at the Emory University School of Medicine and the Department of Epidemiology at Rollins School of Public Health.

For over 20 years, Dr Cetron has conducted epidemiologic research globally, developed global health policy and led domestic and international outbreak investigations including high profile international emergency responses to emerging infectious disease outbreaks. He played a leadership role in CDC responses to the 2001 anthrax bio-terrorism incident, the 2003 SARS epidemic, the 2003 US monkeypox outbreak, the 2005 Hurricane Katrina/Rita response, the influenza A (H1N1) pandemic 2009, and the on-going outbreak of Middle East respiratory syndrome coronavirus. His primary research interests are global health and migration with a focus on emerging infections, tropical diseases, and vaccine-preventable diseases in mobile populations.

Dr Cetron is currently a member of the IHR Emergency Committees concerning Ebola and Middle East respiratory syndrome coronavirus (MERS-CoV). Previously, he served as a member of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009 and participated in the US delegation's intergovernmental negotiations during the revision of the IHR.

Dr Stela GHEORGHITA, Department of Epidemiology of Communicable diseases, National Centre for Public Health, Chisinau, Republic of Moldova

Dr Stela Gheorghita is deputy director of the National Centre for Public Health in Republic of Moldova. As part of the IHR National Focal Point for the Republic of Moldova she is responsible for intersectorial coordination, communicable disease surveillance and outbreak response, pandemic preparedness as well as for the monitoring and evaluation of IHR implementation. She is also actively involved in both the National Immunization Technical Advisory Group and the Expert Commission in Epidemiology at the Moldovan Ministry of Health.

Dr Gheorghita is actively involved in the implementation of International Health Regulation in the Republic of Moldova since 2007. In this capacity, she has been especially engaged in the development of legal documents required for IHR implementation. From 2002 until 2007, she conducted research in the area of surveillance and control of vector-borne diseases at the National Center for Public Health.

Dr Gheorghita was previously involved with WHO in a number of training courses including the Public Health and Emergency Management course (PHEM-EURO II), the International Health Regulations in Practice course and the IHR Implementation course. She has also served as a WHO temporary advisor for the working groups on Early Warning and Event Based Surveillance as well as on Rapid Risk Assessment of Acute Public Health Events.

Dr Hayat KHOGALI, Director of Epidemics and Zoonosis Departments, Federal Ministry of Health, Khartoum, Sudan

Dr Hayat Khogali is Director of the National Epidemiology and Zoonotic Disease Program at the Federal Ministry of Health (FMOH), Sudan. She is also the responsible person for the National IHR Focal Point in Sudan and serves as the National Surveillance Officer for outbreaks detection and response.

Previously, Dr Khogali was the head of the Epidemiology Department at the Public Health Institute, FMOH. From 2007 to 2011 she was the head of Epidemiology Department, Khartoum State Ministry of Health. Before that, Dr Khogali worked as team lead for outbreak investigation and control and as surveillance officer at the State Team for Controlling Acute Watery Diarrheal Outbreaks in Khartoum State, Epidemiology Department, Ministry of Health.

She is also Assistant Professor at the School of Medicine of the Khartoum College of Medical Sciences since 2008. Her professional experience includes epidemiological surveillance and outbreak investigation with special focus on zoonotic event surveillance and response, health education, and the application of public health measures in emergencies and humanitarian crises.

Dr Khogali's committee memberships include the National Committee of Emergency Response and Outbreak Investigation, the State Higher level Committee for Emergency Response and Disaster Management, the National Technical Committee for Communicable Disease Surveillance, Preparedness and Control, the National Committee of IHR Implementation, and the Technical Research Committee for reviewing and approving quantitative and qualitative research.

Dr Khogali has engaged with WHO on many occasions. She has served as a WHO Temporary Advisor in assessing the "Implementation of the Required Capacities for the International Health

Regulations (2005)” in the State of Qatar and the Kingdom of Bahrain, and in finalizing different manuals for influenza surveillance, meningitis outbreak response and event based surveillance. She also served as a facilitator in many training workshops organized by WHO.

Professor Abdulsalami NASIDI, Director, Nigeria Centre for Disease Control, Abuja, Nigeria

Dr Abdulsalami Nasidi is a medical officer with over 36-years of experience in public health, virology and biotechnology. He is also a professor of virology and technology.

Dr Nasidi was previously a Senior Research Fellow at the National Institute for Medical Research, Yaba, Lagos. Later he became the head of the Federal Vaccine Production Laboratory, Yaba for a period of seven years. In 1991 he was appointed the nation’s Chief Epidemiologist and in 1996 Director of Special Duties at the Federal Ministry of Health. In 2007 he was appointed Director, Public Health at same Ministry. He was the first Chairman of the Country Coordinating Mechanism (CCM) of the Global Fund to Fight AIDS, TB and Malaria, in which position he oversaw the development of proposals that generated more than \$680 million for Nigeria’s HIV/AIDS, TB and Malaria programmes. He was appointed as the Chairman of the Presidential Task Force for Polio Eradication in 2008 which developed strategies that lead to the sharp reduction by more than 95% and virtual elimination of circulating wild poliovirus in Nigeria by the year 2010.

Dr Nasidi’s other achievements include the co-development of Hepatitis B vaccine and snake anti-venom against the carpet viper and two other Nigerian poisonous snakes. He has more than 50 publications in national and international journals and was recognized by the Nigerian Government with the award of a national honour of the Officer of the Order of the Niger (OON) in 2002. Dr Nasidi is also a Professor of Virology and Biotechnology. He currently serves as the Project Director for the Nigeria Centre for Disease Control (NCDC).

Dr Nasidi has been recognized by the WHO Regional Office for Africa for championing the establishment of public health institutions in the region.

Dr Kazunori OISHI, Director, Infectious Disease Surveillance Center, National Institute of Infectious Diseases, Tokyo, Japan

Professor Kazunori Oishi is currently the Director of the Infectious Disease Surveillance Center at Japan’s National Institute of Infectious Diseases.

From 2006 to 2012, Professor Oishi was an appointed Professor at the International Research Center for Infectious Diseases, Research Institute of Microbial Diseases, Osaka University. From 1997 to 2005, he was an Associate Professor within the Department of Internal Medicine, Nagasaki University.

Professor Oishi’s fields of professional concentration include countermeasures of emerging and re-emerging infectious disease worldwide; the strengthening of national infectious disease surveillance and vaccination programme in Japan.

Professor Oishi is Chairperson of the Vaccine Working Group of the Japanese Respiratory and Infectious Disease Societies. He is also a member of the advisory committee on the National Pandemic Influenza Plan and the National Committee of Infectious Diseases.

In 2012, Professor Oishi chaired WPRO's Second Meeting of the Technical Advisory Group for the Asia Pacific Strategy for Emerging Diseases.

Mr Graham RADY, Monitoring and Evaluation Consultant, Canberra, Australia

Mr Graham Rady is a self-employed Monitoring and Evaluation Consultant.

From 2003 to 2014, Mr Rady was a Senior Quality Adviser to the Department of Foreign Affairs and Trade (formerly the Australian Agency for International Development (AusAID)).

Mr Rady's fields of professional concentration include monitoring and evaluating development programs, projects and strategies; developing and reviewing organizational performance management information systems; and designing and appraising new development programs or projects.

Mr Rady currently holds no professional positions. He was Co-chair, Secretary and Delegate of AusAID's Staff Association from 2001 to 2014 and Secretary of the Papua New Guinea Rubber Board from 1982 to 1985.

From 2010 to 2014, Mr Rady has been a Technical Adviser to WPRO and SEARO for the Asia Pacific Strategy for Emerging Diseases (APSED) program attending various Technical Advisory Group (TAG) and special working group meetings.

Professor Petri RUUTU, Department of Infectious Disease Surveillance and Control, National Institute for Health and Welfare, Helsinki, Finland

Professor Petri Ruutu is a visiting scientist at the National Institute of Health and Welfare, as well as a consultant for the comprehensive revision of communicable disease law, the Global Health Security Initiative and immigrant health. He is the former Head of the Department of Infectious Disease Surveillance and Control at the National Institute of Health and Welfare, Finland.

Professor Ruutu's fields of professional concentration include working as Finland's National IHR Focal Point responsible person from 2007 to 2013. He further coordinated IHR-related activities nationally and acted as an international liaison. Prior to this he was the national expert delegate developing the IHR during the WHO consultation processes for its revision and supported the incorporation of the Regulations into national legislation. He was also the national expert coordinating the anthrax threat, SARS and pandemic influenza A (H1N1) 2009, including pandemic preparedness planning. From 1995 to 2013, Professor Ruutu was Head of unit(s) implementing the comprehensive revision of infectious disease surveillance and control systems in Finland through multi-sectoral collaboration. Professor Ruutu worked as a clinical infectious disease consultant in a university hospital from 1981 to 1995. He has 25 years of experience in setting up surveillance for serious infections and large-scale vaccination field study infrastructure in low-income countries.

Professor Ruutu has worked as an expert consultant for the European Centre for Disease Prevention and Control (ECDC) to assess communicable disease surveillance and control in European Union (EU) candidate Member States. He is also a consultant to a three-year EU-funded development project on the role of travel hubs in pandemics and on the intentional use of microbes.

In 1988, Professor Ruutu worked as a short-term consultant for WHO to develop the Acute Respiratory Infections control program in Burma (now Myanmar).

Professor Kuku VOYI, Professor for Environmental and Occupational Health, University of Pretoria, Pretoria, South Africa

Professor Kuku Voyi is currently the Head of Environmental and Occupational Health at the Faculty of Health Sciences, University of Pretoria. She is also Research coordinator at the School of Health Systems and Public Health.

Professor Voyi previously held the position of Chairperson, School of Health Systems and Public Health at the University of Pretoria from 2004 to 2010. She has held several chairperson positions at the South African Medical Research Board. Professor Voyi was also Chairperson of the International Management Team for the System-wide Initiative on Malaria and Agriculture from 2003 to 2006. She has further held several advisory positions, including with the National Environmental Health Research, the National Research Foundation, Technikon Research Development Programme on Pollutants and toxins, and the South African Bureau of Standards, Chemical and Biological standards. She was a Board member of the Group for Environmental Monitoring from 2001 to 2005.

Professor Voyi's professional fields of concentration include epidemiology and exposure assessment to environmental and occupational health risks. She is a Member of the Society for Risk Analysis, the International Society for Environmental Epidemiology, the Global Asthma Network, the Public Health Association of South Africa and of the National Association for Clean Air.

Professor Voyi has held several positions with the World Health Organization (WHO), including with the WHO Regional Offices for Africa and South-East Asia. She was also a subject matter expert for the development of the IHR implementation course development in the areas of surveillance and risk assessment. Finally, Professor Voyi was a Member of the Review Committee on the Functioning of the International Health Regulations (2005) and on Pandemic Influenza A (H1N1) 2009 from 2010 to 2011.

Dr Somsak WATTANASRI, Senior Consultant, Bureau of Epidemiology, Department of Disease Control, Ministry of Public Health, Nontaburi, Thailand

Dr Somsak Wattanasri is a retired Government Official. He is currently Senior Advisor to the Bureau of Epidemiology at Thailand's Ministry of Public Health (MOPH). He is also a Lecturer and Mentor of Medical Epidemiology (Field Epidemiology Training Residency Program). Finally, he is a consultant to the Dean of Ramathibodi Hospital on Hospital Infection Control.

Dr Wattanasri was previously a Senior Expert in Preventive Medicine at the MOPH's Department of Disease Control and Prevention, as well as Director of the Bureau of Epidemiology and Director of International Health division. He was the leader in developing the ASEAN Plan of Action to strengthen epidemiological capacities and co-founder of the International Field Epidemiology Program for the Association of Southeast Asian Nations.

His fields of professional concentration include health information systems, infectious disease surveillance and control, pediatrics and hospital infection control and prevention. He is the current President of the Central Sterilizing Service Association in Thailand.

Dr Wattanasri has been a WHO temporary advisor in several consultancies within his areas of expertise.

ANNEX 2

DRAFT RESOLUTION ON THE RECOMMENDATIONS OF THE REVIEW COMMITTEE ON SECOND EXTENSIONS FOR ESTABLISHING NATIONAL PUBLIC HEALTH CAPACITIES AND ON IHR IMPLEMENTATION

The Executive Board,

Having considered the report of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR implementation,¹

RECOMMENDS to the Sixty-eighth World Health Assembly the adoption of the following resolution:

The Sixty-eighth World Health Assembly,

PP1 Having considered the report of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR implementation;

PP2 Reminding Member States of their rights and obligations under the International Health Regulations (2005) and their responsibility to the international community;

PP3 Recalling the final report of the Review Committee on the Functioning of the International Health Regulations (2005) and on Pandemic Influenza A (H1N1) 2009 transmitted by the Director-General to the Sixty-fourth World Health Assembly;²

PP4 Recognizing the establishment of a Review Committee as required under Articles 5 and 13 of the International Health Regulations (2005) and as provided for in Chapter III of Part IX of the said Regulations;

PP5 Commending the successful conclusion of the work of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR implementation, the leadership of its chair, the dedication of its distinguished members, and the submission of its report to the Director-General for transmittal to the Sixty-eighth World Health Assembly,

(OP1) 1. URGES Member States to support the implementation of the recommendations contained in the report of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation;

(OP2) 2. REQUESTS the Director-General:

(1) to present an update to the Sixty-ninth World Health Assembly, through the Executive Board, on progress made in taking forward the recommendations of the

¹ Document EB136/22 Add.1.

² Document A64/10.

Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation;

- (2) to provide technical support to Member States in implementing the recommendations of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation.

ANNEX 3

**REPORT ON FINANCIAL AND ADMINISTRATIVE IMPLICATIONS FOR THE
SECRETARIAT OF THE DRAFT RESOLUTION PROPOSED
FOR ADOPTION BY THE EXECUTIVE BOARD**

<p>1. Draft resolution: Recommendations of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation</p>	
<p>2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)</p> <p>Category: 5</p> <p>Programme area(s): 5.1 and 5.2</p> <p>Outcomes:</p> <p>5.1.All countries have the minimum core capacities required by the International Health Regulations (2005) for all-hazard alert and response</p> <p>5.2.Increased capacity of countries to build resilience and adequate preparedness to mount a rapid, predictable and effective response to major epidemics and pandemics</p> <p>Outputs:</p> <p>5.1.1. Countries enabled to develop core capacities required under International Health Regulations (2005)</p> <p>5.2.1. Countries are enabled to develop and implement operational plans, in line with WHO recommendations on strengthening national resilience and preparedness covering pandemic influenza and epidemic and emerging diseases</p> <p>How would this decision contribute to the achievement of the outcome(s) of the above programme area(s)? This will provide impetus to the implementation of the Review Committee recommendations.</p> <p>Does the Programme budget already include the outputs and deliverables requested in this decision? (Yes/no) Yes.</p>	
<p>3. Estimated cost and staffing implications in relation to the Programme budget</p> <p>(a) Total cost Indicate (i) the lifespan of the decision during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).</p> <p>(i) One year (covering 2015)</p> <p>(ii) Total: US\$ 2 100 000 (staff: US\$ 1 500 000; activities: US\$ 600 000)</p> <p>(b) Cost for the biennium 2014–2015 Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).</p> <p>Total: US\$ 2 100 000 (staff: US\$ 1 500 000; activities: US\$ 600 000)</p>	

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

Headquarters and the six regions

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

No.

If “no”, indicate how much is not included.

US\$ 2 100 000 – the costs are currently not foreseen in the Programme Budget 2014–2015; however, we will reprioritize activities among the category network and request additional space if necessary.

(c) Staffing implications

Could the decision be implemented by existing staff? (Yes/no)

No.

If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

– one full-time staff, P4, one year in each region

– one full-time staff, P4, six months at headquarters

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)

No.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

US\$ 2 100 000; source(s) of funds: The funding gap will be addressed through the Organization-wide coordinated resource mobilization effort.

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