

**WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC**



REPORT

**WORKSHOP ON THE INTERNATIONAL HEALTH REGULATIONS (2005) AND
PANDEMIC INFLUENZA PREPAREDNESS IN THE PACIFIC**

**Nadi, Fiji
2- 5 November 2005**

**Manila, Philippines
January 2006**

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PANDEMIC INFLUENZA PREPAREDNESS IN THE PACIFIC**

Convened by:

**WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC**

**Nadi, Fiji
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Printed and distributed by:

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

January 2006

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08 JUN 2006

NOTE

The views expressed in this report are those of the participants of the Workshop on the International Health Regulations (2005) and Pandemic Influenza Preparedness in the Pacific and do not necessarily reflect the policies of the World Health Organization.

This report has been printed by the Regional Office for the Western Pacific of the World Health Organization for the participants in the Workshop on the International Health Regulations (2005) and Pandemic Influenza Preparedness in the Pacific which was held in Nadi, Fiji, from 2 to 5 November 2005.

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Keywords:

International health regulations, pandemic influenza preparedness, communicable disease surveillance and response

SUMMARY

WHO workshop on the International Health Regulations (2005) and Influenza Pandemic Preparedness in the Pacific, was conducted from 2 to 5 November 2005, Nadi, Fiji. The workshop was convened by the World Health Organization for the Western Pacific, in collaboration with the WHO Representative in the South Pacific.

The objectives of the workshop were:

1. to advocate and increase awareness amongst policy-makers and health officials in the Pacific island countries and areas (PICs) concerning the implementation of the new International Health Regulations, i.e IHR (2005);
2. to identify gaps and priority action areas for the implementation of IHR (2005) in the PICs;
3. to provide updated knowledge about the current situation of the avian influenza A (H5N1) outbreak, and the risk and possible impact of pandemic influenza;
4. to advocate and increase awareness about the importance and urgency of strengthening national pandemic influenza preparedness in the Pacific; and
5. to discuss feasible action plans for improving pandemic influenza preparedness in the Pacific

Representatives from the 19 Pacific island countries and areas (PICs) attended this four-day workshop. WHO temporary advisers and short-term consultants from the Secretariat of the Pacific Community (SPC), Tonga, Australia, New Zealand, and Republic of Korea were invited to give related presentations and provide technical advice. Observers from the Australian Agency for International Development, the Australian High Commission, the Fiji School of Medicine, the International Federation of Red Cross and Red Crescent Societies, the Fiji Centre for Communicable Disease Control were also invited to participate in the workshop.

Dr. Timaima Tuiketeci of Fiji was appointed as Chairperson and Dr Jean-Paul Grangeon of New Caledonia as Vice-Chairperson. The methods of work included plenary presentations, scenario exercises, and small group and plenary discussions.

The main conclusions and recommendations from the workshop were:

International Health Regulations (2005)

Conclusions

1. Workshop participants recognize that the revised International Health Regulations (IHR 2005) set out challenging new requirements. At the same time, they also provide new opportunities for all the Pacific island countries and areas (PICs) to strengthen their local and national public health capacities.

2. The participants also recognize the importance of starting preparations for the effective implementation of IHR (2005) in PICs. However, there are some major challenges to be met, including resource constraints, limited public health infrastructure, lack of national and local capacities for surveillance and response, and capacities at points of entry in many PICs.
3. The legal framework which IHR (2005) will provide when they enter into force can be considered a model for influenza pandemic preparedness and response. The implementation of IHR (2005) will contribute directly to preparedness for all public health emergencies, particularly pandemic influenza.
4. PICs, regional networks (particularly Pacific Public Health Surveillance Network, PPHSN), WHO and other partners all have synergistic roles to play in preparations for IHR implementation and improving influenza pandemic preparedness in PICs.

Recommendations:

1. A functional National IHR Focal Point needs to be established as a priority, using existing national structure as appropriate, to drive preparations for the effective implementation of IHR (2005).
2. National and local public health capacity is essential to the IHR implementation. The process of assessing existing national and local capacities should be started as soon as practicable to identify shortfalls and gaps for implementation of IHR (2005). Based on the capacity gaps identified above, workplans to prepare for implementation including capacity strengthening should be developed, or incorporated into an existing national plan.
3. It is also important to secure political commitment, allocation of resources and support of other government and of external agencies to fully implement IHR (2005). Conducting scenario exercise at national level with senior decision-makers and politicians would raise their awareness of the expectations for fulfilling national obligations under the IHR (2005).
4. All PICs should use IHR (2005) as an opportunity to promote intersectoral and regional communication and coordination, and to mobilize and share expertise and other resources.
5. All PICs should review and amend as necessary all existing national legislation to ensure its compatibility with IHR obligations and influenza pandemic preparedness requirements.
6. IHR(2005) should be addressed in high-level national, regional and international forums, such as the Pacific Island Forum. IHR (2005) should be proposed to be included as an agenda for the next Pacific Island Forum and be included into the Pacific Plan, when possible.
7. WHO and PPHSN should continue working with PICs to help further strengthen a regional approach to capacity development in public health, including IHR implementation and influenza pandemic preparedness in the Pacific.

Influenza Pandemic preparedness

Conclusions:

1. Influenza pandemic preparedness has current global attention and momentum and political leaders are calling for urgent actions. This is a great opportunity to strengthen preparedness for influenza pandemic and other public health emergencies.
2. The participants recognize that influenza pandemic poses a significant potential threat to the PICs. The range of options that PICs have to address is both limited and unique with specific issues in the Pacific. Pandemic preparedness needs to address these limitations and unique opportunities.
3. Whilst significant progress with influenza pandemic preparedness in many PICs has been made, the participants fully recognize the urgent need for all the PICs to further develop and test their national influenza preparedness plans.

Recommendations:

1. WHO and SPC under a framework of PPHSN should mobilise and coordinate external funding and other support for national influenza pandemic preparedness in PICs to ensure optimal utilization of limited resources and avoid duplication.
2. The membership of the national influenza pandemic preparedness task force (or equivalent) should be reviewed to ensure multi-sectoral and National IHR Focal Point representation.
3. All PICs should accelerate, finalize, review and test, as appropriate, national influenza pandemic preparedness plan.
4. WHO and SPC should encourage and facilitate all the PICs to share their national influenza pandemic preparedness plans and to improve inter-country coordination of pandemic planning, including harmonization of recommendations on public health measures, when possible.
5. PICs should carefully consider the effectiveness, feasibility, and economic and other consequences of border control measures in their national influenza pandemic preparedness plans. WHO should provide a review of available evidence of the effectiveness of all possible options of border control measures and their appropriateness in the Pacific.
6. PICs should address other public health measures before considering stockpiles of antivirals and use of pandemic vaccines, given the limited availability, high cost, and uncertainty of effectiveness of these interventions.
7. Regional coordination mechanism should be explored by WHO/SPC and other regional and international forums to address procurement and stockpiles of medical supplies in the Pacific.
8. PICs should make their efforts to ensure that their surveillance system is sufficiently sensitive to detect any unusual cluster of influenza-like illness. Given that the laboratory capacities are limited for confirmation of influenza virus sub-type in the Pacific, PICs should ensure they can transfer relevant specimens urgently to a reference laboratory for characterization and confirmation, with assistance from WHO/SPC.

INTRODUCTION

1.1 Background

The International Health Regulations (IHR) are the legally binding international instruments for preventing international spread of diseases to ensure global health security. The current IHR, in force since 1969, prescribe notification requirements only for three diseases: cholera, plague and yellow fever.

The IHR have undergone substantial revision to make them responsive to the new challenges of communicable disease threats in 21st century posed by the increased volume and complexity of international trade and travel, and the widespread use of electronic communications. The revised IHR, i.e. IHR (2005), adopted by the World Health Assembly in May 2005, will enter into force in June 2007.

Member States are now encouraged to mobilize the necessary resources which will guarantee the Regulations' full and effective implementation. Member States also need to prepare for the incorporation of IHR (2005) into their respective national legislation and to begin using the decision instrument for the assessment of all events that may constitute a public health emergency of international concern. Together with WHO and other partners, Member States shall also plan for the assessment of their existing public health capacities in order to meet the core capacity requirements.

Outbreaks of avian influenza A (H5N1), which started in late 2003, are historically unprecedented in terms of its geographical spread and impact, and have already affected many countries in Asia and Europe. More than 160 million poultry have died or been culled. The H5N1 outbreaks also represent a serious threat to human health. Since Dec 2003, more than 120 human infections have been confirmed in Viet Nam, Thailand, Cambodia, and Indonesia. Given the increasing risk of next influenza pandemic, the resolution WHA58.5 urged Member States to develop and implement national plans for pandemic-influenza preparedness and response.

In the Pacific, many PICs are currently experiencing rapid social and environmental changes (migration, urbanization and globalization), the risk of cross-border transmission and spread of communicable diseases is real and significantly increasing in the region. The Pacific will need to be better prepared for early detection of and response to future public health threats and to improve preparedness for pandemic influenza in order to minimize their health and social-economic impact and social disruption.

To facilitate the implementation of IHR (2005) and to improve preparedness for pandemic influenza in the Pacific, it was proposed that a 4-day WHO workshop on IHR (2005) and pandemic influenza preparedness in the Pacific be held from 2 to 5 November 2005, in Nadi, Fiji.

1.2. Objectives

The objectives of the workshop were:

- to advocate and increase awareness among policy makers and health officials in the PICs concerning the implementation of the International Health Regulations (2005);
- to identify gaps and priority action areas for the implementation of the IHR (2005) in the PICs;

- to provide updated knowledge about the current situation of the avian influenza A (H5N1) outbreak, and the risk and possible impact of pandemic influenza;
- to advocate and increase awareness about the importance and urgency of strengthening national pandemic influenza preparedness in the Pacific; and
- to develop feasible action plans for improving pandemic influenza preparedness in the Pacific.

1.3. Organization

A 4-day WHO workshop on IHR (2005) and pandemic influenza preparedness in the Pacific was held from 2 to 5 November 2005, in Nadi, Fiji. The workshop agenda and the programme of activities are attached in *Annex 1*.

Representatives from 19 Pacific Island Countries and areas attended the workshop. WHO temporary advisors from the Secretariat of the Pacific Community (SPC) in New Caledonia, the Ministry of Health of Tonga, Australian National University, Yonsei University of Republic of Korea, the Ministry of Health of New Zealand, and the Victorian Infectious Disease Reference Laboratory in Australia were invited to provide technical inputs to the workshop. In addition, observers from the Australian Agency for International Development, the Australian High Commission in Fiji, the Fiji School of Medicine, the International Federation of Red Cross and Red Crescent Societies, the Fiji Centre for Communicable Disease Control were also invited to participate in the activity. Two WHO consultants were recruited to provide technical assistance for the workshop and conduct follow-up visit in selected PICs (*Annex 2*).

Dr Timaima Tuiketeti of Fiji was appointed as Chairperson and Dr Jean-Paul Grangeon of New Caledonia as Vice-Chairperson for the workshop. Dr Jacob Kool of the United States was identified as rapporteur for the whole workshop and Mr Andrew Forsyth of New Zealand and Dr Heath Kelly of Australia as rapporteurs for the working group discussions.

The methods of work included plenary presentations and discussions on the topics related to IHR (2005) and influenza pandemic preparedness, scenario exercises on implementation of IHR (2005) in the Pacific, and small group discussions. The draft conclusions and recommendations were presented by Chairperson to a final plenary session for review and revision.

1.4 Opening ceremony

Dr. Chen Ken, WHO Representative in the South Pacific, delivered an opening speech on behalf of Dr Shigeru Omi, WHO Regional Director for the Western Pacific Region. Dr Chen welcomed participants and expressed sincere thanks to the Honourable Minister of Health, Fiji, for hosting the workshop. The International Health Regulations are the legally binding international instruments for preventing international spread of diseases. The newly revised Regulations, adopted by the World Health Assembly in May 2005, have a much broader scope and will come into force in June 2007. Dr Chen Ken emphasized the following points and highlighted several issues to be discussed during the workshop with regard to the implementation of IHR (2005) in PICs: (1) the new Regulations set out many new requirements for Member States, but they also provide new opportunities for PICs to strengthen their national and local public health capacities; (2) building and strengthening national capacities are essential to the effective implementation of the new regulation in PICs; (3) strengthening regional collaboration and coordination, particularly through PPHSN will facilitate and enhance national efforts for implementation of IHR; (4) PICs should mobilize the necessary resources and work together to fulfil the new obligations which will also help achieve the common goal of "Healthy Islands" and contribute to regional and global health

security. Regarding influenza pandemic preparedness, Dr. Chen pointed out that an influenza pandemic has been of immediate global concern, and if an influenza pandemic would occur, no countries, including PICs, would be spared from the impact. The outbreaks caused by influenza A(H5N1) are unprecedented both in terms of geographic spread and magnitude of the problem. It is believed that the world is closer now to an influenza pandemic than at any time in recent years. Dr Chen strongly emphasized the importance and urgency of taking the issue of influenza pandemic preparedness seriously and the needs for immediate actions to improve influenza pandemic preparedness in PICs. (*Annex 3*).

The Honourable Minister of Health of Fiji, Honourable Mr Solomoni Naivalu, welcomed all the participants, felt privileged to open this important workshop and thanked WHO for organizing this event in Fiji. He said that IHR (2005) are an important and timely endeavour since the world is in influenza pandemic alert phase 3, and H5N1 avian influenza has been spreading in Asia. The Government of Fiji has committed to implementing the new IHR. The Ministry of Health in Fiji has briefed parliament on the threat of pandemic influenza and the urgent need to prepare for it. With technical support and help of WHO, a health emergency and national disaster management plan has just been drawn up. A multi-sectoral meeting with the participation of all key sectors and agencies will be held in Fiji in November to further discuss pandemic influenza preparedness. Involvement and close coordination among all sectors is necessary for a timely response to a possible pandemic. Planning and practise exercises are also required. Honourable Minister Mr Naivalu made his commitment to the implementation of IHR (2005) in Fiji and to the prevention of international spread of diseases. Fiji occupies a critical position in the Pacific, and therefore its actions in this area are crucial. Should no pandemic occur, the preparations will still provide important improvements of its public health infrastructures and capacities. The Honourable Minister wished a good and fruitful workshop and declared the workshop officially open.

Dr. Hitoshi Oshitani, Regional Advisor, Communicable Disease Surveillance and Response (CSR), WHO Regional Office for the Western Pacific (WPRO), thanked the Honourable Minister and the WHO Representative for their opening remarks and supporting the workshop. He welcomed country participants, WHO Temporary Advisers and observers to the workshop. As a responsible officer, he gave a briefing introduction on the background, objectives, expected outcomes, proposed agenda, and the conduct of the workshop.

2. INTERNATIONAL HEALTH REGULATIONS

2.1 The Revised International Health Regulations, Dr Maxwell Hardiman, WHO/Geneva

The International Health Regulations 2005 (IHR 2005) have been negotiated and adopted by WHO's Member States at the World Health Assembly in May 2005. Both Member States and WHO are responsible for implementing the Regulations. IHR (2005) seek to achieve their purpose by establishing the legal framework to prevent international spread of disease while avoiding unnecessary interference with international traffic and trade. IHR (2005) require the detection, verification of and response to public health emergencies based upon a basic level of core capacity maintained in every State to carry out these tasks at national and local level. They also should notify WHO when the event meet the criteria for public health emergency of international concern. In preparation for the entry into force of the Regulations in 2007, all WHO Member States need to be starting the processes of analysing the Regulations, identifying the structure including designation of the IHR National Focal Point, reviewing the need to adapt their existing public health legislation and begin assessing their national capacities in the light of core capacity requirement of the

IHR (2005). This capacity assessment should lead to plans of action to ensure that infrastructures and systems are in place to meet the IHR requirements by 2012. Dr Hardiman summarized some of the key elements of IHR (2005) and the principal directions that guided their development.

2.2 Asia Pacific Strategy for Emerging Diseases, Dr Hitoshi Oshitani, WHO/WPRO

The Asia Pacific Strategy for Emerging Diseases (APSED) was developed jointly by two regions of WHO – the South-East Asia Region and the Western Pacific Region and endorsed by two Regional Committee meetings in September 2005. The Strategy was developed to address the continuing emerging disease threats in the Asia-Pacific region, in particular the increasing risk of cross-border transmission of emerging diseases. The Asia Pacific region has experienced significant emerging diseases in recent years, including SARS and avian influenza. IHR 2005 set out many new requirements for countries, including national and local capacity requirements for surveillance and response. The overall goal of the strategy is to improve health protection against emerging diseases in the Asia Pacific Region through productive partnerships for preparedness, prevention, and prompt detection of and response to emerging diseases. It should be used as a roadmap to strengthen national capacities and as a framework for development of improved collaboration and coordination. It should be used as a stepping-stone to meet many of the core capacity requirements under IHR (2005), and as a document for advocacy for financial support and human resource development. The issue of implementing the Strategy in the Pacific need to be addressed. WHO will continue to provide necessary support to PICs to strengthen their capacities required for emerging diseases, using the Strategy as a strategic framework. In the Pacific, the Strategy will need to be harmonized with the PPHSN strategies and other existing plans.

2.3 Public health threats in the Pacific, Dr Tomasz Kiedrzyński, Secretariat of the Pacific Community

Historically, epidemics of infectious diseases have had a severe impact on the populations of the Pacific region: In 1875, measles importation to Fiji killed 40% of the population. In 1918 the Spanish Influenza decimated some PICs by up to 25%. Since the 1980s the world has been continuously facing emerging and re-emerging infectious diseases because of changing ecological and environmental factors, inappropriate use of antibiotics, increased crowding and travel, and a decline of the public health infrastructure. Substantial progress has been made in some areas, including control of vaccine preventable diseases, such as measles and rubella. There are continuing challenges posed by other diseases such as cholera and dengue fever. There were eight confirmed cholera outbreaks over the past 30 years in the Pacific. An influenza pandemic will pose a serious threat to PICs. The Pacific region is vulnerable to epidemic communicable diseases and these will come back if we do not sustain prevention programs and control activities. The Pacific Public Health Surveillance Network (PPHSN) is a regional network of countries and institutions that is dedicated to the promotion of surveillance and response to infectious diseases in the Pacific. The Samoa Commitment recommended that PPHSN should be used as a mechanism in facilitating IHR implementation in the Pacific such as notification, verification of public health events and capacity strengthening to meet the core capacity requirements under IHR (2005). The IHR focal point should be a member, and where possible the chair, of the national PPHSN EpiNet team.

2.4 National legislations and IHR (2005), Dr Myongsei Sohn, Yonsei University, Republic of Korea

Public Health Law has recently come into focus as the World Health Assembly adopted the revised International Health Regulations (IHR) in May 2005, and as the Framework Convention on Tobacco Control (FCTC) has made a forceful presence in the field. IHR (2005) will enter into force in 2007 and countries need to review and adjust their current national public health legislations to ensure their compatibility with IHR (2005). The implementation of revised or new

legislations of each Member State can be communicated internationally by updating the entries into the WHO's International Draft of Health Legislation (IDHL) Website (according to the Article 62 of the Constitution of the WHO). The Asian Institute of Bioethics & Health Laws (AIBHL) has been working with WHO to improve and coordinate this effort. The Institute has recently conducted surveys on national public health laws to facilitate global exchange in the field of Public Health Law, and to compile profiles of public health legal structures of Member States. An updated print publication and the IDHL website's on-line publication have been scheduled for 2006. These multi-level collaborative and supplemental reports of information will enhance the understanding between countries, and further promote public health initiatives and legislations in the Member States. Additionally, the WHO as a whole will utilize the reports in aiding to constitute the draft for the Model Public Health Act of the Public Health Law that will be introduced at the beginning of 2006. Ultimately, these reporting mechanisms will serve as invaluable tools for each Member State to individually create and implement national public health legislation.

2.5 Public health emergency preparedness and response plan in New Zealand.
Mr Andrew Forsyth, Ministry of Health, New Zealand

New Zealand has developed a generic approach to improve its health emergency preparedness. National health emergency plans cover all sources of harm, including infectious diseases and natural disasters. Public health emergency planning contributes directly to emergency preparedness across the wider health sector. The wider health sector plan can be activated by itself, or can function as just one part of the broader National Civil Defence Plan. All plans need to address role coordination within the different parts of the health sector and with other sectors. Common themes for all plans are the four stages of:

- Reduction of risk
- Readiness
- Response
- Recovery

The International Health Regulations (2005) also provide a useful planning framework for public health emergency planning. In particular by specifying a range of capacities that countries need to develop/maintain in relation to detection of events, assessing their significance, responding to such events and reporting. These capacities need to be in place locally, nationally, and at the border.

2.6 Scenario exercises on IHR (2005), Dr Mahomed Patel, Australia National University

Two scenario exercises were conducted in four small working groups over two sessions. The exercises provided the opportunity to explore how the articles of IHR (2005) could be applied when a country experiences an outbreak of an event that may constitute a "public health emergency of international concern".

The objective of the scenario exercises was to provide the national policy-makers, health officials and technical staff who attended the workshop the opportunity to experience the process and requirements of IHR (2005) by applying the provisions to hypothetical events with relevance to PICs. The scenarios were developed in collaboration with WHO and SPC staff. As the first such regional workshop held since the adoption of IHR (2005), the scenario exercises were also expected to provide an opportunity for WHO to evaluate the methodology and utility of such an exercise.

The first scenario exercise was designed to address an unknown disease, emerging initially as deaths in animals and then developing into a respiratory illness in human with human-to-human transmission. The second scenario covered a resort island cholera outbreak, initially diagnosed in

another country in returning tourists which then progressed to raise issues of shipping quarantine, trade restrictions and dispute resolution.

The exercises were developed to have: (1) covered the basic process of the IHR, progressing through the following key steps in dealing with a potential PHEIC under the IHR: early detection of such events through responsive and timely surveillance, the assessment of the event through outbreak investigations and application of the IHR decision instrument, the notification of the event to WHO, and the appropriate implementation of control measures; (2) required participants to describe the roles and responsibilities of a National IHR Focal Point (NFP); and (3) enabled participants to experience advocating to senior national decision-makers of the need to strengthen capacity for surveillance and response in order to meet IHR (2005) requirements.

For the exercise, the participants were allocated into 4 groups, with each group facilitated by a WHO expert familiar with IHR (2005). The process varied between groups, with some groups referring to the text of the IHR, while others focused on developing answers consistent with good epidemiological practice, without direct reference to the Articles. Some groups used the written exercise as given, while others adapted this to a role-play format. Different methods were used to evaluate the exercises. Key points provided from the evaluations were that participants learned several new concepts including practical aspects of NFP function, use of the decision instrument, understanding of WHO's role in collaboration and assistance, and the need for information sharing. The exercises helped identify challenges and gaps, in particular, the roles and responsibilities of NFP, which all groups found difficult to address in an applied context.

In feedback, some participants said they would have liked the following areas addressed in more detail; communication and the reporting format to WHO; preventative measures such as border controls and infection control; and the legislation relevant to IHR, as well as the legal consequences of not notifying. All groups found that the time allocated was not enough to allow full discussion. Many participants found the exercises useful to learn to use the decision instrument and to get to know the implications of the new IHR.

Future work in follow up to this exercise will be to incorporate the suggestions received from workshop participants for improving the exercises. Most participants reported that they were keen to use a similar scenario exercise in-country for improving IHR awareness, and were prepared to facilitate such exercises. Development of a guide for facilitators, and where feasible, providing on-site training for them, will assist this.

2.7 IHR (2005) obligations and requirements, Dr Li Ailan, WHO/WPRO

The new International Health Regulations (IHR (2005)) set out many new requirements for Member States concerning the verification, assessment and notification of significant public health events, the implementation of WHO recommended measures, the development of core capacities for surveillance and response and at points of entry, and, where necessary, the adjustment of national legislation. All State Parties to IHR (2005) are required to establish a National IHR Focal Point (NFP) as an operational link for urgent communications concerning the implementation of the Regulations. The NFP should be accessible at all times and perform its key functions. The decision instrument (an algorithm) containing four criteria should be used for assessing public health events and all State Parties should notify WHO of any event that may constitute a public health emergency of international concern within 24 hours of assessment. Member States should also respond to requests for verification of information (including unofficial reports) regarding public health risks. With regard to response to public health emergencies of international concern, all Member States will need to make every effort to implement WHO recommended measures and provide scientific justification for additional measures. The best way to prevent international spread of diseases is to detect and respond to events quickly and effectively when the problem is still small

and at local levels. IHR (2005) therefore request Member States to develop, strengthen and maintain their core capacities for surveillance and response at the local community, intermediate and national levels. In addition, national legislation needs to be reviewed and adjusted (when necessary) to ensure its compatibility with IHR (2005).

2.8 Working groups and plenary discussion on IHR (2005)

To provide country representatives and other participants with an opportunity and a forum to discuss some key issues arising from IHR (2005), express country perspectives and make suggestions concerning their implementation in the Pacific, four working group discussed were convened. The objectives of these working groups were to discuss and identify new challenges and new opportunities for PICs concerning the implementation of IHR (2005); to discuss and suggest how to establish and maintain functional National IHR Focal Points (NFPs); and to identify capacity gaps, discuss priority actions to fill the gaps, including needs for external support, in preparations for and facilitating the effective implementation of IHR (2005) in PICs. Expected outcomes were: identification of main challenges and gaps concerning the implementation of IHR (2005) in the PICs; concrete suggestions on the establishment and practical operation of functional National IHR focal points in PICs; and identification of priority action areas for the implementation of IHR (2005) in PICs.

A summary report of the outcomes from these working groups, highlighting major challenges, opportunities and priority action areas, is shown in *Annex 4*. The report of the results of the working groups was followed by a plenary discussion. Participants agreed that IHR (2005) and influenza pandemic preparedness should be mutually reinforcing. Strengthening surveillance and response capabilities will also benefit PICs in the ongoing control programmes of other diseases and will provide increased protection against emerging diseases and other global public health threats, including pandemic influenza.

Participants agreed that PacNet-Restricted, a PPHSN component for exchange of confidential information about significant health events among PICs, should be utilized as a mechanism to facilitating implementation of IHR(2005). In other words, many IHR related activities in PICs such as consultations, verification and notification of public health events, dissemination of guidelines and tools, update on IHR implementation, and other technical assistance can be implemented through PacNet-Restricted, given that WHO has already been part of PacNet-restricted. If PacNet-Restricted is used for the notification of an event that may constitute a public health emergency of international concern (PHEIC), then it should be made explicit that the message is to be considered an official notification to WHO and that the National IHR Focal Point is involved in the process. The participants also recognized that PacNet-restricted might be more useful for initial consultation and information sharing than for an official notification to WHO of events that may constitute a PHEIC, as IHR (2005) actually request Member States to notify such an event through a National IHR Focal Point by the most efficient means available.

3. INFLUENZA PANDEMIC PREPAREDNESS

3.1 Current situation of avian influenza A (H5N1) outbreak and the risk of an influenza pandemic, Dr. Hitoshi Oshitani, WHO/WPRO

Since December 2003, highly pathogenic H5N1 avian influenza viruses have caused poultry outbreaks in many countries in Asia and Europe. The outbreaks are historically unprecedented in their scale, geographical spread and economic impact. Human infections of H5N1 are continuously occurring. As of 1 November 2005, a total of 122 human cases have been reported from Cambodia, Indonesia, Thailand, and Viet Nam. It is thought that most human cases were infected through direct contact with infected poultry. There is no evidence of efficient human-to-human

transmission of H5N1. However, influenza viruses are genetically unstable and their behaviour cannot be predicted. H5N1 virus that is circulating in Asia is particularly prone for changes. If H5N1 undergoes further changes and acquires more transmissibility among humans, pandemic with huge morbidity and mortality may occur. The longer the current situation continues, the higher is the risk that a human pandemic strain will emerge. WHO strongly recommends that all Pacific island countries and areas strengthen their preparedness for a next influenza pandemic.

3.2 Global pandemic influenza preparedness plan and major issues,
Dr Jacob Kool, Consultant/WHO/WPRO

Historically, influenza pandemics have occurred once in about every 30-40 years; the last one was in 1968. The "Spanish Flu" pandemic of 1918-1919 was particularly severe, resulting in the death of 1-2 % of the world population and up to 25% of the population of some Pacific islands countries, although some of PICs were fortunately spared maybe through imposition of strict quarantine measures. The current outbreaks of avian influenza in Asia and Europe pose a risk of becoming the next pandemic. WHO recommends that countries prepare for a possible pandemic by strengthening their ability to detect and respond to local outbreaks. WHO urges all Member States to develop a national influenza pandemic preparedness plan to minimize the impact of next pandemic. To aid countries in developing such a plan, several documents are available from WHO and PPHSN, and plans from other countries can be used as examples. In the Pacific, seven countries currently have a draft influenza pandemic preparedness plan. WHO has defined six pandemic phases, depending on the level of threat of a pandemic. Currently the World is in phase 3, meaning that human infections with the avian influenza virus occur, but without evidence of human-to-human spread. Planning for an influenza pandemic requires high-level political commitment and should involve various sectors of government. Some issues that are of particular importance for PICs are the role and effectiveness of border controls, the utility of stockpiling of drugs such as antibiotics and of personal protective equipment, and the logistics of triage of patients and shipment of specimens for reference laboratory confirmation.

3.3 National pandemic influenza preparedness plans

3.3.1 National pandemic influenza preparedness in Australia. Dr Heath Kelly, Australia

Australia is well advanced with pandemic preparedness planning. The first plan was developed in 1999 and updated regularly to address the new development. The current plan, endorsed by the Minister of Health, was published in June 2005. Australia has adapted the WHO-defined pandemic phases to differentiate between disease overseas and disease in Australia. In addition, phase 6 has been divided into sections reflecting localized disease, widespread disease, subsiding disease, and a new pandemic wave. These divisions have been made because they will require different responses. Australia has established a number of stockpiles, including antiviral medication, personal protective equipment and needles and syringes. Border control measures have been considered, including thermal scanning, health card declarations by incoming passengers, quarantine, and border closure. Those responsible for the pandemic plan acknowledge that potential responses will need to be reviewed regularly. For instance, the plan currently recommends that Australia's antiviral stockpile should be used for prophylaxis of essential workers, given the uncertainty of effectiveness of treatment. However the current stockpile is sufficient only for one million people for six weeks. Recommendations for use of the antiviral stockpile may need to be modified if new information becomes available from ongoing human infection with avian influenza. Although relatively well advanced with pandemic preparedness, Australia recognizes that preparedness is a continual process and envisages revision of the plan following testing and reviewing new information.

3.3.2 Commonwealth of the Northern Mariana Islands (CNMI) influenza preparedness plan, Dr Joseph Santos and Dr John Tagabuel.

CNMI has no experience with major outbreaks except food poisoning outbreaks. CNMI may not get timely federal assistance from the US during a pandemic. The US has "push packages" that can be requested by the Governor and dispatched within 48 hours. CNMI is part of the PPHSN and can also rely on support from the US CDC. However, viral surveillance is elusive; currently the arrangement is that CNMI needs to send specimens to the US for confirmation. Other regional options should be developed in collaboration with WHO, PPHSN, and regional reference laboratories. The CNMI Department of Health will need to partner with veterinary services for animal/poultry surveillance. US vaccines for pandemic strain will be available through the Strategic National Stockpile, probably with a 4 months delay after the start of a pandemic with a new viral strain. There are also stockpiles in the US of the antiviral drug oseltamivir (Tamiflu®). CNMI have 24 state-of-the-art isolation rooms with negative flow and HEPA filtration. As part of the pandemic plan, CNMI has planned the use of facilities outside of the health care system for surge capacity. The ICU capacity will be expanded and renovated and regional sentinel sites will be better equipped to detect a possible urgent public health event such as bioterrorism but also pandemic influenza. Infection control guidelines have been developed as part of pandemic planning. The only hospital of CNMI has its own generator and a fuel supply to last four days. The U.S. have recently earmarked a significant budget for pandemic preparedness. There is an emergency CNMI health act (EHPA) that defines responsibilities. CNMI will also strengthen ties with regional partners such as the PPHSN. The territory will hold an emergency preparedness exercise under CDC/US jurisdiction. A National Incident Command System is in place. National EpiNet members were trained in surveillance, disease detection, and response. The Department of health is planning to improve training for health care workers in surveillance and outbreak response, and will strengthen surge capacity.

3.3.3 Nauru national influenza pandemic preparedness plan, Dr Jacob Kool and Dr Godfrey Waidubu

Nauru is in the central Pacific and is a major hub for wild bird migration, which increases its risk of importation of avian influenza. The Nauru pandemic plan was developed using the CNMI plan as a framework and following the WHO and PPHSN guidelines for pandemic preparedness. The first draft was developed during a 2-day workshop in which all relevant sectors of government and Nauru society participated. The Nauru pandemic taskforce chose to use a simplified format for the main table of activities; a single table was used instead of 6 separate tables for each pandemic phase. For each item, the phases during which it should be activated are listed in a separate column. A differentiation was made for whether cases would already be occurring in Nauru or not. The latter is important in particular for phase 6 (the pandemic phase), when Nauru plans to implement strict quarantine and travel restrictions in the hope of keeping the infection out. Limited supplies of personal protective equipment, rapid influenza tests, and specimen transport containers were stockpiled with the help of WHO. A list was drawn up of priority essential staff that should be first in line for prophylaxis with antiviral drugs and, possibly, for the pandemic influenza vaccine, if it becomes available. The list has health care personnel as the top tier, followed by high-risk patients and other essential services. Other issues that are addressed in the plan are infection control guidelines, case definition of influenza-like illness (ILI) for surveillance purposes, criteria for hospital admission of severe cases of influenza, and procedures for shipping and testing of specimens.

3.3.4 New Caledonia influenza pandemic preparedness and response plan, Dr Jean-Paul Grangeon and Dr Martine Noel

New Caledonia has a total population of 234,000 and two main ports of entry. The health care system will be quickly overwhelmed in case of a pandemic. For risk assessment, two models were used: (1) FluAid; and (2) a model from the Institute the Veille Sanitaire (InVS) in Paris. It was assumed that the pandemic would come in two waves, that 35% of the population would be affected, with 4,039 persons needing hospitalization. The estimates are lower when using FluAid than with the InVS model, which predicts a severe overload of the health care capacity. A New Caledonia health conference was held in September 2005 with broad participation from all sectors. A draft plan for influenza pandemic preparedness was developed and will now be presented to the government. An intersectoral working group will be working to make the plan more practical and operable. Unlike WHO's plan where 6 phases are defined, New Caledonia made two different sub phases for the pandemic phase, depending on whether cases are occurring in New Caledonia. The aim of the plan is to detect and respond to the initial pandemic wave and to be ready to interrupt the second wave. Case definition, surveillance and outbreak investigation will be further updated and enhanced. Border measures, such as information to travelers, entry screening, quarantine of arriving passengers, and border closures will be considered, but the latter will be a decision of the French government. A multi-sectoral working group was convened and it recommended setting up an antiviral stockpile, coordinating with countries and agencies within the region, and considering restriction of travel. The government is working on revising the legislation to include some of the measures in the pandemic plan. The recommendations have been endorsed by the government in October 2005. Stocks of antiviral drugs (oseltamivir) and personal protective equipment have been ordered. Quarantine areas have been identified, and training of professionals has started.

3.3.5 Strategy for strengthening influenza preparedness in the Pacific, Dr Seini Kupu

No H5 subtype pandemic has happened yet, this means that there is universal susceptibility. Dr Kupu gave an overview of the history of influenza in the Pacific, in particular the severe mortality associated with the 1918-19 pandemic in some island countries such as the 22-25% mortality in Samoa. American Samoa, Tuvalu, Kiribati, parts of French Polynesia, and Vanuatu were spared thanks to strict quarantine. The impact of the 1918 pandemic was aggravated because of the total lack of preparedness. Pacific island nations are particularly vulnerable because of limited surge capacity, relative isolation, and the lack of antivirals and vaccines. Dr Kupu then discussed the components needed to start pandemic preparedness planning. She emphasized that it has to be multi-sectoral. WHO guidelines are very useful but have to be tailored to the local situation. Several strategic preparedness issues such as surge capacity planning were discussed. Linkage with animal health services is essential, as is linkage to international regional networks. Existing influenza preparedness plans from other Pacific countries should be used as examples.

3.3.6 Working groups and plenary discussion on pandemic preparedness

Four working groups were formed to discuss influenza pandemic preparedness. The objectives were: (1) to review the status of pandemic preparedness plan in each country based on a previously distributed questionnaire; (2) to identify key issues on pandemic preparedness in the Pacific, which should be discussed by the PPHSN Influenza Specialist Group (ISG); and (3) to discuss and identify necessary technical and financial resources to support each country in the Pacific with its national pandemic preparedness plan. The expected outcomes were: (1) completion and discussion of the questionnaires on pandemic influenza preparedness for all countries; (2) identification of the main issues for pandemic preparedness to be discussed by the influenza specialist group (ISG); and (3) a listing of resources necessary for each country in the Pacific to

develop a national pandemic preparedness plan. A summary report of the working group discussions and the results of the survey on influenza pandemic preparedness are shown in *Annex 6* and 7. The report of the results of the working groups was followed by a plenary discussion.

Given that antiviral drugs (especially Oseltamivir) are very expensive and their availability is limited, PICs need to consider using limited resources to improve their surveillance and health infrastructure which will have an immediate benefit, and other public health measures before considering the procurement of antivirals for stockpiles in PICs. However, there is a possibility that antivirals may be wider available and cost less in the future.

There was considerable discussion on the possible availability of pandemic influenza vaccine. The seasonal influenza vaccine only contains H3 and H1 strains, so it does not protect against H5 infection. But it may have a role in preventing reassortment that may occur during dual infection with avian and human influenza virus, and which may lead to emergence of more virulent influenza strains. At this moment, however, seasonal influenza vaccination may not be cost effective for PICs. Vaccines for H5N1 virus are still not available, currently clinical trials are still underway. Only a limited number of countries in the world have vaccine production facilities. Pandemic influenza vaccines will probably only be available after the pandemic starts; it will then take five to six months to produce any vaccine, but even after that time there will not be enough to provide vaccines to all other countries. None of the vaccine-producing countries have enough capacity even to produce enough vaccine for their own population. Some type of agreement might be considered, between PICs and vaccine manufacturers or the governments, on the procurement of pandemic vaccines, as they become available. Vaccines may also have adverse events, such as occurred in the swine flu vaccination campaign of 1976 in the U.S. Pneumococcal vaccine is expensive and should be lower on the list of priorities than other measures in most of PICs.

Pros and cons of border closures should be carefully considered. WHO does not recommend border measures or screening at phase 3 (current situation). At phases 4-6 we may need to consider some measure of border control. It is possible that WHO will make a recommendation on travel restrictions and various border control measures at different phases of a pandemic but these are difficult to foresee. Most experts are not convinced that border controls can keep out an influenza pandemic, however, border controls including border closures may be a possible and effective option in isolated Pacific islands. At least, border controls can possibly delay the arrival of the pandemic virus. However, negative aspects of such border controls measures should also be considered. They may have significant economic implications if the country depends on tourism or trade. Some PICs rely for food supply on imports, so border closures cannot be sustained for a long time. Quarantine and restrictions of incoming passengers also pose many questions: who will you allow back into the country? Countries should consider carefully the legal and ethical implications of such measures. Coordination with other countries, including New Zealand and Australia may be a good idea, for instance by creating a "pandemic-free zone" of multiple countries with no travel restrictions within the zone.

Laboratory issues: most countries do not have capacity to confirm infections with pandemic strain, therefore they have to rely on reference laboratories for confirmation. This requires meeting international requirements for shipping specimens such as IATA regulations. Specimen packaging training may be necessary. In addition, shipments will need to comply with national regulations, such as the rules of AQIS (Australia Quarantine and Inspection Service) for shipment of influenza specimens to Australian laboratories. Testing of the pandemic strain is complicated because it needs a high level of biosafety. Moreover, testing should be done by a laboratory with ample experience with H5 and other new viruses. There are few laboratories that can do this. WHO has designated six laboratories in the world and four of these are in the WPRO region: 2 in Hong Kong, 1 in Japan, 1 in Australia. Other laboratories can do some testing using PCR but there are some problems with that. It is therefore recommended that typing should be done in the WHO reference

laboratories. It is recommended that countries should already initiate testing of ordinary strains, of influenza in order to establish and test a reference laboratory referral system before there is an emergency. Particularly capacity of level 2 laboratories under PPHSN LabNet including Mataika House in should be strengthened. The Northern Pacific likely can send specimens to the Institute of Infectious Disease in Japan, which is a WHO Collaborating Centre for influenza. WHO/WPRO can assist to establish a referral system. During a pandemic situation, it may become difficult to ship specimens to any laboratory.

Avian influenza is currently very high on the political agenda of many countries; donors are very interested to support influenza pandemic preparedness in the Pacific. After an emergency management meeting in Fiji, SPC/PPHSN have created a list for potential donors. New Zealand has agreed to fund a 2-year post on pandemic influenza preparedness and provided funds for country workshops. The Asian Development Bank has given support to SPC to hire an infection control expert, who is currently visiting countries to assess readiness and to see what supplies and equipment need to be provided. CDC has recently approved a grant to pay for improvement of laboratory-based surveillance and for improvement of shipping options. PPHSN influenza guidelines should be updated to reflect the new WHO phases. PPHSN will also develop sample protocols for patient management and infection control guidelines. Further, PPHSN wants to help to harmonize the approach in the different countries and to increase collaboration between the countries in the field of pandemic preparedness. WHO and PPHSN should work closely to coordinate the donor support and to improve pandemic influenza preparedness in PICs.

Risk communication can be a cost-effective intervention to minimise the negative impact of an influenza pandemic. WHO will have a meeting about risk communication in December 2005 in Geneva. Guidelines resulting from this meeting will be distributed soon afterward. Another meeting on risk communication was recently held in Singapore from which guidelines are already available.

3.3.7 Outcomes of the PPHSN-CB meeting

Dr Tomasz Kiedrzyński briefed the participants on the main outcomes of the PPHSN-Coordinating Body Meeting, held on 29 and 31 October 2005.

Dr Kiedrzyński gave an overview of the objectives and methods of the PPHSN and described the countries and agencies that are members. He then discussed the work plan for 2002-2006. One of the objectives is to strengthen the national EpiNet teams. This ties into the IHR objectives. PPHSN does training and support, among others through the regional EpiNet team. PPHSN has produced a directory of resources with addresses of all the key people in the PICs who do surveillance and outbreak management. Another issue was the setting up of a regional 'rapid response' fund. Collaboration with animal health services is another priority that has been started in view of the threat of avian influenza. Pandemic Influenza Preparedness (PIP) is another priority. PPHSN has an Influenza Specialist Group (ISG) for technical expertise and advice. Dr Seini Kupu has done much work as temporary advisor of PPHSN on PIP. PPHSN has hired an ADB funded infection control specialist who will go around to countries to help them improve their IC procedures. There is a CDC-funded laboratory-based surveillance project that will start early next year. PPHSN felt there was a need to coordinate donors who are interested to support PIP; a discussion list was started with great success. NZ agreed to fund a 2-year position of an influenza expert to support the countries with their PIP, for example through organizing exercises. Australia has also pledged \$8 million for PIP in the Pacific so more projects are expected. Other matters are that they plan to finalize guidelines for other target diseases, setting up a regional database on communicable diseases at SPC, and training in airline regulations for shipping of infectious substances. Data for Decision Making courses are held throughout the region and have been held in the CNMI as a pilot project. Finally, PacNet-Restricted (PacNet-R) should become the IHR related

communication medium for IHR development, early sharing of notifications and warnings, requests for information about rumours. This list should include the IHR National Focal Points and the national EpiNet team members, WHO, other PPHSN-CB members. This can be started directly after this meeting.

4. CONCLUSIONS AND RECOMMENDATIONS

4.1 International Health Regulations (2005)

4.1.1 Conclusions

- Workshop participants recognize that the revised International Health Regulations (IHR 2005) set out challenging new requirements. At the same time, they also provide new opportunities for all the Pacific island countries and areas (PICs) to strengthen their local and national public health capacities;
- The participants also recognize the importance of starting preparations for the effective implementation of IHR (2005) in PICs. However, there are some major challenges to be met, including resource constraints, limited public health infrastructure, lack of national and local capacities for surveillance and response, and capacities at points of entry in many PICs;
- The legal framework which IHR (2005) will provide when they enter into force can be considered a model for influenza pandemic preparedness and response. The implementation of IHR (2005) will contribute directly to preparedness for all public health emergencies, particularly pandemic influenza; and
- PICs, regional networks (particularly Pacific Public Health Surveillance Network, PPHSN), WHO and other partners all have synergistic roles to play in preparations for IHR implementation and improving influenza pandemic preparedness in PICs.

4.1.2 Recommendations

- A functional National IHR Focal Point needs to be established as a priority, using existing national structure as appropriate, to drive preparations for the effective implementation of IHR (2005);
- National and local public health capacity is essential and the key to the effective implementation of IHR (2005). The process of assessing existing national and local capacities should be started as soon as practicable to identify shortfalls and gaps for implementation of IHR (2005). Based on the capacity gaps identified above, work plans to prepare for implementation including capacity strengthening should be developed, or incorporated into an existing national plan;
- It is also important to secure political commitment, allocation of resources and support of other government and of external agencies to fully implement IHR (2005). Conducting scenario exercise at national level with senior decision-makers and politicians would raise their awareness of the expectations for fulfilling national obligations under the IHR (2005);

- All PICs should use IHR (2005) as an opportunity to promote intersectoral and regional communication and coordination, and to mobilize and share expertise and other resources;
- All PICs should review and amend as necessary all existing national legislation to ensure its compatibility with IHR obligations and influenza pandemic preparedness requirements;
- IHR(2005) should be addressed in all high-level national, regional and international forums, such as the Pacific Island Forum. IHR (2005) should be proposed to be included as an agenda item for the next Pacific Island Forum and be included into the Pacific Plan, when possible; and
- WHO and PPHSN should continue working with PICs to help further strengthen a regional approach to capacity development in public health, including IHR implementation and influenza pandemic preparedness in the Pacific

4.2 Influenza Pandemic Preparedness

4.2.1 Conclusions

- Influenza pandemic preparedness has current global attention and momentum and political leaders are calling for urgent actions. This is a great opportunity to strengthen preparedness for influenza pandemic and other public health emergencies;
- The participants recognize that influenza pandemic poses a significant potential threat to the PICs. The range of options that PICs have to address is both limited and unique with specific issues in the Pacific. Pandemic preparedness needs to address these limitations and unique opportunities; and
- While significant progress with influenza pandemic preparedness in many PICs has been made, the participants fully recognize the urgent need for all the PICs to further develop and test their national influenza preparedness plans.

4.2.2 Recommendations

- WHO and SPC under a framework of PPHSN should mobilise and coordinate external funding and other support for national influenza pandemic preparedness in PICs to ensure optimal utilization of limited resources and avoid duplication;
- The membership of the national influenza pandemic preparedness task force (or equivalent) should be reviewed to ensure multi-sectoral and National IHR Focal Point representation;
- All PICs should accelerate, finalize, review and test, as appropriate, national influenza pandemic preparedness plan;
- WHO and SPC should encourage and facilitate all the PICs to share their national influenza pandemic preparedness plans and to improve inter-country coordination of pandemic planning, including harmonization of recommendations on public health measures, when possible;
- PICs should carefully consider the effectiveness, feasibility, and economic and other

consequences of border control measures in their national influenza pandemic preparedness plans. WHO should provide a review of available evidence of the effectiveness of all possible options of border control measures and their appropriateness in the Pacific;

- PICs should address other public health measures before considering stockpiles of antivirals and use of pandemic vaccines, given the limited availability, high cost, and uncertainty of effectiveness these interventions.
- Regional coordination mechanism should be explored by WHO/SPC and other regional and international forums to address procurement and stockpiles of medical supplies in the Pacific; and
- PICs should make their efforts to ensure that their surveillance system is sufficiently sensitive to detect any unusual cluster of influenza-like illness. Given that the laboratory capacities are limited for confirmation of influenza virus sub-type in the Pacific, PICs should ensure they can transfer relevant specimens urgently to a reference laboratory for characterization and confirmation, with assistance from WHO/SPC.

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**ORGANISATION MONDIALE
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**REGIONAL OFFICE FOR THE WESTERN PACIFIC
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WORKSHOP ON INTERNATIONAL HEALTH

**WPR/ICP/CSR/1.1/001/CSR(5)/2005.1A
20 October 2005**

**REGULATIONS (2005) AND PANDEMIC
INFLUENZA PREPAREDNESS IN THE PACIFIC**

**Nadi, Fiji
2 – 5 November 2005**

ENGLISH ONLY

AGENDA

1. Opening ceremony and introductions
2. Presentations on the International Health Regulations (IHR 2005) and related issues
3. Questions and discussions
4. Scenario exercises on IHR (2005)
5. Working groups on the implementation of IHR (2005)
6. Presentations on avian influenza A(H5N1) and pandemic influenza preparedness
7. Questions and discussions
8. Working groups on actions for strengthening pandemic influenza preparedness in the Pacific
9. Conclusions, recommendations and next steps
10. Closing ceremony

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IN THE PACIFIC**

**WPR/ICP/CSR/1.1/001/CSR(5)/2005.1C
1 November 2005**

**Nadi, Fiji
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ENGLISH ONLY

PROGRAMME OF ACTIVITIES

Day 1 – Wednesday, 2 November 2005

- 08:30 – 09:00 Registration
- 09:00 – 09:10 Opening remarks
 - Dr Chen Ken, WHO Representative in the South Pacific, WHO/WPRO
- 09:10 – 09:20 Welcome speech
 - Honourable Minister of Health, Ministry of Health, Fiji
- 09:20 – 09:30 Objectives, expected outcomes and conduct of the workshop
 - Dr Hitoshi Oshitani, Regional Adviser, CSR/WHO/WPRO
- 09:30 – 09:45 *Group photograph*
- 09:45 – 10:10 *Coffee break*
- 10:10 – 12:10 Plenary session
 - The revised International Health Regulations (IHR 2005)
 - Dr Max Hardiman, Team Leader, IHR Revision, CSR/WHO/HQ
 - Asia Pacific Strategy for Emerging Diseases
 - Dr Hitoshi Oshitani, Regional Adviser, CSR/WHO/WPRO
 - Public health threats in the Pacific
 - Dr Tom Kiedrzyński, Epidemiologist, Secretariat of the Pacific Community
 - National legislations and the IHR (2005)
 - Prof. Myongsei Sohn, Associate Dean, School of Public Health, Yonsei University, South Korea
 - Public health emergency preparedness and response plan in New Zealand
 - Mr Andrew Forsyth, Ministry of Health, New Zealand

Annex 1

Questions and discussions

12:10 – 13:30 *Lunch*

13:30 – 13:50 Plenary session
Explanation and requirements on scenario exercise
- Dr Mahomed Patel, Senior Lecturer, Australian National University

13:50 – 15:00 Scenario exercise (4 groups)

15:00 – 15:20 *Coffee break*

15:20 – 17:00 Scenario exercise (continued)

18:00 *Dinner*

Day 2 – Thursday, 3 November

08:00 – 10:00 Scenario exercise (continued)

10:00 – 10:20 *Coffee break*

10:20 – 11:20 Scenario exercise (continued)

11:20 – 11:40 IHR (2005) obligations
Working group on the implementation of the IHR (2005) in the Pacific
- Dr Li Ailan, Medical Officer, IHR, CSR/WHO/WPRO

11:40 – 12:00 Questions and discussions on working group arrangements

12:00 – 13:30 *Lunch*

13:30 – 15:00 Working groups (4 groups)

15:00 – 15:20 *Coffee break*

15:20 – 17:00 Working groups (continued)

Day 3 – Friday, 4 November

08:00 – 08:40 Plenary session on the IHR (2005)
- Report back from working groups
- Questions and discussions

08:40 – 09:40 Current situation of avian influenza A(H5N1) outbreak and
the risk of an influenza pandemic
- Dr Hitoshi Oshitani, Regional Adviser, CSR/WHO/WPRO

Annex 1

Global pandemic influenza preparedness plan and major issues

- Dr Jacob Kool, Medical Officer, Centers for Disease Control, USA

National pandemic influenza preparedness in Australia

- Dr Heath Kelly, Victorian Infectious Disease Reference Laboratory, Australia

09:40 – 10:00 Questions and discussions

10:00 – 10:20 *Coffee break*

10:20 – 11:20 Developing a national pandemic influenza preparedness plan

- Commonwealth of the Northern Mariana Islands

- Nauru

- New Caledonia

11:20 – 11:40 Strategy for strengthening influenza pandemic preparedness in the Pacific

- Dr Seini Kupu, Senior Medical Officer, Ministry of Health, Tonga

11:40 – 12:00 Questions and discussions

12:00 – 13:30 *Lunch*

13:30 – 15:30 Working groups on actions for strengthening pandemic influenza preparedness in the Pacific

15:30 – 15:50 *Coffee break*

15:50 – 17:00 Plenary session

- Report back by working group

Day 4 – Saturday, 5 November

08:00 – 08:10 Main outcomes of the PPHSN-CB meeting

- Dr Tomasz Kiedrzyński, Epidemiologist, Secretariat of the Pacific Community

08:10 – 08:40 Summary report on challenges, opportunities and priority actions in the implementation of IHR (2005) in the Pacific

- Mr Andrew Forsyth, WHO Temporary Advisor

08:40 – 09:00 Questions and discussions

09:00 – 09:40 Summary report on action plans for strengthening national preparedness for influenza pandemic in the PICs

- Dr Heath Kelly, WHO Temporary Advisor

09:40 – 10:00 Questions and discussions

Annex 1

- 10:00 – 10:20 *Coffee break*
- 10:20– 11:45 **Conclusions and recommendations**
- Chairman to present to the participants
- 11:45 – 12:00 **Closing ceremony**
- WHO
- SPC
- One country representative
- Chairman

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**Opening Remarks of Dr Chen Ken,
the WHO Representative in the South Pacific
at the Workshop on International Health Regulations (2005) and
Pandemic Influenza Preparedness in the Pacific,
Nadi, Fiji, 2-5 November 2005**

HONOURABLE MINISTER, COLLEAGUES, DISTINGUISHED GUESTS, LADIES AND GENTLEMEN,

On behalf of Dr Shigeru Omi, the WHO Regional Director for the Western Pacific, I am very pleased to welcome you to the WHO Workshop on the International Health Regulations and Influenza Pandemic Preparedness in the Pacific.

I would like first to thank the Honourable Minister of Health for taking time from his busy schedule to be here with us and for supporting this workshop. I am also very pleased to see such full participation from countries and areas in the Region for this very important workshop.

The International Health Regulations are the legally binding international instruments for preventing the international spread of diseases. As you are aware, the current Regulations have been in force since 1969 and cover only three infectious diseases: plague, cholera and yellow fever.

However, with the world facing growing public health threats and with the rapid globalisation and the accompanying increase in international trade and travel, the current Regulations have been revised to meet these new challenges. The new Regulations, adopted by the World Health Assembly in May this year, will come into force in 2007. The new Regulations have broader scope than the 1969 Regulations. They make both Member States and WHO responsible for detecting, reporting and responding to all events that may constitute a public health emergency of international concern, including those caused by new and unknown diseases.

Are we ready to fulfil these new responsibilities? Whether Pacific island countries are well prepared to effectively implement the new Regulations? These are unavoidable questions in front of every one of us here as well as to those who are not able to join us this week, but with responsibilities to deal with outbreak of diseases.

If our answer is not yet, we have many more questions to consider: What are the major challenges and gaps in the Pacific that must be met in order to implement the new Regulations? Do we have the core capacities in place for surveillance and response, particularly at designated ports and airports? How can a really functional National IHR Focal Point be established and maintained in small Pacific island countries where both human and financial resources are limited? Can Pacific Public Health Surveillance Network (PPHSN) be fully utilized wherever possible as mechanisms to supplement IHR implementation in the Pacific? What should be our priority actions over the next two to three years to prepare for the full implementation of the new Regulations in Pacific island countries and areas?

I know I don't have answers to all these questions yet. These should be at the centre of your discussions during the workshop. But one thing is certain: We, in the Pacific need to work together to fulfil the new obligations which will also help achieve our common goal of "Healthy Islands". By doing so, we can definitely contribute to regional and global health security.

It is really time now for all countries and areas to mobilize the necessary resources that will guarantee the full and effective implementation of the Regulations. In the Pacific, we fully recognize that implementation of the new Regulations will be a great challenge. But I would also like to emphasize here that the new Regulations actually offer us new opportunities to support and

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collaborate with each other to improve our public health infrastructure and systems. During the 6th meeting of Ministers of Health from Pacific island countries held in Samoa in March this year, ministers and directors of health concluded that in the Pacific, building and strengthening national capacity are essential to the effective implementation of the new regulation. At the same time, strengthening regional collaboration and coordination, particularly through PPHSN will facilitate and enhance national efforts for implementation of IHR. We are very pleased to note that our friends from other partners are here with us. I would like to specially welcome our colleagues from SPC, CDC, Red Cross, from Australia and New Zealand to be here. Your participation demonstrates the team work spirit in Pacific which we all join and enjoy in various areas. I would also like to use this opportunity to welcome my colleagues from Geneva and Manila. With your support, Pacific island countries become the first group of WHO Member States to discuss the implementation of new IHR.

Now let me say a few words about avian influenza and pandemic preparedness. While we are preparing for the effective implementation of the new IHR, it is very likely that an influenza pandemic will become the next public health emergency of international concern. If this scenario unfolds, it would allow us to use the new Regulations as a legal framework to respond to it more effectively.

Indeed, an influenza pandemic is of global concern. If an influenza pandemic occurs, no country, including our Pacific island countries and areas, will be spared from the impact.

The unprecedented outbreaks of avian influenza A(H5N1), which started in late 2003, has now affected 16 countries. It is estimated that more than 150 million poultry have died or been destroyed. As of today, a total of 121 human cases have also been reported in Cambodia, Indonesia, Thailand and Viet Nam.

The avian influenza A(H5N1) outbreaks serve as stark reminders that the world faces a great threat from an influenza pandemic. We at WHO believe that the world is closer now to an influenza pandemic than at any time in recent years. I cannot tell when the next pandemic will occur. It is also difficult to estimate its exact impact because it depends on many different factors. However, during the Spanish Flu pandemic of 1918-1919, it was estimated that between 40 to 50 million people died. We now face a different world. Our population is much greater, and we have many mega-cities with high population densities. Air travel has become a part of daily life for many people, something that certainly did not exist in 1918. New viruses can travel faster than ever before.

But we also have some good news. The pandemic in 1918 started without any warning. No one was prepared for such an event. Although the risk of an influenza pandemic certainly has been increasing, we still have time to better prepare for a pandemic and thus minimize its impact. I do not want to go into details of influenza pandemic preparedness, as this will be at the centre of your discussions during this workshop. I just want to stress that we all have to take this issue seriously and take action now. Our window of opportunity may be very limited.

In closing, once again, I would like to welcome you all to this important workshop. I would like to thank the Ministry of Health in Fiji for supporting this event. With your support and active participation, I am sure we will have a successful workshop.

Thank you.

**WORLD HEALTH
ORGANIZATION**



**ORGANISATION MONDIALE
DE LA SANTE**

**REGIONAL OFFICE FOR THE WESTERN PACIFIC
BUREAU REGIONAL DU PACIFIQUE OCCIDENTAL**

**WORKSHOP ON THE INTERNATIONAL
HEALTH REGULATIONS (2005) AND
PANDEMIC INFLUENZA PREPAREDNESS
IN THE PACIFIC**

**WPR/ICP/CSR/1.1/001/CSR(5)/2005.1C
29 October 2005**

**Nadi, Fiji
2-5 November 2005**

ENGLISH ONLY

**Scenario exercise
on the implementation of the
International Health Regulations (IHR 2005)
in the Pacific**

Background

Member States adopted the revised International Health Regulations (IHR 2005) at the World Health Assembly in May 2005. It is expected that the IHR (2005) will enter into force in June 2007 for WHO member States. Accordingly, Member States committed themselves to plan, develop and implement a range of actions to comply with the IHR (2005). This includes strengthening capacity for surveillance and response to a standard that would meet the expectations for implementing the IHR (2005).

Aim

To provide national policy makers, health officials and technical staff with an opportunity to experience the process and requirements of the IHR (2005) through scenario exercises.

Learning objectives

On completion of the exercise, participants should be able to:

1. Explain the basic process of the IHR (2005) implementation and the application of the Articles in the Regulations for:
 - a. the early detection and identification of an event that may constitutes a public health emergency of international concern (PHEIC);

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- b. the assessment of the event using the decision instrument included in the IHR (2005);
 - c. the notification of the event to WHO through a National IHR Focal Point; and
 - d. the implementation of the response to the PHEIC.
2. Describe the roles and responsibilities of a National IHR Focal Point (NFP) in response to potential PHEIC.
3. Describe the requirements for Member States to implement the IHR (2005).
4. Advocate to senior national decision-makers of the need and obligation under international law to develop the necessary structures, systems and capacity for strengthening surveillance and response.

Workshop participants

National IHR Focal Points, key decision makers at national level and national technical staff who are responsible for surveillance and control of communicable diseases.

Table 1. Proposed groups for scenario exercises

Group	Participants	Facilitator	Rapporteur
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Group 2	Cook Islands, Samoa, Tokelau, Tonga, Nauru, Niue, Tuvalu	Dr Michael Baker	Dr Kamalini Lokuge
Group 3	French Polynesia, New Caledonia, Vanuatu, Wallis & Futuna	Dr Tom Keidrzynski	Dr Jacob Kool
Group 4	American Samoa, Commonwealth of the Northern Mariana Islands (CNMI), Federated States of Micronesia (FSM), Guam, Marshall Islands, Palau	Dr Narendra Singh	Dr Mahomed Patel

Acknowledgements

This scenario exercise document, funded and supported by the WHO Regional Office for the Western Pacific (WPRO), was prepared by National Centre for Epidemiology and Population Health, The Australian National University, Canberra. In addition to WHO staff, valuable technical feedback for development was also provided by the Secretariat of the Pacific Committee (SPC).

Scenario Exercises

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Scenario 1: Public health event on a Pacific Island

Background

Islandia is an archipelago nation made up of many islands in the Pacific. People travel frequently between neighbouring island countries. The region has been affected by outbreaks of avian influenza in poultry over the last two years. Occasional cases of influenza in humans, through transmission from poultry, have been reported from neighbouring countries. There have also been regular outbreaks of various vector-borne diseases, including dengue.

There are ongoing reports of deaths in poultry and several wild animal species. However, the Ministry of Agriculture (MoA) has not taken any action, nor have any reports been received by the Ministry of Health (MoH). As there is no poultry industry in Islandia, only small scale rearing for domestic use, there has been little interest in assessing the extent of the outbreak. The MoH has not done an assessment of the possible health risks to humans due to lack of resources. Surveillance data, which includes zero reporting of influenza cases, has not identified any cases of influenza. Although surveillance is weak in the remote islands, the MoH considers it to be adequate for detecting a possible case of human infection with avian influenza strains. Of greater concern to the MoH is an outbreak of Japanese encephalitis (JE) in a neighbouring country, as pigs are an important part of traditional festivals, are kept by all households, and previous JE outbreaks have affected many pigs and humans.

Step 1 – Detection, identification and confirmation of a possible PHEIC

Timeline : Previous months

Unofficial Reports

Newspapers have reported deaths in pigs in the remote islands over the last two months, and disease in people in contact with the pigs. However, the MoH took no action because there is no expertise or resource for an outbreak team to visit the remote islands. Both MoH and the IHR National Focal Point (NFP) are reassured that the sentinel pig surveillance system, established by a donor country, has not detected any JE.

Similar reports, of human disease linked to deaths in animals, have also been posted on ProMed. WHO asks Islandia to provide further information on these reports.

National Focal Point

A NFP has been established as part of the IHR (2005) obligations.

1. *What are the roles and responsibilities of the NFP? What should the link or relationship be between the NFP and the National EpiNet Team in your country?*
2. *Are there any coordination and operational links between the MoH and other ministries and senior governmental officials? If not, what needs to be done to establish these links for effective communication of possible PHEIC?*
3. *How will the NFP ensure it receives reports of possible or suspected PHEIC?*
4. *Who will be responsible for assessing such reports within a reasonable time frame?*
5. *Apply the decision instrument and discuss your interpretation?*
6. *What should be done if it is difficult to make a decision or if there is not enough information to make a decision?*
7. *What action does Islandia and its NFP need to take in response to WHO's request for further information?*

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Answers

1. *What are the roles and responsibilities of the NFP? What should the link or relationship be between the NFP and the National EpiNet Team in your country?*

The NFP is responsible for coordinating activities essential for the detection of a possible PHEIC, its assessment, confirmation and notification to WHO. In the case of Islandia, the national law also states that the role of the NFP includes coordinating the response to possible PHEICs.

(Facilitator or rapporteur should document responses to the question on links between the NFP and the EpiNet Team).

IHR (2005)

- Article 4 Responsible authorities

2. *Are there any coordination and operational links between the MoH and other ministries and senior governmental officials? If not, what needs to be done to establish these links for effective communication of possible PHEIC?*

The NFP must ensure that it has regular input from all sectors with relevant input into early detection and response to PHEICs. Islandia has decided also to form an NFP committee to oversee the functions of the NFP. It consists of representatives from primary health care sections, the hospital, and surveillance units of the MoH. This NFP committee meets monthly to assess possible public health events of international concern (PHEICs), and assess the country's compliance with the requirements of the International Health Regulations (IHR 2005). So in the case of Islandia, this inter-sectoral input may mean including relevant parties such as the MoA on its NFP Committee, and legislating regular reporting to the NFP from such sectors. Many outbreaks of new and emerging diseases start in livestock, and therefore the MoA is an important stakeholder. Early data from effective surveillance in animals is critical to identify such outbreaks.

Discuss all the sectors and stakeholders important for early detection and response to outbreaks in your country.

IHR (2005)

- Annex 1 (A) 6. (d) & (e)

3. *How will the NFP ensure it receives reports of possible or suspected PHEICs?*

The NFP needs to ensure that it has links with all the relevant organisations and stakeholders in the country, and meets with or receives input within 48 hours from possible reporting sources such as health centres, medical practitioners and animal health officers in the affected areas on possible PHEIC. Since the NFP should be available at all times to receive reports of possible PHEIC, it will need to be part of both the formal reporting structures (national surveillance systems etc) and also the informal systems (private laboratories, relevant experts and media reports).

IHR (2005)

- Article 6 Notification

- Annex 1 (A) 6. (d) & (e)

4. *Who will be responsible for assessing such reports within a reasonable time frame?*

The Government is responsible for reporting these type of events to WHO. The IHR (2005) recommends changes to national legislation to delegate this responsibility to the NFP. The NFP will need to develop and ensure it has access to expertise and resources to assess events within 48 hours and notify events assessed as possible PHEIC to WHO within 24 hours. Discuss whom you think would be important to include on a possible NFP Committee for your country. Refer to your discussion on Question 2.

IHR (2005)

- Article 6 Notification
- Annex 1 Assessment and notification.

5. *Apply the decision instrument to the information available at this stage and discuss your interpretation?*

Deaths in animals such as poultry and pigs, particularly in large numbers and in regions where zoonotic diseases are present, should indicate a possible PHEIC, and the need for further assessment.

IHR (2005)

- Annex 2 Decision instrument and examples
- Article 6 Notification

Annex 2 (Examples I. 2) of the IHR (2005) states that events such as deaths in animals without identified human disease can be a PHEIC as it states a PHEIC includes an “ Event [which] represents a significant public health risk even if no or very few human cases have yet been identified.”

6. *What should be done if it is difficult to make a decision or if there is not enough information to make a decision?*

The main need is to investigate to get the information needed.
The NFP may consult with, and request assistance from, WHO.

IHR (2005)

- Article 1 Definitions
- Article 8 Consultation

7. *What action does Islandia and its NFP need to take in response to WHO's request for further information?*

Islandia will need to, within 24 hours of WHO's request, acknowledge this request and provide WHO with all the information it has on the events occurring on these remote islands. If it does not have enough information to make an assessment of the event as a possible PHEIC, it will need to make sure it can obtain such information. In order to do this, it can ask WHO for assistance and collaboration.

IHR (2005)

- Article 10 Verification

Annex 4

Step 2 – Assessment of a possible PHEIC

Timelines: Day 0

Hospital cases

A physician in the only tertiary level hospital reports three patients in one family who died after a febrile illness and cough in the previous week. Three health staff who have been in contact with these patients have also developed fever and a cough.

8. *What should the NFP do now?*
9. *Do you think Islandia requires assistance in obtaining further information?*
10. *Where will it get such assistance?*

Answers

8. *What should the NFP do now?*

This information needs to be assessed. Use the decision instrument, considering this information, and decide what do next.

IHR (2005)

- Annex 2 Decision instrument and examples

Because human-to-human spread of the disease may have occurred, including possible spread in a hospital setting, infection control measures must be implemented and evaluated. Appropriate biological samples must be sent to a laboratory capable of testing these samples for a wide range of possible pathogens. An outbreak investigation must be initiated.

Islandia should hold urgent meeting/s with experts to discuss case definitions and strengthening of existing surveillance systems.

IHR (2005)

- Article 13
- Annex 1 A (4) & (6) Public health response (Local and national level)

9. *Do you think Islandia requires assistance in obtaining further information?*

PPHSN

Several organisms may cause severe respiratory symptoms, and health staff must use appropriate infection control measures for conducting further investigations. It is likely that Islandia will need assistance with the necessary expertise and equipment, and will need help in identifying laboratories with appropriate facilities, equipment and biosafety clearance.

IHR (2005)

- Article 5 (3) Surveillance

10. Where will it get such assistance?

If requested, WHO will provide appropriate advice and help identify and mobilise the necessary expertise and other resources. This could include assistance from other countries and other international organisations

IHR (2005)

- Article 8 Consultation
- Article 44 Collaboration and assistance

Annex 4

Confirmation

Timelines: Day 2

Outbreak investigation

The MoH initiates an outbreak investigation with the assistance of WHO staff.

The 37-year-old father of the family was the index case in the outbreak. He became ill while visiting his home village in the remote islands for a funeral. This island is in the same region as those reported to have had outbreaks of disease in pigs. He returned to the capital by bus, was hospitalised 3 days later, and died 2 days after hospitalisation. The other patients who died were his wife and mother. Two young children in the family are symptomatic, but appear to be recovering.

Staff who have become unwell developed symptoms within 2-4 days of direct contact with members of the family. Initial symptoms included high fever, myalgia, cough, with rapid progression to severe respiratory compromise. In the initial phases of hospitalisation, no protective measures were taken when managing these patients aside from routine hand washing. All staff who are symptomatic have now been sent home, and one has died. Most of these staff worked in the ICU of the hospital, where all three patients were admitted for mechanical ventilation in the days before their deaths.

The EpiNet Team collects biological samples from all hospital staff and family contacts of the cases, and from equipment in the ICU. Symptomatic health staff and family contacts are told to remain in home isolation.

On day 3 following the initial report of hospital cases, an EpiNet Team is sent to the home village of the index case. On day 5, the EpiNet Team reports that it has found ten other people with a similar influenza-like illness in the index patient's village, with an unusually high case fatality rate among healthy adults.

11. *Apply the decision instrument to the available information and discuss the results?*
12. *If a decision is made to notify WHO of these events as a possible PHEIC, who in the MoH should be informed before WHO? Will it be possible to get clearance from the MoH to notify WHO within 24 hours?*
13. *What mechanism and means of communication should be used to notify WHO of a possible PHEIC?*

Answers

11. Apply the decision instrument to the available information and discuss the results?

There are several factors that indicate this outbreak should be considered a possible PHEIC, including

- The deaths of several members of one family, and in particular, the death of previously healthy adults;
- Evidence of hospital acquired infections;
- A probable respiratory route of spread.
- The evolution of cases more severe than expected (including morbidity or case fatality)
- Occurrence of events such as this is unusual for the area.

It should be noted that the timelines are already delayed. Events that may constitute a PHEIC need to be assessed within 48 hours of first being detected. There have been both delays in detection, and in assessment once detection occurred.

IHR (2005)

- Annex 2, decision instrument and examples

12. If a decision is made to notify WHO of these events as a possible PHEIC, who in the MoH should be informed before WHO? What arrangement will have to be put in place to ensure clearance in 24hrs?

In the national legislation, the NFP should have been authorised to notify WHO when a PHEIC is detected. Although consultation and information sharing with all sectors is important, this cannot be allowed to delay notification to WHO once events have been assessed as possible PHEIC. Delaying the notification to WHO by more than 24 hours in order to get official authorisation from the government will contravene the IHR (2005).

IHR (2005)

- Article 6
- Annex 1 (6) b.

13. What mechanism and means of communication should be used to notify WHO of a possible PHEIC?

The NFP is responsible for confidentially notifying the potential PHEIC to WHO, using the most effective and rapid means of communication available to Islandia. The NFP will therefore need basic communication equipment such as telephone and e-mail through which it can communicate and be contacted at all times.

IHR (2005)

- Article 4 Responsible authorities
- Article 6
- Annex 1 (B) 6

Annex 4

Step 3 – Notification to WHO

Timelines: Day 6

Following the report by the outbreak investigation team, the NFP has notified the NFP Committee, which has met to assess the information. The MoA, which now has a representative on the NFP Committee, argues that the outbreak does not have to be notified to WHO because it is likely to be an outbreak of seasonal influenza. He is concerned that notifying a disease spread by pigs will be disastrous for the country's economy, as pork is a traditional asset and a major source of income to many people during the coming festival season.

In addition, the Minister for Tourism objects to notification because of the coming tourist season.

14. What should the MoH and the NFP do in response to the Minister's objections to notify WHO?

Answer

14. What should the MoH and the NFP do in response to the Minister's objections to notify WHO?

It is critical to explain to the Minister of Agriculture the reasons to initiate immediate investigation and to notify WHO. The reasons for this action include:

- The need to identify and treat any other possible cases in the country, and in people that may have left Islandia;
- The need to plan and implement urgent and effective infection control measures;
- The opportunity to then ask for support, including technical assistance and resources from WHO and the international community;
- The fact that delaying notification, will cause delays controlling such an outbreak, which will result in even greater loss of lives and economic impacts;
- The obligation to notify WHO under the national legislation related to the IHR (2005);
- The notification of a possible PHEIC does not mean that the event then becomes a definite PHEIC. Such a decision will be made by the Director-General of the WHO, in consultation with the IHR Emergency Committee;
- Notification is confidential and does not result automatically in information sharing with others; and
- Media attention to the events may lead to inaccurate or misleading reports on the nature and extent of the problems.

IHR (2005)

- Article 7 Information-sharing during unexpected or unusual public health events
- Article 6 Notification
- Article 11

WHO requests verification of an event

Timelines: Day 6

While the NFP is debating with MoA whether WHO should be notified, WHO has received several unofficial reports regarding the events and requested verification of these from Islandia. WHO is mandated to assess and act on any information it may consider relevant to possible PHEICs, regardless of its' source. In addition, a new virus is identified in biological samples sent from a pig farm in Islandia to a private veterinary reference laboratory in Country A. WHO has received this information through the global network of reference laboratories.

15. What should WHO do now, and how should Islandia and the NFP of Islandia respond to WHO?

Answer

15. What should WHO do now, and how should Islandia and the NFP of Islandia respond to WHO?

WHO needs to investigate any link to human disease, and request further information from Islandia regarding the source of the samples, and events related to this.

Islandia will need to respond appropriately, and must provide all available information and detail actions it has taken since identifying the event.

IHR (2005)

- Article 9 Other reports
- Article 10 Verification

Annex 4

Confirmation of the new virus

Timelines: Day 8

Samples taken from the human cases in the hospital in Islandia that were sent to WHO reference laboratories revealed a new virus with characteristics similar to the virus isolated in samples sent from the pig farm in Islandia.

More reports are received of outbreaks from outbreak response teams in the remote islands where the index case acquired the infection. In response to this and further deaths in patients and health staff in the main hospital, and lacking resources for appropriate isolation of patients, Islandia notifies WHO of a possible PHEIC, and requests assistance.

In response to the ongoing reports of animal and human deaths, several countries surrounding Islandia request further information from Islandia.

- 16. What will WHO do with the information it has received regarding a new virus, and regarding the notification by Islandia?*
- 17. Does the NFP of Islandia need to provide any further information to WHO and the global community?*
- 18. Where else apart from Islandia can other countries obtain information regarding the PHEIC, both before it is confirmed as a PHEIC and following the determination by WHO?*

Answers

16. What will WHO do with the information it has received regarding a new virus, and regarding the notification by Islandia ?

The final determination of whether an event constitutes a PHEIC, and the appropriate response, will be made by the Director General of the WHO, in conjunction with the WHO Emergency Committee. WHO will inform Islandia and offer assistance to identify the source of the outbreak and design and implement control measures.

The events reflect the detection of a new virus that spread from person-to person, probably through the respiratory route, and with a very high case fatality rate in healthy adults and children. Such an event has significant health implications globally, both due to its pathogenicity and potential for rapid spread.

As this is a potential global threat, it will require a global response. Therefore in this case, WHO will issue a global alert to notify all member states of the series of events, outlining the possible implications for global spread and advising on measures for controlling this threat.

Under the IHR (2005) WHO has established a roster of experts who can be called upon to provide technical advice in the event of a PHEIC. Selected members of this roster will be asked by the Director-General of the WHO to form an Emergency Committee that will provide recommendations on response to Islandia and the international community on how to respond to the PHEIC. An important part of this Committee's role will be to meet with and listen to information provided by Islandia. Islandia will need to present its views to the Emergency Committee at the time set by the WHO D-G.

IHR (2005)

- Article 11 Provision of information by WHO
- Article 12 Determination of a PHEIC
- Article 48 The Emergency Committee
- Article 49 Procedure

17. Does the NFP of Islandia need to provide any further information to WHO and/ or the global community?

The need for communications regarding possible PHEIC does not end with notification to WHO. Information regarding the evolution of the event, and measures taken to respond, will need to be continually communicated to both WHO and if necessary, other States. In practice, this responsibility will rest with the NFP.

IHR (2005)

- Article 6 Notification (2)
- Annex 1 (A)

Annex 4

18. Where else apart from Islandia can countries obtain information on the PHEIC, both before it is confirmed as a PHEIC and following the determination by WHO?

Other States concerned by the events in Islandia can request information and technical advice from WHO.

WHO may provide information to other countries before the determination on whether the events constitute a PHEIC.

Once the event has been determined to be a PHEIC, WHO will provide information to all countries on how the PHEIC is evolving, and disseminate recommendations received from technical advisory groups including the WHO IHR Emergency Committee.

IHR (2005)

- Article 11 Provision of Information by WHO

Step 4 – Implementing the response

Timelines: Day 10

A PPHSN (Pacific Public Health Surveillance Network)/ WHO team visits Islandia to assess the investigations and the appropriateness and effectiveness control measures.

Only some hospitals in the country have adequately trained staff to collect surveillance data. There are reports that staff are not attending health facilities for fear they may catch the disease. Personal protective equipment (PPE) ordered some weeks earlier has not arrived due to cancellation of all shipping and air flights into Islandia.

19. Does Islandia have enough capacity to respond promptly and effectively to the PHEIC? What should Islandia do?

Answer

19. Does Islandia have enough capacity to respond promptly and effectively to the PHEIC? What should Islandia do?

If Islandia does not have the expertise, resources and capacity to respond, it has the responsibility to request assistance from WHO and the global community.

IHR (2005):

- Article 6 (2) Notification
- Article 44 Collaboration and assistance
- Article 13 Public health response

Conclusion

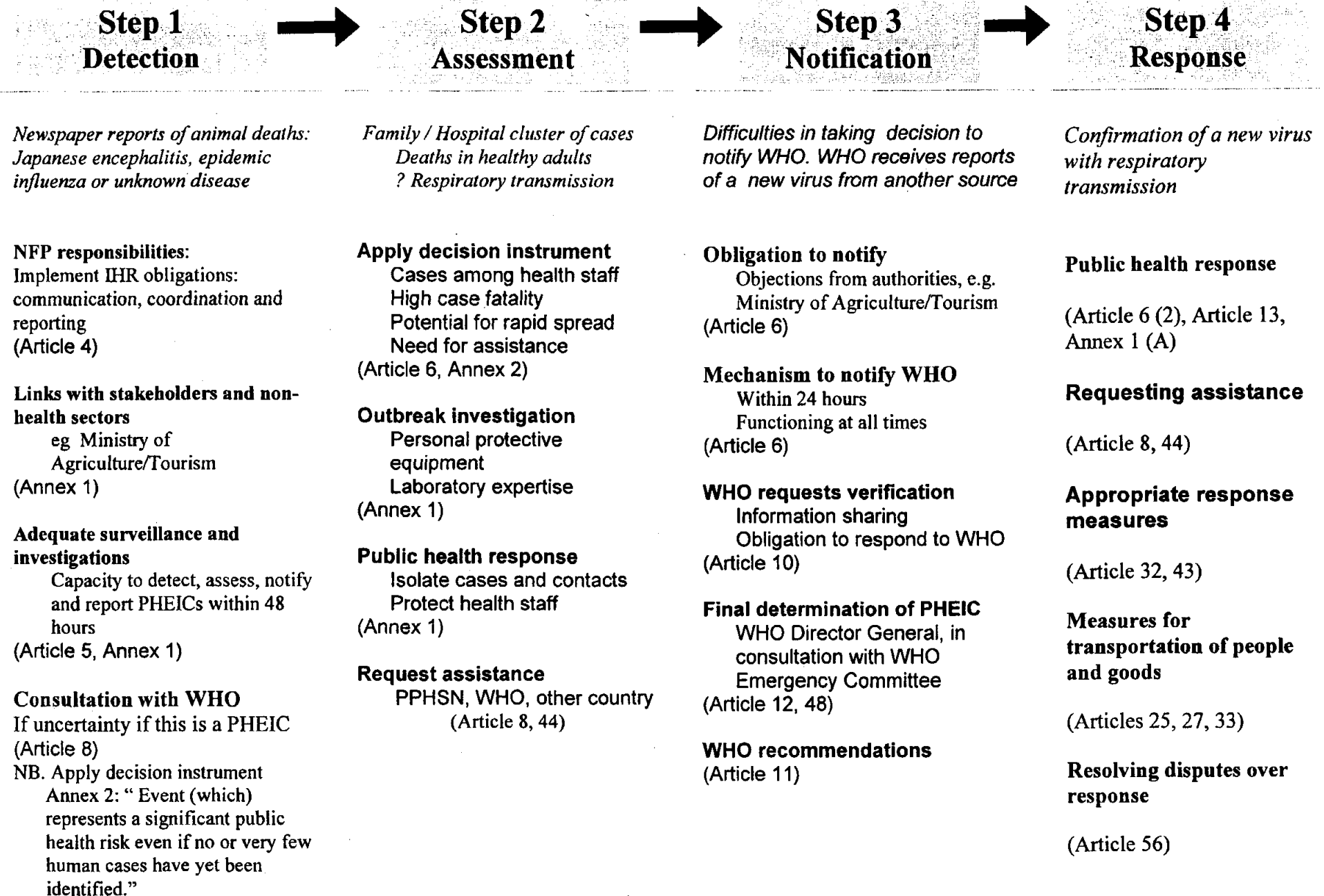
This outbreak was due to a virus that first caused disease in animals and then spread to humans. It then spread from person-to-person mainly through the respiratory route. Due to weak surveillance and lack of linkages between MoH and different sectors of the Government, it was not until cases were detected in referral hospitals that an outbreak was identified in the country of origin, Islandia. This delay resulted in rapid spread of the outbreak to many countries. Several hundred people died, and many regions, in particular Islandia and its neighbours, suffered economic losses due to reduced trade and tourism.

However, once the outbreak was recognised, coordinated action by PPHSN/ WHO and all countries, resulted in control of the outbreak, and it was finally declared over 19 months after it was first notified to WHO.

Annex 4

One page summary and exercise

Review the following one-page summary of the key events and responses to this scenario. Use the summary to identify what legislation, structures, systems and training activities your country needs to develop to implement the IHR (2005).



Input on lessons learned

Please complete the following table, and detach and hand it to the facilitators before you leave today.

From this session, list:	(1)	(2)
- The 2 most important things you learned in this scenario exercise.		
- The 2 most important things you wanted to learn but were not covered in this scenario exercise.		

Thank you

Scenario 2: Cholera outbreak on a resort island

Background

Surveia is a small Pacific Island country. Its population lives on 3 main islands. The primary industry is tourism. There have been past outbreaks of gastrointestinal illness on the island's tourist resorts due to various pathogens related to poor maintenance of water supply and sewerage systems. Although epidemiologists have recommended preventive measures, outbreaks continue to occur.

Annex 4

Step 1 – Detection, identification and confirmation of a possible PHEIC

Timelines: Day 0

Gastrointestinal Outbreak

Five people, including two children, become severely ill with acute gastrointestinal symptoms during a flight from Surveia to Country Z. *Vibrio cholerae* is identified in the stool of three of these patients. They had stayed at Paradise Hotel, a large tourist hotel on a small island in Surveia.

20. *What should Country Z do, as the source of the infection is in another country?*
21. *What are the functional capacities required for effective surveillance and response under IHR(2005)?*
22. *What are the requirements for inclusion in national legislation under the IHR (2005)?*
23. *If Surveia does not have the capacity to prepare for or implement these standards, where can it look for assistance?*

Answers

20. *What should Country Z do, as the source of the infection is in another country?*

If a country becomes aware of a possible PHEIC in another country, it must report this to WHO under the IHR (2005).

Country Z should apply the decision-instrument to ensure compliance with IHR (2005) requirements. However, it is only if the event meets the criteria defined in Annex 2 (Decision instrument and examples) that it would need to notify WHO of a possible PHEIC related to this detection of *Vibrio cholera*.

There have been several cases detected with severe symptoms, the source of the disease is unclear, and it is likely that there are more cases, with international spread due to tourists returning to their home countries. Therefore, the criteria for a possible PHEIC exist. Country Z should notify WHO and the Government of Surveia accordingly.

IHR (2005)

Article 9 (2) Other reports

21. *What are the functional capacities required for effective surveillance and response under IHR(2005)?*

Surveia needs to be able to, within the time frame set by the revised IHR (2005), implement systems that will allow it to detect and respond to outbreaks with significant international health implications in a timely and effective manner.

IHR (2005)

Article 13

Annex 1(A)

Public health response

Core Capacity Requirements For Surveillance and Response

22. What are the requirements for inclusion in national legislation under the IHR (2005)?

When a country agrees to comply with the IHR (2005), which includes the fact that it agrees to make the IHR compatible with its national law. The national obligations under the IHR (2005) obligations may need to be included in national legislation by the time they come in to force for Surveia. If this is not done, then Surveia will have to provide justification to the World Health Assembly why it was unable to do this.

IHR (2005)

Article 59 Entry into force; period for rejection or reservation

23. If Surveia does not have the capacity to prepare for or implement these standards, where can it look for assistance?

WHO, PPHSN and all Member States, as parties to the IHR (2005) should assist and collaborate with each other to achieve the requirements of the IHR (2005).

Therefore Surveia can call on WHO and other countries for assistance in achieving the objectives of the IHR (2005).

IHR (2005)

Article 44 Collaboration and assistance

Annex 4

Step 2 – Assessment of a possible PHEIC

Timelines: Day 2

WHO provides details of the cases diagnosed in Country Z to the NFP in Surveia, and requests further information from the MoH in Surveia.

24. *What should NFP in Surveia do when informed of such an event?*
25. *Who will be responsible for the assessment of the event in Surveia?*
26. *How will the NFP in Surveia assess this report?*
27. *What course of action should be taken if it is difficult for Surveia to make a decision on whether this is a PHEIC?*

Answers

24. *What should NFP in Surveia do when informed of such an event?*

It will be necessary to carry out an outbreak investigation, to identify the source and put in place control measures.

The NFP should notify all the relevant Ministries (eg, MoH, Public Works or equivalent, Tourism, Trade), and ensure the event is assessed and managed to in accordance with the IHR (2005).

IHR (2005)

- Article 4 Responsible authorities
- Article 6 Notification
- Annex 2 Decision instrument and examples

25. *Who will be responsible for the assessment of the event in Surveia in accordance with IHR (2005)?*

The NFP must coordinate with the MoH to mobilise the EpiNet Team for assessing the report, and ensure they have the necessary expertise and resources to conduct the assessment.

IHR (2005)

- Article 6 (1)
- Annex 1(6)

26. *How will the NFP in Surveia assess this report?*

The NFP must apply the decision instrument to the information on the event. The decision instrument shows that cholera qualifies as a PHEIC if it meets at least 2 of the criteria set out in Annex 2 (Examples section), and it should then be notified to WHO within 24 hours.

IHR (2005)

- Annex 2 Decision instrument and examples
- Article 6 Notification

27. What course of action should be taken if it is difficult for Surveia to make a decision on whether this is a notifiable event?

It would be important to collect further information, and re-evaluate the events using this information.

The first step is to conduct outbreak investigations using conventional epidemiological methods, looking for cases, for the source of the outbreak, and for possible causes of the outbreak.

Assistance can be requested from WHO and PPHSN.

Note that cholera the disease is a trigger disease, and its detection therefore triggers the need for an assessment to decide whether the event will need to be notified or not. Further assessment will be needed to decide if the criteria for a possible p

PHEIC have been met. Further laboratory investigations may be indicated to determine whether the illness may be attributable to other pathogens, and whether the *V. cholera* was a known pathogenic strain and produced a toxin.

IHR (2005)

- Article 1 Definitions
- Article 8 Consultation
- Annex 1 (A)
- Article 8 Consultation

Annex 4

Step 3 – Notification to WHO

Timelines: Day 3

Previous investigations of gastrointestinal disease outbreaks in Surveia were inconclusive in implicating *Vibrio cholerae*. This is because of uncertainty whether this was a pathogenic or non-pathogenic strain of *V. cholera*, and because other pathogens such as *Salmonella* and *Shigella* were also identified in the stool of people with a diarrhoeal illness.

The Minister of Health decides the outbreak should not be notified until further investigations can be completed. The MoH will continue to monitor the incidence of diarrhoeal illness through its routine surveillance system.

Routine surveillance is weak across most of Surveia. Notifications of cases occurring in health centres reach the central surveillance unit after a delay of about 2 months, and most resorts do not have any links for routine reporting to MoH.

28. What level of surveillance and laboratory support would justify the decision to rely on routine surveillance data to decide whether there is a problem?

Answer

28. What level of surveillance and laboratory support would justify the decision to rely on routine surveillance data to decide whether there is a problem?

An effective surveillance system should:

- Be able to detect an increase in the number of diarrhoeal cases in all areas of the country, including resort islands;
- Have delays of no more than 24 hours for the reporting diseases such as suspected cholera from the district to the central level; and
- Be linked to laboratory results where appropriate, with access to laboratories capable of detecting *Vibrio cholerae*.

IHR (2005)

- Article 5 Surveillance
- Annex 1 (A)

As the outbreak originated in a private island resort well as national surveillance, investigation and focussed surveillance of the implicated resort will be needed. As previous outbreaks have also occurred in such resorts, these need to be integrated into the reporting system.

Events originating in another country

Timelines: Day 5

A reference laboratory in Country Z notifies WHO and Surveia that the *Vibrio cholerae* strain in the initial cases has the gene for toxin production.

An MoH team sent to Paradise Resort reports that according to the records held in the resort clinic, several dozen guests and staff have been very unwell with gastrointestinal symptoms, and that initial testing has detected faecal coliforms in many points of the drinking water supply. They report also that many of these guests were foreign tourists who have now left the resort.

The NFP in Surveia applies the decision instrument to this and previous information, and decides that the outbreak constitutes a PHEIC that must be notified to WHO.

29. *Who should the NFP in Surveia communicate with before notifying WHO, and how quickly should WHO be notified?*
30. *What mechanism should be used to notify to WHO?*
31. *The Minister for Tourism, who has been informed of the decision to notify WHO, requests the Prime Minister to suspend the notification until " We are sure of our facts". How should the NFP respond?*
32. *Do the responsibilities of the NFP end once the event has been notified to WHO?*

Answers

29. *Who should the NFP in Surveia communicate with before notifying WHO, and how quickly should WHO be notified?*

The decisions on who should be informed in the event of a PHEIC need to be made during the establishment of the NFP. However, national legislation should give authority to the NFP to notify WHO without having to wait for approval from government. It is in contravention of the IHR (2005) obligations to delay notification of a possible PHEIC for over 24 hours.

IHR (2005)

- Annex 1 (A) 6 Public health response.
- Article 6 Notification

30. *What mechanism should be used to notify to WHO?*

The NFP is responsible for notifying the PHEIC to WHO, using the most effective and rapid means of communication available to Surveia.

IHR (2005)

- Article 4 Responsible authorities
- Article 6
- Annex 1 (B) 6

Annex 4

31. The Minister for Tourism in Surveia, who has been informed of the decision to notify WHO, requests the Prime Minister to suspend the notification until " We are sure of our facts". How should the NFP respond?

It is critical to explain to the Minister for Tourism the reasons to initiate immediate investigation and to notify WHO. The reasons for this action include:

- The need to identify and treat any other possible cases in the country, and in people that may have left Surveia;
- The need to plan and implement urgent and effective infection control measures;
- The need to invite assistance from WHO and the international community;
- The obligation to notify WHO under the national legislation related to the IHR (2005) of a possible PHEIC within 24 hours; and
- Media attention to the events may lead to inaccurate or misleading reports on the nature and extent of the problems.

IHR (2005)

- Article 7 Information-sharing during unexpected or unusual public health events
- Article 6 Notification

32. Do the responsibilities of the NFP end once the event has been reported to WHO?

The need for communications regarding possible PHEIC does not end with notification to WHO. Information regarding the evolution of the event, and measures taken to respond, will need to be continually communicated to both WHO and if necessary, other States. In practice, this responsibility will rest with the NFP.

IHR (2005)

- Article 6 Notification (2)
- Annex 1 (A)

Step 4 - Implementation of response

Timelines: Day 8

The MoH sends the EpiNet Team to Paradise Resort.

33. What resources does Surveia need to respond promptly and effectively to an outbreak of cholera on Paradise resort?

Answer

33. What resources does Surveia need to respond promptly and effectively to an outbreak of cholera on Paradise resort?

The outbreak response team needs to include appropriate experts including an epidemiologist, water and sanitation engineer and a medical doctor.

Resources needed will include equipment for sample collection, transport and possibly field-testing, and materials for disinfection of all possibly contaminated water sources.

Surveia will need to have access to laboratory facilities for testing environmental samples. The only laboratories in Surveia are Level 1, and unable to carry out tests aside from coliform counts. Water samples are sent to WHO reference laboratories.

IHR (2005)

- Annex 1
- Article 13 Public health response

Annex 4

Outbreak on a ship

Timelines: Day 10

A doctor on a cruise ship anchored in Surveia's harbour, which had previously stopped at Paradise Resort, reports to MoH that several passengers are very ill, with gastrointestinal symptoms. There is only one major port in Surveia, and it has no facilities for assessing or issuing sanitation certificates to the ship's captain.

Responsia, an island country which neighbours Surveia (its territorial waters are in some places, only 200km from Surveia's), says all cruise ships scheduled to arrive from Surveia will not be allowed to enter Responsia's territorial waters, due to risk of cholera from ballast and waste water. Responsia has very limited resources to investigate and control potential outbreaks of cholera.

34. What should Surveia do in response to the cases on board the ship? Should the cruise ship be allowed to leave Surveia?

35. Can Responsia turn away the ship or prohibit it from entering its waters on the grounds that it arrived from Surveia that has an outbreak of cholera?

Answers

34. What should Surveia do in response to the cases on board the ship? Should the cruise ship be allowed to leave port?

Surveia should collaborate with medical staff on the ship to conduct an outbreak investigation aimed at detecting the source of the outbreak on the ship, and preventing further spread of disease. This includes assessing if its water supply and sanitation conform to international requirements. If it is unable to do so, it will need to request assistance from WHO or another country with appropriate expertise. However, it cannot stop the ship from leaving port.

IHR (2005)

Article 27 Affected conveyances

35. Can Responsia turn away the ship or prohibit it from entering its waters on the grounds that it arrived from Surveia that has an outbreak of cholera?

No, it cannot stop ships from entering its territorial waters. However, if it does not have the facilities to assess or respond to possible outbreaks at its ports, it can ask the ship to go to a port that has appropriate facilities and expertise. However, the ship must be allowed to take on board essential supplies.

IHR (2005)

Article 25 Ships and aircraft in transit

Additional health measures and dispute resolution

Responsia imposes restrictions that require all passengers arriving by ship or air from Surveia to have received a cholera vaccine prior to arrival. Responsia has also banned all goods and shipments from Surveia.

Both Surveia and WHO disagree with the need for Responsia to impose these requirements.

- 36. Should all travellers from Surveia be vaccinated or provided with medical examination or other prophylaxis? If these measures are in accordance with the national legislation of Responsia, but not consistent with WHO recommendations, what could the NFP in Surveia do?*
- 37. What should Surveia do if other countries such as Responsia impose travel and trade restriction it considers unnecessary?*

Answers

- 36. Should all travellers from Surveia be vaccinated or provided with medical examination or other prophylaxis? If these measures are in accordance with the national legislation of Responsia, but not consistent with WHO recommendations, what could the NFP in Surveia do?*

Countries can implement health measures over and above those recommended by WHO.

However, these measures should be consistent with accepted standards for protecting public health, but without imposing undue restrictions on travellers or other countries. Any additional measures must have a scientific basis that justifies their implementation.

All measures implemented by states in response to public health threats must be consistent with international law. There is no evidence to suggest that mandatory vaccination of travelers from an infected country will prevent an outbreak of cholera, and there are only certain goods that may be the source of outbreaks. Measures may be applied to these goods in accordance with accepted international law, such as in the Sanitary and Phytosanitary Agreement. The NFP of Surveia should discuss the additional requirements with Responsia's NFP and with WHO.

IHR (2005)

- Article 32 Health measures relating to entry of travellers
- Article 43 Additional health measures
- Article 33 Goods in transit
- Article 57 Relationship with other international agreements

Annex 4

37. What should Surveia do if other countries such as Responsia impose travel and trade restriction it considers unnecessary?

WHO will issue specific recommendations regarding appropriate measures for responding to this PHEIC. If Responsia takes measures that it considers inappropriate or unnecessary, WHO will provide guidance on what steps need to be taken to modify these measures.

If Responsia continues to insist on these measures, Surveia and WHO can take alternative steps as outlined in the IHR (2005) treaty to achieve a reasonable compromise. These steps cover negotiations:

- 1. Among Surveia and Responsia themselves
- 2. With WHO
- 3. With arbitration

The measures decided upon should not unnecessarily impact on tourism and trade from Surveia to Responsia, but should safeguard Responsia's interests.

IHR (2005)

- Article 56 Settlement of disputes

Conclusion

This cholera outbreak was found to be due to poor maintenance of the water sewerage treatment and distribution systems in Paradise Resort. Inadequately treated sewerage was allowed to leak into the water distribution systems, and also to back flow onto the recreational beaches in Paradise Resort. Using recommendations from previous outbreak investigations, Surveia, with support from WHO and other countries, was able to control the outbreak.

Surveia implemented regulations for resort operators on minimum standards for these systems, and with support from WHO and other countries, established a system for monitoring compliance with these regulations. This included the provision to MoH of regular surveillance reports from all health facilities on Paradise Resort and other resort islands.

SUMMARY REPORT OF THE WORKING GROUP DISCUSSIONS ON INTERNATIONAL HEALTH REGULATIONS (2005)

Challenges, Opportunities and Priority Areas for Action for Pacific Island Countries and Areas

"As strong as the weakest country"

Major Challenges and Opportunities

Challenges and Gaps

- Existing local and national surveillance systems within Pacific island countries and areas (PICs) are of variable effectiveness, sometimes hampering decision making, timely response measures and priority setting;
- Resource constraints affecting public health workforce (eg numbers and skill-mix), infrastructure (eg labs, equipment) and surge capacity (extra resources) to deal with outbreaks and emergencies;
- Despite their adoption at the World Health Assembly, for practical purposes it is not always easy to ensure that there is high level/political understanding of, and support for, the International Health Regulations 2005 (IHR 2005);
- National legislation may not adequately support effective public health action. Alternatively, it may be adequate, but still require amendment to accommodate new IHR requirements;
- While the IHR 2005 will not enter into force until June 2007 (and additional time is allowed, if necessary, to develop the specified capacities), the deadline for lodging reservations is earlier (December 2006) and the sheer scale of the task to strengthen surveillance systems, develop capacities of competent authorities/points of entry, review and amend legislation, prepare a fully functional National Focal Point etc mean that it is actually urgent to begin preparations now;
- Need to strengthen relationships (eg, surveillance and briefings) between WHO/PPHSN and PIHOA members;
- All the challenges identified in the notes (prepared by WHO) for the working groups were considered to be relevant, but some more or less so depending on the circumstances of each PIC;
- Addressing public health and sanitation issues in primary and secondary points of entry;
- The isolation of many PICs can delay detection, assessment of and response to public health threats (as well as sometimes having advantages);
- Need to maintain and strengthen aspects of the valuable PPHSN, in particular EpiNet surveillance and response components;

Annex 5

- Areas which have political relationships with other countries will need to clarify how NFP functions (including decision making and notification) will be managed;
- The complexity of the IHR requirements coupled with competing priorities and staff turnover can present challenges; and
- PICs need to support each other and progress together, as we are only as strong as the weakest country in the face of emerging and re-emerging diseases.

Opportunities

- Use the IHR as a planning framework to help to assess public health capacities and determine which need development;
- Use the surveillance and reporting requirements of the IHR as an opportunity to strengthen collaboration within the Pacific Public Health Surveillance Network (PPHSN);
- Take advantage of the justifiably high level of concern over pandemic influenza, to leverage resources for, and commitment, to the IHR;
- Take advantage of the Samoa Commitment to sustain and strengthen political support for the IHR and to engage beyond the health sector (Samoa Commitment: Achieving Healthy Islands, 2005, addresses healthy lifestyles, supportive environments and the prevention and control of communicable disease);
- Use the framework of the Pacific Plan to promote IHR capacity building and pandemic influenza preparedness (the Pacific Plan for Strengthening Regional Cooperation and Integration, Pacific Islands forum, establishes four goals: economic growth; sustainable development, good governance and security);
- The tourism sector should have an interest in the effective management of risks to public health;
- Strengthening public health legislation to meet new IHR requirements will also contribute to pandemic preparedness;
- Increase collaboration with civil society and NGOs; and
- Even with relatively limited resources PICs, can achieve public health gains.

Asia Pacific Strategy for Emerging Diseases and external support

- The APSED appears to be useful, but the challenge will be to operationalise it and synchronise it with existing plans;
- PICs interested to see the consolidated report of the capacity inventory submitted to WPRO;
- WHO and PPHSN to provide technical support to assist with the assessments of core capacities and to validate the reviews etc referred to below (under priority actions); and
- Where external advice or support is provided, PICs need to satisfy themselves as to the appropriateness of such support and its relevance to their requirements;

Priority Actions and External Support (next 2 – 3 years)

Pacific Island Countries and areas (PICs)

1. Use the IHR as a planning framework to systematically review existing surveillance, early warning, response, laboratory and other public health capacities, and to help determine which capacities need development (see in particular Annex 1 of the IHR 2005);
2. Use pandemic influenza preparedness as a springboard for planning for IHR implementation (eg, to strengthen public health capacities, engage with other sectors, update legislation etc);
3. Brief Cabinet and/or other key decision-making bodies on the implications, timetable and proposals for full implementation of the IHR. Use this process to strengthen involvement with other government sectors and service providers;
4. Review, and if necessary revise, existing IHR National Focal Point arrangements in light of the findings below (see Establishing IHR NFPs below);
5. For points of entry, strengthen border management workforce, public health emergency planning and capacities (this will contribute both to IHR and pandemic preparedness);
6. Review and amend existing legislation in light of IHR obligations and the requirements identified as part of planning for pandemic preparedness;
7. Review and increase resources for, and linkages with, animal health surveillance, eg through animal reference labs, SPC and links between Ministry's of Health and Agriculture;
8. Consider use of syndrome-based surveillance systems, including in collaboration with other PICs and regional networks;
9. PICs should maximize sharing of IHR-related resources and expertise e.g. share protocols and standards; and
10. Areas to clarify their reporting arrangements e.g. American Samoa, CNMI and Guam to seek clarification about communication and support channels with USA and WHO.

Annex 5

WHO/PPHSN/Pacific Islands Forum/External support

1. Develop a brief guideline for IHR implementation planning. This could include an IHR implementation checklist and updated capacity inventory, support with applying this and a useful way of disseminating results to other IHR NFPs e.g. via secure website;
2. WHO/PPHSN co-ordinate development of a region wide proposal for external assistance to develop essential IHR/pandemic related capacities;
3. Recognising that regional surveillance networks and early warning functions are in place, review these to identify shortcomings and plan enhancements to support IHR implementation;
4. Support awareness of IHR requirements and processes by developing and supporting use of IHR scenario / simulation exercises;
5. Provide technical assistance to PICs to support review and amendment of existing legislation in light of IHR obligations and the requirements identified as part of planning for pandemic preparedness;
6. Use the IHR as a vehicle to strengthen communication channels/networks and share resources and expertise between PICs; and
7. Support addition of IHR/pandemic preparedness in the *Pacific Plan* (Pacific Island Forum). This *Plan* already includes matters relating to HIV/AIDs, because of their direct relevance to three of its four goals (economic growth, sustainable development and security), IHR and pandemic preparedness should be appended to the *Pacific Plan*.

Establishing Functional National IHR Focal Points in PICs

The National Focal Point should be a centre or an office or group, rather than an individual. This is because of the wide range of co-ordination functions and the requirement to be continuously available for (sometimes urgent) communications. Existing structures and systems should be used, with adaptation as required.

The NFP needs to have the authority to speak on behalf of the Government to WHO and the international community – the NFP should therefore have *sufficient seniority* for this purpose, and to be able to reflect the views of the whole health sector and, depending on the circumstances, to undertake urgent consultation with other government departments and Ministers.

The NFP centre will need to:

- be familiar with the provisions of the IHR 2005;
- communicate with WHO concerning all aspects of the implementation of the IHR, including consultation, notification, verification, assessment of, and public health response to, public health events;
- co-ordinate with other ministries/sectors within a country;
- have full and timely access to *all* national surveillance and response information;
- include appropriate EpiNet team members;
- have (or have access to) the expertise necessary to apply the decision instrument (see Annex 2 of the IHR); and
- provide 24/7/365 cover and have the technology (eg, e-mail, phone and fax) to support urgent communications.

As the lead government agency for public health functions, PICs consider that the NFP should generally be located within the Ministry of Health or equivalent. However, this will be for individual countries to decide and should make maximum use of pre-existing systems and structures.

Preliminary communications with, and formal notifications to, WHO may also be copied to the PPHSN PacNet-restricted.

Subject to clarification by the parties concerned, ensure that areas with political relationships with other countries (eg France, USA) are able to co-ordinate their respective decision making and communication channels.

SUMMARY REPORT OF THE WORKING GROUP DISCUSSIONS ON INFLUENZA PANDEMIC PREPAREDNESS PLANNING

Key issues on pandemic preparedness in the Pacific

- Vaccine and antiviral
- Maintaining essential services
- Better inter-sectoral collaboration and partnership
- Legislation
- Lack of funding
- Preparedness: low priority level nationally
- Operational protocols
- International pandemic response and 'tabletop' exercises

Key issues for discussion by the Influenza Specialist Group (ISG)

- Technical assistance for
 - capacity building, including workshop
 - legislative support
 - external comprehensive review of the plan
- Donor assistance for
 - Antivirals, including procurement, stockpile and security
 - Vaccines availability, i.e.
 - pandemic vaccine procurement and access
 - pneumococcal vaccine: explore vaccine availability and costing
 - Antibiotics
- Border control/closure (partial/total):
 - Prewarning to other countries when a country decides to close border.
 - When is it time to close border? Criteria
 - Will WHO provide guidance/advice on this?
 - Legal authority in place to close or restrict trade & immigration (also including the ability to restrict inter-island travel within PICs)
 - Maintenance of medical overseas evacuation
- IC: specialist equipments
- Stockpiles: antivirals, IC equipment, lab reagent/materials and others
- Further modelling with FluAid and/or FluSurge, as well as modelling targeted to unique pre-conditions facing Pacific populations
- Surge capacity with current medical & other resources (medical equipment, staff, surveillance tools, etc.)
- Sustainable training and supplies for surveillance at the front line (strengthening EpiNet teams, formulating methods and means to consolidate information for analysis, ensuring accuracy of surveillance information received)
- Human right issues relating to isolation, quarantine and forced vaccinations and the related legal issues
- Risk communication in multiple languages
- Maintenance of operational essential services

Annex 6

- Development of guidelines for hospitalization, home care, contact tracing, infection control
- Provision of updated information on:
 - the most efficient methods of screening passengers upon arrival
 - diagnosis, treatment, resistance and other effective measures.

Necessary technical & financial resources for pandemic preparedness

- Support from WHO, SPC & other partners
 - Funding for planning and implementation
 - Training
 - To improve regional collaboration
 - To reinforce surveillance capacity
 - To develop technical guidelines
 - Epidemiological technical support for modelling to understand particular risks/issues for Pacific populations (pre-conditions, NCDs, etc)
- Use of PPHSN mechanisms
 - Technical assistance: verification and notification to WHO (IHR)
 - Information sharing
 - ESR/ Wellington- New Zealand
 - Coordination of regional support to the countries
 - LabNet: use for the identification and monitoring of the virus, with capacity to identify pandemic strains (access to L2 labs)
 - PacNet: monitoring of the outbreak on
 - EpiNet: cluster investigation
- Funding
 - Accessible funding support from donors
- Training-short and long term
 - Epidemiologist
 - Laboratory - specimen packaging
 - Clinical management/ infection control
 - Ability to handle crises independently once pandemic starts (without assistance from other countries, CDC or WHO)
- Regional/national workshops
 - Financial resources for regular regional and national training workshops (on technical issues, awareness, etc)
- Technical guidelines
 - Availability of updated technical guidelines
 - On actions to implement at various levels of prevention/treatment of cases (when and how to distribute medicine and supplies, triage for treatment of patients when resources limited)
- More practical tools (table top exercise, etc.)
 - Funding and materials/ tailored
- Stockpiling of medical supplies, equipment, etc. (including antivirals and vaccines, as well as disinfectants, masks, shipping containers to ship specimens, food, water, etc.). If a country shuts its borders or is shut off by other countries, enough food and other stockpiles to sustain itself, possibly for months.

RESULTS OF THE SURVEY ON INFLUENZA PANDEMIC PREPAREDNESS IN THE PACIFIC

Current status of national pandemic preparedness in the Pacific: Two countries have a completed and approved plan; two have a completed plan that is not yet approved; three have a draft plan; nine have planning activities underway; two have decided to start planning but have not started yet; and one country had not taken a decision to begin planning for a pandemic. Every country has a national planning committee or working group for other health threats:

- SARS (15)
- Bioterrorism (8)
- Natural disasters (13)
- Other infectious diseases (14)

Of all health threats, pandemic influenza was ranked highest by the Ministries of Health of 12 countries. Next were: avian influenza (3); SARS (1); Bioterrorism (1); Natural Disasters (5); and Dengue (1). In only four countries, additional resources had been allocated for pandemic planning: Commonwealth of the Northern Mariana Islands, French Polynesia, New Caledonia, and Samoa. In six PICs, information on the threat of pandemic influenza had been shared with the head or deputy head of State, and in 17 of 18 countries this information had also been discussed with the Minister of Health.

The pandemic preparedness checklist items that had already been addressed in the national pandemic plan were Preparing for an emergency (2 countries); Surveillance (4); Case investigation (2); Preventing spread (3); Maintaining essential services (2); and Implementation and revision had been included in the national plan of none of the countries and territories. Nine countries have seasonal influenza vaccine available, and in one country (Fiji) antiviral drugs are available in the private sector.

Public health strategies to decrease the spread of influenza during a pandemic that are considered by the countries are: restricting travel from other countries (13 countries); closure of schools and/or businesses (13); cancellation of public gatherings (15); isolation of infected persons in the community (17); quarantine of contacts of infected persons (16); actively tracing of contacts of infected persons for quarantine (16); recommending to people with symptoms to wear masks in public places (16); recommending wearing of masks in health care settings (17); and recommending increased hand washing (16).

Types of assistance that is needed by PICs was reported as follows:

- Surveillance (13)
 - Strategies to investigate and contain outbreaks (12)
 - Interventions to decrease international spread (12)
 - Interventions to decrease community spread (12)
 - Guidelines for outpatient care (11)
 - Guidelines for hospital care (11)
 - Guidelines for infection control (11)
 - Guidelines for vaccine use (11)

Annex 7

- Guidelines for antiviral drug use (13)
- Procurement of vaccine (13)
- Procurement of antiviral drug (11)
- Information sharing and risk communication (14)

Approaches that were ranked of highest priority for international collaboration were:

- Regional meetings coordinated by WHO Regional Offices (3)
- Pacific islands countries meetings coordinated by WHO (1)
- Documents posted on WHO or PPHSN websites (2)
- Working sessions with planners in neighbouring countries (5)
- High level meetings (6)
- Country visit by external consultant to assist developing their plan (4)
- Assistance to hold desk-top exercise (1)
- Email exchanges to discuss pandemic issues (0)

The greatest barriers to pandemic preparedness that were listed were:

- Lack of guidance on needed preparedness activities (6)
- Lack of interest among Ministry of Health leaders (1)
- Lack of interest among other Ministers (2)
- Preparedness is a low health care priority (3)
- Preparedness is a low national priority (4)
- Lack of funding to support preparedness activities (10)

14 countries are currently carrying out surveillance of influenza-like illness. All countries expressed interest in international as well as national pandemic response tabletop exercises.