MCDOUGALL

The State of National Governance Relative to the New International Health Regulations

Ottawa, September 20-21, 2006
IDRC Boardroom/Nayudamma Lounge, 14th Floor, 250 Albert St., Ottawa

<u>Legend</u>:
RS = Dr. Ron St. John
BP = Dr. Bruce Plotkin
RH = Rebecca Hathaway
HJ = Dr. Howard Njoo
JZ = Dr. Jianzhong Zhang
VP = Val Percival
YF – Yuri Fedorov
KW = Dr. Kumanan Wilson
SL = Dr. Stefano Lazzari
EL = Dr. Expedito Luna
JS = Dr. Jeffrey Scott
SV = Dr. Stephane Veyrat
BT = Dr. Barbara von Tigerstrom
SK = Dr. Sampath K Krishnan
DF = Dr. David Fidler
AM = Dr. Anthony Marfin
AMc = Dr. Allison McGeer
JG = Dr. Jian Guo
HL = Dr. Harvey Lazar
CH = Cath Halbert
SP = Unidentified Speaker

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Morning, September 20, 2006

SETTING THE STAGE

Chair: Dr. Ron St. John

I am the Director-General for the Centre for Emergency Preparedness and Response at the Public Health Agency of Canada. It’s a privilege and a pleasure to welcome you here, first to Canada and second to the International Development Research Centre... Council, sorry, and to this meeting.

I’d like to first of all introduce our Deputy Chief Public Health Officer of Canada, Dr. Bob Clarke, who will say a few words as well.

Dr. Bob Clarke

Thanks, Ron.

Again I’d like to just welcome you all here on behalf of the Canadian government and also the Public Health Agency of Canada, IDRC and all those who helped prepare for this meeting. This is a very important meeting for us, and I think just from the interest that has been generated in this meeting. The International Health Regulations are certainly something that we need to learn more about, and the issues around governance and application of these International Health Regulations will be a very interesting discussion.

So I really welcome you here and look forward to hearing the proceedings of this meeting. Thank-you.

Dr. Ron St. John

Thank-you. Dr. Lazar?

Dr. Harvey Lazar

I’m Harvey Lazar. I’m not on the agenda, but I’d just like to tell you in 15 seconds that the boardroom you’re in is the boardroom of the International Development Research Centre, which is an NGO, a Canadian NGO with sponsorship from the Canadian government which works at arm’s length, and it’s one of the... The pictures you see on the walls around you are former members of the board of IDRC and I would just say, in Canada we think it’s one of the most effective NGO's around the world, and I just thought you might want to know where you are. If there's anyone from IDRC who would like to add a word about just the nature of what you do...? No? Okay, so thank-you for that.

Dr. Kumanan Wilson

I thought we'd begin with just a round of introductions. My name's Kumanan Wilson. I again would like to thank everybody for participating in this event.

I'm a physician at the Toronto General Hospital, I'm with the University of Toronto and Queen's University, and I'll be making a few more comments later about how we hope this workshop unfolds.

Dr. David Fidler

I'm David Fidler. I'm a Professor of Law at Indiana University School of Law in Bloomington, Indiana.

Dr. Jeffrey Scott

I'm Jeff Scott, I'm Chief Medical Officer of Health, Province of Nova Scotia, in Canada.

[Several speakers inaudible]

Dr. Jianzhong Zhang

I'm Zhang Jianzong from the National Institute of Communicable Disease Control and Prevention, China's CDC.

Dr. Sampath K. Krishnan

I'm Dr. Sampath Krishnan, I'm the Coordinator of Communicable Diseases Surveillance at the country office of the WHO in India.

[Several speakers inaudible]

Mr. André Basse

Je suis André Basse. Je suis diplomate de formation et j'ai négocié donc le Règlement sanitaire international pour le compte du Sénégal et pour le compte du Groupe africain. Merci.

[inaudible]

Dr. Expedito Luna

I'm Expedito Luna, I come from the Ministry of Health of Brazil, where I'm the Director of Communicable Disease Surveillance and Control.

Dr. Anthony A. Marfin

Hi, I'm Anthony Marfin, and I'm the Deputy Director of the Division of Global Migration and Quarantine at the United States Centers for Disease Control and Prevention, and I'm here representing the Department of Health and Human Services.

[inaudible]

Mr. Bruce Plotkin

Good morning. Very glad to be here. My name is Bruce Plotkin. I am the legal expert on the International Health Regulations implementation team, so I work at WHO together with the rest of the team that is implementing the IHR.

[Two speakers inaudible]

Dr. Ron St. John

Thanks very much. I would ask please that you remember to use the microphone when you speak because we do have translation and we are trying to record the proceedings, so they'll miss it if we don't use the microphone, so I would appreciate it if you would just press the red button when you speak. Thank-you.

Dr. Kumanan Wilson

Once again I'd like to thank everybody on behalf of the conference organizers for making it to this workshop, and in particular I would like to thank those that have travelled long distances to make it here. I know many of you were on flights most of the day yesterday, and I apologize for any inconvenience you may have experienced.

Up-front, is there any logistical issues or concerns? I think we can direct people to Christopher, myself or Patty and we'll try to help with any of those issues.

Most of you have received some of the information leading up to this workshop, and again the very broad objective is to understand the governance challenges to implementing the International Health Regulation, focusing specifically on how these governance challenges are unique to federal nations or non-federal nations that have decentralized systems of government.

And in essence there'll be two major points of emphasis during this workshop. One is I think obviously everybody here recognizes the importance of the IHR and the importance of the work a lot of people are doing around the table here, and the necessity to effectively implement the International Health Regulations. And then the International Health Regulations also offer several unique challenges, it's in many ways a revolutionary new approach to managing some of the problems in a globalized world, and because of its uniqueness countries with older systems of government – such as federal states and unitary states – may have difficulties in adapting to this new approach.

The overall goal is to hopefully have a relatively frank and open discussion on these governance challenges, but most importantly it'll be for each of us to learn from each other and learn from each other's experiences, and then from the synthesis of the information that comes out of this workshop we hope to provide some key messages and learning materials for others to benefit from as well.

The general approach is this will be a two-day workshop. We are fortunate to have nine country presentations – these will be approximately one hour each – and we'll also have two presentations representing more regional perspectives.

In general these presentations will be approximately 20 to 30 minutes – there's obviously flexibility depending on the amount of content – and then I think the most critical component will be a discussion where each of you will have an opportunity to ask questions – and very specific questions if you wish – about some of the challenges countries may be experiencing.

Just a point of clarification, people were invited here as experts in public health in the IHR from a specific country, not necessarily as representing that country. If they wish to state that they would be representing the position of their country they are free to do so, but otherwise we will not take the comments as being representative of the country from which they came. Not an official statement.

Again, just another point of clarification. This again is not in a... the objective of this workshop will not be to identify past problems or any challenges people have had in the past – unless that's an essential part of the background – but primarily to look forward and again to describe strategies countries may be working on or beginning to examine to overcome the potential governance obstacles to implementing the International Health Regulations.

And finally – and we'll discuss it a bit more at the end of the workshop – we will be providing edited transcripts to all participants for their comments and feedback. From the information we obtain from this workshop we hope to develop a list of key messages and the suggested strategies to assist federal nations and decentralized states to assist them with some of the governance challenges that will be discussed, and then ideally we could develop learning materials to more concretely assist countries in the WHO in this very important process.

Perhaps we can take a few quick questions on any points here that were particularly unexpected or require clarification...? No? Okay, thank-you very much. I think we'll begin with our first presentation. Does anybody on the conference organizing committee want to make any comments? No?

Dr. Ron St. John

The first speaker I believe is Bruce. You're going to speak first, is that correct? Tony, I mean. Sorry, beg your pardon. Sorry, Bruce is WHO. No, I'm sorry, is David Fidler speaking now? Yes, you put me off-track, Kumanan.

Dr. Kumanan Wilson

I apologize.

Dr. Ron St. John

Sorry, I apologize. I got off-track. David, you're going to go first. Sorry about that. I got off-track.

Dr. David Fidler – Overview of the New IHR

Thank-you. Just let me first personally thank Kumanan, Chris, Harvey, and Ron for inviting me to participate in this event. It’s those gentlemen that really had the vision, the perseverance and the patience to see this gathering come together, and I just wanted to thank them personally for including me in this. I’d also like to thank all of you for coming to be a part of this. I know many of you have busy and probably impossibly busy schedules but you found time to join us on this effort.

I say these thank-you’s not just a matter of etiquette but I think that it also reflects well on all the time and effort that you and the organizers of this effort have put together, and it sort of underscores for me, I think, the two themes of what I want to talk about in my brief remarks this morning, and I promise I’m going to be brief.

I think this event and your participation in it highlights the importance of the new International Health Regulations in two contexts. First, I think us getting together to talk about this signals appreciation of the new International Health Regulations as a governance mechanism in global health, and second it also signals appreciation that this important innovation that the new IHR represents in terms of global health governance depends critically on its effective implementation in countries throughout the world, and I just want to briefly share some thoughts on the themes of innovation and implementation that I think are really at the heart of what we’re going to be doing today and tomorrow.

Now, a major theme of the writing and the scholarship that I’ve done on the new International Health Regulations has attempted to convey both conceptually as well as practically how radically different the new International Health Regulations are from the approach that was taken in the past with the IHR and the predecessor international legal regimes that were established, and I call that older approach the classical regime.

My talk is billed as an overview of the new IHR but I just want to make sure that... you should rest assured I’m not going to go through all the different ways in which the new IHR differ from the old classical approach, which is actually a relief for me because most audiences I talk to about this have absolutely no idea about the details. I think this group actually understands the way in which it’s different so I’m not going to go into those details.

But what I do want to talk about is to focus a little bit on these themes of innovation and implementation, because I think it’s important. And as I started thinking about making remarks to this group I began to sort of have flashbacks, memories of the years that I'd been working on the IHR, and I can still vividly recall some of my first forays into the world of international law and public health, which would be just about over ten years ago now. I naively assumed, as a rather ill-informed international lawyer on issues of public health, that people in both international and public health would know about the International Health Regulations and would also be interested in them. The most typical response I received to my early inquiries were either blank stares of total incomprehension – which is indicating that people I was talking to had absolutely no idea that the IHR existed – or laughter, which indicated that the people I was talking to thought that my interest in the International Health Regulations, or that the International Health Regulations themselves, were something of a joke.

It's very different today. Today I get inquiries from people about the new IHR. People are interested in how the new International Health Regulations relate to security objectives concerning biological weapons. They want to know about how the new International Health Regulations fit with the rules of international trade law that operate at the World Trade Organization. They want to know how the International Health Regulations contribute to the health-related millennium development goals that the United Nations has established. And they want to know how the new International Health Regulations incorporate human rights principles.

Now, often these questions – and others which I haven't mentioned – they come from people who are not experts in public health, they're not experts in international law, they come from people working on national security, development policy, the protection of human dignity, or issues related to the liberalization of international trade, and this indicates just an extent to which the new International Health Regulations has impacted across such a wide range of policy areas.

I've also been asked why has the UN Secretary-General stressed repeatedly the importance of the new International Health Regulations with respect to strategies that he and others are devising for reform of the entire United Nations. Why, I've also been asked, have high-level panels and experts linked the new International Health Regulations with developing new forms of governance, not only globally but also at the national level.

Now, the nature and frequency of these questions have of course been stimulated by the impact of events that have taken place in the world, particularly the outbreak of SARS, the concerns that exist about bioterrorism, the issues related to avian influenza, and of course the fear about pandemic influenza.

Now, recognition of the importance of the governance innovation that the new International Health Regulations represents comes, I think, tempered with an appreciation of the seriousness of the challenges that the new International Health Regulations and I explain to people how radically different and historic the new International Health Regulations are as a matter of international law and international governance, people don't stare at me with blank faces and – at least not to my face, anyway – they're not laughing at what I'm saying. But what I do tend to get is the raising of the skeptical eyebrow when I describe how new and different this is. They understand conceptually what I'm talking about in terms of how innovative the new International Health Regulations are, but I think they're wondering about the implementation of this new innovation, and you sort of see them thinking, "If it sounds too good to be true, it probably is."

Now, international lawyers are accustomed, they're very used to this kind of skeptical reactions because we have to live with them all the time. States' international organizations in many different realms of international relations create new, innovative schemes, new treaties , all the time, and these often raise hopes that we're finally going to turn the corner. Of course often those hopes are never achieved because those innovations are never implemented to the point at which the promise becomes reality.

And we've actually seen this pattern in global health on a number of occasions. After all, once upon a time the classical regime in the old international health regulations were also considered innovative and progressive, and of course that image no longer exists because that image has been tarnished by the failure of states to implement the innovations effectively and to comply with those regimes.

So implementation is really what this meeting is all about. The scope and substance of the new International Health Regulations are innovative but they're also much, much more demanding of countries and of the World Health Organization than any previous incarnation of these set of rules. In addition, the harmonization of a global strategy – which is achieved at the level of the International Health Regulations – meets in this implementation phase the diversity of governmental systems and public health realities that exist around the world.

We are essentially facing today a challenge – and I'm going to paraphrase Edmund Burke, here – and that challenge is achieving a unity of purpose globally through the diversity of operations locally.

This is why I personally think that this meeting – as well as WHO's ongoing efforts on implementation – is so critical, and I do really look forward to hearing the views and the opinions of the people that are gathered around here today.

And I really can't think of any better way to close my brief remarks this morning than to yield the floor to our colleagues at the World Health Organization who I think shouldered successfully the need to achieve innovation in global health governance, but who also now have to face, shoulder to shoulder with the rest of us, the challenge of implementation, the challenge of turning that remarkable vision into a sustainable governance framework for the 21st century.

Thank-you.

Dr. Ron St. John

Thank-you very much, Dr. Fidler. We'll now turn the floor over to – in proper order, Stefano, you go first – Stefano Lazzari from the Lyon Office of WHO.

Dr. Stefano Lazzari – Current WHO Approaches to Implementation Activities

Yes, good morning everybody. We decided to switch presentations simply because mine will be a bit more informative in providing you with an update of where we are in terms of WHO activities towards the implementation of IHR, and Bruce will go there a bit more into the more key topics for discussion for this meeting which is the governance and the issue of federalism and how this can be addressed.

I have a short presentation. I'm going to try to keep it just to the main points, the main concept, and provide you really with some useful information on that.

Perhaps while the presentation is coming up let me just say that WHO is organizing itself in terms of IHR implementation re. IHR secretary to the group that followed discussion the text of the regulations is now being restructured under the leadership of Dr. Rodier that most of you know, and is organizing itself around a number of areas that I will illustrate you in implementation, recognizing that so many different partners and peoples and expertise is required.

This is very much construction and work in progress, and I'm just going to try to give you an update of where we are with some of these aspects.

Of course a major step in the implementation strategy has been the World Health Assembly resolution on early IHR implementation last May that sort of accelerated the whole process of implementation based on the agreement among WHO member states to apply the early implementation of some aspects of the IHR on a voluntary basis, and this very much in the context of pandemic influenza, so there are a number of elements that are under the IHR that now member states and state parties have committed to implement voluntary earlier on from this initial directional focal point to some of the specific work related to pandemic influenza. And I'll come back later to this, but definitely this resolution has sort of accelerated the whole process of implementation and put also some pressure on WHO and I think all member states to start to becoming more active in addressing the issue of implementation.

WHO is defining a WHO strategy as such – again, as I said under the leadership of Dr. Rodier – that is built around three different domains and seven specific areas of work. And this is all done building on existing, we're not really starting from scratch in IHR. (There is a whole?) background of work done first of all (by the various?) IHR implementation teams. Many of the background consultation and documents prepared will be also very useful during the whole implementation phase.

The whole structure of WHO alert and response operation is very much important in the context of the implementation strategy. Other ongoing efforts in terms of disease surveillance, of disease response and other WHO relevant control programs also come into the picture, and we have a number of regional strategies for surveillance and response that very much meet many of the elements and the requirements of IHR implementation. So there are a number of things already in place that we have to keep into consideration in developing the strategy.

The three areas, the three domains we find are the very management of the project as such and the way WHO organizes itself. The whole alert, preparedness and response operation side, and the national core capacity – what member states and countries with WHO support have to put in place – and we have identified these different seven areas. Going anti-clockwise you have the overall coordination of this IHR implementation project or effort; some specific IHR bodies and procedures that need to be put in place, the IHR focal points, the roster expert, the emergency committee, review committees and all that are these other requirements which are in the IHR. Some IHR communication strategies are required, that is very much to build (that focus in?), interest and knowledge about International Health Regulations more broadly than what it is nowadays. In terms of national core capacity we have of course the country alert and response operations as well as the whole issue of points of entry and what needs to be built in terms of point of entry. And then for alert and response operation there's a number of elements already in place, the whole process of intelligent information collection, verification, assessment and response to global threat, as well as some work that is ongoing on specific threats, and of course pandemic influenza's the first one that come that comes into the picture but there are many others the WHO programs are already involved with.

So we feel that our efforts in IHR implementation will have to revolve around these seven areas, and specific strategies are being developed for each and every one of them.

I will use this framework just to update you on where we are, starting a bit with the project management side, the coordination, the bodies and procedures, and the communication side.

And coordination is going to be an issue here. IHR touches so many different domains and areas and expertise that many players have to be brought on board, they have to understand and they have to in a sense speak the same language and work together if we are to achieve the results. And this is a challenge in itself, I think – within the organization, but also globally – to achieve this coordination of many different players, institutions, agencies, both at international but also at regional level. And of course the issue of federal states it's part of this coordination challenge.

We have decided to build, in the WHO in Geneva, a WHO taskforce that will comprise many of the players within the organization has the tools to ensuring this coordination at least within the organization. And this taskforce is not found yet but it's going to be that people are going to be identified and put together within the next few weeks, so it's a process already in motion.

In terms of bodies and procedures the resolution of the Assembly has called for identification of national focal points, and of course this is the definition that we have in the text of the regulation. I would like to stress here that the regulations talk about a national centre, not an individual, whereas many state parties in fact have come back appointing an individual to that, and this is still an ongoing discussion that we have with each of the state parties.

This is the situation as of mid-September, 60 national focal points have been officially designated and WHO has been informed of their details and contact details, and you have also distribution by regions, which for some regions I must say it's still a bit disappointing, but we hope as we keep negotiating with them the procedure will accelerate.

If your country's not on the list, of course, the message is clear. [laughter]

The information on each national focal point is put in a database – and this an example database – with all the contact details and how they can be reached by e-mail, phone, fax, and every other means, and this database will be continuously updated as we get new nominations or as, perhaps, member states or state parties decide to change the definition of the focal point. So, 60 out of 192 member states still is a bit of a way to go.

Also, the roster of experts is being put together. These are experts in relevant fields of expertise that can be utilized in terms of a response to a public health emergency of international concern, and it's also the source of members for the emergency committee or review committees, and it's appointed by the DG. As of today 45 states have proposed experts for membership. And once again, if you haven't done it yet I think we would very much encourage your countries to come forward and propose experts because we want the roster to be of course as broad and as rich as it can possibly be. All this will go, again, into a public database, an IHR expert roster that is being put together.

On the alert response operations side, many of the elements in relation to the IHR are actually already in place in the overall ___ (and goals and actors?) but there's a couple of things that have been done. One is in trying to apply the concept of the IHR to the existing system, and you see here a bit of a summary of how an event will have to go a different... a series of steps during the notification and determination process starting from, of course, the detection by the disease surveillance system in the country, through the national IHR focal point that will have the responsibility to communicate with WHO contact points – usually at regional level but also in Geneva – and then it will go to the WHO director-general who actually has the responsibility to determine whether the event constitutes or not a public health emergency of international concern and recommend appropriate members, of course in consultation with state parties and with the advice if required, of the emergency committee.

So all these elements and the notification system is now being revised and discussed, and let's say in a sense re-adapted to the requirement of the IHR, and in particular we have identified

IHR counterpoints in every regional office which will have a dedicated phone number, a dedicated fax number and e-mail, and also will be provided where feasible with BlackBerries so they can be reached any time, and a roster of duty offices being organized so that the presence and the contents will be available 24 hours a day 7 days a week. And standard operating procedures are being developed for each region on how this whole system should work.

And some of the work will have to also filter down to our country offices that as well are going to have to organize themselves in terms of facilitating the contact between the national focal point and our IHR counterpoints. This is a work in progress and I think in a matter of a few weeks the system will be in place in every region.

Also in terms of specific threats the influenza pandemic taskforce has been put together. It functions similar to the emergency committee but it will basically end its functions when the emergency committee of the IHR will come into place ___ (to force of?) the IHR. The mandate is to provide technical advice to the DG on all issues related to pandemic and avian influenza, and there is a meeting of the influenza pandemic taskforce already planned for the end of September. It’s the first organizational meeting to really see how, again, they can function in the interim and how then their functions can be transferred to the emergency committee.

I will then go into things that are more close to the work we’re doing in Lyon, and that’s the development of national core capacity. That, in some ways, is going to probably be one of the most challenging aspects of IHR implementation. We have organized in Lyon – and I think some of you might have attended or seen the results on international consultations specifically on the topic national capacities – with the objective no identify how to translate Annex 1 in the requirements of the IHR into operational guidance, and develop out of that strategies and mechanisms to develop this capacity within the time-frame of the IHR.

We focus there on three or four areas of functions: the early warning system; laboratory support; response capacities required at country level; and the whole issue of communication and coordination, always at the national level. The report is available, and out of that report now an advanced draft is being developed on what we interpret as national core capacity for IHR.

It is quite a difficult issue. Defining what we mean by core or minimum as opposed to a perfect system is quite challenging, and defining it in a sense that is universal and applicable to countries as different as maybe China and Tonga, or Burkina Faso and Belgium. It’s really challenging, and we're trying to address this is very many different ways. This work will have to be done, brought up to more global and international discussion.

Also an issue is at what level this capacity will actually be required, and the issue of federalism here is very important because of course some of these functions may be a central level but it could very well be delegated in some countries at the more peripheral level, requiring a whole different set of implementation.

A special point is also how can we then assess this core capacity within the time-frame required by the IHR – which is two years – and we're looking at what existing guidelines, tools, training materials, can actually be used or adapted to the IHR requirement. All of this will be part of a strategy as well of the definition of this core capacity.

I will touch very briefly on two concepts. One is how can we develop a system that is universal, and one idea is to have maybe IHR Level A, Level B, Level C, according to the status of development of the country, which is a possibility but it will make it difficult to define which countries go in A, B, C or D or so on. I prefer – and I put this together for you this morning so I apologize – a concept car. What does this mean? It means car some in all sorts of shapes and flavours all around the world and in history, right? And you have some examples here of very different cars. But if you look into it, in fact cars have some key components that exist everywhere. They have a steering wheel for the direction, they have an engine for propulsion, they have a fuel tank to get fuel to the engine, they have lights, they have wheels.

So when we talk about core function and core requirements, in a sense – and this is my view at least – we are trying to identify these elements, key elements that make up an IHR car. And then it will be up to the country, to the state party, depending on their resources and their willingness to invest to decide how complex, how elaborate, how performing they want the system to be, but in terms of IHR I think we need to make sure that these key elements that make the IHR car are all there. And the effort we're trying to do is to identify these key things that have to be there to make the IHR car come together.

In general terms we've talked about the capability of detecting an event coming from very many different sources, the capability to verify, assess and investigate and confirm an event with a major epidemiological but also laboratory support component required, the capability to respond in the most appropriate way at national level to this event, and the capability to communicate it properly, both to WHO on an international level but also nationally within the country and particularly with the media and the general public because we know sometimes bad communication can cause more damage than the event itself.

We have tried to redevelop all this in the sense of IHR monitoring and evaluation system, trying to identify the key indicators that will tell us that the car is there, and we have divided these indicators in five broad areas. One is policy, planning and financing and it includes the existence of some legal framework; a national plan for responding to public health emergencies of international concern; a budget allocation for this; some on infrastructure and institutions; others on the availability of human resources and skills and knowledge required for IHR; the specific technical resources, and something on the IHR system and services, and the list of indicators is there. It's still on discussion but I just wanted to give you an idea of the direction we are taking. And it's important that we can come to a consensus on this because in a way it's the only way we can eventually say a country is complying with the requirement of the IHR or not, we have to be able to have some sort of a universal understanding of what we have to put in place.

A document with more details of this is on an advanced draft and I think will be going out for discussion soon, but I just wanted to give you basically (the concept?).

And finally another major challenge is points of entry. There's been a meeting held in Montréal – again around May, if I'm not mistaken – and various working groups have worked on standard operating procedures on the various aspects in terms of points of entry that will be required, and the expectation is that the work will advance on all the SOP's fairly rapidly. We might be able to produce some draft by the end of the year. The list of SOP's that have been identified is here and will go from inspection standard operating procedure to hospitals and clinics and transport and many different aspects, and I think the work is definitely going in this area.

And finally there are two guides which are planned for publication, one is on ship sanitation and the other one is on hygiene and sanitation in aviation, and both of them are due some time in 2007.

Okay, I'll stop here. Thank-you very much, and *merci beaucoup*. I hope it was informative even if quick, and of course I'm very much interested in the discussion and if some of these points might – or will – come up again during the rest of today. And thank-you very much again to Ron and the organizers for giving me the opportunity to be here with you today. Thanks.

Dr. Ron St. John

Thanks very much, Stefano. Bruce? I think we'll hold questions and comments until Bruce makes his presentation.

Mr. Bruce Plotkin – A WHO Perspective on Legal Challenges and Frameworks

While that's coming up let me introduce myself again. I'm Bruce Plotkin, I'm the legal expert on the IHR implementation team, and I work with the technical personnel in Geneva. I can tell you from my own personal experience that there are enormous activities going on all the way across the organization as the programs that deal with specific diseases, the programs that deal with outbreak alert and response, and the programs that deal with almost any communicable and other disease problems are all working to revise their SOP's, to revise their procedures so that everybody is applying the same basic rules and so that everyone will be ready to go forward under the new IHR when the new IHR come into force.

This is a massive undertaking...

[Start of Side 2]

... At the headquarters the IHR are coming up already in a number of ways, not just in terms of preparation. As you can imagine, there are outbreaks of all kinds of diseases all over the world, and now when major outbreaks come up we are using them as sort of an opportunity to test the new International Health Regulations so that when there is an outbreak of polio, for example, questions are raised about how would this be handled under the IHR, how might it be handled differently, how would it be handled the same. These are all very important questions.

In this context, while there are a lot of important and serious outbreaks that happen, one thing that needs to be kept in mind is that the IHR public health emergencies of international concern, which is one of the aspects of the new IHR that everybody seems to focus on, are not likely to happen very often. Again, it is an aspect that that tends to get so much of the attention, but as a practical matter, true public health emergencies of international concern--with convening of the IHR Emergency Committee and formal declaration of a public health emergency of international concern--at least in terms of the immediate future it appears likely that there won't be a lot of them. We'll have to see what the future holds, but my current expectation is not that you will having three or four public health emergencies of international concern a year, I expect it be a fairly rare phenomenon.

One area where the IHR are already affecting the global scenario is with regard to avian influenza. Stefano touched briefly on the resolution passed by the Health Assembly on early voluntary compliance with a number of the requirements in the International Health Regulations. And I can tell you that as events of various kinds having to do with influenza are arising around the world, they are being measured against the International Health Regulations even though they're not binding yet, in the context of the early compliance resolution. with regard to information or specimens or whatever having to do with influenza.

So on the one hand it's very easy to say this is happening in about eight or nine months from now, and it's not really happening now, but it's already coming forward, we can already see it in the way that we are looking at things, the way that we're analyzing things, and of course the way that Stefano's people out in Lyon are trying to prepare to fill all those requirements.

One of the things that's also important to keep in mind as we go forward is the incredibly tortuous, satisfying, frustrating negotiations that went on with the Intergovernmental Working Group for the revised IHR. You had vast numbers of people all trapped with each other in various kinds of rooms, forced to negotiate things that were often very complex and very difficult. This was done in face-to-face negotiations by the delegates from the member states. And one of the important things to remember about this is not only that it went on for a long time, that it was face to face, that these were hard decisions, that a lot of issues had to be compromised, was that this happened in the shadow of SARS. So it's not like this happened without any particular emergency or without any particular experience having happened. SARS happened in the middle of 2003, our negotiations didn't start until the end of 2004, and I can tell you that for countries that were involved in SARS and the experience of SARS – and countries that weren't – it was on everybody's mind. People were talking about the issues that had arisen and what should be in the new IHR to address those concerns, what should the IHR have in them because we've had this experience.

Very quickly – this is the legal portion of the show – the International Health Regulations, while on the one hand they are very new and really unprecedented in a lot of ways, in one way they're very old, and that is the International Health Regulations are an agreement between states. Under the WHO constitution for the international health regulations and certain other regulations, once they're adopted by the Health Assembly – which happened in the middle of last year – once they were adopted by the Health Assembly all WHO member states are in, all WHO member states are automatically bound by them unless within a limited time period they affirmatively take a step either to make certain kinds of reservations or to reject the new regulations in their entirety.

So, for those of you who may not be watching your calendar every day, the deadline for rejection – or making a reservation, of course – is December 15th. I can tell you that we have received no official notifications of reservations by anybody. The only one that I'm aware of that's even been announced is one reservation by one country that was announced a while back and there has been no further official activity. But in any event, it is – as I indicated – an agreement among member states of WHO.

So what does this mean? I have other interesting bits to say but most of the presentation, for our purposes, as we look forward now, can be summed up right here. Because this is an agreement among WHO member states, no matter what subdivisions are involved, no matter how states may be aggregated for some purposes or divided up for other purposes, like other international agreements the overall rights and responsibilities that come with the IHR 2005 are the focus of states' parties. It is the states' parties that have these obligations, it is the states' parties that have these rights. And one of the obligations that states' parties have – and this is traditional under international law – is that the states' parties are the ones who decide how to implement their international legal obligations within their own political and legal context. And if you think about it, this is logical. I mean, it's a fundamental sovereignty issue. If you go and you try and tell a state, "Well, you have to do this, and you have to do it that way, you have to do it that way," these things are seen as being the fundamental prerogatives of the states themselves. And it also makes sense from a logical perspective because how a state will need to implement its obligations under the IHR is going to depend on a large number of what are going to be essentially unique characteristics. What is the state's legal system? They vary. How are the relevant obligations broken up horizontally among different ministries? How are the obligations broken up vertically among the different governmental units? How do they all relate to each other? Who is responsible for what? Who's responsible for the money, who's responsible for enforcement?

On the one hand you can speak of them generally in terms of listing all of these requirements. At the same time, how they appear in any particular country is going to be unique because it's going to depend on the history and the relations within the country.

That's the first key point to sort of keep in mind. The second one is obvious and rather self-evidence but I wanted to make it anyway, and that is broad participation by all states' parties is the key to benefits for all of us, and this is true whether you have an event which is happening in the capital, whether you have an event that is happening in the periphery of a country or anywhere in between, whether it's dealt with by a local or intermediate governmental unit or a national unit. The point is that what happens in that state is going to affect other states, and the other states... for the other states it's not going to make a big difference if the issue arose at one level or another level, it can still very much affect every other state. And when I say every other state, I mean all of us. And this is the key to this kind of agreement, this is an interdependent world, and because it's an interdependent world we need as many of us and as much of us in the picture for it to work. If you have a hole in the net the net doesn't work nearly as well for any of us.

Federalism. It's an interesting issue. It is, as some of the background materials make clear, it's not an unusual issue, it comes up all the time in agreements because there are agreements in all kinds of areas that require some sort of action or other activities on the part of units other than the federal government or the national government that's actually signing the treaty. This is part of the international legal process, the lawyers, the diplomats, they know all of this going in, and so the question then becomes how best to address these in order to achieve the objectives of the agreement.

I can also tell you from having been through the negotiations – and I know many of you were in the negotiations there too – that participation of multiple governmental levels and entities – whether they're ports, whether they're local health districts, as well as the heads of the ministries – the activities of all of these levels were self-evidence all the way through the negotiations. Everybody knew it, everybody knew that that was going to have to happen, because otherwise you couldn't put together a system that would make any difference in terms of combating these problems on a global level. These were discussed on a routine basis. You should have heard the negotiations about how detailed they were, and how intense various people were about the national capacity-building requirements, how should those be seen, how should the requirements be seen for ports and airport area and issues like that. So all of this, the fact that all of these local areas would be involved, all these different governmental units would be involved, was very much a subject of awareness and discussion by the delegates as it went through the process. And again, feel free to go and talk to some of the people who were there and were involved in it, and some of them are in the room.

In addition – and I have a slide on this in just a couple of minutes – the delegates in the negotiations also reflected the fact that there might be a need for legal or legislative or regulatory revision of the legal systems among various countries and various places around the world. This is inevitable. Again the country saw this as this was being negotiated, saw that this was one of the things that was going to have to be dealt with, and there are provisions on it. I'll talk about them in a moment. The very first resolution that adopted the IHR addressed these and said, "This is coming, we need to..." Well, actually it's the Health Assembly – which means the member states – urged the other member states – which was the same group of them – to start thanking about this because this is part of the process.

The last bullet isn't actually on there, and that is the specific strategies. I think, because so many countries' situations are necessarily going to be unique in the specifics, I think it makes sense to discuss them most in terms of the specific countries, but in general terms you're talking about the same kinds of considerations in all of them. Prioritization: in the context of the country what are the legal arrangements or the changes or whatever that have to be made that go at the most important aspects of the IHR? What are the specific key points within that particular country, within those particular units? We can talk about more of that specifically.

Just a little bit more of the legal part. The IHR generally take a unitary approach to state party obligations. The vast majority of them are in state and in terms of states' parties. At the same time they do recognize that for some purposes you really do have to talk about some subnational unit, and there were a lot of discussions during the negotiations because you would talk about, "Well, the state party shall take the following measures at the port to kill the rats on ships," or things like this, and it would be obvious that it sounded funny to say that the state party would do it, so there was a lot of discussion about what term would you use. And so ultimately, after a lot of discussion, we wound up with "competent authority", and it was an accommodation of a number of concerns that were raised by a number of countries. That's the primary subnational unit that is discussed.

At the same time, of course, what the competent authority does, in whatever context, it is still the state party of course which is the party to the agreement which has the overall responsibilities and rights under the regulations.

There are surprisingly few points in the regulations that actually address legislative or legal or administrative revision. These are the two main ones. You may have seen this in the background materials. The first one is a part toward the very end of the regulations, tacked onto another article that deals mostly with other things, and it provides exactly as it says there. It was put there in recognition that countries will need to address some revisions – and it depends on the country – in their legal or legislative systems, and it provides for this mechanism right here.

I put the little note there that says "notes and questions", and the notes and questions really come down to this. First of all, if a country is going to invoke this provision the deadline is December 15th, just like it is for reservations. So, know that the deadline is out there. But the second one is this was a provision that was drafted very quickly at the end of the negotiations when a lot of things were being done at once, and frankly it's not entirely clear exactly what its effect may be. We can talk about this in more detail, it's just that this is the one provision that actually talks reasonably specifically about some of the issues that we're talking about here and I wanted to make sure that it was out there so you all know that it's there.

The other provision is the one on collaboration, which specifically contemplates that the States Parties would assist each other in this area.

The other items we can discuss as they come up in the course of our discussions, and – like Stefano – if you have questions we are here to provide information and to discuss what's happening at WHO and what we're doing to help support the States Parties in going forward with the Regulations.

Dr. Ron St. John

Thank-you very much, Bruce. We'll entertain some comments and questions for a few minutes from the floor, if people have comments or questions for our colleagues from WHO.

Questions and Answers

RS: Yes, France?

SV: Thank-you for those two presentations. My question is to Stefano Lazzari. Perhaps I can ask him in French? I don't know if people...

RS: I'm sorry, there are translation headphones here for those who would like them for French. Please, *un petit peu*.

SV: Technical pause.

SP: Bien sûr. Pas de problème. Je crois que nous sommes prêts.

SV: Thank-you. Ma question est la suivante, j'ai vu dans la présentation que l'OMS travaillait à identifier des contacts points régionaux et donc dans le Règlement sanitaire international on a vu que les contacts points n'étaient pas précisés s'ils devaient être régionaux ou au niveau du siège. Donc je voulais savoir s'il y avait eu depuis des évolutions et si on partait plutôt sur des points de contact de l'OMS qui seraient régionaux ou si on restait sur quelque chose de centraliser au niveau du siège. Et ma question est double à la fois pour le problème de la consultation (article 6) ou pour le problème de la notification (article 12). Donc est-ce qu'un utilisera les mêmes circuits pour les deux? Est-ce qu'on aura des contacts avec la région pour uniquement la consultation, une sorte de prénotification bilatérale et d'échange ou est-ce que, effectivement, les deux voies seront les mêmes ou distinctes? Voilà ma question.

SP: Oui, effectivement il y a eu une discussion sur à quel niveau le contact point devait être établi et comme c'est pas bien spécifié comme vous l'avez dit dans le texte de Règlement sanitaire international et je crois que la décision serait effectivement d'établir des points de contact au niveau régional. Et pour la raison justement de rapport avec le pays de suivi et de la façon que l'OMS est organisée. Ce qui n'empêche que le système va être mis en place d'une façon que le transfert d'une formation et la discussion avec les pays va être faite assez rapidement avec l'engagement du siège, mais le premier point de contact en principe ce sera pour la notification des événements potentiels au niveau régional. Et justement l'équipe à ____ on a travaillé de façon très étroite et continue avec les régions pour établir des mécanismes de système de communication et de système opératif pour s'assurer que ça puisse marcher d'une façon correcte. Mais oui, je crois que peut-être Bruce était aussi parti de la discussion qui a eu lieu d'ailleurs à Lyon après la conférence de mai et où effectivement on a estimé qu'au niveau régional c'est le bon niveau. Thank-you.

RS: Comments, questions? Additional...?

?: Une question. Quand vous parlez de points de contact régional, vous voulez dire dans le contexte global? Pas à l'intérieur du pays, mais régional au plan du monde c'est-à-dire les… Vous pouvez pas dire le niveau régional à l'intérieur du pays, mais vous voulez dire… le niveau régional à l'intérieur du pays, mais vous voulez dire… global?

SP: Non, non, non, non. Comme j'ai montré, l'événement potentiel va être détecté au niveau pays. Le focal point au niveau national, la responsabilité de notifier l'OMS et la notification sera à travers le point de contact régional, et à travers ce système ça va arriver à Genève et ça va activer le système de l'OMS. Voilà. Et l'OMS c'est un organisme régionalisé, comme vous le savez bien. C'est normal que ça suive la structure, si vous voulez, de l'organisation.

RS: The lady in the back from Foreign Affairs. Just a moment, Dr. Fedorov, you're next. The lady in the back? Would you please...?

KW: If you could just everybody state their name, just for the transcription process.

RS: Yeah, say your name.

VP: Hi, I'm Val Percival from Foreign Affairs, and this question may be self-evident to people who are more familiar with the IHR than I am, but I was wondering what... you talked about the obligations that the IHR put on state parties. What additional obligations does it put on the WHO and what does it mean in terms of the evolution of the WHO as we move forward?

BP:

RS: Thank-you, Bruce. In the interests of time I'm afraid we're going to have entertain one more comment, and Dr. Fedorov you were the next to ask. I'm sorry. Dr. Fedorov?

YF: I have a question to Dr. Lazzari. May I ask you, when you're coming back to the original focal points, when we discuss this matter, do you mean that the original offices of WHO will serve as regional focal points?

SL: They are contact points, they are not focal points.

YF: For organizations, I mean.

SL: What it means is that we're organizing contact points in each region who will be accessible by the national focal points at any time in order to notify potential...

YF: So you will not produce any other new structures or...? The original offer will serve.

SL: It will be within the regional office and it's going to be most likely the existing people involved in epidemic alert or response already.

YF: Thank-you. Yeah, that's clear.

SL: But they're going to organized themselves in order to be available and contactable 24 hours seven days a week.

YF: Thank-you.

RS: Thank-you. One more comment from Senegal. Please state your name.

AB: André Basse, *du Sénégal*. Je voudrais revenir à cette question de point de contact parce que je crois que c'est important, parce qu'il se situe donc dans ma compréhension, dans le cas de l'article 6 de Stefano Lazzari. Et le concept de l'article 6 c'est d'aller très vite dans la notification et à même d'aider les ____ qui sont prévus là-bas de 24 heures notamment. Est-ce qu'en introduisant la notion de points de contact au niveau régional c'est pas une lourdeur qu'on va ajouter au dispositif de notification, et d'autre part est-ce que le point de contact régional sera une option à côté de la possibilité qui sera offerte aux points focals nationaux de communiquer directement avec le siège, parce que le concept de l'article 6 c'est la consultation. En créant une étape intermédiaire entre le pays et l'OMS siège on peut aller lentement. Donc c'est pourquoi cette notion de point de contact régional cause problème par rapport au concept de l'article 6. Je vous remercie.

SL?: Merci pour la question. Effectivement je crois qu'on ne peut pas empêcher un national focal point ou un gouvernement de contacter directement le siège. Mais à ce moment-là ce qui se passe c'est que le point de contact du volet national sera immédiatement informé par le siège. Bon, aujourd'hui les systèmes de communication nous permettent de faire ça dans un temps très rapide. C'est pas vraiment un problème. Le problème c'est d'avoir des mécanismes de systèmes en place qui marchent et qui marchent bien; et à ce moment-là tout le monde va être mis au jour de la situation dans un délai minimal. Mais je ne crois pas qu'on peut effectivement empêcher un gouvernement au point focal de… par exemple s'ils n'arrivent pas à contacter au niveau régional tout de suite de contacter le siège. Je crois que c'est quelque chose qui restera possible. Et après ce sera le mécanisme différent qui entrera en place.

RS: Thank-you very much. I believe in the interests of time now we'll move into the next part of our agenda. Dr. Wilson will introduce the country presentations.

4) Identify national focal point, strengthening coordination: the Chinese government is making great efforts on work relative to national focal point for IHR and keeps improving the multi-sector and inter-regional communication and coordination system so as to effectively implement IHR by joint efforts.

5) Effectively carrying out prevention and controlling measures, respecting and protecting individual rights: IHR states that its implementation should fully respect individual dignity, human rights and basic freedom. The constitution of the People's Republic of China also stipulates that nationality should respect and protect human rights. Every citizen enjoys the right, entitled by the constitution and the laws, and they (must obey?) the obligations stipulated by the constitution and the laws too.

The Chinese government holds that measures taken by the government should accord with the possible characteristics, extent and the scale of the social risk of the emergencies. Alternative measures must protect citizens' rights to the maximum. Every citizen has the responsibility to participate in emergency response.

6) Strengthening the construction of the public health system to lay the foundation for implementation of IHR: the Chinese government pays much attention to the development of a public health system. In the last three years the government's expenditure in this regard amounted to RMB30 billion and over 5,000 construction programs have been started. All these efforts aim to strengthen the mechanism of disease control and prevention, medical assistance and treatment, health supervision, as well as construction of public health emergency reporting systems. All these measures have improved the capacity of responding to public health emergencies.

In January, 2004, China studied the information reporting and management system for public health emergencies in communicable diseases on the basis of individual case reports. Thirty-one provinces in China can directly report related information through the Internet. Currently the report rate among medical institutions above county level reaches 93%; township hospitals, 66%; and the CDCS at various levels, 100%.

The establishment of the vertical reporting system is useful to set up a mechanism of surveillance, evaluation, early warning and the response which has built a sound basis for the effective response to public health emergencies.

In addition, China has set a surveillance network on food pollutants and food-induced diseases which cover 16 provinces and 830 million people. Since 2004 China has renewed and constructed surveillance points at the national level for key 20 communicable diseases and the vector borne by origin. To date 762 surveillance points are in use, which has provided reliable information for the control of epidemics.

7) Investigating on potential risk and evaluation capacities to issue quick response: China will investigate on potential risks and make registry, develop and improve a database for potential risks so that basically information can be provided for the surveillance, early warning and handling of public health emergencies.

A survey on the emergency response resources should be conducted and a database of material reserved, as well as an evacuation plan must be initiated. A study on big resources demanded in times of public health emergency should be strengthened to meet the demand of emergency relief.

8) Strengthening the supporting system of science and technology to prevent and control in a scientific way: emergency response supporting systems should be strengthened.

An emergency response laboratory network made of laboratories of four levels – national, province, prefecture and the county levels – should be built up. Studies on key emergency response technologies should be strengthened, and the emergency response standardized system should be established. Evaluation on emergency response capacity and emergency relief performance should be perfected so that managing standards on quality control, training and evaluation of emergency works.

Surveillance on diseases of unknown causes and emerging infectious disease and the capacities of scientific research such as testing should be improved to respond to public health emergencies effectively.

9) Strengthening financial input on emergency response management: according to the national plan for public emergency response in general, and based on the principle of the division of executive and financial powers, financial departments at various levels (should build?) the expenses concerning public security, public emergency prevention and response, which must also be included in annual budgets.

10) Strengthening international exchange and cooperation: Resolution WHA 58.3 states that based on the related provisions in IHR member countries are encouraged to cooperate with

each other and with WHO to ensure the effective implementation of the provisions about prevention and control of public health emergencies such as human avian influenza. China has had extensive communication and cooperation with WHO and the countries related.

Part III – Weakness in Implementing IHR

1) __ of promotion among the public in health education is not enough. The public still lacks common sense about response to public emergencies, self-protection, awareness and ability to save themselves or others.

2) Emergency response capacity and infrastructure are relatively lagging behind. Emergency relief teams at the community level are poorly equipped, and the lack of flexibility and training, and their training cannot be conducted effectively and systematically.

3) Supporting systems for emergency testing techniques is not perfect. Testing laboratories of different kinds at various levels are poorly equipped, and rapid testing methods and capacity need improving.

Part IV – Suggestions:

1) IHR has made requirements for the capacities of national surveillance, emergency relieving action, and border control. WHO should strengthen guidance and support in each regard, especially support on meeting developing countries' needs on capacity-building and resources.

2) Strengthen technical assistance, guidance and training in terms of national capacity-building, such as prevention guidelines for systems surveillance, early warning, methods of evaluation, regular and emergency measures.

3) Strengthen exchanges of experience about preparation for the implementation of IHR among member countries, setting up frequent communication mechanisms in order to achieve information exchange, technical cooperation, resource sharing, prevention and the control to prevent outbreaks or threats of public health emergencies in a joint manner.

China will closely communicate and cooperate with WHO and its member countries to improve the capacity of implementing IHR and push forward its implementation.

Thanks for your attention. I would like to answer some questions. Maybe in Chinese!

Questions and Answers

RS: Thank-you very much. Excellent. An excellent presentation. May I open the floor for questions and comments? Go ahead, Dr. Lazarri. You have the floor.

SL: I agree with you. I'd like to thank our Chinese colleagues for their very interesting presentation.

At one point in the presentation your colleague made reference to national, provincial, prefecture and county levels, four different levels. I wonder if he could elaborate a little bit on the different roles in implementing the IHR for the national level, for the provincial level, for the prefecture level, and for the county level.

JL: [via translator] I would like to answer this question. This is a very interesting topic, and actually after the SARS crisis in 2003 all levels of the Chinese government – from the central government, provincial government, prefecture governments as well as county governments – all of them have put (special and enough?) attention to this emergency responding system.

First of all, I have to say that the Chinese government, we have a trend of improving gradually to the system management based on the law and regulations.

In 2003 the Chinese government has published of national regulations in response to the emergency disease responding regulation.

In 2005 we have implementing and improving that regulation, and we have globalized policy with regards to the emergency and infectious disease responding system.

After that each of the departments, on the direction of the State Council, each ministry and department individually they have respectively published a total of 105 individual regulations with each of the departments and ministries.

In terms of procedure for the legislature purpose, in the second half of 2006 the Chinese emergency infectious disease responding system law has been approved in the level of the State Council. This legislation proposition has already been tabled on the Chinese National Assembly.

This legislation proposition is already in the National Assembly of China, which (Pudong Fu?) analyzed in the different levels – on the provincial level and the counties, and the individual organizations – to have the feedback of this regulation and law.

I think, from my perspective, this proposition will be passed after three readings in the first half of next year. In that way, after the approval by the Assembly, this kind of emergency response for infectious disease system and public health system will be legalized in terms of legislature, in terms of the local by-law and so on.

So in terms of implementing of IHR, after this proposition has become the law, the four levels of the Chinese governments will act according to the law, they have more power.

Otherwise, remember in 2003, in the case of the SARS in 2003, some of the officials which showed incompetence in the response for this kind of emergency crisis has been ____ and punished. It's because of the law support.

With regards to the management of the system and the leadership management, there's kind of established(?) ___ in the China State Council a kind of specific agency which is named National Council's Emergency Responding Office. Particularly in some of the State Council's ministries, for example in the Ministry of Public Health in which I worked, there was establishment of the Office of Health Emergency and Responding Centre.

Even if in some of the ministries in which there is not this kind of specific office, however, we do have some people responsible for this purpose. In the May of this year – which is 2006 – there was a meeting held in Beijing with regard to the national management on the health emergency and response system. In that meeting something has already clarified.

So in each level of the government it must – this is kind of a compulsory requirement – in each of the levels of government, for example in province, prefecture and as well as the county levels, each of the governments must have a kind of office or the centre for this kind of public emergency and responding system.

So I'm personally very confident with the support of law and legislature with the improvement of the management system so the Chinese public health emergency responding would cause... will be improved and go forwards for the better, efficient way.

Of course we have to be facing kind of weakness, as I mentioned, because due to this emergency health centre and office has newly established we have tremendous problems and issues to be overcome.

Let me raise the example to further explain the situation currently. For example, in terms of the domain of the public health system, if something happened, even if in the rural level, so the report for this kind of event can go over the different levels and go reported directly to the central, because this kind of report will be carried out through our electronic reporting system.

In comparison with this we did have, previously, using this kind of electronic reporting system allowed us to jump over so many inconveniences in terms of administration or the bureaucracy. In that way, once the central government is aware of this event they will make the quick and direct intervention from the central government. If necessary the central government's central office will sent directly some experts – specific experts and officials – to go to the site inspection and visit and give the guidance and help and support right away at that place.

So, after evaluation made by the experts we should have kind of different levels evaluation reports. Currently we do have a four-level evaluation system. For the ordinary events we will let the county level's governments deal with it. Meanwhile, they will receive the support from the prefecture level governments, of course. If something relatively serious – more important, more serious – in that way we let the prefecture level to deal, with the support of the provincial government, where the major crisis will be dealt by the provincial level government with support of central government. In case of extremely serious crises, we do have the central government's direct intervention.

In that way, as we have not only a networked electronic reporting system, however we have kind of a grassroots level reporting, ordinary people reporting system. Also we have a supervision made by the mass media.

So, particularly which is more important than that, of the SARS crisis, each of the government officials have much more conscious intention toward this kind of public health crisis. So, by my personal perspective, the Chinese in the whole – all levels' government officials – particularly in regards to the response of the public health crisis, so the ability to deal with this kind of crisis and the people's consciousness has much more improved.

Of course we do not forget that we have the support international, for example WHO, and for the international societies as well.

Thank-you.

RS: Thank-you. Other questions? One more question. Dr. Luna, from Brazil?

EL: China is currently facing the H5N1 influenza virus in domestic birds and some human cases, and I wonder if you could exemplify how it really works, the surveillance chain really works, how the detection happens, who is responsible for detection, where are the laboratories? Because for every confirmed episode probably there are tens or more of suspect cases. And then in which level that decision is made, which is important, which is not important, which is strongly suspected, and who takes action, specifically in H5N1? Is it the provinces, is it the federal? And who notifies to WHO?

RS: Brief answer, please, so we can have France's presentation next. Thank-you.

JL: [via translator] Also I would like to answer this question. According to my memory, based on China's national statistics in terms of influenza H51, not including the case which happened in September, 1997 and beginning of 1998 in Hong Kong area, in mainland China totally so far now we have reported and confirmed a total of 21 cases.

Actually so far – as I mentioned – totally we have 21 cases, and only one case which happened in the end of year 2003 which has been detected and conformed by the scientific experts and recognized by the WHO, and other 20 cases have been reported and detected in our different levels of laboratories in the second half of last year.

Actually I would like to say that in terms of influenza transmitted to human beings, among those cases I know that for in terms of surveillance reporting and action taken, all those kind of responding measures belong to the Ministry of Public Health in the national level. So in terms of the human being transmitted by the avian influenza, particularly we detected and reported according to the standard made by the WHO, once recognized diagnosis and confirmed by both governments and WHO we have to report it confirmed. So, we have intentions in that to have shortened the time of detection and confirmation.

I'll give you an example. For example, in 2006 in the month of June we have reported one human being transmitted this kind of influenza. From the discovery and detecting to send the confirmed patient to the hospital for treatment until for the confirmation reporting at the national level for all this three matters were taken in the process, the whole process takes less than two days. Even if for the confirmation by the...

it takes us totally less than 50 hours. Once this suspicion happens we immediately report it to both the Hong Kong and Macau public health authorities, because it’s close to the case discovery places. It was in June, 2006.

We have also discovered another patient in the Xinjiang Autonomous Region. Those kinds of patients have been diagnosed and detected by our SARS surveillance detecting system. For example, in the case in Xinjiang Province, once we got this patient which is suspicious we take from his respiratory system some sample and detected negative.

Based on the standard made by WHO we would like to think that we can give it up this kind of suspicious patients because it does not meet for the standard of suspicion made by the WHO. However, our system did not let him go. Instead, we made further detecting based on the sample taken from the patient and we just captured germs off the sample for three generations. Finally after three generations’ detecting we make the confirmation, we can make the final diagnosis.

I would like here to take only one minute to explain a little bit for the situation made ____ in the Agricultural Ministry of China.

RS: If we could just make it very short, please.

JL: You know, in terms of surveillance for the poultry and birds, this kind of surveillance is made normally by the system of ____ in the Ministry of Agriculture. However, we do have, in terms of officials from public health ministries, we have very cooperation between the two ministries.

I’m sorry that I’ve taken long speaking.

RS: Thank-you very much. I think in the interests of time we’re going to have to move on because we do have to vacate the room precisely at 5 o’clock, no exceptions. I do not wish to cut our colleague from France short but is it possible to make your presentation? Thank-you.

COUNTRY 5: FRANCE

Dr. Stéphane Veyrat

Thank-you to welcome a little country like France [laughter] because there is so big countries all around. I'll try to make my presentation as short as possible and perhaps we can have questions tomorrow if there is some. I'll present in French. I apologize for that.

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Donc la France est un pays de 60 millions d'habitants. Nous avons un ministère de la Santé et des solidarités et c'est au sein de ce ministère que je travaille au Département des situations d'urgence sanitaire. Donc on a des lois de décentralisation qui sont intervenues en 1983 en France et une autre loi aussi qui a conforté le rôle local des préfets qui est intervenue en 2004.

Donc on a un État qu'on peut qualifier de semi-centralisé à la différence des nombreux États fédéraux auxquels vous êtes habitués ici avec un président, un premier ministre et évidemment des ministres, un gouvernement et puis au sein de cet État nous avons sept zones de défense qui ont déjà une connotation très crise puisque c'est vraiment des compétences spécifiques autour d'un préfet de zone pour coordonner l'action quand il y a des problèmes d'ordre public. Vingt-deux régions en France, 95 départements sans compter les départements d'outremer et 36 000 communes donc beaucoup, beaucoup de petites communes aussi.

On a donc des préfets en région et dans les départements qui ont des pouvoirs importants. Ils détiennent des pouvoirs exécutifs de faire appliquer les lois votées au niveau national et pour cela ils s'appuient sur les services déconcentrés donc les services déconcentrés de chaque ministère, chaque ministère ayant des agents dans chaque département. On a également des maires qui ont un certain pouvoir, des pouvoirs notamment de police sanitaire et d'hygiène. Quand il y a des problèmes d'habitats insalubres, des problèmes d'insalubrité aussi parce qu'il y a une pollution de l'eau etc. C'est un pouvoir de police du maire. Et le préfet n'intervient que par subsidiarité c'est-à-dire quand le maire fait défaut et n'intervient pas.

L'ensemble des budgets de veille et de sécurité sanitaire depuis très peu, depuis une loi de 2004 est voté chaque année annuellement devant le Parlement ce qui nous donne d'ailleurs beaucoup de travail puisqu'on doit préparer une évaluation des actions et de comment on va consacrer et utiliser le budget voté. On a également une loi très, très importante mais on y reviendra tout à l'heure qui est la Loi de santé publique. La précédente loi était de 1901 donc ça faisait plus de 100 ans et c'est une loi majeure pour nous puisque pour la première fois on a fixé plus d'une centaine d'objectifs de santé publique et on a confié des missions très claires à la fois à l'Institut de veille sanitaire qui au niveau national est chargé de collecter l'ensemble des données sanitaires et qui fixe des missions aussi aux régions pour organiser tout ce qui est la prévention, les politiques de santé publique et la veille et l'alerte.

Très, très rapidement et juste pour vous donner une idée on a cinq niveaux. Ici on parle du niveau du bas c'est le niveau local avec des émetteurs du signal sanitaire donc que ce soit des professionnels de santé qui travaillent dans les établissements de santé ou dans le monde libéral en ville, que ce soient les professionnels des maisons de retraite, d'établissements médicaux, sociaux, que ce soient les exploitants qui sont dans les réseaux d'eau potable pour l'approvisionnement d'eau potable des villes, les exploitations agricoles avec les élevages notamment, les usines et notamment on pense aux installations classées. On a eu un accident 2003 qui était... en 2001 pardon, qui était juste après les *Twin Towers*, beaucoup moins grand mais quand même important à notre niveau qui était un accident à Toulouse avec une explosion dans une usine chimique qui a fait beaucoup de victimes et qui a beaucoup traumatisé la classe politique française et par rapport justement à l'organisation des secours.

On a ici effectivement sur le terrain aussi des vétérinaires et beaucoup de vétérinaires ont des mandats sanitaires et donc peuvent faire des interventions et peuvent signaler aux directions dans les départements, les directions chargées justement du contrôle en santé animale. Quand on remonte d'un cran on arrive au niveau départemental et au niveau départemental on a également un niveau qui est centré sur les préfets. J'ai mis ici tout le niveau vertical en rouge puisque c'est la crise. Quand il y a la crise c'est les préfets donc préfets et ça remonte jusqu'au premier ministre en général par le biais du ministère de l'Intérieur qui prend la main sur tous nos problèmes.

Quand c'est des alertes les préfets savent gérer très bien au niveau local et on a ici l'ensemble des services déconcentrés. Il s'agit de l'équipement, qu'il s'agisse des transports, qu'il s'agisse de services vétérinaires, qu'il s'agisse de l'action sanitaire et sociale, des services déconcentrés du ministère de la Santé. Donc la DDASS ici, la Direction départementale des affaires sanitaires et sociales est une des structures. Et on a à côté de ça des services qui sont départementaux, le SAMU qui est le Service d'aide médicale urgente qui chez nous à la différence de, je pense au Canada, des États-Unis, le SAMU est médicalisé chez nous. Donc on a un médecin à bord dans les camions. Et on a aussi des pompiers avec certains médecins mais pas toujours. On a la police et la gendarmerie ici et donc ces structures-là quand il y a une alerte particulière sur le territoire du département ils vont prévenir le préfet. Ils réfèrent au préfet dès que ça dépasse un petit peu quelque chose de basic.

Au niveau supérieur, le niveau régional et zonal, on a l'équivalent de ce qui existe au niveau déconcentré avec des fonctions supplémentaires d'expertise puisqu'on a des niveaux d'agrégation de signaux sanitaires qui peuvent remonter et ici là... ici c'est la cellule interrégionale d'épidémiologie qui est une des antennes on va dire de l'Institut de veille sanitaire qui est national. Et donc on 16 cellules interrégionales d'épidémiologie pour l'instant. On n'en a pas dans toutes les régions mais on en a 16 sur 22 régions. À côté de ça le CCLIN c'est les Centres de coordination pour la lutte contre les infections nosocomiales puisque comme partout dans le monde les infections nosocomiales c'est un vrai problème et probablement une des émergences qu'on aura... sur lesquelles le RSI devra intervenir. On en parlait tout à l'heure. On a effectivement des structures régionales d'appui à chaque fois qu'il y a des alertes dans les établissements.

Et puis au niveau national, ici on a un point focal national qui est positionné au ministère de la Santé et dans notre département. Et puis on a à côté de ce point focal national qui est juste là pour faire le lien finalement surtout ici vertical mais aussi ici horizontalement, on a également évidemment une très grande importance pour à la fois l'Institut de veille sanitaire qui va collecter les données analysées remontées du terrain et pouvoir détecter une alerte et puis les agences de sécurité sanitaire. Donc on voit qu'elles ont été créées par la Loi de 1998. C'était le premier étage de la fusée, la Loi de 2004 étant le deuxième étage, mais les agences de sécurité sanitaire ont été créées justement pour pouvoir à la fois garantir, améliorer la sécurité sanitaire. Ici l'AFSSA pour les produits de santé. L'AFSSA c'est les aliments. L'environnement et le travail c'est l'[AFSET] et on a une agence de biomédecine qui vient d'être constituée.

Donc à côté de ça vous voyez que dans cet organigramme sur la veille et le signalement on a effectivement l'Institut de veille sanitaire et on a l'administration de la santé. Il y a un partage des tâches qui est assez précis entre les missions de veille, de surveillance, d'expertise et d'alerte et les missions de l'administration qui sont d'élaborer les politiques de santé publique et les mesures de gestion, et l'administration de la santé avec à côté aussi l'administration de l'agriculture qui est chargée de la même chose mais pour son champ de compétence.

Donc le résumé des diapos précédentes se retrouve ici avec la même difficulté qu'on a déjà vue chez les collègues pour arriver à positionner les trois puisque effectivement des choses sont faites au niveau local. Ça dépend de quoi on parle. La détection des cas et la notification on la met au niveau local mais c'est évident que pour des phénomènes rares et des émergences on pourra avoir en fait une pertinence simplement et une détection qui ne pourra se faire qu'à un niveau régional de ____ ou à un niveau national puisque ça peut être réparti et pris individuellement au niveau local où un peut très bien ne pas avoir de détection particulière.

La collecte et l'uniformisation des données là aussi se fait dans les trois niveaux plus particulièrement aux régions nationales mais le niveau local aussi a son rôle à jouer. L'analyse et interprétation de la même façon. Les confirmations diagnostiques ben c'est plutôt du ressort du niveau local et donc on avait vu tout à l'heure les Directions départementales des affaires sanitaires et sociales, les Directions des affaires vétérinaires. Elles vont voir sur place quand il y a des épidémies et des *outbreaks*. Ensuite la diffusion de l'alerte elle est plutôt soit du niveau local, soit du niveau national, rarement du niveau régional mais on a vu quelques alertes coordonnées par un niveau régional. Et puis l'intervention elle est aussi soit du niveau national quand il s'agit de communications principalement et les niveaux locals quand il s'agit d'imposer des mesures de correction localement.

Alors si on passe à la négociation et à l'approbation du nouveau récit on a eu un récit qui a été adopté sans réserve par le gouvernement français. Le ministère des Affaires étrangères a transmis l'information à l'OMS. Il s'impose pour nous sans aucune... il n'a pas besoin que ça passe au Parlement. Il n'a pas besoin que ça soit voté. Il n'a pas besoin de choses comme ça puisqu'on a un décret en fait qui est seulement nécessaire à des décrets d'application, mais il est prévu que tous les accords internationaux conclus et dans lequel fait partie la France s'appliquent automatiquement puisqu'on a... la Constitution de 1958 le prévoit.

Par contre on a un certain nombre d'évolutions réglementaires juridiques et l'accompagnement à faire passer et c'est notamment le fait que dans les missions de mon département il n'est pas prévu qu'on soit un focal national donc il va falloir l'identifier. Il n'est pas prévu que la Direction générale de la santé puisse communiquer non plus sur des mesures par exemple du ressort du monde vétérinaire. Ça c'est une des questions aussi qui se posaient donc il faudra faire évoluer ces missions. De la même façon on a un certain nombre d'éléments dans le code de santé publique qu'il faut ajuster pour répondre à tout ce qui est USPPI (Public Health and Emergency International Concern). Et puis on a un certain nombre de missions aussi, des DAS, donc dans les départements des cellules d’épidémiologie dans les régions à faire préciser puisqu’il y a des évolutions sur les contrôles et les missions dans les points d’entrée/points de sortie.

Enfin il y a une question mais qui dépasse encore et qu’on aimerait mieux voir traiter au niveau de l’OMS que ce soit région ou que ce soit Genève, c’est le problème des compagnies aériennes et les compagnies de transport, agences de voyages, tours opérators avec la grande question qui est « quelles sont leurs obligations en matière d’information et de traçabilité des voyageurs ». Alors à défaut s’il n’y avait pas de décision au niveau d’OMS, pas de possibilité de faire évoluer les choses avec des systèmes de réservation en ligne comme AMADEUS ou d’autres choses comme ça il faudra que nous on prenne des décisions et probablement une réglementation spécifique obligeant les tour opérators en France et les agences de voyages à signaler les choses.

Alors je ne vous apprends rien en vous disant qu’on s’est penché tout d’abord sur tout ce qui était contenu dans la décision de voter par l’assemblée l’OMS, par l’assemblée mondiale sur l’application anticipée de certaines mesures pour la mise en oeuvre du RSI dans le cadre de la prévention de la pandémie grippale et donc on avait identifié effectivement ces cinq points à la fois la mise en place de l’algorithme, annexe 2, à la fois le point focal national, la désignation – donc je vous dis qu’on vient de le désigner – le dispositif de surveillance et de notification bien on a déjà vu une partie et on pourra peut-être éventuellement développer si on en a le temps. Les mesures de santé publique pour les voyageurs on va y revenir. Elles posent un certain nombre de problèmes. J’ai évoqué le problème des agences de voyages, de la connaissance, de l’action des compagnies mais il y a d’autres sujets aussi. Et puis évidemment le problème des données personnelles et les transports des matériels biologiques.

Donc sur ces cinq actions on s’est penché et on a essayé d’évaluer ce qui était déjà fait, ce qui nous posait problème et là où on a laissé. Sur le système de surveillance la France est déjà relativement structurée en termes de réseaux de surveillance à la fois sur le volet santé animale. Je vous ai parlé des vétérinaires. Donc il y a les vétérinaires sur le terrain qui vont dans les fermes et il y a les vétérinaires qui travaillent dans les directions départementales dans chaque département, et puis il y a des vétérinaires au niveau national. Et puis la même chose au niveau santé humaine, on a des médecins généralistes donc qui sont libéraux ou pédiatres ou médecins généralistes qui travaillent et qui participent à un réseau qu'on appelle un réseau de médecins sentinelles – donc il y a deux catégories – et ces médecins se sont engagés, enfin ce sont des médecins assez volontaires qui s'engagent à faire à la fois des prélèvements – ils peuvent faire des prélèvements à la recherche de virus de la grippe – et puis ils signalent, ils renseignent et ils remontent leurs informations de manière hebdomadaire au niveau national.

Il y a certains laboratoires aussi qui agissent de la même façon et qui remontent des souches pour caractérisation aux laboratoires nationaux de référence, et donc on a les laboratoires nationaux de référence qui suivent tout ça. Et puis en parallèle de ça on a un autre réseau que je n'ai pas mentionné ici qui est un réseau de veille entomologique. Vous savez que la France a été quand même très touchée par effectivement des alertes *vector-borne disease* avec notamment le *Chikungunya*, une épidémie de dengue qui a touché aussi les Antilles et la Guyane et *Chikungunya* à la Réunion et à la Mayotte. Donc on est très sensibilisé et on s'aperçoit qu'effectivement on a des nouveaux vecteurs en France qui apparaissent. On a notamment des familles d'[AIDS] qui semblent remonter d'Italie pour s'implanter dans le sud de la France. Donc cette surveillance mise en place aussi pour le West Nile virus puisque comme pour l'Amérique on a également du West Nile virus de temps en temps sur l'arc méditerranéen, sur les départements du bord de la Méditerranée. On a aussi une surveillance sur tous ces arbres de virus.

Sur la deuxième étape dont j'ai parlé tout alors c'est la Loi de la santé publique du 9 août 2004. On voit bien qu'on a un Institut de veille sanitaire qui doit monter en puissance mais comparé au CDC d'Atlanta l'Institut de veille sanitaire est encore très, très faible en termes d'effectifs. C'est tout petit mais c'est... la France est aussi plus petite que les États-Unis d'Amérique. Donc c'est une petite structure mais qui monte en puissance et qui doit pouvoir s'appuyer sur un réseau de correspondants qu'il soit au niveau local, au niveau régional, au niveau national avec des laboratoires et des partenaires. Donc tout phénomène menaçant en santé publique doit pouvoir en plus lui conférer... la loi lui confère une possibilité d'investigation, d'aller voir exactement ce qui se passe et de demander à des entreprises, à des structures, à des compagnies aériennes ou à d'autres compagnies des données mêmes nominatives quand il y a une menace pour la santé publique avec un phénomène émergent.

Pour nous on a un gros travail qui est de diffuser l'information aux autres ministères qui n'est pas encore fait aujourd'hui, diffuser l'information sur ce qui entraîne l'application de l’annexe 1 et l’annexe 2 du règlement sanitaire international et ça c’est un gros travail à venir. Sur la détection, notification, vérification, déclaration je ne reviens pas. On a vu avec le tableau la présentation simplement deux accents et deux focus, l’un sur le fait que la France vous avez vu est un système avec plusieurs ministères donc on a un fonctionnement historiquement qui est un peu en tuyaux d’orgue vertical et la difficulté c’est que selon la nature du risque les compétences ne sont pas forcément à la santé.

C’est par exemple pour la radiologique et le nucléaire où on a une structure qui maintenant ne dépend plus directement de la santé même si on y est plus ou moins rattaché, mais qui gère tous les phénomènes d’alertes nucléaires, donc alertes météorologiques, accidents de radiothérapie importants mais aussi éventuellement problèmes de diffusion d’un nuage radioactif. Et donc tout le travail va être de remettre de l’horizontalité, de la transversalité dans des remontées qui se font plutôt verticalement jusqu’au premier ministre pour revenir ensuite vers nous éventuellement avec retard. Et puis pour rappeler qu’en France on a un État qui s’est présenté pendant longtemps comme un peu providence et garant de la sécurité, on a eu beaucoup d’implication d’hommes politiques, de ministres de la Santé sur des alertes. Le plus récent c’était 2003. Vous savez qu’on a eu une canicule et que notre ministre de la Santé de l’époque n’a pas résisté à la canicule non plus.

Donc on a cette obligation de détection des phénomènes, obligation d’alerte et puis obligation de gestion, et le problème ça va être justement de travailler sur qui valide finalement la communication à l’OMS quand on fait soit une consultation (article 6) soit une notification (article 12). Ça va être à quel niveau est-ce que cela va être arrêté. Est-ce que ça va dépendre du directeur général de la santé, mon supérieur direct, ou est-ce que ça va dépendre du ministre de la Santé ou est-ce que ça va remonter jusqu’au premier ministre avant de vous être retransmis? C’est une des questions qui est encore un peu ouverte à vrai dire. Et en plus de ça il va falloir qu’on ait la validation avant de communiquer des autres directeurs d’administration, agriculture ou fraude ou douanes ou que sais-je encore... même intérieur peut-être. Donc voilà, donc on a encore des sujets.

Ça je viens de vous le dire de toute façon. Un autre point peut-être important c’est de dire que la Direction générale de la santé donc ma structure à moi n’a pas d’armes directes, on va dire pour imposer les choses au niveau local. On n’a pas d’agents de police. On n’a pas de structure comme ça. On a bien des médecins inspecteurs dans les départements qui peuvent faire des missions d'inspection et de contrôle, mais bien souvent pour faire appliquer une politique on passe aussi avec d'autres intervenants, d'autres ministères. Donc je vous ai parlé des deux lois, je ne reviens pas dessus mais elles sont fondamentales. Pour nous elles nous donnent surtout les outils pour faire appliquer le RSI et pour intervenir.

Sur le sujet qui était une des préoccupations sur comment faire pour travailler ensemble ben je vous ai expliqué qu'on avait ces structures. On a à travailler sur l'horizontalité, la transversalité, travailler sur ce qui se fait déjà au niveau local avec la Loi de la décentralisation et puis surtout les avancées d'une loi de 2004 autour des préfets. On a une Constitution de délégation interservices. Par exemple on a un pool de sécurité alimentaire au niveau des préfets de département constitué à la fois par les Directions des affaires sanitaires et sociales de la santé, des Directions des services vétérinaires et les Directions des fraudes et de la consommation. Donc tout ça travaille autour du préfet pour essayer d'agir à la source quand on détecte quelque chose. C'est ce que j'appelle les pools de sécurité sanitaire.

On a aussi un rôle de coordination au niveau national c'est le Service général du gouvernement qui dépend du premier ministre, le SGDN. Le SGDN étant donc la structure qui quand on est en situation de crise... vous vous souvenez du tableau de tout à l'heure, et bien c'est la structure tout en haut ici qui est chargée de coordonner et pis finalement de mettre de l'huile entre les différents ministères. Et puis on a un certain nombre de plans de prévention. On a le plan de prévention pour le SRAS, pour la grippe aviaire pandémique et puis pour d'autres plans qui sont d'autres plans de type variole, peste, charbon, tularémie ou d'autres maladies non infectieuses comme par exemple la canicule qui intègrent un certain nombre de logigrammes organisationnels et décisionnels qui permettent de préciser qui fait quoi à quel moment, et à quel moment la santé par exemple va passer la main au ministère de l'Intérieur voire au premier ministre.

Quelles sont rapidement les difficultés identifiées? Je vais vous parler tout à l'heure pour les mesures de santé publique aux voyageurs. On a à la fois la problématique de ces interconnexions internationales en Europe. On a cinq *hubs* internationaux qui sont des plateformes aéroportuaires de transit majeurs. Il y en a d'autres bien sûr en Asie. Il y en a d'autres partout mais pour l'Europe on en a cinq principales avec Heathrow à Londres, Francfort en Allemagne, Zurich en Suisse et puis aussi Schiphol à Amsterdam et puis Roissy chez nous en

France, Roissy-Charle de Gaulle. Et donc c’est des problèmes majeurs pour tracer les personnes, pour identifier les personnes.

Cinquante pour cent des voyageurs de Roissy il y a 30 millions de passagers à peu près par an et 50 pour cent des voyageurs sont en transit quand ils sont à Roissy c’est-à-dire qu’en fait ils vont passer par Roissy mais ils arriveront dans un aéroport, un petit aéroport en France X ou Y et il va falloir... évidemment c’est beaucoup plus difficile de tracer à ce moment-là ces passagers, de les identifier pour les informer ou pour simplement les prendre en charge. Donc c’est le problème du *screening*, c’est le problème d’avoir des moyens adaptés, c’est le problème d’avoir dans les aéroports des locaux parce que j’ai visité même le local à Dallas à Washington au mois de mai et c’est pareil. Il y a le même problème c’est-à-dire qu’il y a des agents mais il n’y a pas de local précis pour isoler les personnes en quarantaine et au moins pour les examiner de manière approfondie. Enfin il y a une petite salle mais en tout cas qui ne peut pas permettre d’accueillir tout un avion entier.

Donc on a le même problème en France. On a le problème aussi d’identifier autour des aéroports des lieux où on pourrait avoir éventuellement une quarantaine quand il y a un cas déclaré à bord puisque le principe c’est que quand le cas n’est que suspect on prenait plutôt une quarantaine à domicile sur la base du volontariat. Bon il y a tout le problème des conventions avec les médecins, avec les hôpitaux pour les prises en charge. On a le problème très clairement posé par aussi le Règlement sanitaire international qui est-ce qu’on peut faire ou est-ce qu’on ne peut pas faire un examen invasif et notamment un prélèvement oropharyngé puisque dans la liste des choses qu’on peut faire pour lesquelles le RSI nous dit qu’effectivement qu’on considère que cet examen n’est pas invasif, il n’y a pas de prélèvement oropharyngé. Donc il y a l’examen buccal oui. Il y a les examens des urines, des selles, mais il n’y a pas le prélèvement oropharyngé. Donc là une des questions c’est est-ce qu’on pourra le faire quand même dans le cas du RSI ou est-ce qu’il faut une disposition particulière qu’on pourrait prendre nous au titre de la loi du 9 août 2004 si la personne refusait comme menace grave à la santé publique, mais c’est encore une question ouverte aujourd’hui.

On a tout le problème de la traçabilité des voyageurs à posteriori. On a l’exemple tous les jours avec la tuberculose quand on a eu récemment un problème en Finlande avec un passager qui revenait et qu’on a découvert avec une tuberculose multirésistante et bacillifaire. La question derrière c’est effectivement comment identifier à posteriori nos deux rangs devant, deux rangs derrière si on a des passagers. On a des listes mais les listes des compagnies ne sont pas très fiables et les coordonnées qu'on peut récupérer comme ça nous permettent difficilement d'identifier les personnes.

L'information des touristes j'en parlais. Quel est le rôle des agences de voyages? Quel est le rôle qu'on peut aussi donner comme obligation d'information pour les ventes en ligne sur Internet qui seront de plus en plus fréquentes. Et puis enfin le passager en transit. Le RSI nous dit qu'il va voyager et qu'il peut poursuivre son voyage, qu'il n'y a pas de problèmes particuliers. Effectivement c'est un cas suspect. Même s'il est suspect à priori dans le temps du voyage il a le temps d'arriver avant d'être infectieux. Ceci dit il faut encore convaincre à la fois l'aéroport de destination, le toucher, et surtout le commandant de bord puisque le commandant de bord a cette capacité de garantir... a cette obligation de garantir la sécurité des gens qui seront dans sa cabine pendant le temps du voyage. Donc il pourrait très bien refuser de prendre le passager.

Pour les biens je serai plus bref. Notre principale difficulté c'est que pour l'instant on était concentré. Nos actions de contrôle sanitaire en frontière, démoustification, désinsectisation sont des actions qui sont menées en routine soit par la Direction départementale des affaires sanitaires et sociales dans les départements mais uniquement pour les gros aéroports à trafic international et donc principalement Roissy actuellement et Orly pour nous. Et maintenant il va falloir étendre ces mesures-là a beaucoup d'autres aéroports du fait d'une part qu'il y a des liaisons indirectes avec des transits, mais d'autre part parce qu'on doit mettre ça au point d'entrée de tout ce qui peut rentrer même indirectement mais avec un point d'entrée sur le territoire et de la même façon sur les points de sortie.

Et puis on a encore plus difficile pour l'instant comme *challenge* c'est de mettre ça aussi sur l'ensemble des ports à trafic international puisque jusqu'à maintenant on estimait que les délais nous permettaient quand même en général d'avoir une application plus stricte sur les aéroports mais c'est vrai que sur les ports on avait moins d'action musclée, d'intervention musclée pour garantir le côté exempt de germes, exempt d'insectes.

Donc pour ça on doit faire évidemment tout un tas d'évolution et de concertation avec nos partenaires. Sur le matériel biologique j'ai parlé. Et les données personnelles le problème on a aussi chez nous une Commission nationale informatique et liberté et effectivement ça pourrait poser problème si on levait les secrets avec des listes nominatives. Ceci dit dans un cadre de menaces sanitaires et dans le cadre de la Loi de 2004 il est possible à l'InVS d'obtenir ces listes à des fins d'investigation de santé publique avec bien sûr une consigne pour une destruction ultérieure.

Donc sur le financement, le partage des frais, là aussi on a un vote annuel. Je vous disais tout à l'heure chaque année on doit travailler à présenter ce rapport. On a des objectifs qui sont définis et donc chaque année aussi on doit dire comment on a atteint, à quel degré on a atteint nos objectifs et puis on doit enfin d'essayer de travailler en amont puisqu'il y a une sorte de mission veille et sécurité sanitaires qui dépasse le ministère de la Santé et donc on doit évidemment intégrer les contributions des uns et les autres à l'amélioration. Donc la part de l'agriculture par exemple qui a travaillé à son plan d'urgence pour la prévention d'influenza aviaire en France, on a eu cette alerte au mois de mars de l'année dernière et donc on a bien sûr tout intérêt à travailler ensemble pour voir qui contribue à quoi et dans quel domaine et pour quel montant.

C'est un peu le résumé de ce qu'on est en train d'essayer de mettre en place. Donc la transversalité bien sûr, le travail en interministérialité quelque chose d'assez nouveau aussi en France, le travail pédagogique, d'explication des enjeux du RSI, du règlement pour éviter que chaque administration aille jusqu'à la validation complète de tout le signal avant de transmettre au point focal national et ça c'est évidemment quelque chose de très délicat puisque derrière il y a des engagements. Il y a des conséquences financières. Il y a éventuellement si on communique trop tôt, on a joué la transparence pour donner un exemple avec le cas de Versailleux dans l'Ain. Vous savez qu'on l'a tout de suite transmis en disant qu'on avait un élevage de dindes qui était contaminées. Évidemment derrière il y a des répercussions en termes d'arrêt des importations, de tas de pays qui se sont aussitôt positionnés en disant ben nous on mangera plus de poulet français alors que c'était un élevage de dindes ponctuel dans l'Ain donc qui est un département quand même relativement circonscrit. Et là c'était l'ensemble du poulet de la filière de production et de l'exportation du poulet français qui était visé. Donc on voit bien que c'est très difficile et que c'est pas simple de prendre une décision de communication d'information.

On a effectivement une toute nouvelle structure aussi qu'il faudra consulter puisqu'on a la Haute autorité de santé qui doit être consultée quand on prend des mesures de santé publique notamment une urgence et donc il faudra voir comment on l'associe aussi à cette consultation avant transmission, ou avant ou après transmission. Et donc ces niveaux de validation je vous ai dit tout à l'heure qu'ils sont fondamentaux.

Peut-être trois propositions à l'OMS puisqu'on a la chance qu'ils soient avec nous, donc travailler sur effectivement cette harmonisation européenne aux points d'entrée/sortie par rapport au problème du trafic international. C'est vrai que c'est assez peu pour nous... moi je suis le seul représentant ici de la Vieille Europe et c'est une petite structure avec beaucoup, beaucoup de pays et de liaisons donc les liaisons sont énormes entre les pays et la France a des frontières avec plus de six pays différents. Donc bien évidemment on va pas fermer les frontières, et bien évidemment on ne peut pas prendre des mesures comme ça, mais il va falloir qu'on travaille à harmoniser pour qu'aux points d'entrée...

Je vous ai parlé d'Amsterdam, je vous ai parlé de Francfort, de Zurich. Il y a Rome, pareil Barcelone ou d'autres. Il va falloir qu'on travaille ensemble pour qu'on prenne les mêmes dispositions à tous les points d'entrée par exemple il ne s'agirait pas que les Anglais laissent... on va dire Neuchatel pour le trafic trans-Manche ouvert et pis que la France décide de fermer parce qu'à ce moment-là il y aurait comme un problème diplomatique. Donc on doit vraiment travailler là-dessus.

Le deuxième point c'est... Alors à la fois on va travailler au niveau entre nous, je pense, mais je pense qu'il y a un rôle important pour au moins l'OMS Europe à jouer là-dessus et le CDC et je pense que de côté-là on doit travailler ensemble puisqu'on a un centre européen de contrôle des maladies maintenant. Le deuxième point c'est le renforcement des obligations des compagnies de transport et de voyages. Je ne reviens pas dessus. Je vous ai dit que c'était important pour nous pour assurer à la fois l'information aux voyageurs et la traçabilité si on a des cas suspects.

Et le troisième point important pour nous c'est le centre RSI de l'OMS. Pour nous on pousse effectivement pour qu'il y ait une implantation sur le pool de Lyons d'un centre qui aurait pour mission d'aider les maillons faibles puisqu'on n'est jamais aussi fort qu'on a la force du maillon le plus faible en termes de vigilance pour aider les maillons faibles justement à *capacity building* et surtout en termes de surveillance, détection, signalement et gestion à la fois pour la formation, la coopération technique ou l'aide financière.

Voilà. Donc c'est un peu les points importants. Le dernier point que je rajouterais effectivement c'est que vu ce qui a été dit ce matin par Stéfano, si on a une région OMS Europe comme une région OMS ailleurs qui est le point focal... le point de contact pour les points focaux nationaux, il faut absolument qu'on ait un système concerté et cohérent avec le dispositif de signalement qu’on a au sein de l’Union européenne puisqu’on a effectivement tout un tas de dispositifs et de réseaux d’information. Voilà. Je vous remercie.

Dr. Ron St. John

Thank you very much. I’ve been informed by Dr. Lazzari we do have a little extra time so if we have some time for questions and comments. Thank you very much. It was a very nice presentation. Dr. Lazzari.

Questions and Answers

SL: I’m going to ask the question in English if you allow so that people can take... It’s actually a very simple question. If I understood correctly then the national focal point in France is the Department of General Health. But information in terms of events is likely to come to the InVS or go through other surveillance and reporting systems. So how do you envisage to articulate the communication between InVS or other systems at local level and the Director General in order to acquire all the information required? Is this going to request some change in mechanism or some better articulation of exchange of information between these different institutions? And you’ve mentioned other institutions as well would be [__] but I think that transmission is crucial. And it might apply other countries as well that decide to put the focal point not in a technical unit but in a more senior level managerial unit in the Ministry of Health.

SV: Yes. That was a big debate, a big discussion between the InVS and us and in fact in this, about 90% of signals and alerts are transmitted to European Commission or European Union, and we only make about 10% of the French transmission. It’s about all the management and the management measure. So I think we have a big discussion, but the fact is the International Health Regulation does not only concern some infectious disease and that’s the main point. It can concern other administrations and nobody can understand or could understand why InVS can transmit some information from the directory of agriculture or the directory of fraud, you know, customers or things like that. So it’s not for radiological and nuclear accident. InVS is not competent to transmit to an authority about that type of incident or event so that’s why the choice is to put the focal point on the Ministry of Health and not on the Institute. But you’re right. If have to move some... and to get better for transmission and the reciprocity of signals. But we have also some signals that we are used to give to [__] so we must improve that but it's already possible.

RS: Thank you. Other comments, questions? Dr. [__].

Dr.?: Yes. Without going into any detail I can tell you that some of the questions you asked do have answers, some specific, some very indirect in the IHR and we'd be happy to discuss it with you specifically and some of them only have very, very vague answers, and some of them actually say consult your national law which may or may not help, I'm not sure. It depends on the issue. I can tell you that under the IHR, and this was a subject of big debate, they are actually listed what is invasive and what is non invasive and it was a big debate because you can imagine how many doctors were involved in this and everybody, you know, has a different view, you know, is it x-ray invasive is it not invasive? But external collection of urine sample: non invasive. That much we answered specifically. But as to the other ones, if you want to follow up later of course we can go through some of the provisions and see how much help they make.

SV: ... prelevement but for old prelevement for [H_1] is not recorded in the list of non-invasive examination.

Dr.?: These [__] swabs would be... Is that invasive or non-invasive? I remember the debate really well. I was there. I think it may be bad news. If invasive means the puncture or incision of the skin or insertion of an instrument or foreign material into the body or the examination of a body cavity, so if that involves going into something like that then it may be invasive. And I just want to make sure it's not covered in one of the specifics. You can do a temperature assessment in somebody's ear but I think that's... wait, wait... medical examination of the nose. Medical examination of the nose. Then you may have a problem. I should say it doesn't mean you can't do it. It just means that you can't do it on a routine basis. There has to be a specific justification for it. That's the difference.

Dr.?: Right. That was the sort of the way out of the dilemma since as a physician we know that a lot of our diagnostic testing depends on the vena puncture and the extraction of a blood sample. And technically speaking that is invasive. You do puncture the skin. You do select blood. But again that was the caveat that opened the door for a broader interpretation.

RS: Other comments?

Dr.?: Thank you and I apologize if you have addressed this topic in the presentation. Maybe for a point of clarification. It seems like a lot of this ought to be addressed legislatively. I'm just wondering how... are there any mechanisms to ensure that local officials are able to comply with the legislation or have the capacity to comply, and are there any ongoing mechanisms to ensure ongoing compliance?

SV: Peut-être je vais répondre en français si c'est possible. En France nous avons effectivement des Directions départementales des affaires sanitaires et sociales avec des ingénieurs d'étude et du génie sanitaire, des médecins inspecteurs de santé publique. Et au niveau régional nous avons en plus des pharmaciens inspecteurs de santé publique. Donc ces personnes qui sont des agents du ministère de la Santé placées au niveau local ont déjà l'habitude de travailler sur des sujets d'infectieux. C'est eux qui gèrent la plupart des *outbreaks* et épidémies localement soit seuls soit en lien avec l'Éducation nationale pour le... quand c'est en milieu scolaire ou avec la Direction des services vétérinaires quand c'est un *food-borne disease* et des choses comme ça. Maintenant plus spécifiquement par rapport à la mise en oeuvre de l'application du RSI aux points d'entrée si les multiplie effectivement sur le territoire, on a un problème de ressources c'est-à-dire qu'aujourd'hui on a... C'est pas des grosses structures. Il y a peu de techniciens sur ces départements-là donc c'est sûr qu'ils ne pourront pas assurer des veilles 24/24 si on ne les renforce pas. Donc il y a tout un travail pour voir si on renforce spécifiquement ces structures lorsqu'elles ont un aéroport ou un port à trafic international. Et c'est en cours de débat. Est-ce que j'ai répondu à la question?

Dr.?: Yes, thank you very much.

RS: Other questions? I'm sorry, I missed... oh yes Dr. Lazarri.

[Start of Side 10]

SL: J'aimerais clarifier quelque chose. Si je comprends bien en France on fait une distinction entre la déconcentration et la décentralisation, parce que dans votre présentation vous avez utilisé l'expression « déconcentration ». Et pour moi cela suggère que le pouvoir ultime reste à Paris. Il y a des pouvoirs qui sont exercés pas à Paris mais au niveau régional ou local, mais c'est quelque chose… ce pouvoir n'est pas décentralisé à des régions. C'est déconcentré, ça veut dire quelque différent? Est-ce que je…

SV: Je crois que vous avez bien compris, oui, c'est-à-dire qu'on a…

SL: Dans ce contexte c’est une déconcentration, pas une décentralisation?

SV: C’est-à-dire qu’on a des lois de décentralisation en 83 mais qui aboutissent dans les faits à un état semi déconcentré effectivement. Mais l’ensemble des ministères, le gouvernement, le premier ministre restent à Paris et on a des préfets de région qui ont de plus en plus de pouvoir mais plutôt des pouvoirs d’organisation par exemple de l’éducation, des infrastructures routières, des choses comme ça, mais ils n’ont pas vraiment… ils n’ont pas pour l’instant le pouvoir sur tout ce qui est les choses sensibles comme justement l’organisation des secours, l’organisation de la santé, l’organisation de tous ces dispositifs sensibles.

SL: Merci.

Dr. Ron St. John

Apologies to our colleague from Senegal. We will open the place first thing in the morning for your presentation. We did build in some flexibility into the program so we do have room to make up some of the time that we did lose today. Would you like to make any concluding remarks on today?

Dr. Harvey Lazar

No, I was scheduled to say a few things but I think it’s too late to do that. I think you should just focus on logistics for this evening, Kumanan.

Dr. Kumanan Wilson

I hope you all received the invitation for dinner to tonight at the Westin, I think it’s at 7 o’clock, and there’s a map in your program... no, Chris is handing out the map right now. And I believe all hotel issues have been resolved, is that correct? I think it is. Chris, all hotel issues are resolved? I’m asking. Yes, okay! So al hotel issues have been resolved. I don’t think there’s anything else to discuss, so we’ll be starting I guess breakfast again at 8:30 and hopefully starting sharp at 9:00 tomorrow. And again, thank-you very much. A long day but a very informative day, and very useful presentations.

Dr. Ron St. John

Thank-you. We'll consider the session adjourned.

[End of Side 10]

Ottawa, September 20-21, 2006
IDRC Boardroom/Nayudamma Lounge, 14th Floor, 250 Albert St., Ottawa

Legend:

RS = Dr. Ron St. John	KW = Dr. Kumanan Wilson	DF = Dr. David Fidler
BP = Dr. Bruce Plotkin	SL = Dr. Stefano Lazzari	AM = Dr. Anthony Marfin
RH = Rebecca Hathaway	EL = Dr. Expedito Luna	AMc = Dr. Allison McGeer
HJ = Dr. Howard Njoo	JS = Dr. Jeffrey Scott	JG = Dr. Jian Guo
JZ = Dr. Jianzhong Zhang	SV = Dr. Stephane Veyrat	HL = Dr. Harvey Lazar
VP = Val Percival	BT = Dr. Barbara von Tigerstrom	CH = Cath Halbert
YF – Yuri Fedorov	SK = Dr. Sampath K Krishnan	SP = Unidentified Speaker

Good morning and welcome back. I think we'll try to start relatively close to on time this morning. I know some people have flights to get to and we need to get through our items to leave a good amount of time this afternoon for a discussion on several of the issues that are coming up.

The plan today is for four country presentations this morning, a very brief synthesis session that the organizers will present back to the group early in the afternoon, followed by structured discussion on some of the issues that have been emerging through the presentations. So we’re hoping to have Australia, India, Russia and Senegal speak this morning.

If I may suggest, I think in the importance of getting the country presentation done this morning we’ll do our coffee break like we did yesterday, we won’t actually take time out but if people want to come in and out during the morning, I’ll announce when the coffee has arrived. That way I think we’ll make sure we do get through the presentations.

So I think we’ll begin with Australia.

Good morning. Again, thanks very much to the organizers and the other presenters so they can be swapped ’round because I’m the person who is catching a flight later on this morning, so... this afternoon, but I have to leave this morning, so thanks very much to the organizers.

Just as a matter of introduction, I guess Australia thinks that we’re pretty well placed to meet our obligations under the International Health Regulations but we do have some work to do to make sure that we’re (on the second round?), meeting those obligations.

As a bit of background, Australia is a federation with six states and two territories, the two territories being basically Canberra and the Northern Territory. There’s a separation of powers between the Commonwealth and the states. What’s not explicitly given to the Commonwealth in the constitution resides with the states.

We don’t have – as I said yesterday – any specific powers in relation to public health at the Commonwealth level apart from the *Quarantine Act* which only deal with communicable disease but certainly gives us very broad powers. The states and territories have most of the power – as some other federations have been talking about – in relation to public health.

This flow chart represents the possible activities that might be undertaken by the major public health institutions at various levels of government. As you can see, at the national level the National Incident Room – which is the focal point for the IHR’s – is located in the Office of Health Protection of which I’m the head, and the Department of Health and Ageing. You can also see that the Commonwealth is supported by advisory committees, which I'll go into in a little bit of detail later. At the regional level state and territory health departments, emergency services and laboratories provide the support as well, and at the local level we have medical practitioners, emergency departments, local hospitals and local health centres.

Our assessment of where activities are performed is not that dissimilar to others who've shown it. You can see most of the public health powers lie at the regional and local level – state or local level for us – and the state and territory health departments collect notifications of communicable disease, and they voluntarily forward this on to the Commonwealth. Each state and territory has a list of notifiable diseases, we don't actually have a national list of notifiable diseases in a formal sense, although we have a list of things that we ask them to report on.

Laboratory services are also an integral part of the surveillance and reporting system, and I'll talk a little about our networks there.

The power to enter into the International Health Regulations for Austria is an executive power under Section 61 of our constitution. Under the constitution the Commonwealth enters into all treaties. We're using the External Affairs power to use as the head of power to implement any legislation that we need to meet our obligations.

The existing Commonwealth, state and territory administrative practices already provide a very strong foundation for us to meet our obligations under the IHR's. We're currently taking a consensus approach with the states and territories, encouraging them to use their own legislation where possible to meet those obligations, but I mentioned yesterday that we are consideration national health security legislation at the moment and we're considering how far to go with that in terms of Commonwealth power.

As I mentioned, public health measures for surveillance and response is mandated through state and territory public health legislation. It's a little variable in the kinds of powers that it gives some states and territories: some have very comprehensive powers, others are looking to us, perhaps, to give them some support.

The responsibility for border protection is the Commonwealth government's responsibility. The *Quarantine Act* provides, obviously, for incoming screening. We also – and this perhaps is something that we want to confirm with the WHO, what are obligations are in relation to exit screen – we think our *Quarantine Act* gives us the power to undertake exit screening, but obviously we don’t currently do that and it certainly would need some administrative support.

We have to work with the state and territory governments to implement border controls of any kind while the chief medical officer delegates his power under the *Quarantine Act* to chief quarantine officers in the states and territories, and they work with our Australian Quarantine Inspection Service at the border once the Quarantine Service finds someone who might need to be assessed, and they’ll be picked up by the state and territory health departments.

The Commonwealth government has responsibility for animal, food, surveillance, chemical, radionuclear hazards, environmental hazards detection and response capacity, although the environmental hazards a lot of powers reside at the state level as well.

All of the states and territories have given their in-principle agreement to implement the IHR in their jurisdictions, and as I said we feel we’re fairly well placed at the moment.

I mentioned that our notifiable diseases arrangements are voluntary between the Commonwealth government states and territories. One of the things we’re considering with the national health security legislation is whether we want to give some more formal status to a list of notifiable diseases, although we don’t think that we want to put the actual list in legislation because it would be far too difficult to change when we needed to, but we wonder whether we might want to put... in fact, some of the states and territories were asking us whether perhaps a bit of compulsion or a bit of authority from us would help them to meet their obligations.

Each jurisdiction forwards the data to us. At the moment it’s a manual process where you have sending it in basically by fax and e-mail and other means, but we’re in the process of building a new system which I’ll talk a little bit about.

The *Privacy Act* provides safeguards against collection and use of personal health information, which we don’t intend to override but the *Privacy Act* is one of our... is in fact the key obstacle that we’re concerned about in meeting our obligations under the IHR’s, and I’ll talk about that.

Verification of incidents undertaken at the local level, as I said the WHO focal point has been incorporated into the surveillance system. That focal point, for us, is very hazy because the National Incident Room – which is a health incident room – is the place that all states and territories would go to for any kind of incident or emerging issue of concern, so it’s an obvious contact point for us. That sits within the Office of Health Protection as well.

I mentioned under the *Quarantine Act* the Commonwealth has a range of powers in cases of epidemic or disease emergency, not necessarily in relation to other things – and that imposes the reporting obligations on ships and aircraft to notify of ill passengers and other incidents – and we also have a range of powers that can be exercised in relation to people who are subject to quarantine, including the power to order a person into quarantine and to submit to treatment as required. But as I have said to a couple of people here, our *Quarantine Act* hasn't changed, basically, since 1908, and it's very broad powers that have never been tested, and during our pandemic planning we – as others would have found too – there's all of those questions, "Are you sure you can do that? Does it really allow to do that? And what if you do it, who's going to protect you?" We're having a good hard think about this at the moment, whether we want to take such broad power. We do want to take the broad power, don't get me wrong, but whether we think the broad power is sufficient to give us the authority for specific actions is another question.

The states and territories, as I've mentioned, have public health and emergency laws, and one state in particular has recently updated its legislation to give very, very comprehensive powers, and we're having a look at that as a model, possibly, for national health security legislation that could be picked up by all the states and territories if they were agreeable.

Some of the powers that the states and territories have include the power to restrict movement in and out of places – again, not tested – impose areas of quarantine, detain persons, require medical examinations and to seize goods, buildings, land, cleaning and disinfecting buildings and disinfecting or destroying goods. As I said, the powers are there but we'll wait and see what the reaction would be if we actually exercised those powers in an emergency situation.

Coordination arrangements in Australia are fairly strong. We have Australian Health Ministers Advisory Council, which is comprised of the heads of all of the health departments including the Commonwealth Department of Health. It sits at the top of the tree under the minister's council.

The Australian Health Protection Committee is the key health committee for coordinating emergency responses between states and territories and the Commonwealth. That's chaired by my deputy secretary for the Department of Health and Ageing. It has the chief medical officer, and all of the chief health officers from the states and territories are members. We also include Emergency Management Australia, defence – New Zealand is a member of that as well – and when we're looking at an international incident we also include AusAID, which is our – obviously – aid organization, so we have fairly good links with other areas of emergency management and response.

I might just note that others have talked about their coordination arrangements, but this Australian Health Protection Committee meets four times a year, or has been scheduled to meet – it usually meets more frequently than that – and we regularly convene by teleconference, even if there's just an issue of concern emerging such as a few months ago in Sumatra where there appeared to be limited human-to-human transmission of H5N1. We immediately convened a teleconference with the states and territories just to get shared views and decide whether any action was required at that stage. So it's a very strong informal network that was recently formalized in a process that's described, the reporting arrangements up through the Health Minister's Advisory Council.

We also have the Communicable Disease Network of Australia which is made up of all directors of public health in the states and territories, it's got Commonwealth members and it has other experts – some of them are not government experts – who are part of that. That network meets by teleconference on a fortnightly basis and meets face-to-face a few times a year, but again they convene all the time by teleconference if there's an emerging issue and it needs to be discussed. So it provides a great support to the directors of public health in the states and territories.

What's not shown up there is the Public Health Laboratory Network, which is a similar setup to the Communicable Diseases Network, it's the heads of all the public laboratories in Australia and they also meet regularly by teleconference and face-to-face a couple times a year.

We also have an Environment Health Committee that operates on a similar basis, and my area provides the secretariat to all of those committees, so we certainly are across what's going on in the states and territories at all those different levels.

Financing for Australia, we don't think we're needing a major additional commitment of funding, here. We're going to build on existing surveillance and reporting infrastructure. We've, as I mentioned earlier, already committed funds to build a new biosecurity surveillance system to try and... we will be converting our current manual system into an electronic system. We were talking to Public Health in Canada about their system in the last couple of days. This will enable us to get real-time data and also obviously to do better analysis and so on. But the funding's already committed, we don't need additional funding for that.

We fund the states and territories for health. It's a cost-shared arrangement, but through the Australian healthcare agreements – which are five-year agreements – we transfer funds annually to the states and territories to support their health services.

We also have special-purpose appropriations. For example, we recently gave $63 million over a few years to Royal Darwin Hospital to build itself up as a trauma centre. Most of you would be aware we had major impacts from the two Bali bombings, and people have been in. And when there was trouble in East Timor recently they always come through Darwin, and so we've boosted Darwin's capacity to deal with all kinds of emergencies including if we had people coming back in because of communicable disease and so on.

I mentioned that privacy issues are... well, it's not an obstacle for us, we currently – as others have mentioned – we share information on a fairly voluntary level at the moment. The Commonwealth doesn't receive any identified data from the states and territories, but we think that we need to have that capacity and that's another question for the WHO. We think we do need to have the capacity to receive personalized information from the states, and for them to be able to share that information between states, and for us to be able to give it to the WHO in very limited circumstances, and we don't think our legislation... we know it doesn't support that at the moment, so we think we're going to clarify our ability to do that.

We also, as is the case for anyone, the nation emergency capacity to non-disease threats needs to be strengthened. We've got good powers in the *Quarantine Act* for communicable disease but not necessarily for other emerging issues.

We also think that regional cooperation is a very important element for Australia in helping our neighbours meet their obligations under the International Health Regulations, and we're an active participant in all kinds of regional forums. We're committed to the Asia-Pacific Strategy for Emerging Diseases, but I know we were a little disappointed recently. There was a cross-regional meeting to look at the strategy, and we are in the Western Pacific Region and we're hoping for strong support from the South-East Asian Regional Office, but they didn't seem that keen, which is a problem for us because our closest neighbour – Indonesia – is in a different WHO region from us, but we certainly have very strong supporters and I believe that we're providing some direct support to Pacific island nations to help them implement the IHR's as well.

I think that's the end of my presentation. Has anyone got any questions?

KW: Thank-you very much. Anybody have any questions? If not, maybe I could start with a couple. I guess we're starting to see some of the same themes emerge in some of these presentations about whether some of these powers should be centralized or not, and my sense is Australia's primarily going upon a collaborative approach with the exception of this new security legislation you were talking about.

I sort of had two questions. On the issue of this new security legislation, would there be any explicit Commonwealth powers to require data sharing or data transfer through this legislation? And the second question is you mentioned the surveillance capacity that's been developed at the state level. Is there harmonization in the nature of the data collected through the various dates, and is this data shareable and with common standards?

CH: In relation to your first question, yes, the national health security legislation, the key module of that legislation will be a surveillance module which will give legislative support to the sharing of data specifically for the purpose of meeting our obligations under the IHR's, but as I mentioned we're looking at strengthening some of our other surveillance elements such as the list of notifiable diseases and so on. That will be included.

In relation to your second question, the data that we ask for from the states is standardized and harmonized, though within their states they will collect a different set of data, so they've got their own lists and their own requirements but what we ask them to give to us is standardized. And when we build the biosecurity surveillance system obviously the data will be much more shareable electronically and so on. And we're still working through exactly the degree to which it'll be shared, given privacy constraints and so on, but certainly the states are very willing to share data with us and have us perform an analysis and detection function.

KW: Thank-you. Dr. Lazar?

HL: Dr. Wilson – Kumanan – mentioned that he thought he saw a pattern emerging, and his interpretation of your presentation was that Australia was relying on a relatively cooperative intergovernmental process. I interpreted your presentation slightly differently. See how controversial you can be without even trying! I make a distinction between who sets the rules and sort of the framework for action and then the actual operational activity. My sense from your presentation was that because of the treaty power in Australia that in fact the Australian government, the Commonwealth government, has extensive powers to set the legal framework. As a practical matter, in operational sense, you were relying heavily on a relatively unhierarchical cooperative approach, and so at the level of who sets the rules and so forth that there's a lot of power resting with the Commonwealth government and it exercises it, but it chooses to do so in a way so that operationally there's a cooperative intergovernmental process. Is that fair, or am I...?

CH: It's certainly not unfair. I'd say not so much that the Australian government has a lot of power, it has a lot of authority, so we don't necessarily currently have the legislative power to do things that we may need to do, but we've seen an increasing trend over recent years in response to emergencies of states and territories wanting the Commonwealth to take the lead. As I've said, we've only got the *Quarantine Act* as our only specific health power, but in the national health security legislation the states are indicating a fairly strong desire for the Commonwealth to have more explicit powers that, as you say, would set the framework and provide an overarching governance structure for their operational activities.

HL: Let me more specific. I think you said that some of the powers around surveillance and so forth were state powers, but if the Commonwealth government chose to use the treaty power it could basically override...

CH: If they weren't agreeable we most probably could.

HL: That theoretical power exists.

CH: That's right.

HL: Okay.

JS: Jeff Scott from Nova Scotia. If you have an outbreak occurring between states, how is the management of that coordinated and what's the role of the Commonwealth in a major incident?

CH: What would happen is that the Communicable Disease Network of Australia would immediately convene and share views on how to deal with that outbreak. In terms of sharing specific information about individuals and so on we're on shaky ground in terms of sharing data, but certainly there would be an informal immediate exchange of information about that. The Commonwealth, if it was a serious incident that one state felt they couldn't manage, the Australian Health Protection Committee would be convened and the chief health officers of each state and territory and our chief medical officer and deputy secretary would decide on what action to take. So the states and territories always have the operational responsibility but if it was multi-state it would be coordinated at the Commonwealth level.

JS: Thank-you.

KW: Dr. Fidler and Dr. Plotkin?

DF: I was intrigued by your brief forays into the *National Health Security Act*. I was just wondering if you could give us a bit more of the scope and content of what that's about and why a security approach is being taken.

CH: Actually, I probably can't. Well, I can guess why the last one, because security was a very trendy word – and still is – in Australia. Security issues have been very much at the forefront of policy in the last few years. I wasn't actually in this position when the national health security legislation was being formed, but I would guess it was to bring it in line with other actions.

DF: I was just wondering whether that's the approach being used because security is usually a federal or a Commonwealth authority from the constitution.

CH: Yes, it is. That's right. If I just described to you what's in it you'll also see that. We're taking a modularized approach to this legislation so that we can add bits onto it as we need to. The first module will be a surveillance module to meet our obligations. We don't think it's major changes, but some changes to meet our obligations under the IHR's. We also have responsibility... there was a recent Commonwealth and state and territory process looking at hazardous materials of interest to terrorists. That includes radiological, biological and chemical agents, and as it just so happens responsibility for all three of those things rests all or to some extent in the Department of Health and Ageing. We have the agency that looks after radiological issues, we also have an Office of Chemical Safety, and I have responsibility for laboratories in the sense of policy. So we have to implement the recommendations from that process which include setting up national authorities to register and monitor laboratories and to monitor the movement of chemical agents of interest to terrorists, and radiological agents which are already obviously heavily regulated, so we needed to do that and that's got a clear security focus.

And as I mentioned, our pandemic planning has thrown up a lot of questions around the *Quarantine Act* or what powers actually do sit with the Commonwealth, and the discussion has been around – as we've all been talking about – whether or not to give the federal government more explicit powers in relation to health emergencies which it currently has in relation to communicable disease. And at the end of this month, which is the next of next week, we'll be having a discussion with the Australian Health Protection Committee to get down to some level of agreement on that, what kind of powers we want to give to the Commonwealth.

The final module that we're thinking of putting in this legislation is a governance module which might just formalize the coordination and, I suppose, decision-making role of the Commonwealth in health emergencies, but it's not a definite that we're going to go that way.

KW: Mr. Plotkin?

BP:

CH: Certainly. SARS provided the motivation for us to set up a whole new set of arrangements. The National Incident Room's actually set up...

BP:

CH: Incident Room, the Health National Incident Room. We call it Bali 1 and Bali 2. After Bali 1 where we had I think 88 Australians died and many were very badly injured, many, many more than that, were coming back through Darwin and it exposed our complete lack of coordination in a health emergency. Not that we didn't cooperate in emergencies but we didn't have any specific processes or committee or anything to deal with this issue because what we needed to do was get the patients through Darwin and out to the other hospitals because obviously Darwin couldn't cope with that. So, administrative processes were set in place following that, and the Australian Health Committee – I don't remember what they were called, a very long name they had before they were called the Australian Health Protection Committee – was established. SARS obviously tested those arrangements to some extent. We had the National Incident Room by then, and it was operational on a 24-hour basis during all of the SARS activities. We, as some of you will know, were very strong supporters of the renegotiation of the IHR's because of the changed global environment and because we realized our own arrangements needed strengthening and clearly others would as well, particularly in our region, so we have supported that very strongly. And I suppose the IHR's have just provided the additional motivation to have a look at our legislative basis. We say we have a very strong capacity to respond, to detect and respond, but we've had reason to look at that over and over in the last few years because of SARS and AI and we've obviously found areas in which we could improve, and the ability to share data confidently is one of the areas that we think needs legislative improvement.

KW: Dr. Veyrat?

SV: France is a small country but has got many islands all over the world, and one of those islands is near your country, Australia, so my question is if there is some resortment(?) of virus – H5N1, for example – should you close the borders? Because you are an island.

CH: We've had to advise government a couple of times on this. What we've said to them is our advice on border control – we don't call it border closure anymore because it wouldn't necessarily be that – our advise on how drastic the measures need to be at the border would be dependent on how lethal and infectious the virus was when it hit Australia, so it would be a proportional response. If we had a very lethal, very infectious virus that was going to have a major impact, we may say that... the Health Department might advise the government that the best health action would be to stop flights from a certain region or possibly... we don't think, realistically, we can stop all flights. I mean, Australians would want to come home and it's very difficult to not let Australians home, so that if the border's not closed it's not going to be effective. So, just letting some people in defeats the purpose of closing the borders, so we don't really think it's a practical measure.

We also have another issue in our northern border area where, one, we have allowed traditional movement in the Torres Strait between Papua, New Guinea and the Torres Strait islanders who traditionally related and had a lot of traditional activities that they undertake, so there's free movement there. And we also have a lot of illegal fishing – fishers we're supposed to call them – fishing people coming in from the north. While there's a major detection operation going on up there we don't really have any control over it. So, what we've said to the government is we believe border control would only be effective if it was really comprehensive, border closure would only be effective if it was really comprehensive. We don't think it's that realistic to say that you could close the borders and therefore our advice would be to increase border control measures in the initial stages in the hope of buying time to get ourselves organized to deal with a possible pandemic and always trying to buy time until the development of a vaccine.

KW: Dr. von Tigerstrom?

BT: Thanks. I don't know whether or to what extent you'll be able to answer this, but you mentioned regional cooperation briefly and I wonder if you could speak a little bit more about that. I'm wondering about the assistance and cooperation that Australia's involved with in the region, with especially the small Pacific islands and trying to deal with bringing them into compliance with IHR obligations, and more broadly the extent to which Australia acts as a resource for public health in the region.

CH: Yes, well, we've had very strong... an increased regional engagement in the last couple of years. We've had a very strong program with Vietnam with exchange visits, we've had a couple of very senior-level delegations going to Vietnam, but we've also provided money through AusAID to help boost surveillance and reporting, and I think we're funding a field epidemiology program at the moment as part of that effort – that's been very much appreciated in Vietnam- and there have also been exchange visits where we've had delegations come into Australia to undertake sort of study tour type activities.

We also have quite an investment in Indonesia as well. That's a little more difficult for us, but still the relationship's pretty strong on the health side.

In relation to the Pacific we a couple of years ago established something called the Pacific Leaders Network, which is the heads of Pacific health departments, and they meet with our senior staff yearly, not just specifically about pandemic or avian influenza but to provide them with a forum not dissimilar to the one we have ourselves with our states and territories, but the Pacific islands all being individual nations they’re saying they lacked that kind of ability to share information and experience on a regular basis, so we’ve helped in that way.

And I’m afraid I just didn’t check this before I left – because I used to be in the international branch – one of the activities we agreed to was to help Pacific nations implement the IHR’s and we set off an activity where they were going to do a sort of inventory of where they thought they were up to, and as I say I apologize I just didn’t check where that process is up to but I believe that’s still moving forward. And if there are areas that Australia can provide financial support that it would be effective I’m sure that we will.

KW: Thank-you very much. If there are no further questions we can move on to our next speaker, from India.

Good morning. I will be presenting the implementation of IHR in India.

First of all I’d also like to clarify that I am the IHR contact point in the WHO country office in India. The actual IHR national focal point was the director of the National Institute of Communicable Diseases which composed the entire communicable diseases network in the country, but the present director, Dr. Shiv Lal, could not make it at the last minute so I’ll be presenting on that.

But I’d also like to emphasize, like the Australian team had just said, that the country office’s role is very particular as far as the IHR is concerned, and we work very much in coordination with the government of India in most of their activities related to the IHR.

I will be making a presentation on three major areas, that is the health legislation and governance; the disease surveillance in the country; as well as the plan of action for the implementation of IHR because we have already had a few workshops planning for this, how it’s going to be implemented. And I’ll be a little diverting from the template that was given by the organizers, but I’m sure that at the end of the meeting most of the issues would have been clarified.

India has a federal structure where health is a state subject in the main. We have three lists, basically, a central or a union list, a state list, and a concurrent list. So the central list is the one which has most of the public health legislations which are more linked to public health aspects like water, sanitation and many other issues. The state lists do have some of the same but also have a lot of areas like health emergencies, especially of diseases specific to the states. And we also have a concurrent list which has a lot of areas which can be interstate issues and also which we have these emergencies which can be made by the state or the centre.

Now, a new development is that certain diseases, like pandemic diseases like in the case of SARS or avian ’flu or pandemic ’flu it could be declared as a public health disaster and the centre could take complete control. We have also recently established a national disaster management authority, so these issues come up in front of them and it is controlled by the Home Ministry so all the issues – especially inter-sectoral coordination and funding – is much more easier in this type of a system.

The Constitution of India guarantees the right to life in Article 21, and right to health has also been a prerequisite recognized by the Supreme Court. And many judgements of the Supreme Court have helped a lot in health legislation. I was just giving the example of including pollution – air pollution – in (the list, that it was?) controlled by the Supreme Court giving an order that most of the industries have to move out, and a shift from diesel to CNG gas in vehicles has made a big difference in bringing down pollution in Delhi.

Many times, though, individuals have got rights but the public health can override the individual rights in many cases. In this example of the recent outbreak which we had in avian influenza, social isolation and limited quarantine were introduced in the affected areas, and we had a lot of cooperation from the poultry farmers in this area, but I’m sure that even if we had a legislation in place there could have been some problems. And also I will give you an example, if the outbreak had not been controlled in the short time-frame that we had there would be an issue of farmers committing suicide because they’ve lost their income, you know, so that type of issue which Dr. Allison raised yesterday would also make a big impact on the government taking a decision in such long-drawn outbreaks.

Now, there would be a requirement of enactments and amendments for effective implementation of IHR, but as Dr. Lazzari – Stefano – said yesterday, the IHR implementation is already linked with many other issues like disease surveillance, early warning and response, so existing systems are already in place for the basic requirement of implementing the IHR, but definitely much more could have been done.

Now, many of the health legislations are quite old but still they are very broad and they're still being utilized, and there are some areas where the amendments are already in the process. Much before the IHR they were already in process but now, after IHR, certain amendments have been added to it. But at the same time we find that many of the places other legislations have been used, like during the avian influenza outbreak in Madhya Pradesh the CPC – the Communicable Procedure Code – was used, and then similarly Maresha(?) the *Police Act* was used which basically is a broad heading of maintenance of public law and order, so the administrative head of the district can impose a law and coordinate all activities with that type of a law.

Now, many states have... there are different states in the country, there are 35 states and union territories, so some are very well developed – you can see the southern states, and some of the northern states – but some are backwards states and less developed or they got statehood later on so they are still lagging behind. So there's a vast difference of the state legislations in different states.

States have a surveillance system. Though surveillance is not a legal requirement but they all have a surveillance system, and initially they were just reporting about 30 diseases on a monthly basis, which is more of a health information because most of the activity is to be done by the state, but later on the government has introduced a central program called the National Surveillance Program for Communicable Diseases, and this was directly getting information from 101 districts, and this was being coordinated by the National Institute of Communicable Diseases which I told you was the coordinating authority for communicable diseases.

Now, a district in the country is the independent administrative unit, and it can vary with a population of one to four million population, and they do the early warning, they do the response, but at the same time they do inform the state and he centre.

Now, states do report sometimes late to the centre due to various reasons, and one of the major causes could be lack of information or diagnosis, because many of our labs are centrally located. Though we have state labs which are of good quality but they're not linked very effectively with the surveillance system.

Now, states also obtain significant funding from the centre for their sub-centres, that is the health unit which is in the villages, so those are completely funded by the centre. Then we have the primary health centre or the community health centre which is a little bigger-level health centre covering 1 lakh to 3 lakh population – so 100,000 to 300,000 population – and some of the temporary staff, the drugs, the lab equipment, these are all funded by the centre.

And also we have another system which is from the social welfare department which is called the Integrated Child Development System, which has *anganwadis* which look after the under-five children. It's more like a government creche, and we provide nutrition and immunization, so these are all supported by the centre. So a centre has a large amount of control in many of the activities because of their funding support.

Now, also the centre... although we have district rapid response teams which have been trained by the centre, as well as we have state rapid response teams which are multidisciplinary – consisting of epidemiologists, microbiologists, entomologists and the other specialists, pediatrician and physicians – but as long as if it's a small outbreak and it is able to be controlled by the district it is controlled at that level and the information is passed on, but otherwise if suppose two or more districts are affected the state rapid response teams enter into the situation. But if the outbreak is significantly large and there are, say, reported deaths, then the centre usually sends a central team, and this central rapid response team is made up of members from the National Institute of Communicable Diseases – which functions somewhat like the CDC – and they co-opt other members, and so they could go in with or without the request of the state. Most of them, the states do request, but invariably... I mean, it is automatically understood that they can move in.

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The centre is also involved in a large amount of capacity-building and laboratory support, so most of the samples as far as samples, as far as communicable disease outbreaks are concerned, would land up in a central laboratory or a referral laboratory, so the centre's always aware of what is happening in states.

Now, many of the programs like the Integrated Disease Surveillance Project, the National Aids Control Project, the Revised National Tuberculosis Control Project, or the National Polio Surveillance project, so these are projects which function on a project mode and are directly funded by the centre for these important diseases, and as they progress they can move into national health programs. So these are vertical programs and they ensure that two-way communication between states and the centre.

As far as emergencies are concerned, like in SARS and avian influenza, the centre is always involved in these activities. They are monitoring it around the clock. Although the state has the powers to do most of their activities but the central team is always deputed and closely support the response activities.

Now, states can also directly obtain external funding from different agencies – including the World Bank – but for all these they have to get sanction from the centre.

Now, the national health programs are listed out there. We've got most of the important diseases in them. They also have a strong surveillance component, disease-specific, but these are all vertical and it is direct information flows from the district, state, directly to the centre, so the centre's always aware of these diseases.

Now, as far as reform is concerned, there are already changes to existing legislations at national and state level which have been an ongoing process depending on the diseases which have been coming up at different parts of years, and although disease surveillance itself is not a legal requirement but most states have a disease surveillance system.

Now, some of the existing legislations which govern the key IHR-related issues, the *Public Health Act of 1925* is being revised, but even that is quite broad enough, it covers a lot of area. The *Public Health Emergencies Act* is being processed at present. This should have come out 2005 but with some additions from the IHR this is going to be... (I'll just clarify some more on it?). Then there is, under the concurrent list, entry 29, there is a prevention of extension of infectious diseases from one state to another. Port quarantine is again a very old listing based on the union list entry.

The *National Disaster Act*, which came into existence last year – 2005 – it gives very broad powers under the... it's just a management authority totally independent under the whole ministry, controls all the other activities and inter-sectoral cooperation.

And the *Right to Information Act*, this was recently passed in 2005, where any person from the public or a journalist can get any information from the government on any issue.

Now, this is draft *Public Health Emergencies Act* which under process. It provides for the control and management of all public health emergencies, including PHEIC. And the scope of the *Act*, basically from the draft which we have seen, it covers the invasive(?) epidemic diseases which have a potential to spread rapidly, it has a list of epidemic-prone diseases which cover most of the important diseases – 29 diseases – plus a PHEIC which is when notified by WHO. So they implicitly have taken into consideration the decision instrument, and if WHO says that... like, say, the country office says this constitutes a potential PHEIC the government can take action in this act. They also cover bioterrorism with 34 listed agents – viral fungal and bacterial agents, and others – and also disasters – mostly natural and man-made disasters, again others – and the centre will have powers to direct the states when this type of occasion occurs, and they will declare that area – it could be a district, it could be a state, or many states – as a public health emergency area for a three-month duration and will have all powers to coordinate all activities in that area.

Now, while this act was being reviewed there was a need for a draft model Public Health Emergencies Act from countries so that we could adapt it, and we did search the ___ WHO also, country office, to search for it. We searched, we found New Zealand has passed a recent act – I think in 2006 – but we were not able to get any material on these acts because the government wants to compare this act. I think it would be useful if we could have a draft model available for countries who would like to amend their acts.

As far as vertical policy coordination and coherence is concerned, the current strategy is we have one of the important programs called the National Rural Health Mission which is covering the 18 major states which are lagging behind, you can say, from the other states, and this is an umbrella organization where all the public health programs are coming into this. It is catering mainly for the rural areas.

Then we have our India services system that the bureaucrats – that is the Indian Administrative Service or the Indian Police Service, as well as the central government health schemes – these officers are posted at all these states and districts so we have a central service. So you can say their allegiance is to the centre although they function at the state level.

Similarly we have the regional Offices of Health and Family Welfare covering all the states and union territories, so their main role is to monitor the implementation of central health programs.

And then the whole communication network comes under the centre, so all information – whether it is through the IT or the telecom – is all under the central control.

And we have a dispute resolution system, the Central Council for Health and Family Welfare, which meets almost twice a year or whenever there is a dispute, so this is also available as far as conflict resolution is concerned.

Now, as far as the budgetary issues are concerned, there are adequate resources at present to fulfill the basic obligations of IHR implementation but additional funds would be required for capacity-building because that’s a huge area, both at the centre, state and districts. The public health laboratories, we do have funding for the public health laboratories but to include the networking and many... especially important reagents which have be imported.

Then border crossings is a major area, and the number of border crossings, we have a very large international border so we have a large number of crossings. And the border network has authority because the number of ports and airports in India is increasing significantly and some of them are becoming privatization, and this is another area where the private airports are not willing to have the government port health officers located in their airport, so this is going to create a problem. We are still negotiating on how they are going to sort this out.

And then hospitals for admitting large numbers of patients under isolation, is this another area which we find requires a lot of attention and would require additional funds.

The other non-governmental actors, the major metros, we have got very large metros – that is Mumbai, Kolkata, Chennai and Delhi, with populations of, you can say, about 20 million population. So these are cities which their health budgets also are very huge, and they are almost separated from the state government system, so getting them involved... but they do not have a very organized structure compared to what we have in the states, as well as a lot of healthcare is in the private sector, so getting them in is also a problem, but we are working on that.

And then different airlines, railways, these others, they are all in dialogue, they are providing the support, but that requires improvement.

Now, as far as the media is concerned, the freedom of press is a major factor in frequent reporting of outbreaks, so in every paper you’ll find at least ten to twelve outbreaks reported every day, and they often – for sensationalism – always report it as a mysterious illness or unknown disease, and this creates a problem for us because the networks pick it up, but until the lab confirmation comes up invariably these diseases will be considered as uncontrolled outbreak.

And there are 24-hour news channels, so they want news, so health is now becoming very interesting news for them and so they keep on getting a lot of information.

But we are using the media also for providing information to the people, to convey the status report as well as NIEC activities, so media can be used and harnessed to play a positive part in the IHR.

Now, as far as the surveillance is concerned we have got this National Surveillance Program for Communicable Diseases which has now been replaced with the IDSP – that is, the Integrated Disease Surveillance Project – which is a World Bank project. And also we have the five-year planning, the budget is allotted in a five-year plan, so the [le-ven-fire?] plan, already the budget support is there for the surveillance as well as IHR implementation. The laboratory strengthening on the IDSP has been provided, especially in the context of the avian ’flu and pandemic ’flu preparedness, so we have operated our labs. All year we had only one BSL3 lab, now there are going to be four more coming up so the lab structure has been in increased. And the training of health staff is an ongoing process.

Now, there were... initially the Disease Surveillance System was very local and information was not available at the centre level, and there were different gaps. Some states had very good surveillance systems, some states did not have a good surveillance system in place, so there was a need for uniformity and so the National Surveillance Program for Communicable Diseases was started, and they trained the Rapid Response Teams both at the state as well as the district levels and this information was passed to the centre. This one was covering 101 districts. We’ve got 600 districts in the country, so it covered all the states but only three or four districts per state – just as, you can say, the pilot – and the national focal point was at NICD __ which is coordinating the whole activity.

Just to give you an example of how the villager(?) works and the country office works, we have one microbiologist, one epidemiologist placed in the National Institute of Communicable Diseases, and so whatever information comes from the states or districts to the National Institute of Communicable Diseases is immediately available to the WHO. Similarly now with the IHR and with the Emerging Infectious Diseases program expanding, a subregional office of the CRO – the south-east regional office – is also located in the National Institute of Communicable Diseases. So again there’ll be an epidemiologist and microbiologist located there. And so as far as the international health part is concerned I’m sure that we’ll be taking care of it.

Now, you’re in this program, this was basically outbreak reporting only, so these two only report... this was an early warning system, they used to report outbreaks only, they never reported on a daily basis the number of cases, and that's just any outbreaks reported in the past week, and the rapid communications were established through fax and e-mails. And the state and these district laboratories were strengthened to do a rapid confirmation or diagnosis. At the district level it's basically rapid diagnostic kits, but at the state level you have a little more sophisticated labs – but not of the BSL3 labs – but basically they can do ELISA and those types of tests, and a large amount of capacity-building as well as IEC activities were involved in that.

Now, this is how it was distributed, covering the entire country, 101 districts used to report on a weekly basis directly to the National Institute of Communicable Diseases – they used to bypass even the state – so that type of system was in place and this never had any problem as far as the states were concerned. They felt it was an important program.

It covered most of the epidemic-prone diseases which is common to the country – this is cholera, viral hepatitis, dengue, Japanese encephalitis(?), meningitis, measles, viral hemorrhagic fevers, leptospirosis and others – and also it had this thing that pathogens with bioterrorism potential could also be included, as well as drug-resistant pathogens. So it was a very simple and a comprehensive program. And there was an outcome of early detection of outbreaks, early institution of containment measures at the district level itself, and to reduce the morbidity and mortality as well as minimize economic loss.

And you can see that over the years – that is 2001, 2002, 2003 – you can see that the outbreaks were increasingly being reported and the state and district were independently able to manage those outbreaks, otherwise earlier NICD teams had to go in almost every fifteen days travelling, investigating some outbreak or other in the country. So that reduced a lot, the states became... capacity was developed to directly do the investigation themselves. Too, whenever they required central assistance it was provided.

Now, this improved the capacity. It was not felt that we could expand this program to all the 600 districts and they wanted a more case-based type of reporting where you find out actual number of cases and actual number of deaths, so we shifted to the Integrated Disease Surveillance Project, and even these 101 districts have into this program.

Now, this is a World Bank related project with about $68 million spread over five years, and it is a decentralized system, and it has target diseases, it has a regular weekly surveillance of the important diseases. The ones in yellow are the ones which come under the IHR, also cholera, polio, plague, unusual syndromes, and this has suspect cases of the syndromic surveillance as well as we have suspect case, probable case and confirmed case reporting. And all these three are parallel, they do not merge at any level, so there's three information is available at national level. So this helps. Earlier what was happening was only lab-confirmed cases were being reported, and that was a very small tip of the iceberg, so now we have a system that all three are being reported.

Then you have (segment surveillance?) which is a totally different agency, including inter-sectoral. It comes from the police, it comes from the water pollution control boards. And we have also surveillance for non-communicable diseases also in this.

Now this is a phasing of the project, so at present we are already finished phases 1 and 2 so reporting has started, and the phase 3 states are being taken in, so by the time the IHR gets into implementation the entire country will be covered under this program.

Now, the structure in this is basically similar to the NSPCD(?) where the district surveillance unit is the one which does most of the reporting. But we have increased their district surveillance committee so that inter-sectoral coordination would be there, and this committee consists of all members including veterinary, pollution control board, police for the road and traffic accidents, so all the groups which are involved are a part of that committee, and the administrative head is the bureaucrat that is the district magistrate or collector, and you have the security is the district surveillance officer.

And this information flows to the state as well as to the national, this information, and this is how the information flows in. And it also has built-in taking in information from a select number of private practitioners, nursing homes, not all of them but a few number of them just to get started, and then we may increase and expand to more of them. And the whole flow goes upwards from the district surveillance unit to the state surveillance unit to the central surveillance unit.

It involves medical colleges also, which a large number of patients do go to medical colleges so those hospitals also add on the information. And it also involves private laboratories and the other areas that is military and municipalities.

Now, the linkages at the central level again you can see clearly the different national health programs. These are the programs. This is the NICD which has a central surveillance unit at NICD itself. You have the Central Bureau of Health Intelligence which was getting the information earlier, on a monthly basis. That information still feeds back so you can counter-check if the information coming in is matching with the data. And you also have the Indian Council of Medical Research which is a network of organizations spread all over the country, about 35 of them, which have sophisticated labs doing research on particular diseases, so those information also feed in.

And you can see that the emergency medical response is also very much a part of the diseases surveillance system, so it is always built in that if it is to be declared an emergency they are very much there. And the WHO country offices also are very much part of the information coming directly to us also.

And these are showing our network of reference laboratories. These are mostly the ICMR laboratories, but all states also have a state level laboratory, and some of them have got disease-specific laboratories also, so that the total network is quite a large network, and we have established the network of this lab system to give more authentic information and so the lab confirmation doesn't get delayed.

Under the National Rural Health Mission the community health... there will be a link worker located at the village level who will also be assisting in passing on this information, and they're going to extend the ___ which ____ up to block level, that is up to the CHCS(?) level. It will now go right up to the PHC(?) level.

There is also a use of the satellite for improving communications at the state and district levels, and also lab services are being strengthened under this program.

And this gives an idea of how the satellite linkages have been established, especially the recent one or two outbreaks, chicken pneumonia(?) and avian influenza. The health minister sitting in his office can have a teleconferencing with the state health ministers and their secretaries and discuss the preventive measures being applied.

Now, this has got a lot of strengths. We have an integration of all the surveillance components of the vertical programs. Now we have those in roving reporting which is what we felt was very important, because otherwise cases were not being reported. It has a strong IT component. It's still being finalized. A state will be reached when all this data will directly flow into the Web site – there will be no interference at any level – this will be available right on the Web site. Even in the present outbreak of avian influenza, both the Ministry of the Health and Family Welfare, as well as the animal husbandry side, daily updates were put on the Web site. So this that transparency has started showing up and the government is now putting all the information on the Web sites.

You have trigger level in this program that the field worker right at the village level, knows that if he gets two measles what action has to be taken, the medical officer at the primary health centre level knows what has to be taken, so there is action and response component laid down that what action to be taken, what samples to be collected, everything is laid out in this.

And there is a streamlining of the flow of funds to the districts directly so there is never a shortage of funds as far as the surveillance program is concerned.

Now, the same thing, you can say surveillance has got three links, one is the government system. WHO itself has a collaborative network, we have got different programs of tuberculosis, polio, disease surveillance, leprosy, viruses(?), malaria, kala-azar, HIV/AIDS, routine immunization, plague surveillance. So we’ve got a complete network of WHO consultants in the field – more than a thousand people are there – and so they always SMS us or send us e-mails if they suspect any outbreak in that area. So they are informants, they inform us of an outbreak, they do not divert from their programs which they’re doing but they at least give us the information. So this works in alerting us for any outbreaks.

And the third group is the media, which is very active in the country. You’ll find many times it is the media which reports first, and that helps a lot in the disease surveillance.

And lastly, the plan of action. We had a workshop with the different stakeholders and it was identified what are the areas of the IHR which require special attention. I will not discuss in detail the issue but basically we followed up on the IHR activities to plan what are the actions required to implement the IHR in the country, and this was discussed in very much detail, and we got a whole matrix which I’ll be giving to you, but basically some of the highlights are that all rapid response team trainings now include the IHR, so they know what is the IHR part of it. Even the administrators and the politicians, (there’s trial cases?) being done at national, state and district levels, so they have been given a time-frame. And then rumour verification is being strengthened at district, state and national levels, so this also has been given so that by June, 2007 we should many of these things in place.

Then evaluation of isolation facilities and hospital infection practice in all states and districts. This is becoming a major issue. We feel that if we have a pandemic ’flu the capacity at the state and district level will be taxed heavily.

Then involvement of the private sector for disease surveillance, including the Indian Medical Association and others, so that is again a really important area.

Then assessment of these disease surveillance and response capacities, this checklist they had wanted us to give it from the WHO. We are waiting for the list, but at the same time the government will be going ahead and doing it around the middle of June of next year.

And then identification of high-risk areas near international borders so that we can have programs for cross-border control of diseases, because we have a lot of free movement between countries like Bhutan, Nepal, Bangladesh, so this is including even now Pakistan also there's a lot of trains between India and Pakistan, so this type of cross-border control of disease is very important.

The national IHR focal point also has become very important, and so we have even strengthened, we made a BSL3 lab level(?), always getting the samples earlier also. They do not have a BSL3 lab, so some of the sample results had to be awaited from the other BSL3 lab that was at Pooning(?), so now this... and ICD itself has become self-sufficient, they can do all the tests themselves.

And then also operation of a national public health emergency response plan, this is also planned very much.

Then assessment of present capacities that are designated airports, ports and ground crossings. This is a meeting which we actually do next month, and we are expecting even calling some international experts from Australia regarding what are the issues actually faced at the airports and ports, and as Dr. Stefano said about already this meeting in Canada which occurred, if we could some of those draft documents it would help a lot in this meeting. We will also be having an increased number of public health units at the airport because a large number of airports have now become international.

This again is a revision of the *National Aircraft and Port Health Act and Rules,* because they have to change, and also prepare the updated health rules for designated ground crossings, which is very large in number, there were almost 800 ground crossings, and this is going to be a very significant challenge. I do not know how we are going to address this.

The public health emergencies of international health concern, also the Ministry of Health and Home Affairs, like I told you, has got the national disaster management authority.

Now, they have been informed very well that these are the areas where you can include as a national disaster.

The basic obstacles to implementation would be the inter-sectoral coordination. I'll give you the example of avian 'flu. Because it was only with the chickens the agriculture sector took complete control of the activities, which created a lot of problem. We could not do any IEC activities for the risk to humans because that would plummet the sales of chicken, so we had a very tough time with this issue, though throughout we have joint monitoring groups meeting – every two weeks we have a joint monitoring group meeting – but when the actual avian 'flu hit the country then immediately there was a __ because the chicken sales had gone down significantly, and we in the health could not take much of a stand because we did not have human cases. So this will create a problem in the sectoral coordination.

Then border crossings, we have a large border with a large number of migrants, so again that is going to be a major problem. And we have frequently large outbreaks. On a daily basis we'll have about three to five important outbreaks. Like I have listed now we're having chicken pneumonia, about almost one million cases affecting about almost six or seven states, the Japanese encephalitis(?) outbreak going on, the leptospirosis outbreak after the floods. So we do have at any time a large number of outbreaks of this type because the sheer size of the country makes a large number of cases, so these are some of the obstacles to implementation.

Another issue which is coming up increasingly is the corruption at some levels. Now, this is either diversion of funds or the medical officers are not available, they're doing private practice at some other areas. So, those type of issues, which are state-centric, will be very difficult to overcome, and which will also have an impact on the reporting system.

Thank-you.

[Applause]

DF: Thank-you, Dr. Krishnan. An impressive, comprehensive review. The floor is now open for comments and questions. Dr. Bruce Plotkin?

BP:

SK: Actually, whenever the technical agencies put up any bills for approval, the first question the government will ask is, "Show us any other similar acts in other countries," so they can compare it with... which is all-inclusive, because these legislations cannot be revised frequently so naturally you like to be as comprehensive and cover all the issues. So it is not only for our country but I'm sure many other countries will benefit, because if they are going through a revision process they would like to have such a legislation easily available and incorporate as many applicable clauses into their own legislations.

BP:

DF: Dr. Lazar?

HL: Thank-you, Dr. Krishnan. That was a very comprehensive presentation.

I guess I've been... as I listened to you I was wrestling with a comparison between the extraordinary planning effort which India has obviously undertaken in this area and the seeming – if I interpreted you correctly – extensive use of law and regulation as a device for making sure that you can do what you need to do in the circumstances required as compare to some of the other country presentations where I had the sense that the approach was one more of voluntary cooperation, less reliance on law, in the belief – possibly, I'm not sure – possibly in the belief that one cannot anticipate all circumstances no matter how hard one tries, and that extensive reliance on law and regulation risks creating rigidities, perhaps, that would not be in place in countries which relied less on law and regulation.

I doubt that there's a right or a wrong approach, I think different countries do things that are consistent with their history and their culture, but I guess the question I would ask you is am I interpreting correctly that the Indian authorities believe that it's important to specify in law and regulation as much as can be anticipated, that that is consistent with the Indian tradition? Or am I misinterpreting you, perhaps.

SK: Actually, I'll clarify I think the slight misinterpretation. Most of the diseases surveillance and the other public health activities are being done without the law, these things are done. Now, the issue comes up that more and more the private sector is getting involved in the healthcare, and especially in the urban areas. You can say it's almost 40% is public and 60% is private. So for them, yes, you have to have health legislation in place because otherwise they're not bound to report certain cases. So that is why the states and the centre are realizing that a legal framework has to be there.

But as far as the normal disease surveillance and response is concerned, at every level the government has got the powers normally also to do it without legal backing.

HL: You have the powers without the...?

SK: The surveillance system and all this is a national program, it has to be done, so there's no requirement of using the legal backup for it.

HL: Help me out, here. If there's a national power and it needs to be done, doesn't that power rest on law?

SK: Yes, in the constitution itself. I agree, it is in the constitution itself, but what I'm trying to say is many of the laws are 1905 and things like that, but no one refers to them anymore, it has just become acceptable.

HL: It's just the way it's done.

SK: Yes.

HL: Okay. The other thing I wanted to clarify – I think maybe many people in this room know it but for those who don't – in India the civil service is a united civil service, and you're a civil servant in India you can be assigned to the federal or the state or the local level and you're still part of the ICS. For the people who are involved in monitoring and surveillance and reporting, are they usually civil servants or are many of them outside the ICS? You mentioned the private sector just a moment ago.

SK: The district head is the... what do you call it? The IES, we call them the district magistrate or collector. So he's a non-medical person, he's the head of the district. Now, the District Surveillance Committee, the head is this person but the actual implementation is the District Surveillance Unit, which is the medical person. So, all activities are done with this but there will be a meeting once a month or once in two months where any issues which come up are discussed, but otherwise they are separated from the system, they do not interfere that much in the system.

HL: They are not part of the India Civil Service? No? Thank-you.

BT: Just a quick question of clarification or elaboration. You mentioned briefly a dispute resolution mechanism, I think the Central Council for Health and Family Welfare. Can you explain a little bit how that works, what kinds of disputes they would deal with and how that works?

SK: It’s mostly, you can say, issues of allocation of funding, some cross-border issues, they may have some discussion about the border issues which the information has not been communicated to them, or shortage of staff or logistics like drugs, those are the issues mostly. It is not much on the surveillance as such but mostly it’s the other issues.

HL: I just want to follow up on one item in the presentation and that was an item concerning preparation for dealing with some of the new international documentary requirements, so for those of you who deal with ports and airports and international shipping and international air traffic, and who deal with international travellers, the documentary requirements, there are new forms in the IHR, there’s a new maritime health declaration to be filled out by ships on arrival with all kinds of information about sick persons or conditions on the ship, the forms for international air traffic are being revised with ICAO – the International Civil Aviation Organization – in conjunction with WHO, so those are changing as well. The international model form of vaccination that is the one specific part of the little yellow booklet that international travellers carry around that has to do with yellow fever and maybe other diseases. That has been revised as well, as also the main sanitation documentation having to do with ships, how many rats you’ve killed, where you’ve looked, what kind of bugs you have and things like this.

And so to the extent that you deal with these or you work with people who deal with these, these are all important international traffic issues that will be entering into practice in the middle of the next year as well. So, your port people and your airport people will be seeing new forms, or forms that look similar but also have different parts.

SL: Dr. Krishnan, thank-you very much for the presentation.

You mentioned a few times the rapid response teams are present in every state, and I think it’s the first time that this comes into the discussion. And rapid response teams we are considering as a key component or a key core capacity within the IHR, but there’s been quite a bit of discussion at what level we think they should be placed, actually, and it comes again is this a function of central level or the intermediate level as mentioned in the IHR, and there’s a question of whether the intermediate level in India would be the state level or a sub-level.

But in the case of India could you maybe go a bit more into the details of how they are organized and how they function, and how they come into the decision-making?

Because in fact the rapid investigation response teams are going to be the main provider of information you need as a national focal point and as WHO to determine whether it is a public health emergency of international concern or not.

SK: The rapid response teams, as far as our thing is concerned, is at the district level. That is about 600 districts, so you'll have to actually identify population-wise, because a district in India is very large, it's about one to four million size, so we have one rapid response team per district.

Now, at the central level we train the state rapid response team, so from the 35 states they send the team centrally, and it's for combined training – WHO's also involved in it – it's a one-week training, we train those... it's a multi-disciplinary team of physicians – a pediatrician, entomologist, microbiologist and the epidemiologist – and sometimes a statistician also there. So, these teams are trained at the central level at an ICD. It's a one-week training.

Now, they are also the training of trainers, so they go back and they train the district level teams in that state. So this is a continuous process, because many of them that the people may retire or transfer and things like that keep happening, so this is a continuous process.

So the rapid response team is located at the district level as well as state level as well at the central level.

Now, the exact role, they have not been used to the full extent. Many times an outbreak is concerned the family health centre doctor just goes and carries out a very simple investigation and comes back, so we have been emphasizing again and again that the rapid response teams should be deployed more frequently to investigate, because then they go into much detail and you may find out the real extent of the outbreak, just getting otherwise more of an administrative report rather than an outbreak investigation report, so that emphasis we have been stressing in the trainings, and it is improving but it's still not... at the state level, yes, the rapid response teams are quite effective, but at the district level, some of them it's depending on the capacity of the different states.

DF: Are there any further questions or comments? Kumanan Wilson?

KW: A quick question actually for others around here and from the other presentation. Correct me if I'm wrong, but I think this is the first presentation we heard where Annex 2 is explicitly being introduced as a component of the legislation. I think that's clear from your presentation. I just was wondering – I mean, I don't want to get into an extensive discussion and this is probably something for the afternoon – but have any other countries considered specifically introducing Annex 2 into legislation? No? Okay, thanks.

DF: Thank-you again, Dr. Krishnan. I think we'll move over to Dr. Yuri Fedorov from The Russian Republic.

My presentation is short because of time problems. Anyway, I'm here to present to you information on the state national governance relative to International Health Regulations.Beforehand, I'd like to excuse me for my not very fluent English, say, and if you will have questions I'll try to respond.

So, dear colleagues, the Russian Federation is a state with a federative structure. It consists of 88 (equal-in-rights?) administration units, including 21 republics, 7 territories, 48 regions, and one regional autonomy.

The Minister of Health and Social Development of the Russian Federation is responsible for all questions of curative care and preventive medicine in Russia. It defines national policy in the fields of medicine and public health with the Russian Federation, including prevention and control of communicable diseases. According to the national legislation, development and implementation of the policy in the field of provision of sanitary and epidemiological well-being of the population of the Russian Federation have been entrusted to the federal service for surveillance on consumer rights protection and human well-being. For short, [Russian name], which I present here.

The federal law, on 30 March of 1999 with amendments of 2003 and 2004 established a legal framework of state policy with regard of the provision of...

[Start of Side 3]

...sanitary and epidemiologic well-being of the population.

The federal law defined various terms in the field of sanitary and epidemiological well-being of the population, its provision and powers of disseminational entities and local administration.

The [Russian name] – I mean, my federal service – has a vertical structure and presented at the territorial management in every territorial level, with centralized financing. It provides a vertical policy, coordination between different levels of public health authorities from national to regional and local levels.

The system of sanitary and epidemiological surveillance in Russia has a long and rather successful history in terms of capacity to detect, notify, verify and report public health emergencies, including emergencies of international concern. As an example, I should say that a couple of weeks ago we had celebrated the birthday, 84 years. It was established 84 years before.

It is necessary to add here that according to existing regulation every order or a solution of the federal service should be considered by the Ministry of Justice in order to give them legislative power obligatory for other ministries and institutions. I mean, in the case where developed some order for our service and for the population it should be submitted to Ministry of Justice, just to stamp it, and in this case it's obligatory for other ministries.

The Russian Federation took an active part in a number of discussions on development of International Health Regulations. The Minister of Health and Social Development in the Russian Federation already informed the secretary of the World Health Organization that our federal service for surveillance on consumer rights protection and human well-being have been recommended as a national coordinator as a focal point in Russia for International Health Regulations which were adopted in May, 2005.

I'll finish my presentation, and if you have questions I'm ready to answer. Thank-you.

As you can see we have a highly vertical and very rigid system of epidemiological surveillance. (We have a law?) and of course one of the nice points for, I say for our federal service, is vertical financing. It helps a lot, of course, to be frank.

DF: Thank-you, Dr. Fedorov. A question from Dr. Lazar.

HL: I think I know the answer to this question but I want to be sure. When you describe the Russian system and the Russian Federation as vertical, if I interpreted you correctly – which I always don't do – the law-making is vertical, the necessarily legislation is passed at the level of the Russian Federation, but also the operations themselves are also managed more in a top-down than in a bottom-up fashion.

DF: Dr. Fedorov?

YF: In some republics, I mean in some administrative territories, they also prepare a kind of legislation, but it goes alongside the federal law, so it's approximately the same, practically the same. Sometimes they even rewrite it with some, (you know?), ___.

HL: And can you tell me what your judgement is on Russia's experience in managing diseases with this kind of vertical system? Is it working well, in your opinion?

YF: Well... [laughs] I should say yes. Of course there are some weak points. Sometimes the system of identification, for example, obliged them to send for... there is a list of diseases, actually, more than 40 diseases, and for so-called top dangerous diseases – say cholera, plague, some hemorrhagic fevers – they're obliged to send notification from the lower level, from... by the way, from immediately as soon as the clinician finds a case – suppose there is a case of something – the clinician should inform, according to the legislation, inform Public Health Service at the local level. Afterward the local level, within 24 hours should send the notification to the higher level. If everything's okay they send the notification to the federal level. And there's also the monthly statistic and annual statistic and so on. But for such diseases like cholera, say, and plague, they're allowed to send to the federal immediately, just as soon as there is a kind of suspicion, then can send the notification – or at least information – by e-mails, faxes and so on, the most expedited manner.

Like in many countries I have heard here, the main operation of business is going on the lower level, at the grassroots level...

JL: Another Chinese expression! I like it very much.

YF: Yes, as they say, at the grass level. Okay, so in case they are not coping with the situation, the same like in India where they are sending the team of experts, probably, for according ___, sometimes without ____, it depends on the situation. And so we have also mobile teams, mobile teams about 30 people, which can do laboratory, they can do epidemiological investigation, those teams are mobile teams, they are ready to go in, say, 12 hours, they're in constant readiness. And in the case of, say, earthquakes or ____ disease, in order to (avoid the epidemiological?) complications of disturbances they can allocate... they have 15, I think, highly mobile teams with nice equipment, and they include epidemiologists, bacteriologists, virologists, an infectious disease doctor and all this stuff. They have their stuff with them so we can bring by plane to any place. And they can work for – our experience – they can work say one month, two months – it depends on the situation – then we change the people, the stuff is in the place. So, those mobile teams are very... we consider them very useful for different situations.

DF: Are there any other comments or questions? Dr. Lazzari?

SL: You defined the system as centralized or vertical in many of its aspects, right? My question is, Russia is changing like everything else, so would you say in the future this could be revisited and modified, there could be more decentralization of some of these? Is that the direction, in your view?

YF: Sir, I got your question! They tried to modify us. [laughter] Well, actually... look, in curative medicine they gave their power to the local levels, so now we'll see that the quality of assistance for the population came lower, and like in many countries the country is very huge, we have plenty of different small outbreaks, small episodes, and in case it goes at the local level I think we'll ruin the country. We can assist in any... you know, there are some areas where we can send people immediately. They don't consider, "Well, to go or not to go? Where can we find finance?" and so on and so forth. So I think that the vertical system in this particular country in this particular time gives us a chance to support the people.

And I should say that nowadays the government and the president, they allocate more attention for this business. And probably you have heard that there was a G8 meeting, we strongly support WHO idea about this infectious disease control and so on and so forth. Now, I can't say the golden rain had come in, but they bring much more financial resources and I hope we can manage ourselves and for sure we can help the other countries, for example countries of former Soviet Union, I mean NIS countries. According to our ideas and according to the decision of G8 we'll organize a special centre on avian 'flu in Novosibirsk in Siberia. For NIS countries – and maybe other countries who are just near – they can send strains or materials to be examined and so on.

I also want to say that Australia is doing a lot, by the way, in this 'flu business. They organized and utilized the idea of international cooperation and these table-top exercises in real-time. At least they got e-mails of all our cooperators, at least, (but not the last?).

DF: Dr. Lazar has another question I believe for you, Dr. Fedorov.

HL: I just wanted again to make sure I understood. Of the, say, local and regional people who work in this field, how much of their budget comes from the Russian government, from the federal government?

YF: You mean public health?

HL: Yes.

YF: One hundred per cent.

HL: Thank-you.

YF: Sometimes they're allowed to make some extra analysis or something even for private business so they can earn some more, let's say, but normally they are governmental employees.

HL: Funded from the top.

YF: Funded by the top, yeah, from Moscow.

DF: If there are no... sorry, Dr. Wilson?

KW: Within the competing funding priorities within Russia for where money should be allocated or where money should be provided, how important are the IHR and the surveillance requirements that go along with the IHR with respect to many other public health issues that Russia is confronting now?

YF: Russia – I will explain something – they have a mentality, a Russian mentality that if something is outside, this is good. So in case – and we'll ___ this for sure – say it needs some money for implementation, so it will go to the Ministry of Finance and I think get some more money for service, because for the purposes of, say, diagnostic, they should... actually they were involved in a so-called syndromic approach – remember? – some years ago. But we were absolutely sure that the laboratory support is crucial for epidemiology, and if it will come to this syndromic approach it will ruin our laboratory service. And laboratory service should be supplied with the nice equipment, with different reagents: it needs money. So now the government gives us money for development of our __ epi(?) service, say. Of course we'll need to increase the salary, of course the equipment should be up to date, this PCR business, you know, takes a lot of money.

But thanks to, say, the SARS epidemic – or pandemic, whatever – we'll just say, "Well, it's very dangerous, and we will have a huge headache," so they immediately gave us money and we bought nice equipment and equipped practically the whole __ centres throughout the country. Now they have nice equipment. This is the way we are living. This is real life.

DF: Thank-you, Dr. Fedorov.

YF: My pleasure. Thank-you very much for your attention, and I got a lot from all of you so I hope we'll cope with the International Health Regulations. [laughter]

DF: I'd like to invite everyone to take a short break, about fifteen minutes. Coffee has been served outside. We'll come back in at 11:15 to listen to the presentation from M. André Basse. Thank-you.

...listen to the presentation from Monsieur André Basse. Thank you. There you go. You may take the mike.

Merci beaucoup. Avant donc de commencer ma présentation je voudrais juste signaler que cette présentation donc je la fais à un double titre. D'abord parce que j'ai eu le privilège donc en tant que diplomate à la mission parlant du Sénégal à Genève de prendre part du début à la fin au processus de négociation du Règlement sanitaire international. Ensuite parce que en tant que Africain moi-même je crois être en mesure de donner une perspective africaine pour ce qui est de la mise en oeuvre du Règlement sanitaire international. Je le fais donc à ce double titre et c'est la raison pour laquelle je voudrais donc adapter le contenu, le titre de la présentation à cela. Donc au lieu de capacité de santé publique en Afrique il s'agira plutôt de parler du Règlement sanitaire international, de la mise en oeuvre du Règlement sanitaire international dans le contexte africain en identifiant les obstacles éventuels et assortis certainement de recommandations.

Il y aura donc, si vous le permettez, trois parties dans ma présentation. Dans la première partie j'essaierai de mettre le Règlement sanitaire international en contexte donc de mettre ça dans le contexte africain. Ce sera l'objet de ma première partie. Dans la seconde partie j’aborderai la problématique de la mise en oeuvre du Règlement sanitaire international dans le contexte africain. Et enfin dans une troisième partie donc j’énoncerai un certain nombre de recommandations qui de notre point de vue pourraient aider à une bonne mise en oeuvre du RSI dans les pays africain. Voilà donc ma proposition de cheminement que je vous fais.

Sans tarder je voudrais donc aborder la première partie c’est-à-dire la mise en contexte du RSI donc en Afrique. Et là je voudrais énoncer trois considérations. La première considération c’est que la situation économique et géopolitique de l’Afrique fait qu’elle est naturellement exposée aux problèmes de santé publique. En particulier les maladies transmissibles infectieuses. La deuxième considération c’est que quand on parle de l’Afrique dans le cas présent, et là je parle sous le contrôle des collègues du Secrétariat de l’OMS, je parle des 46 pays membres de la région Afrique de l’OMS car comme vous le savez les 53 pays traditionnellement considérés comme pays africains, donc membres de l’Union africaine, ne sont pas tous dans le contexte de l’OMS membres de la région Afrique. Il n’y a que 46 pays et essentiellement les pays de l’Afrique sud-saharienne plus l’Algérie qui est le seul pays du Maghreb à être membres de la région Afrique de l’OMS.

Ça m’amène donc à la deuxième considération c’est-à-dire la relative homogénéité épidémiologique de ces pays-là, de ces 46 pays. Donc ils ont une relative homogénéité épidémiologique qui fait que par rapport au défi de santé publique il est important qu’il y ait une approche intégrée.

La troisième considération dans leur mise en contexte c’est la rareté ou si vous voulez l’insuffisance des ressources économiques qui font qu’il y a un intérêt évident de coopérer, en d’autres termes de mise en commun des moyens pour faire face au défi de santé publique. Voilà donc trois considérations qui m’amènent à la conclusion suivante que l’Afrique a un intérêt tout particulier pour le RSI. Ceci d’autant plus que le RSI actuel – le RSI 2005 – intègre désormais la dimension transport terrestre qui comme vous le savez constitue l’essentiel des mouvements transfrontaliers entre pays africains. Par rapport à cette mise en contexte donc il y a la mise en oeuvre elle-même du RSI donc l’objet de ce contexte-là.

Ceci m’amène donc au deuxième grand point de ma présentation c’est-à-dire la problématique de la mise en oeuvre du RSI dans le contexte africain. Je commencerai par une considération tout à fait luminaire qui voudrait que mettre en oeuvre le RSI reviendrait en quelque sorte à l’assimiler, à en avoir la conviction que c’est utile mais également à se donner les moyens de la performance. Par rapport à cette considération luminaire il y a donc si vous voulez trois défis de mise en oeuvre qui se présentent dans le contexte africain.

Le premier défi c'est celui de l'appropriation. On aurait dit en anglais *ownership*. Qu'est-ce que nous appelons appropriation? Nous parlons de l'appropriation en termes de sensibilisation des décideurs sur ce document, sur l'importance n'est-ce pas que revêt ce document. Nous parlons également d'appropriation en termes d'information et de sensibilisation de la cité civile. Je pense en particulier aux organisations non gouvernementales et je vais faire le rapport avec l'article 9 du Règlement sanitaire international qui pour la première fois – ce n'était pas le cas auparavant – prévoit un mécanisme de rapport autre que les notifications gouvernementales. Et donc ces rapports pourraient entre autres sources venir la communauté des ONG dont la cité civile.

Il est bon que ces documents aient déjà été adoptés que des stratégies puissent être envisagées pour permettre à cette cité civile de s'approprier les documents pour que demain si une maladie n'est-ce pas survient dans un pays X ou Y si pour une raison ou pour une autre le gouvernement du pays concerné ne veut pas notifier que ce [_] en vertu du RSI elle a la possibilité d'une rencontre à l'OMS pour que les dispositions [douanes] puissent être prises. Donc je parle d'appropriation également sur ce plan-là, la sensibilisation de la société civile.

Je parle également d'appropriation en termes d'adaptation législative et réglementaire. Le RSI contrairement à d'autres documents internationaux – je parle des accords et traités classiques – n'appelle pas au plan interne un mécanisme de ratification qui fait que si c'était le cas, il y aurait un débat forcément au moins au niveau du Parlement pour ratifier ces documents-là. C'est pas le cas donc du RSI parce qu'il a été adopté comme l'a rappelé hier le collègue de l'OMS dans le cadre des articles pertinents de la fonction de l'OMS qui en font des règlements.

Et donc il est aujourd'hui important, en l'absence de ces mécanismes de ratification qui auraient permis d'avoir un débat qui permettrait aux uns et aux autres, et au moins aux décideurs, de s'approprier le document qu'il y ait des stratégies également qui permettent aux décideurs politiques de savoir qu'il y a un document qui est à leur disposition et qui doit être utilisé en cas de survenance d'une crise de nature d'ampleur nationale. Donc je parle d'appropriation également dans ce sens-là. Donc voilà les trois, si vous voulez, les trois piliers de l'appropriation. Les décideurs politiques, la communauté des ONG mais également le processus d'adaptation législative et réglementaire en l'absence de ratification.

Le deuxième défi qui se pose en termes de mise en oeuvre c'est le défi des ressources humaines. Nous constatons que le RSI, en tout cas dans sa formulation actuelle, va au-delà des ministères de la santé. Le RSI n'interpelle pas uniquement les ministères de la santé. Il interpelle beaucoup d'administration au plan national que ce soient les douanes, les forces de sécurité dans certains cas ou d'autres administrations, le RSI est un document qui appelle par définition une approche nationale intégrée. Pour qu'il ait cette approche il faut non seulement que les ressources humaines soient disponibles, donc la sélection, mais il faudrait surtout que ces ressources humaines soient en mesure d'agir parce que c'est ça l'objectif final du RSI, c'est que en temps de crise les gens puissent agir. Et pour qu'ils puissent agir il faudrait non seulement qu'ils soient compétents pour le faire mais également qu'ils aient les outils nécessaires.

Et donc il est important dans le contexte présent qu'il y ait en tout cas des stratégies qui permettent aux ressources humaines de faire face à ces défis et j'ai entendu tout à l'heure dans l'une des présentations, je crois que c'est notre collègue de l'Inde qui parlait de la coordination intersectorielle qui en l'espèce nous paraît très important. Donc le défi des ressources humaines est le deuxième défi en termes de mise en oeuvre qui se pose donc dans le contexte africain.

Troisième défi et non des moindres c'est le défi du renforcement des capacités. Comme vous le constaterez également, l'annexe 1 un RSI traite du volet capacité. Ceux qui ont été à Genève pendant les négociations se souviennent des difficultés qu'il y avait à obtenir un consensus entre autres sur cette partie du document. Pourquoi? Parce que tout simplement c'est de notre point de vue en tout cas, du point de vue n'est-ce pas d'un Africain, ça va déterminer la réalité du RSI sur le terrain. On a beau avoir compris ce qu'est le RSI, on a beau avoir les ressources humaines appropriées, si on n'a pas les capacités on ne peut pas agir et donc le renforcement des capacités est un volet très important en tout cas pour ce qui nous concerne pour ce qui est de la mise en oeuvre du RSI.

Et donc il s'agit ici, en tout cas il s'agirait pour nous de la création de dispositifs conformément à l'annexe dont je viens de parler, c'est-à-dire l'annexe 1. Et puis il est important également qu'on sache que dans le cas du renforcement des capacités il faudrait qu'on aille au-delà de la bureaucratie, c'est-à-dire de la simple communication de points focaux à l'OMS. Un point focal n'aura de valeur en termes de mise en oeuvre que s'il peut, au plan national, s'appuyer sur une administration qui peut l'aider à répondre à une crise donnée. Donc la communication comme prévu par le RSI c'est une excellence chose mais au-delà de la communication il y a surtout le système interne qui soutient, qui permet n’est-ce pas à ce point focal là d’agir en temps de crise.

Voilà si vous voulez donc les trois défis que j’ai pu identifier pour ce qui est en tout cas de la mise en oeuvre du RSI dans un contexte africain. Par rapport à ces trois défis il y a un certain nombre de recommandations qu’on peut énoncer et c’est là la troisième et dernière partie n’est-ce pas de notre présentation.

La première recommandation naturellement tend à répondre au défi de l’appropriation. Comment faire face à ce défi? Je crois qu’il s’agirait aujourd’hui comme l’ont fait par exemple des pays comme l’Inde et là également j’ai suivi avec beaucoup d’intérêt l’atelier national qu’ils ont eu récemment sur ça. Il s’agirait pour nous de faire ce que nous appelons répandre le message RSI. C’est quoi le RSI et cibler des personnes qui peuvent faire la différence en temps de crise pour qu’elles comprennent n’est-ce pas c’est quoi réellement le RSI. Parce que ce n’est qu’en le comprenant qu’ils seront en mesure demain d’agir.

Donc il s’agit surtout pour l’OMS en tout cas, qui est la principale agence concernée, d’aider les pays à répandre le message RSI par l’explication par la sensibilisation et ça peut prendre différentes formes parmi lesquelles des discussions officielles mais également des ateliers interministériels ou des séminaires pour permettre aux différentes administrations concernées de comprendre réellement, donc ce qu’est le RSI et quel en est finalement l’objectif. Donc première recommandation donc c’est répandre ce message-là, de vulgariser en quelque sorte le RSI dans sa formulation actuelle.

Deuxième recommandation c’est pour répondre au défi des ressources humaines. Il est important d’or et déjà, je crois qu’on est à quelques mois de l’entrée en vigueur du RSI, il est important que d’or et déjà qu’on puisse préparer les ressources humaines à la mise en oeuvre du RSI donc c’est-à-dire à traduire sur le terrain le RSI. Et ceci ne pourra se faire que par le biais entre autres de la formation, mais également par le biais de création de cadres types de mise en oeuvre que ce soit par exemple comme l’a dit ce matin notre collègue de l’Inde, des législations types ou bien en tout cas des cadres types dans le modèle des procédés opérationnels qui sont en train d’être développés dans le cadre que constitue le groupe informel de travail sur les transports qui concerne les aéroports, les ports et les moyens de... et les points d’entrée terrestres. Donc il s’agit sur ce plan-là de la préparation des ressources humaines en les formant mais également en leur donnant des outils d’action en temps de crise.

Troisième recommandation et c'est par là où nous allons terminer c'est l'appui au renforcement des capacités. Il s'agit... hier je crois c'était le premier présentateur, le professeur David Filbert, je crois, a parlé... a fait le rapport entre le RSI et les différentes prises de parole publiques du secrétaire de l'ONU. Il a également fait mention des OMD c'est-à-dire les Objectifs du millénaire pour le développement. Je vais ajouter à cela que juste avant que le RSI ne soit adopté en mai 2005, l'Assemblée générale de l'ONU avait adopté une résolution qui encourageait les États à aller assez rapidement dans le sens de l'adoption et ceux qui ont vu la résolution par laquelle l'assemblée de la santé a adopté le RSI s'en rendront aisément compte.

Je veux dire qu'il y a un contexte politique également qui entoure le RSI et il est bon de saisir cette opportunité qui est offerte pour appuyer le renforcement des capacités et ça peut prendre diverses formes parmi lesquelles je crois que c'est surtout les agences de développement qui seraient interpellées, il s'agirait pour elles en particulier d'envisager la possibilité d'intégrer le RSI dans leur programme de coopération avec les pays concernés. Je crois que ça serait une manière concrète et pratique d'avancer cet agenda et RSI dans ces pays-là qui malheureusement ont un problème de capacité, l'intégration du RSI ou en tout cas certains de ces volets dans les programmes de coopération.

Donc voilà si vous voulez les trois recommandations qui émergent des défis que nous avons identifiés plus tôt et c'est avec ça donc que je voudrais terminer en me mettant naturellement à votre disposition pour les interpellations et commentaires éventuels. Je vous remercie.

Et je vous remercie M. Basse pour votre intervention. J'ai l'impression qu'il doit avoir des questions et des commentaires à la suite... I'm opening the floor for questions or comments. Mr. Bruce Potkin or he likes to be known doctor.

BP:

AB: Merci beaucoup Bruce pour cette question. Oui, je crois que pendant les négociations le groupe africain n'a eu de cesse d'articuler en rapport avec d'autres groupes, je pense notamment au groupe [SIRO], n'a eu de cesse d'articuler l'importance des points d'entrée terrestre pour une raison toute simple. L'essentiel de l'activité transfrontalière en Afrique, en tout cas le mouvement des personnes, se fait par ce biais-là et ceci est dû à diverses raisons parmi lesquelles la plus évidente c'est le caractère artificielle des frontières entre pays africains.

Je vais donner un exemple tout simple: entre le Sénégal qui est mon pays et la Gambie qui est au passage à l'intérieur même du Sénégal, vous avez d'un côté comme de l'autre de la frontière les mêmes populations. Et vous pouvez par exemple prendre votre petit-déjeuner au Sénégal et avant midi vous retrouver en Gambie pour prendre un thé et revenir au Sénégal pour prendre votre déjeuner. Donc je donne cet exemple à titre anecdotique pour montrer le caractère artificiel de ces frontières.

Et donc si on adapte ça au RSI en cas de survenance d'une maladie infectieuse il est évident que la personne qui se promène avec autant de facilité dans la frontière, s'il n'y a pas un dispositif ou un filet de sécurité, il est évident que la maladie se propagera d'une manière vraiment insoupçonnée. Donc c'est la raison pour laquelle entre autres nous avons estimé qu'il est bon, pour une fois, parce que ce n'était pas le cas dans le précédent RSI que ce volet-là puisse être pris en charge. En le faisant nous sommes conscients du fait qu'il va falloir, comme c'est le cas aujourd'hui pour les aéroports ou les ports où il y des systèmes plus ou moins avancés, parce que tout simplement ils ont le [privilège] d'être [traités] auparavant, il va falloir dans le cas des points d'entrée terrestres, faire preuve de patience compte tenu de l'énorme défi que ça constitue pour tout le monde. Et donc nous nous inscrivons dans une dynamique de développement progressif des mécanismes de contrôle au niveau des points d'entrée terrestres. Je vous remercie.

DF: Dr. Krishnan?

SK: I think about two years back we read a lot about the Afro region disease surveillance system, and in fact when we were helping the Indian government prepare the integrated disease surveillance project we copied or relied heavily on the Afro system of diseases surveillance which involved all these countries together, not as individual surveillance systems but putting all these countries together and having a unified type of a surveillance system. And lately I've not been hearing much about that system. Is it that because of funding constraints or anything that this has slowly gone in decline? Because it's important that such systems continue to be in place, otherwise it can affect International Health Regulations.

AB: Merci beaucoup. Théoriquement oui. Donc je crois que... je vais donc s'il le faut... les collègues de l'OMS vont me compléter sur l'effet par rapport à ça. Mais ce que j'ai pu dire en tant que observateur attentif des questions de santé en Afrique c'est que théoriquement on a un cadre qui nous permet d'agir ensemble. Or comme je l'ai dit dans la présentation c'est pas très envisageable que chacun des 46 pays puisse agir de manière isolée. Donc l'idéal c'est qu'on puisse agir ensemble et on a un cadre pour cela c'est la région Afrique donc de l'OMS plus connue sous le nom de Afro. Et donc ce système dont vous parlez pourrait par exemple être envisagé dans ce cadre-là. Et c'est là malheureusement la limite. Vous comprendrez que dans la région africaine il y a beaucoup de priorités et tout est prioritaire. Et dans le cas de RSI il s'agit d'un mécanisme de réponse à des crises.

Ça veut dire que vous répondez à quelque chose et tant que ça ne survient pas, en tout cas de manière vraiment très imposante, vous pouvez être hésitant par rapport aux programmes et politiques que vous allez mettre en oeuvre. Et ce système pourrait être victime des hésitations qui a moins à faire avec une volonté d'aller de l'avant que la gestion du réel, du quotidien qui fait qu'il y a beaucoup des priorités qui malheureusement sont toutes pressantes. Et ceci remet sur la table l'importance qu'il y a de répandre le message que constitue le RSI. Il faudrait que les gens sachent que c'est très bien de gérer le quotidien mais également c'est très bien de se préparer à des situations qui ne manqueront pas de toute façon de se poser. Et donc là je crois que la responsabilité est partagée entre les états membres mais également l'OMS en tant qu'agence responsable et interpellée pour aider la mise en oeuvre des stratégies qui rendent cette partie prête ou pour le moins quelque peu prête à mettre en oeuvre le RSI.

DF: Dr. Lazzari?

SL: Monsieur Basse, je crois que vous avez touché le problème plus grave effectivement de la mise en oeuvre de RSI dans la région africaine. Et c'est le fait qu'ici on est en train de discuter des risques potentiels et essayer de mieux s'organiser pour répondre à des risques potentiels. Dès que la plupart des pays africains font face chaque jour à des véritables fléaux tels que le sida, la malaria, la tuberculose et beaucoup de maladies, et ils ont du mal effectivement à gérer la crise journalière. Alors à ce moment-là investir des ressources et s'engager sur des risques potentiels futurs deviennent une décision politique difficile. Et moi je crois qu'il y a deux stratégies possibles sur ça. La première justement c'est l'intégration et c'est ça qu'a dénoté le collègue de l'Inde qui est la stratégie de la région africaine d'agir d'une façon d'intégrer que ce soit la surveillance ou le système de réponse pour les différentes maladies infectieuses. Et la mise en oeuvre de RSI dans la région, ce renforcement dans le contexte de système de surveillance... à ce moment-là de placer des ressources ou investir des ressources et s'engager sur des risques potentiels futurs devient une décision politique difficile.

Et moi je crois qu'il y a deux stratégies possibles sur ça. La première justement c'est l'intégration et c'est ça que vient de dénoter le collègue de l'Inde qui est la stratégie de la région africaine d'agir d'une façon intégrée que ce soit la surveillance mais aussi le système de réponse pour les différentes maladies infectieuses, et la mise en oeuvre de RSI dans la région, ce renforcement dans le contexte de système de surveillance de réponse intégrée. Et ça c'est la première chose.

Et la deuxième je trouve, un peu touché assez rapidement hier sur ça, les éléments fondamentaux de base qui sont vraiment nécessaires et qui sont pas forcément trop coûteux, trop complexes, qui demandent pas trop de ressources et qui peut utiliser ce qui existe déjà dans la meilleure façon. Il faut pas, et je crois que ça va être le danger peut-être de certains pays africains, être trop ambitieux, c'est-à-dire aller construire de grands laboratoires au niveau P3 ou P4 ou P6 qui existe quand même, ou essayer de développer des systèmes trop complexes autour d'un risque parce qu'à ce moment-là je crois que la réponse politique, la réponse de ressources et peut-être aussi la réponse de bailleurs de fonds potentiels va être négative ou limitée, si vous voulez. Et c'est une véritable approche stratégique qu'il faut faire, mais je crois que le défi sera justement ici.

Par contre on a peut-être une attention à ces problèmes dans les pays africains qui peuvent sont plus relevés que dans les autres régions ce qui rendra certaines choses plus faciles et je suis optimiste que beaucoup de pays en Afrique soient déjà bien avancés dans les concepts. Ils ont déjà pas mal de choses en place, pas mal de ressources disponibles. Ce sera peut-être le cas de mieux les organiser, mieux les gérer et les développer davantage si on peut. Voilà.

[Start of Side 4]

SV: Donc pour suivre en français... Alors en français de Paris... La question aussi se pose par rapport à l'exemple récent qu'on a eu au Nigeria avec à la fois une importation de volailles clandestines, apparemment, d'après ce qu'on a pu en savoir, qui a contaminé pas mal d'élevages domestiques et une dispersion ensuite de volailles contaminées dans différents marchés du Nigeria avec une non-décision, on va dire, des autorités sanitaires du Nigeria de fermer les marchés. Et donc on voit bien que ça répond aussi à des problèmes économiques puisque c'est des élevages familiaux, bon il n'y a pas vraiment de possibilités de compenser les pertes de vente et donc il y a eu un libre marché qui s'est maintenu même en période d'alerte y compris sur des marchés transfrontaliers avec les pays riverains et donc une grande inquiétude de certains pays riverains du Nigeria.

Donc la question qu'on peut se poser par rapport à cette présentation, si on a une démarche effectivement intégrée à la fois de surveillance et de réponse, quelle va être la possibilité d'action donc supranationale et éventuellement pour pouvoir d'abord imposer certaines mesures sanitaires de base, pouvoir fournir un certain nombre d'aide financière pour justement compenser les pertes chez les éleveurs qui signaleraient les élevages contaminés, et puis s'assurer de la traçabilité des poulets que ce soit en importation donc tout le réseau de contrôle vétérinaire, de contrôle des fraudes, est-ce qu'il y aurait moyen dans ce cadre-là de le renforcer par une action qui serait un peu comme les casques bleus sanitaires?

AB: Merci beaucoup. Je crois que l'intervention du docteur Lazari c'est plus une addition à ce que j'avais dit donc des commentaires que je trouve d'ailleurs très pertinents et c'est la raison pour laquelle donc que je ne suis pas intervenu à sa suite. Donc je crois que c'est à titre de contribution qu'il a fait ça et c'est une contribution donc qui va dans exactement le même sens que nous l'envisagions.

Par rapport au docteur Végrat, le problème de l'action dans un cadre plus ou moins supranational. D'abord la question de la démarche intégrée. Je crois que quand on parle de démarche intégrée peut-être que j'aurais dû préciser ça auparavant. La région Afro constitue le dernier palier pour ce qui est d'une démarche intégrée éventuelle qui serait en tout cas efficace. Au sein de cette région vous avez des sous-ensembles. Et pour ce qui concerne par exemple l'Afrique de l'Ouest vous avez au moins deux sous-ensembles, vous avez le sous-ensemble [UEMOI] une organisation économique mais également qui s'affirme de plus en plus n'est-ce pas sur les questions de santé et ça regroupe huit pays qui sont tous frontaliers et sont un groupe homogène parce qu'ils sont tous francophones également comme vous le savez.

Il y a un autre sous-ensemble qui est plus large donc c'est la CDAO, donc ECOAS en anglais. C'est également un sous-ensemble qui s'affirme de plus en plus sur le plan sanitaire et qui pourrait être le cadre, le plateau d'une démarche intégrée de premier niveau avant d'aller maintenant donc au niveau supérieur. Et dans le cas justement de cette CDAO-là le Nigeria qui est d'ailleurs le plus grand pays de cet ensemble pourrait naturellement être amené à une certaine supranationalité car il serait un peu difficile de le faire s'il n'y a pas un plateau déjà créé pour cela. Et cette supranationalité prendrait la forme d'une responsabilisation de ces organisations dans le domaine de la santé en matière de surveillance mais également en matière d'action quand c'est nécessaire et sous l'umbrella de l'OMS au niveau régional d'abord et puis peut-être éventuellement au nouveau siège.

Donc voilà les possibilités qu'on aurait en termes d'action supranationale. En dehors de ces plateaux, de ces cadres il serait difficile d'envisager une quelconque supranationalité car ce serait la faire prendre la forme d'accords bilatéraux et c'est pas encore le cas et c'est pas non plus envisageable dans l'immédiat. Merci.

DF: D'autre questions? Other questions, comments? Bon, je rends merci, M. Basse, and thank-you to all of you. I think we'll break a little early for lunch. Bon appetit. We'll start again at 1:15, une heur et quart.

For this last afternoon the procedure we're proposing to follow is the following. For the next hour or two we will have some substantive discussions. First David Fidler then I and then Kumanan Wilson will convey to you some of the things that we've learned from the presentations, the country presentations. There will then be some opportunity for discussion amongst all of us about what we have said, and we look forward to a good dialogue amongst all of us on sort of the analytical conclusions that we are drawing, and I would hope you would participate fully in that discussion.

And then the last part of the afternoon – and we will be finished by 4 o'clock – the last part of the afternoon will be devoted to next steps, where we plan to take the work of this workshop over the next couple of months.

So, first part of the afternoon will be on sort of observations, analysis – at last preliminary analysis – and some evaluation. The three of us will start the conversation but I would hope you would all participate on next steps. And at end the afternoon if any of you have any logistical questions about hotels or airlines or anything else, please do let us know.

We'll start off with David Fidler.

Thank-you. All of us, in terms of what we're going to present this afternoon from the panel organizing committee, we've obviously drawn these thoughts together quickly, so they remain works in progress themselves.

I want to talk about issues related to what I call public health sovereignty, and perhaps my comments might be the most conceptual of the responses that we're going to give, but let me try to lay out some of the trends with regards to how countries are exercising sovereignty for public health purposes that we've been talking about in relationship to the implementation of the IHR.

We've been focusing on different country level responses to how the implementation of the IHR may or may not challenge how governments go about exercising their public health sovereignty. And I'm using "sovereignty" in, really, two legal senses. One is in connection with the international context or international law, and the International Health Regulations are a Treaty, it's international law that relates to issues of sovereignty from a nation state point of view, but we've also focused quite a bit on issues of constitutional or domestic government and how governments are organized to deal with things, and how the international legal obligations may or may not fit into the existing constitution or domestic legal system that countries may have, and what may or may not be responses with regards to that issue.

In connection with thinking about what's happening to public health sovereignty with regards to the issues that we've talked about in terms of the implementation of the IHR, I've tried to identify what I see as some trends, and this is where I want to focus my remarks this afternoon, because I think I see three basic trends as I listen to the material presented from the different countries, and also reflecting on the work that I'd been doing on the IHR myself, as well as issues of global health governance.

And I'll just briefly describe these. Obviously I can't go into a lot of detail given the limited time that I have but I hope I at least can communicate to you in simple terms what I sense is our trends.

The first is I think we're moving from a situation of more traditional intergovernmental forms of cooperation – which we saw, I think, illustrated in the old International Health Regulations – to what I call the globalization of governance. And I think the new International Health Regulations are one of the best examples of this type of globalization of governance that's happening not only in the public health context but in other areas of international law and international relations, and I'll come back to that with some examples.

The second, particularly in relationship... this trend particularly relates to those states that have a deep tradition of federal government and a decentralized approach to public health. I think we're seeing a trend away from decentralized government to a centralization of governance, and I want to stress that there is a difference between governance and government. We have talked about the challenges that federal states are approaching, and sort of the static constitutional or domestic law aspect of that, but that framework doesn't match the type of collaboration and coordination and changes that are happening as a matter of governance within these countries, and it seems to me that the trend is towards centralization of that process.

Third, I think there has been a change from, I think, complacency at the level of governments – this could also be at intergovernmental level as well – but a shift away from sort of complacency and a go-along-get-along attitude towards and intensification of governance activities. Whether we're talking about the global level or the local level things have dramatically changed. Dr. Marfin talked about the change at the CDC where they were ponderous and slow but they got things right, but that's not the reality they work in today, it's sped up tremendously in terms of the demands on their time and their energy, and I think that's happening across the board in terms of actors that are involved in governance activities.

And fourth, I think we've moving away from a heterogeneity of approaches to public health problems towards and a harmonization of strategies and operations in terms of dealing with this issues, and again I think we see that at all different levels from the global to the local level, and I think that's an important trend to keep in mind.

As I look at these different trends I think it's important to realize that they're interdependent trends. In other words, the trend of the globalization of governance is connected to intensification and centralization as dynamics that are also taking place with regards to these issues, and I think those are also all feeding into how we are in the process of slowly – if painfully – harmonizing our approaches to these particular events and problems that we're trying to deal with from the point of view of public health.

And I think it's also important to see these trends all converging, I think, to really change the entire nature of governance that we're thinking about with regards to public health. In some of my writings I've tried to communicate this by using this term that public health governance has sort of moved into a new world order, and these are I think four of the trends or factors that are driving public health governance into this dramatically new environment that we face. Yes, not everything is new but I think even when we talk about the importance of collaboration and voluntary compliance between state level and federal level, yes that still goes on, but I think that collaboration and coordination is fundamentally different today than it was ten years ago, and I think these trends help explain why that's the case.

And just some examples of each of these trends to put a little more specificity in these conceptual issues that I'm talking about – and this may or may not help you understand what I'm trying to communicate – as I said, I think the IHR 2005 are one of the best examples you could find of the globalization of governance, there are various aspects of this which indicate that we're moving the strategy, we're moving authority away from the nation state level up to the global level. For example, WHO has more authority to make decisions and to act than it did under the old International Health Regulations. I think that's a significant change which illustrates the globalization of a governance approach. The involvement of non-state actors through WHO being able to access and act upon information received from non-state actors I think is an example of that. And finally, there are much more demanding obligations on WHO member states than we've ever seen in any previous incarnation of the IHR or its predecessor regimes.

In terms of the centralization of governance, I think we've seen, even in those states with a deep tradition of centralization, a growing role for federal and national governments in public health, especially in the infectious disease area. I don’t think it’s, particularly from the U.S. point of view and perhaps even the Canadian point of view, that there’s no question that today the federal government plays a bigger role in terms of public health. And again that’s part of authority moving up to a higher level of political accountability and political responsibility than we’ve seen in the past, much in the same way that some of that public health sovereignty at the national level has gone up towards the WHO.

In terms of intensification of governance we see... and here the examples comes from, really, non-federal governments, or governments with a stronger history of centralized, hierarchical government, but even in that context we’ve seen intensification of governance activities taking place, and we’ve heard examples from China, India, France and Russia about this intensification process that’s taking place as countries try to catch up with these problems that we face today with the issues that IHR 2005 are designed to deal with.

And finally, in terms of the harmonization of governance, again I think the IHR 2005 is important in that regard. And you can think, for example, about Annex 2, the algorithm, about how we’re going to approach this type of notification is something that’s sorting of catching on from the global level and countries are thinking about using that at the national and the local level. We’ve even heard the concept of public health emergency of national concern, which is really based on the algorithm of public health... you can see the harmonization of the strategy taking place here. And I think that also helps explain why the cooperation between federal and sub-federal levels is both intensifying but that cooperation is also focusing on and trying to achieve harmonized strategies. So we’re not changing the underlying constitutional structure. The governmental structure remains the same but the governance is fundamentally being changed.

I think as Bruce Plotkin pointed out earlier many of these changes that we’re seeing in terms of globalization, centralization, intensification, harmonization, are not caused by or necessarily even driven by the new international health regulations. What’s fascinating about the new IHR is that they’re hitting this trend and they’re sort of catching the wave and riding these forward to create this new regime, but I think there are other driving factors that we have to keep in mind that feed into all four of these trends.

The first I think is the heightened importance of the use of new information and new communications technologies. For example, in terms of harmonizations you begin to use these technologies, you’ve got to have standard operating procedures in order for them to be interoperable. I mean, that by its very nature forces harmonization, and it also then facilitates intensification, etc., etc.

We also see the design of new public health strategies for these globalized problems, and again that’s where I think the IHR 2005 is important, but we also see these changes taking place at the national and the subnational level and sort of rethinking how we approach public health in a globalized world.

I also think another driving factor of this is how conceptually we’ve begun to think about public health problems differently, and for me one of the best examples of that is the use of security as a lens in thinking about public health. The International Health Regulations are directly tied, in WHO’s thinking about this, to the concept of global health security – we heard the Australian presentation talking about a new national health security act – and so when we started thinking about public health differently as well that also, I think, encourages us to move in the direction of the four trends that I illustrated earlier.

The involvement of non-governmental actors I think is critical as well as a driving force in these situations. Again, think of the international health regulations. WHO gets lots of information from all different kinds of sources but it has to verify what is rumour and what is fact, and in order to do that properly you have to have a centralized, harmonized approach to that particular problem.

Then I think we can also see as driving these trends the demand for as well as the supply of either new legislation or new norms or new principles or new standard operating procedures, call it whatever you will we need to have sort of a framework of rules and principles that drive and that move these trends forward in a way that hopefully has an impact on public health problems.

So these trends, I think, are going to be continued in the future, that’s why I said they’re becoming trajectories with regards to how the exercise of sovereignty for public health purposes in the future is going to unfold. The IHR is an important part of that but it’s only one part of a much larger transformation of the nature of governance with regards to the public health that we’re going to be seeing in the near and far future.

I’ll stop there.

As David mentioned, we were all making notes as the conversations were proceeding over the last day and a half, and David has given you some broad trends. My remarks will not be on trends but they will be on a more static analysis of what I interpreted you to be saying.

I have to say my remarks will not focus on the African presentation for two reasons. The first one is that I was finishing my notes as the African presentation was being made, but also because – and more importantly, I think – because the substantive presentation from M. Basse highlighted for me the differences between Africa and other parts of the world, and I would have to think more about whether what I have to say has any relevance for Africa.

When I try to understand what you were saying over the last couple of days it struck me that the governance that was being talked about fits into at least two categories. One is the architecture or the rules, the broad rules, and who makes the rules, who makes the legislation, who makes the broad framework for your country. When I say "who" is it the national government, is it the regional government, is it the local government, is it some combination of governments. So, who makes the rules, and then secondly who operates, who does things in the field? So my comments that follow will make a distinction between rule-making and operations.

When I think about governance I often ask this type of question. When there's intergovernmental relations involved is the relationship between the different levels of government hierarchical or non-hierarchical? And by "hierarchical" I mean is one order of government – one level of government – imposing its will on the other level of government, or are the different levels of government interacting with one another largely on the basis of equality and partnership, so is there hierarchy or is there partnership.

The second question I ask myself is whether or not the relationship between the governments is one of interdependence or autonomy, and of course in relation to rule-making and in relation to operations you can get different answers to those questions about hierarchy and non-hierarchy, and interdependence or autonomy.

I usually end up with a diagram that looks something like this, apart from problems in spelling in this. You can have relationships which are hierarchical but interdependent, and in that particular case one level of government is the more powerful and forceful level of government but it still is working in a partnership with the other levels of government. You can have governments acting independently of one another. This may not be very common in the public health field but in other fields it may be. Of course you could have also a relationship of interdependence but which is reached on a largely voluntary non-hierarchical basis. And so government relationships can be characterized by any of these four quadrants.

Now, what I have done is I have decided to try to characterize each of your countries by putting you on the map here, somewhere on this particular map, and what I expect you to do is when you see the way in which I have characterized your country to tell me I have it wrong. And I don't mind that because I probably will have it wrong, but if I can get you to tell me I have it wrong then you'll be telling me what's right and I'll be drawing you out.

Now, one of the difficulties when I do such a simplifying exercise is you may well say to me, "It's impossible to cover all the diverse activities that we're describing in public health or the new International Health Regulations in one simple characterization. The world is far more complex and far more nuanced," and of course I know that, but I'm still looking to try to compare and contrast among the different countries, and so what I will do first is show you this same simple diagram with a focus on rule-making rather than on operations.

Now, the impression I got from what was said was that in three of the countries – again, I didn't cover Africa here – that in Russia and Brazil and in China the rule-making was largely done at the central level, that the central government – the federal government or the central government – set the rules both for the central level and for regional and local levels, that there's not a lot of interdependence in the making of the rules, that the Russian, the Chinese and the Brazilian governments – if I interpreted you correctly – basically set the rules at the central level, and that the other levels of government, if you want, are rule-takers, they are not rule-makers, there is not a lot of cooperation in how the framework is established, it's done hierarchically and it's done independently by the central government.

At the other extreme – again this is just my interpretation – is this lonely northern country called Canada where the framework, the broad framework for decision-making, the rule-setting, is done in some sort of collaborative fashion without a substantial force of... without a lot of imposition, sort of a cooperative basis, by the federal and provincial governments – not by the local governments, by the federal and provincial governments – and that it's implicit in what they do that there is going to be a lot of interdependence and a lot of cooperation in rule-making – not operations – but that there is no strong imposition.

I thought from the U.S. presentation that in a rule-making, rule-setting context where there was a strong reference to the history of the United States and what the constitution said and so forth, that the framework struck me as being one which depended on cooperation between governments – which is kind of my horizontal axis – but that it was done in a relatively non-hierarchical fashion.

And with respect to Australia, France and India, you can see that I've characterized things as a stronger imposition from the centre downward in terms of setting the rules. In the case of France there's the history of being a unitary state which is in the process of being changed over recent constitutional amendments. It remains a unitary state, but a unitary state which is becoming much more deconcentrated and decentralized – both of them – and so someone who knew France 30 or 40 years ago and knew its governance and looked at it today would have a hard time recognizing the old French regime with its reliance on the prefects and so forth compared to the new regime, but I still think the rule-making is significantly centralized. And Australia, which is of course traditionally a strongly-centralized federal state I think is in the same category. And I also had the sense that India, that the rule-making came strongly from the centre.

I didn't reach the same conclusions with respect to operations. In the operations sense, again I thought that Russia, Brazil and China, my impression was that it wasn't just the rules that were driven from the centre and quite a large amount of hierarchy, but also that the operations were very similar. Dr. Fedorov talked about the fact that all of the money flows down from the centre to the local regions and that in fact they rely almost entirely on central government money – federal government money – to operate at the local level.

I was not sure I interpreted the Chinese situation correctly so you may well want to correct me, but I had the impression that the operations in China, even though there was four levels from a central to a regional to prefectural to a county level, I had the impression that this was heavily managed from the centre, and so if I'm wrong you can correct me about that.

And in the case of Brazil, again I'm open to corrections.

With respect to France, even though I thought the French rule-making was quite centralized it was my impression that the operations in France have become much more cooperative, all governments are often at the table and that it's become a more decentralized form of operation in France than was the case years ago.

With respect to the United States, I'd put the United States in the bottom left-hand quadrant in rule-making, but my sense is that the central government, that the federal government – indeed the White House – has become much more important in driving the federal system.

So what I've really tried to do is play back for you my impressions of how, both in rule-making and in operations, the different countries gathered around this particular table compare to one another.

Now, what I did not do in this, and what David did in his presentation, is David talked about trends, the dynamics, the direction in which he sees things going. Whether this is accurate or inaccurate this is static, this is a snapshot of what I heard you to be saying to me about your particular countries today. And interesting, even once you've reacted to this and I've made some adjustments and corrections to take account of how you will correct me, a separate question would be, whatever the correct snapshots may be, is there a trend within your country, and is that trend along the lines... remember David made a distinction between international law and domestic law in his presentation, and when you react to my particular presentation it would also be helpful to have a sense from you whether your domestic law is moving in a direction which he talked about, which was moving towards more centralization – or not – and whether it's moving in some of the other directions.

I will stop my presentation now – and we can bring these back later and you can make comments on it – and I'll turn it over to Dr. Wilson for the last of our quick presentations, and then we will open it up to a general conversation.

Thank-you. My presentation really is more intended to be a lead-in to a discussion rather than a synthesis, but in leading into this discussion I thought it might be worth discussing some guiding principles that seem to be overlying the discussion today, so obviously the discussion being characterized by the importance of the International Health Regulations, importance of countries being able to comply with them, and also with some of the challenges the IHR poses to decentralized states.

I think it also became clear that this is... we’ve been talking a lot about governance here but this is really a combination of both governance and capacity and the two need to work hand in hand. Having one without the other will reduce the effectiveness of any approach.

And was mentioned by Dr. Fidler and Mr. Plotkin, the changes to public health governance are influenced by the IHR – the IHR is obviously, to an extent, prescriptive – but also several other processes occur coincidentally, and the changes had been occurring in nations prior to this.

I think it’s also important to emphasize – and I think this is a critical issue – every country is unique, every country will have a unique governance system, and obviously it would be impossible to have one solution that fits every country, recognizing this. Every country also has a different history, a different history of centralization versus decentralization, and it also became clear – we heard about the U.S. talking about anthrax and September 11th, Canada talking about SARS, Australia talking about Bali – they’ve all had their own unique experiences that have influenced how they’re approaching these issues.

It was also evident in several of the presentations that the sovereignty of regional governments within countries is critical and must be respected, and that has to be taken into consideration when developing these governance strategies.

And it is also clear that public health responses are fundamentally dependent upon effective public health collaboration which goes through all of the orders of government, and strategies that may perhaps on the surface result in a better ability to comply with the IHR may impact upon this collaborative relationship and may actually ultimately be dysfunctional.

This is essentially what I was hoping maybe we could have some discussion on, and I open it up to my colleagues here as well to ask questions on these issues. Essentially the question is when do we centralize or when do we rely on a more decentralized system, and obviously there are tensions between both options and we need to balance these trade-offs. And particularly with respect to centralization I heard here in several presentations different approaches to trying to centralize operations.

Obviously public health legislation – or legislation of some sort – was frequently mentioned, particularly in more of the centralized federal states or the unitary states. In states where that clearly is constitutionally not possible I heard about the policy option of using parallel legislation, and security became probably the one that seems to be coming up most frequently in that area, and perhaps by using security, which may be considered an issue of federal concern, some of the issues in the IHR could be addressed.

Funding arrangements were also mentioned. There's only two broad categories of funding arrangements. One would be non-conditional funding, or the other option is conditional funding which could be again tied in with legislation, and that seemed to be an effective strategy that's been utilized in several countries. And often, again, the funding goes hand in hand with the legislation.

And finally I also heard about the use of intergovernmental agreements and memorandums of understanding as perhaps a less aggressive way to achieve the same policy objectives.

So I think these are some of the questions that it may be worth just spending some time discussing. There are several core capacities that are in the IHR. On which core capacities is it worth considering to more centralized approaches? Which ones are so important that is worth willing to accept some of the trade-offs and perhaps damaging these collaborative relationships or perhaps infringing to an extent on local sovereignty? And in moving to centralized approaches, how do we manage the impact of these approaches? Obviously simply having legislation doesn't guarantee that you'll be able to meet the requirements of the IHR, it has to go hand in hand with developing capacity at the local level, and it also has to go hand in hand with the ability to enforce the legislation.

Finally, in countries that have chosen to explicitly not take aggressive or more centralized approaches are there mechanisms that they can utilize to ensure that they can comply with the IHR.

So I thought that seemed to be the fundamental issue that was coming up here – I don't think this will be a surprise to anybody here, this is probably what everybody's been... a lot of these people have been struggling with, and I guess it would be worth getting the perspective of some of the people around here on some of these issues.

David, maybe you should come up to the table. I guess we would open the floor for comments and reactions, suggestions, criticisms, improvements, or if there are issues that you think are important that we ignored so far in our comments we'd be glad to have them, so the floor is open. Bruce?

Thank-you very much.

First, although it's way too early to say our final thank-you's I do want to say thank-you because this has been a very, very informative couple of days. It's our job, together with the rest of WHO and all the member states, to figure out how to get this large new car that Stefano was building moving, with all of us essentially in the same direction. And there are a lot of issues, it's true, and so in this kind of gathering we get a lot of questions but at least one of the most important aspects for me is we get specific questions rather than just sort of very generalized concerns, questions about I need to be able to do this, and in order to do this I need x. That's very helpful. It's really critical because otherwise you just have a big, undifferentiated mass of concerns.

[Start of Side 5]

I won't repeat the points that have been made already about the fact that right now we are experiencing a lot of globalizing trends, and that the IHR is part of those trends and one way of dealing with those trends.

One thing I do want to sort of reinforce is again the uniqueness of each country's political system, because it's based on who the country is, where the country comes from, who the country's parents are, what the sensitivities of each of the levels is, and for that reason I think the solutions are going to have to be unique and specific to each country, and that they're going to be largely based on negotiations in terms of allocating responsibilities and rights in terms of accommodating the new IHR.

Now, some of these... like any family, some of these negotiations are going to be weighted in favour of one partner or another, but in this way this kind of accommodation among all of the levels in a government, and this sort of agreed resolution, is no different from what countries have to do under many international agreements, and in fact what countries have to do in response to any international challenge, is they have to figure out who's going to do what in order to go forward.

And what has been very gratifying is to see the way that the countries here have sort of plotted out, “Okay, this is what we have to do, this is who’s going to do this.” It’s very gratifying.

On this, Dr. Wilson pointed up a number of strategies that the States had used – “States” with a capital S – had used, that the various governmental units had employed to deal with each other within the state, but you left out one that I thought was really very important, and one that I hadn’t thought of, and that was the one that my colleagues here brought up, and that is the use of professional associations in standard-setting, because... I mean, it has a lot of advantages, it seems to me, if it can be made to work, because legislation takes time, legislation takes a certain kind of political work that can cost a lot in terms of investment of time and energy and creates a lot of problems that accommodations among professionals, if standard-setting can be done on a reasonable consensus basis, it seems like it’s a much better way to go. It’s not going to be available in all situations but it seems a very good approach to try.

I know I’ve said it before but the IHR really are, for the most part, result-oriented. Now, the results that are mandated under the IHR do of course have some impact on what states have to do in order to get to those results, but for the most part I know the member states tried very hard not to get too specific because the internal situation in Mr. Basse’s country is not the same as the internal situation in Mr. Marfin’s country, and yet you had to come up with Annex 1 which had to be one-size-fits-all, and the result was that for most of these provisions, even when there is some detail, the intent was to leave it up to the country to figure out who does what and exactly how things are accomplished.

One issue that was touched on a little bit but I want to emphasize is that when we talk about federalism we’re talking about vertical relationships, and these are difficulties – I mean, let’s be clear, these have to be accommodated – but in terms of responding to international disease transmission, for me, and based on what I’ve heard – and remember I talked to a lot of health ministry people – one of the biggest challenges is the horizontal challenge, is getting the ministries – all ministries – involved in the process of understanding the IHR, agreeing on the IHR and what they mean, and then moving forward to implementation.

The biggest example of this right now is avian influenza. I mean, in many places it’s a big deal just to get the doctors of human medicine to come to an understanding with the doctors of animal medicine, and then you have the issues between the public health sector and the Department of Agriculture. These are also big challenges.

And what, again, is very gratifying to me is that when I hear the presentations the countries all recognize this, and virtually all of the plans that we've heard about now incorporate all the ministries – all the relevant ministries – and get them involved in the process. And that's very different from the way it was back in 2004 when the negotiations started, because then it was principally Ministry of Health people talking. So that's a big difference from back then, that all of these ministries are involved. And that's critical, because if they're not it's not going to go forward in the way it really should.

And this is just me talking, now. There is a tendency to talk about WHO has if WHO has power, as if WHO is a big box in the middle of the room, and it's a big machine, and you're not really sure what it is and where it's going and all of this, and it has inscrutable power because it has certain things inside of it. Under the IHR the member states got together and faced these issues about who does what, who has responsibility for what, and they came to a decision that in certain circumstances, in order for the benefit of the collective whole, there had to be some sort of ability to act in a fairly rapid, organized manner. And once that conclusion was reached then the question was what kind of procedures, what kind of accountability, what kind of transparency requirements should be imposed.

And that was, to a great extent, what the negotiations were about, exactly how to construct that balance, because at the beginning of the day – and the end of the day – WHO is a constituency organization. I mean, WHO is the member states. Anyway, that's me, that's the way I personally see it.

The last item is that we are here, Stefano and I, to provide support to member states and to provide information to the extent we can to help out address these issues and other issues, so if you have questions we're here. Thank-you.

I just want to follow up that point, because I think avian influenza is a good point, and one suggestion, because I like the analysis you've done, I like the static analysis and the areas where you see the rule-making governance, but the IHR's are meant to deal with threats to human health which are broader, and we've tended to focus, yes, on the SARS, the human-to-human transmission. Avian influenza has raised issues, and in Canada then you have to look at what's the governance of the animal health model, and that may not match the governance and the rule-making of the human health.

Then let's suppose the incident is related to a criminal activity, and I think we saw issues where the experience in the other countries related to what had happened, so a sort of chemical/biological/radionuclear of a terrorist event, which we've not seen in Canada. If that had been an incident and not SARS then the question in my mind is how might we have been responding to the health threats. We've got the issue of it could be an exposure, an environmental exposure.

So one of the complexities is not just this horizontal relationship with other departments but is what is their vertical relationship between the federal and provincial/territorial which may not match in health, and that makes it much more complicated because you're having to deal with agencies where sometimes you're used to your local authority working with your counterpart at a local level, another agency relates very much to the federal level. And so it's good to do that, but an analysis of some of the other likely ministries of areas where health is going to be part of the process and you might see where it matches and where it doesn't match, and that would be country by country.

I think, following up from David's point on global dominance, I think one of the issues which IHR is not very clearly addressing which has been brought up by many of the groups here is the regional forums, like the Asia-Pacific strategy, or the Afro strategy, including within our country – in India – also we have ___ countries where IHR has been brought on the map, we've got the... during the avian 'flu outbreak we called the countries of the region, we had a ministerial level conference. So I think in the G8 and any of these other global alliances I think IHR should be an important topic brought up in those areas as part of more effective implementation of the IHR.

I'd just like to follow on from Jeff's point. We've been focusing, obviously, on corporate governance in these last two days, and whilst that's really important when we're going to the next layer down of people who'll be involved in any implementing of the IHR's in terms of those people on the ground, those people who are providing services, we also run into those issues around clinical governance and what the professions will say about what drives them to do their business and where their responsibilities to their patients and to their peers lie.

So I think as we disseminate these IHR's and as we investigate ways to get these messages across it's really important that we don't lose sight of that driving force, too, around clinical governance and that we actually look at how the corporate and the clinical governance might actually meet somewhere in the middle.

If I could just ask a question following on from that, I'm curious as to the extent to which that has happened in various countries, if at all, because it seems to me that is very important. So the medical associations, what other professional associations are the IHR known by them, are there activities on that front in Australia, and other countries as well?

My sense in Australia is that it's probably very variable, and that's without wanting to sit on the fence but there are people who clearly follow these international health sorts of issues more strongly and have more of a reason to do so. However, I think if you're looking at implementation in any event of any significance we'll be looking at practitioners who may have less interest or less of a need to know about these things, and I think in terms of selling the impacts and the requirements under the IHR's in Australia I'd say it's fairly early days. We've got a lot of work to do with the professions, and taking on Bruce's point about the professions setting standards we certainly have done quite a bit of that in Australia before with a lot of success in terms of engagement with professions and their acceptance of those standards when they're established, but I think we've clearly got some way to go around the IHR's.

No, we've not really approached the professions yet. I mean, the professions are very sensitized by SARS so some of the... I mean, one of the things you have to be able to do is, for example, you have to be able to communicate very quickly, really, with the front-line professional, that’s part of the requirements, but let me tell you that the medical association is very keen to do its own communication and so part of the art is negotiating with them so the same message goes out. It doesn’t matter if they get the same message many times as long as they get the same message. So, yes, there are tensions in that area.

Any of you want to react to Dr. David Fidler’s four trends? Ron?

Thank-you. Yes, in a sense I do, because Dr. Fidler mentioned something sort of almost *en passant* that I think is an interesting development world-wide. And please bear with me for just a bit, but I’ve always seen, personally, I’ve always seen the IHR in kind of two ways. There is certainly an epidemiological kind of component to it which deals with notification and identification of events and notification world-wide, and there’s a long history that goes all the way back to sanitary conferences at the end of the 1800s and the early 1900s requesting that governments, nations, make the community at large aware of what’s going on.

Then there’s another whole piece to the IHR which is kind of... I always sort of characterize it as rules, capacities, process, emergency committees, what you have to do at the airports, you know, it’s kind of a whole bunch of to-do’s. I’d just like to focus a minute on the reporting part, because I really think there’s another sort of thing that’s happening globally that is just going to sort of wash over this like a great tsunami, and this goes back to what you talked about or you mentioned as the non-official sources of information.

We’ve witnessed the growth, the creation of ProMED, and Europe we have MediSys, and in Canada we developed several years ago the Global Public Health Intelligence Network, which is – a bit of a commercial here – it’s a 24x7 computer-based monitoring of all the global outbreaks in the world, and we do that in seven languages. The computer reads Chinese, Arabic, Russian – Cyrillic alphabet – it reads Spanish, it reads English, French, and we’re adding Portuguese, and it reads Farsi, and it collects... it’s the equivalent of reading 20,000 newspapers every day and collecting the information, and that information is sent to the World Health Organization, and that’s been going on for several years. And now we’ve been approached, and you’ll see quite coincidentally an article in today’s Ottawa newspaper, the *Citizen*, about the

Google Foundation approaching us for a huge expansion of GPHIN, not just to look at 20,000 newspapers but to look at millions of sources of information, and to make that information available to every single government world-wide, in maybe as many as 50 different languages.

So, one of the things that's going to happen to us – and will again, I see, put pressure on governments – that once all governments know what's going on in the neighbouring state, and trying to sort out from that mass of information what's of international concern is indeed a challenge. I mean, we get the information that three cows have died of anthrax in Turkmenistan. That doesn't concern us in Canada, but it might concern Kazakhstan. And so there's going to be a pressure, I think, on all governments to be more reactive, to look at this information, and because it's the government that's going to have to acknowledge – very quickly – that something is happening, or else the other countries will begin to worry, speculate and so forth about this. But I see this as a great tsunami sort of washing over the reporting structure and actually being helpful in pushing governments to be more reactive to what's going on in their own back yard. Thank-you.

One other point is I think one of the factors that's not just affecting the IHR's but in terms of harmonization and working, very simply it's the Internet. And the bottom line is that I now can – and do – is if I'm developing a framework for a public health response plan, for example, which would be necessary, yes I go to the Public Health Agency of Canada, I go to the World Health Organization on the 'net, I go to the UK, I probably go to Australia, I go to he U.S. I'd be looking at what's in there and what the local ones are. And there'll be some commonalities, and I'm not going to start afresh, I'm going to build. And this is happening all the time. So, in fact, there's too much information. But that's very critical.

So we're basically begging, borrowing and stealing from each other, and by nature you get commonalities that are occurring because the technology allows you to do that.

Personally I agree with the doctor's point about while everybody talks a lot about notification that far and away the more important part is the authorization and the acknowledgment of the use of unofficial sources, because it's the simple fact that nothing is going to stay hidden for very long. It may be hidden for a while but it’s not going to be hidden for very long.

As to the expansion of Google, I mean, the expansion of GPHIN by that large a margin, that could be huge. I mean, it is, in absolute numbers it’s huge, but the implications, the potential implications really boggle the mind. You have to think of where that will go.

You meant google the mind?

If I may just respond, our problem so far with the evolution of GPHIN has been that the information was only available really to a select few, globally, the World Health Organization and certain countries that were really able to subscribe to the system because while the Canadian government funded its operation it did not fund its development, and in the fast-moving world of electronic technology we needed developmental funds so we had to ask for subscription fees.

What is being taken away, if all these plans work out the way we expect, is there will be no more subscription fees, it will be made free, it will be packaged in intelligent ways because there’s a lot of duplication and noise in the system, and try to narrow it down and then make it available to 192 member states, plus WHO, plus FAO, plus UNICEF, plus, plus, plus, plus, plus.

Pardon me, let me just ask one follow-up question. To me, the question is, is there going to be any predigestion of it, or is it just going to... I mean, once the duplication is worked out is, then, the whole package going to go out, or is there going to be some analysis that is done first and then the results go out, or does the whole thing go out?

Tentatively. It can be available in two forms. For those countries that want to dedicate the number of personnel it would take to look at this system every day, fine, they can look at the entire thing. For those countries that want digests there will be digests available, and they can be daily digests, they can be weekly digests, but there will be digests available.

I just want to step in at this point because I think the example of the ubiquity of the non-state actor, non-governmental sources of information, I think that helps illustrate just the power and also the interdependency of all these particular trends. But specifically I think the use of information technologies and the information being available through these various sources, it’s not just the technological aspect of this, it actually creates in essence a new governance function that really – and this is the verification and sorting out what’s rumour and what’s fact – and this is where again I think that governance function... it’s taken up the chain, and that’s where WHO has that role of acting as that sort of global filter for purposes of that information. So that’s not really... I mean, individual governments will do their own analysis, but again in a way in which this tends to operate WHO will be looked for as a credible filter for purposes of this information, and so that creates a sort of globalization of governance but also then places... you know, if Google is going to do this, this may increase the burden on WHO in terms of acting as that filter, so these trends to accelerate each other. And hopefully they can maintain a common speed, but when you start moving down this path it not only intensifies that governance response for states but I also think for WHO.

Just a clarification, this will not be run by Google. Google is assisting in the expansion. It will not be run by Google, it’ll be totally independent of Google.

I’d like to support the words of Dr. St. John. It’s very important to know what’s going on inside the country, but also very important to know what’s going outside of the country, the nearby countries. To my mind, and to my experience, I prefer to use, for example – it was invented say five, seven years ago – so-called verification list of WHO. I rely on this information. It already has been, let’s say, looked for. I might say to somebody from the top, big-shots, they say, “What’s going on somewhere? I heard in Google,” or a rumour, I don’t know where, “what’s going on in there?” So I immediately take a permit(?) then this verification list and see what’s going on in that country.

And this information already has been... it was considered already by knowledgeable people, experts or something, so I can rely on it. And in this way I pick out the information, say, "Okay, they should not care about somewhere in the corner what's going on," but in case the information is nice for my countrymen so I immediately inform those quarantine points, you know, "Be careful. Something's going on in that corner. The plane will come," or something like that, "so you should enforce the surveillance, ask people what's going on, so on and so on."

So I prefer not to have a so-called non-governmental source of information, but already filtered, I should say. It's rather important those who have information, those people on the top, it's clear.

I think the expansion of GPHIN to cover more languages and more sources of information is an interesting one, but it doesn't really change the system that exists already. I mean, GPHIN, ProMED, the verification list, they're already in place and they're being used widely, so we can improve coverage, we can improve sensitivity of the system.

There are a couple of dangers, again, that we have to be careful, and for me the most dangerous thing is over-charging, over-burdening the system by too much information to the point that it gets paralyzed. It gets paralyzed for us but also for member states. They might receive information of some small outbreak on the other side of the world that really is of no relevance, and this sort of background noise sometimes is more of a nuisance, it's like all the e-mails you get that are spams and things like that, but not that bad.

So that's something that needs to be managed, but in fact it does not change the system as such. And I think, honestly, in today's world it becomes more and more difficult to cover up, not to let information out. If it's not GPHIN it will be the news, it will be media, it will be... it's a matter of time. It can be two days later, or six hours later, or a few more days later, but eventually it does get out, and I think that's an important aspect of that.

Now, to what level you will send this information, who will actually go to use it, is also an important element of the discussion, because if this sort of thing, for example, gets simply out to the media without being inserted in a context with more information then they can generate more problems, we know that, we've seen it, we've experienced that over and over. So it has to be developed with some consideration, but there’s so much experience nowadays around managing this information that I think it’s going to work out pretty fine.

And I like your division of the IHR into different instruments, Ron, but actually normally – and we discussed it last night – I proposed three different. You have the notification, you have – and I think it’s for the first time – a global response tool. The IHR provides clear mechanisms for WHO and state parties, member states, to manage an international emergency response. And then you have the capacity-building part, which for me is perhaps the most difficult, also the most essential.

Going back to information, I think that if countries don’t set up their own internal verification system of events or signals, and they will just simply transmit it over to WHO, all of them, we will be flushed and paralyzed within a day. So there is a need in the countries to do some of this filtering work, and really let only the potential public health emergency of international concern or the potentially serious events filter up, to avoid just congesting the system.

Ron, as a follow-up to that – and I agree, I appreciate what you said – the degree to which the verification process will necessitate enhanced governance, because it’s really important... and this relates to the health professionals too, I mean, ProMED is used by the health professionals, so I’ve got calls from people I respect saying, “I’ve noticed this. What’s going on?” And what we tend to do is to say unless it is officially released by the Public Health Agency, or it’s WHO, that’s what we’re using. But that’s okay as long as it’s accurate and it’s timely, and we will lose the credibility in the system unless we know that that is taking place. I mean, yes, it can be a little bit behind, but it’s got to be right, and it’s got to be in a reasonable amount of time. And I’d much rather... it’s easier for me to defer that to at least the federal level, and if necessary the world level, rather than do the... because quite frankly we’re usually dealing with some problem anyway and we haven’t got time to do that piece of work. So that is going to raise the level by nature of being able to respond and have public confidence you’re responding, and professional confidence that you’re responding.

Scott, I think you hit the nail: timely and accurate, that's the issue, because in today's world if you wait six hours or twelve hours to be accurate you might not be timely anymore, it's already out, and that's a big challenge from WHO because we want to be accurate, we want to be sure, we want the information that is absolutely certain, but if you wait to do that you get CNN, BBC, the local news, all other things coming up that basically put the information there, and you're behind. And that's going to be the big challenge, I think, for the future.

In light of this I guess the question then for federal governments is knowing how vulnerable they are if reporting does not occur from a regional government up because people are going to find out. Did that perhaps encourage federal governments to be more aggressive on that specific issue compared to the other capacities? I guess that would be the question I'd... I know that reporting, mandatory reporting, has been contentious, and I would expect that regional governments would have the same awareness that the federal governments have that if they don't report people will eventually find out.

I think that's part of it. I think that there has been a real drive – at least within our government – both on the state and federal, and I know this from the local level as well, that we want to be the people that control the message, and the six hours makes a difference all of a sudden. If the news services weren't so good we'd have longer to do it, but in fact they're very good at what they do and so we have to get out the message and we have to control it.

That means if you're a public health agency and you're wanting to put out an accurate report you have to be able to know where that test – the confirmatory test – was done, when it was done, which is the sample, what is it, all these things, and so that has driven a lot of what we do with regards to EPIX and our communication packages. Those communication packages have to work well, we have to identify cases in other locales as well, very, very quickly, so that we can give just something that's just a little more than a news service in that time, because then we appear that we know what we're doing and that we control the message.

But I think that there is something else that's going on, at least within the systems that we describe. I think there is basically a desire for local and state health departments to let other people know. That's why they're there. They want the county next to them to know, they want the state next to them to know, and they would like others to know. And that has been as equally important in terms of driving our development of the communication system, that there is that desire – at least within our government – to share this information and to rapidly move it. Again, I hate to keep coming back to West Nile Virus but in fact I know that the communication strategy that we set up around there was driven by that, that we felt that a county in Colorado could be immediately adjacent to a county in Kansas but they may not talk to each other just because of the nature of reporting, and we sought to break that down working with EPIX, EPIX Forum, a lot of communication packages, and so it was more I think... I'll give it at least equal. There was at least an equal interest in reporting, and reporting to your neighbour. I think it as Dr. Lazar who said this... who was it? Anyway, it was about that it's very easy for a country in sub-Saharan Africa, it's easier for them to communicate with Geneva than it is with our own neighbour. That's true within the United States as well, it's easier for a county in Colorado to talk to Atlanta or to Fort Collins than it is for a county in Kansas to talk to that neighbour, and so that was as important a driver as anything else.

The other thing that was mentioned that I think is – I know we're seeing it in Canada – the issue of, at least North America, the cross-border initiatives. In my sense there are more cross-border initiatives around public health preparedness, but even though those are engaged at the national level – so there has to be some agreement between national governments – basically we have to work on that. And so suddenly – and we've had some discussion with the north-eastern states – you have to... when you've got different levels with a different country and you're still trying to do that from perhaps a surveillance protection, so the more centralized it is the easier it is because it's a common understanding. And sometimes you're dealing with what's happening at a federal level in Canada, what's happening with your companion provinces, and then what's happening with the states in the U.S., and what's happening with the federal. And we'd like to keep it simple, quite frankly, so that harmonization really helps there.

The conversation over the last several minutes has been focused on one particular element only of what we've been talking about for the last two days. Are there other comments/questions that any of you would like to raise, either coming out of the three presentations which Dr. Wilson, Dr. Fidler and I made, or from the earlier conversations? Other points that you think need to be flagged?

I would like to comment on your presentation. First of all it's an opportunity for us to think about ourselves for what we are doing. It's very nice. And specifically on the classification of the countries, I think you're right to a certain extent on the rule-making in my country, it's much centralized, it's the ministry who has the active role in proposing new rules, new regulations, new norms. But nowadays with the... as I said in my presentation yesterday, the country's moving from an authoritarian dictatorship to a more democratic state, and then the states at the decentralized levels they have the power to override our groups, to block what we propose, and I have lost several proposals this year, things that we at the central level propose and they say, "No, we're not ready to do that, we do not have the money. That's not going to be done." So there is a... still it's a reactive process. They are not proposing themselves new things, new rules, but they have the power to block the initiatives at the federal level.

And the operational process, well, I'm sorry if I made that impression, but it's all decentralized. The only operational power we have at the central level is our epidemiologists that go and investigate outbreaks. All the control procedures, if you have to vaccinate, if you have to screen people, if you have to control insects, everything's done by the local and state levels, and we only have those – how do I say? – emergency or rapid response teams to investigate, and nothing else.

The same with me, except the law-making. The law-making is okay also. It's highly centralized.

But I'd also like to make remarks concerning the operational level. The main activities of course at the level of the, say, counties... local level, and sometimes on the regional level, the same like in Brazil in case of something huge, they need assistance, we’re going to send a team of investigators or some operational teams to assist them, because it’s not practical – my country is huge – so it can’t work for those people. At least they have their salary, they should work for their salary.

So, I mean, at the operational level it’s not such... Russia is not on the top, say. Or maybe I don’t understand your...

I think that’s probably correct, and of course I may be wrong, but I think in all of the countries the actual practical activity, the public health services, are done locally almost by definition. It would be very unusual for a national government to have a huge team of doctors and laboratories scattered across the country who are directly employed by the national government, that’s not what I mean. I understood that in Russia, for example, that the local public health officials carry out the first response activities of all sorts.

But I also understood you to say – and I may have misunderstood you – that they are fully funded through the federal government and that... and I was judging for that particular reason that the level of discretion that was available was heavily controlled through the federal government, that in fact the – and I may be wrong, of course: you understand this, I don’t – but that the funding basically meant that the operational activity would follow protocols and procedures that were determined in Moscow. Now, maybe that’s wrong but that is what I had in mind.

You’re right up to a certain extent, you know, but I mean that the funding is going from Moscow, the funding, but they have all a regular budget. In spite of any collision, you know, they’ll get their, say, one million of rubles. In case of something they will not cope, they can add them, from emergency funds, some more on the funding. But, I mean, this is a regular budget, I should say. We can add for emergency situations, we can add them... you know, they spend more, they need money for transportation, for fuel and (all of it?), so it goes in this way. But I mean that when you discuss the operational level, the main activities are at the – how do we call it? – grass level, grassroots level. That’s a nice expression.

Thank-you.

[Side 6]

May I speak in French?

SP: No!

SV: Thank-you for your authorization.

En France, par rapport aux deux tableaux qui méritent effectivement d’essayer de positionner les différents pays, sur le premier sur l’établissement des règles on est relativement d’accord les règles sont imposées puisque de toute manière l’accord international qui est conclu avec le RSI s’impose en France et donc chez nous la situation des règles et de ce qu’il faut arriver à bâtir et de différentes actions capacité, building etc. tout ça c’est fixé par le niveau national et le niveau gouvernemental.

Après je pense qu’il y a deux choses. Dans le deuxième diagramme on parle des opérations et là il faut bien distinguer ce qui est de la mise en oeuvre des décisions et de la décision des actions qu’on va mettre en oeuvre. Je m’explique. Quand on va prendre une décision par exemple comme la fermeture temporaire des écoles ou l’interdiction des rassemblements c’est évident que c’est quelque chose qui va être décidé en interministériel.

Donc au niveau du gouvernement il va y avoir une réunion de l’ensemble des ministères concernés et avant de prendre cette décision. Cette décision elle figure parmi les différentes mesures qu’on peut prendre pour lutter contre un phénomène émergent, arrivant sur le territoire et donc toutes ces mesures-là vont être analysées les unes après les autres et puis on regardera si elle est pertinente… pas pertinente, en fonction de sa pertinence et du consensus qu’on arrivera à trouver effectivement. La décision sera prise et à ce moment-là ordre sera donné au préfet de département de mettre en oeuvre les mesures dans les territoires concernés. C’est pas forcément la France entière mais ça peut être une partie. À partir de là il n’y a pas de latitude laissée au département.

Il n’y a pas de décentralisation de la décision. La seule chose c’est que effectivement ça va être au niveau du département que seront mises en oeuvre les mesures, les fermetures d’école et les choses comme ça, mais l’ordre sera donné par le préfet, à l’inspecteur d’Académie pour l’éducation nationale qui fermera les écoles ou les collèges, les universités, les écoles maternelles. Il y aura des ordres à ce moment-là pour que le personnel qui n’est plus employé puisse vaquer à d’autres tâches etc. Mais tout ça est assez centralisé quand même dans la décision.

YF: Merci.

From the squares which we have put the countries in, I would like to ask in the context of IHR, which square would you consider to be ideal square to be in? Because, I'll give you the reason! [laughter] Which square would you consider a country, which would be in the context of IHR ideal?

The reason I will say is when we had the Disease Surveillance System where we hired he National Surveillance Program for communicable diseases was a totally vertical, centrally-controlled system. It worked well, but we wanted to decentralize it, so we shifted to the Integrated Disease Surveillance Project, which is a decentralized system. It was meant to be a decentralized system. But we didn’t find that the information was coming in that quickly. It was taking its time. It was going from the state to the state.

Do we have that response being done at the local level? Fine. But the information is not being received at the Centre. That's why we find we find we are now encouraging more towards the vertical system for information as far as the context of IHR is concerned.

I would like to ask, which square would you feel that a country should be in, in that square? For ideally organizing(?) or implementing the IHR?

Let me weasel on a question. I don't know if you can translate "weasel" into Mandarin very easily, but in contexts outside of public health, I've used this particular device for trying to understand the character of Federal systems in different parts of the world, and even non-Federal systems. I've often said to people that there isn't a best or worst quadrant. There are trade-offs associated with the different quadrants, and if you are in a particular quadrant you get certain advantages and certain disadvantages. If you understand the characteristics of the advantages and disadvantages, you can then plan to exploit the advantages and mitigate the disadvantages.

What I would say in the context that you're posing the question is that in the short run, centralized systems may be very effective, and may be necessary. But if you can develop strong local capacity, then over time a system that integrates well. A strong local capacity with good communications to the top might turn out to more efficient than a highly centralized systems have all of the – in anything in the world – have all of the benefits and all of the dis-benefits of being highly centralized.

They can be too rigid. They can try to fit everything into one particular formula when the situation at the local level may not accommodate that. I would say, if you tried to decentralize it, and it was not working, and you were forced to centralize, there might be advantage in centralizing for a period of time, even while trying to correct what was going wrong in the decentralized model.

If you subscribe to Professor Fidler's view, there's a kind of inexorable pressure towards centralization, which is being just created by a changing world, changing technology... a whole bunch of other forces that are forcing globalization. I think we also know that as these globalization forces proceed, they also create their own reaction. There is, in Marxist terms, there's an antithesis, and there's a pressure for a local reaction.

I think I'm doing a good job of weaselling on this, I have to say! But what I would say, just given the risks associated with local failures, with decentralized failures – my advice for Canada, which has so far been ignored – we have a very decentralized system with a lot of potential cooperation between governments to cope with that decentralization.

My view is that should remain. But my view also is our Federal government should have an ultimate power that, in the event that the intergovernmental relationship does not work in a crisis, we don’t have to wait six months while new legislation is passed, that there is a fail-safe mechanism in place that can exploited very quickly.

I hear you to be saying that when your decentralized model was not giving you good enough results quickly enough, you had the option in a non-crisis situation to compensate for that. As with many things with government and governance, systems of checks and balances... I can't tell you what right for India. I can't tell you what's right for any country. What I can say is you know the risks associated with a centralized system. You know the risks associated with a decentralized system. I think you have to plan to mitigate the risks.

I'd just like to add, this is why I think Harvey's model and my approach actually give you good things to compare: He uses hierarchical and non-hierarchical as sort of an organizing framework. When I talk about the trend towards centralized governance, that is not the same thing as a hierarchical government. It may be a situation – I'm thinking specifically the US Constitution. We don't have to amend the constitution. But clearly there's some... the governance of Public Health has clearly been transformed by a number of different things where the Federal Government now plays a role which has centralized how we approach specific Public Health problems.

That doesn't create a hierarchical form of government in the formal sense, but there is centralized governance taking form within that country, which has a deep tradition of a Federal approach.

Still looking at this – and I like to put what we've been discussing, IHR, and the changes that it might introduce in a broader context of evolution of governance and Public Health.

I don't know if I can agree on all four shifts or evolutions you have presented, and particularly I think there might be different stages in different areas of the world. Some places might now be going towards a more centralized sort of government, others might be trying to decentralize and swing back and forth as they might see fit.

But I do feel there is another trend we are in, which is important and significant, and that is that Public Health is becoming more and more the domain of non-Public Health specialists. It's becoming more and more an area where the involvement of other levels in government, other institutions, other sectors becomes more and more prominent.

I think IHR... well, just the whole issue of security, for example, and how it sometimes interferes with Public Health. I think this is a trend that will continue. Some of the decisions(?) will become much bigger than they were thought to be in the past. They have implementations that go, as we said, on economy, on commerce, on security, and that becomes something that is way out of what used be the normal domain of medicine or Public Health. This is a trend that I don't think we can stop. We just have to manage in the best possible way.

It's got major positive results, for example, more resources, more global attention. Probably 15 years ago, if you tried to generate a discussion on these issues, nobody would pay attention. Now they do.

It also generates interference and less flexibility and freedom to act in what we thought was our safe ground, because many other considerations come in that are not the usually considerations we make. I think this is a major shift also in the role and purpose of the World Health Organization and the role we have to play in the world. We really have to open to all of this.

I think that's an excellent point, speaking as an international lawyer who has no scientific background or Public Health training. One of the things that's been clear to me is the extent to which other disciplines have become interested in Public Health. This is where these tensions between the traditional role, the traditional practice, traditional ethos of Public Health sometimes clashes directly with the practice and ethos of other areas. The best example of that is the security framework.

This is something I think, of the disciplines that have come to Public Health and Public Health itself, I think the biggest transformation has had to be on the Public Health side. They’ve had to sort of rethink how they approach things.

If you begin to argue – as WHO has and other Public Health advocates have – that Public Health ought to be considered a security concern. And if you're serious about that, you put the Security Council on the table and sort of say, "The Security Council doesn’t have any role on this security issue, but on all other security issues," doesn’t understand the way security works at the United Nations level, nor in the Foreign Policy of States.

I think that's hard for Public Health people to adjust to that sort of thinking, but again I think it's illustrative of the extent to which the governance context of Public Health has been radically transformed.

Since Dr. Wilson has mentioned that a lot of the things that we deal with are no longer dealing with a Ministry of Health, but in fact multiple Ministries within government, I agree with that statement. Everything has become multisectoral, and I was trying to think of why. It's getting back to what David was just talking about here. I think I trace it more to SARS than anything else when you see a tremendous economic impact.

I think that anthrax, I think security, I think the World Trade Centre, 9/11, all had some role, and we're only starting to appreciate some of the Public Health aspects that have rolled out of that. But SARS did something. It affected many, many countries; it affected a huge portion of our industry. It was at that point, I think we did undergo a change, and now Public Health problems were seen as multisectoral problems.

In the United States, we now see this playing out in terms of our pandemic influenza. In the United States, pan flu is a multisectoral problem, and it has been like that since we started the planning. We've run into other governments where that has not been so. They've kept it primarily in the Public Health realm, and as a result we sometimes view things very, very differently.

I agree with you. It has been very difficult for some of the Public Health people to understand. There's numerous epidemiologists, State epidemiologists in our country who say, "This is a Public Health problem. This is influenza. Let's not blow it way out of proportion." But it's not an option that they're given any longer.

I don't think some of them have not thought it all the way through. When pan flu begins, the economy around several large international airports in the United States are going to crash, and they haven't thought all this through, that they will be impacted by these things. It's a real twist for a lot of traditional Public Health people.

Newer people in the game, they kind of see this and they're a little more politically savvy, and they have a greater appreciation for it.

I have Dr. St. John and Dr. Njoo, and I think Jeff also, but just before that, I'm going to direct my comments at all you Public Health officials.

Just in the context of this last part of the conversation, it may or may not surprise you, but Public Health is not particularly unique in what you're describing. Political Scientists now use the expression of "network governance" to describe the world in which we've moved. By that, they mean that the old role of government is being gradually replaced in many parts of the world.

In fact, many, many parts of the world by a governing process, which entails multiple governments vertically and horizontally, non-governmental players, private sector, in a very, very complex networked interaction. And what you're describing now in the context of Public Health could be described as environmental issues, economic development issues, and many, many others.

Several of you have used the right words, I think, which ism "It has to be managed." Dr. Lazarri used this, where "managing" is the right word.

Ron, you wanted to comment?

Just to echo a little bit about what Dr. Marfin was just saying. SARS in Toronto was a big wake up call for Canada. Now, there is a chapter in our National Security Policy that has "Health:" first time in the history of the country that I know of that Health is part of National Security Policy.

SARS, while it was a virus, it also was an airport problem, a travel problem, an economic problem, a restaurant problem in Toronto. People wouldn’t go to Chinese restaurants. Then it became even bigger, because when Toronto officials began to isolate people, and they had up to 8,000 people isolated every day, then the questions became, "I have a small child. Where do I get my baby food? Where do I get my diapers?" And the elderly person saying, "Can I just go down to the cash machine and get $10?" "Well, no. You're supposed to be in isolation.

There were a huge bunch of issues not anticipated by the Public Health community that had to be dealt with, and are now recognized as part of what we now call in Canada "a complex medical emergency."

I say, "Yes, it has to be managed, and it's not in the isolation of the doctors..." I still maintain and say, whenever I have a chance, "SARS is not over in Toronto. "There are people there that still remain terribly affected by the SARS experience of watching their colleagues die, and in modern times, doctors and nurses aren't used to watching doctors and nurses die from an infectious disease. Maybe in the 1920s and '30s, yes. But not today. There are a lot of traumatized people still in Toronto, so I don’t consider SARS over yet in Toronto.

Je voudrais rebondir justement sur l’exemple et les modèles qu’on a pu avoir avec la pandémie grippale. C’était il y a trois mois donc à Washington et à Atlanta avec la délégation interministérielle de lutte contre la grippe aviaire puisque vous savez qu’on a en France un système… un plan interministériel justement pour travailler avec les différents ministères pour essayer d’élaborer l’ensemble des mesures et des préparations pour faire face à une pandémie.

Dans ce cadre-là donc on avait été aux États-Unis et ce qui est intéressant c’était justement cette présentation qui avait été faite dans le service du CDC d’Atlanta où on avait eu cette présentation sur les différents résultats des actions très précoces de certains maires de grandes villes pour faire face à l’arrivée de l’épidémie avec des décisions qui étaient de *social mitigation* et de *social distancing*. Donc on voyait très bien qu’il y avait des écarts fantastiques effectivement dans la propagation de l’épidémie d’une ville à l’autre.

Donc ça, ça m’amène effectivement à la réflexion suivante: dans le cas du SARS dont on parle tous depuis deux jours on avait quand même un virus qui a un temps d’incubation de cinq à sept jours. On a un temps effectivement de réapparition qui est quasiment d’une dizaine de jours, donc on a un certain temps devant nous pour arriver à confiner, à contrôler, à mettre en quarantaine, à isoler. Dans le cas d’une pandémie grippale on n’est pas du tout dans ce cas de figure sauf changement de la durée d’incubation du virus mais on est dans quelque chose d’extrêmement rapide qui nous laissera extrêmement désarmés très rapidement avec une propagation assez exponentielle du nombre de cas territorialement et en nombre cumulé.

Donc je pense qu’il est fondamental à ce moment-là d’avoir une capacité de pouvoir avoir une concertation très précoce au sein d’une structure décisionnelle et que cette concertation doit s’appuyer sur un certain nombre de réflexes travailler ensemble, de propositions qu’on peut passer en revue. C’est ce que je vous disais tout à l’heure quand on disait les décisions, on passe en revue les décisions possibles et on en choisit celles qui nous paraissent les plus pertinentes.

Si dans votre exemple avec les États fédérés cette organisation est confiée à des États fédérés souverains vous allez avoir une multiplication de réunions comme ça au niveau de différents ministères de la Santé avec l’Agriculture, avec les Douanes, avec l’Intérieur au niveau de tous les États aboutissant à des décisions qui probablement seront variables d’un État à l’autre avec donc une possibilité que les mesures prises et décidées ne soient pas les mêmes et le résultat au bout du compte c’est qu’effectivement votre maladie virale qui aura disséminé d’un aéroport à un autre dans l’ensemble des états ne sera pas maîtrisée du tout de la même façon d’un État à un autre.

Donc effectivement sans vouloir du tout me donner de piste ou d’orientation mais spontanément en tout cas l’analyse que j’en fais sur ce type de pathologie qui est, encore une fois, particulière au sein des maladies infectieuses, je pense qu’effectivement le fait d’avoir quelque chose de centraliser pour donner une espèce d’instruction générale avec les meilleurs experts nationaux, fédéraux chez vous etc. peut avoir une légitimité.

One of the issues, when I think about it, my sense from many of the presentations was that what countries were trying to do was basically get their system in order to prevent the national spread of disease. That's what you're doing because you really had to make sure that your own house was in order, because you didn’t want that, and you didn’t want the economic affects of that. By doing that, you were already starting to get towards implementation of the IHRs with a few additions on top of that. But basically you needed to do that.

Then when you look at the issue – and it raises the issue to me of the globalization of Public Health in new world order – then when we get the presentation from a colleague from Africa, and then we hear about the stresses and strains there, to what extent do you get to the level of recognizing that in order to really protect your own nation, you have to ensure that the weaker parts of the world system are able to protect their own nations from the spread of disease, which in turn means that IHRs can better implemented which in turn means that you're better protected, and that means that world economy and your economy's protected.

One of the key issues at some stage needs to be, how do you divert the attention to deal with that? Because we're all moving towards getting our own house in order better, but it reaches a stage where you can only do so much, and you get better investment from that investment globally with the resources that you'd be using, and we've not discussed that at all

SP: Actually, if I could interject, I think it might be worth spending a bit of time on that issue, because that is something that is fundamentally related to governance at an international level, and we haven't, perhaps, discussed as much with the attention it deserves. Any perspective on that would be welcome.

(?)

I'll sort of lay out where I see thinking on this going. I think I'm going to be reflecting here a US-centric position rather than one that fits into the analytical framework that I've presented.

I think there is recognition on the part of the United States and other governments that, first, they do need to spend a lot of resources getting their own house in order, so there is an intense amount of effort focused domestically and locally. That does mean that some of those resources will not be available for global efforts.

There is, I think, also recognition of the problem that US Public Health, US National Sec with regards to these issues is in fact threatened if you do not have a basic Public Health infrastructure in developing countries. I think there is a conceptual recognition of that.

Here's the problem I think that I sense amongst people that I talk to about this. If you're going to spend large sums of money to build basic Public Health infrastructure in developing countries and you want that to be sustainable, you have to have some level of confidence or trust in the existing governance systems that are in those countries. If you don’t, because of your other bilateral and develop aid that you've tried because governments are corrupt, or governments are weak and there isn't really an infrastructure there, you aren't going to spend that money on building a basic Public Health infrastructure in that developing country. You're going to spend that money on making sure that you're as strong and ready as possible for the moment comes when the pathogens hit your shores.

Your interest there is to get as much information as early as possible through surveillance, and then you spend your response and intervention money at home to protect yourself. Because if you want to fix the basic Public Health infrastructure in many countries, you're essentially talking about building the entire governance... that's not on. It's just not realistic to expect even in the United States to do... assuming your country wanted the United States to do that.

Because you're essentially saying, that's regime change for Public Health. It gets to that level of seriousness in many parts of the world. If you're not willing to recognize then that if Public Health is an important part of good governance, you have to tackle the other aspects of good governance and then your agenda just got so enormous and so expensive that you then start to pull back and say, "Now I'm going to spend that money on myself to make sure that when it hits I'm in the best position possible." It's not the ideal situation, but the other option is not as easy as it might at first appear.

Just another quick comment. There's kind of a counter... I wouldn’t call it a movement, but it's sort of a counter... well, another way of looking at that, and that has to do with GOARN, the Global Outbreak Alert and Response Network of WHO.

I know that Canada's been a very active member of GOARN, and our thinking is, "Let's stop the disease over there before it gets here." The idea of having a network of almost 120 or 130 institutions that volunteer their resources on very short notice to send teams at the request of countries to stop outbreaks – of course, once we know the outbreak is there – but there is a response mechanism now that has proven itself, at least the last time I looked, 57 times for 57 outbreaks in other countries over the last three years.

It is fast. It is rapid. Teams are assembled and placed for infection, outbreak control, in 24 to 72 hours. There is a sense that it's not just, "Let's create Fortress Canada here and stop the disease from coming." It's more, "Let's get out there and stop the disease before it becomes a big problem for all of us."

Just to carry on with that message, I think that is what has dominated a lot of the pandemic influenza planning in the United States. We see that there is an advantage to creating some infrastructure. David's point is a good one: how far you go, what is the investment? Is this going to be an infrastructure that is going to last 100 years, or is it going to be one that lasts until we identify the virus and then we're out of there?

I think right now it tends to be the latter, that we are creating a separate system in the United States in which we will have surveillance that is out there. We will hopefully identify that the human-to-human-to-human sustained isolate, and then that clock starts for development of the vaccine. The longer that we can put between that virus coming to the United States, there will be a shift.

You see this in the argument about the use of stockpile drugs. We have committed a certain portion of our national stockpile to an international stockpile. That is because there is the hope that we would be able to contain and squelch a localized outbreak that occurred somewhere else. If we were able to successfully do that, we were able to successful recover that isolate and now vaccine production starts, it is to our advantage to keep it squelched. We recognize that that may not happen. This is actually a big part of the discussion about the stockpile.

If, in fact, it escapes that containment, do you then bring back the stockpile drug, the international stockpile drug to the United States? I'm glad to say that more sane minds prevailed here. It's not worth it at that point. There's just not that many doses there. Not only that, that's just not the way that we would do it.

But there is the thought out there, at what point do we now switch to – for your use of the term "Fortress." We know that it's coming. The clock has started. How many resources are we going to put in there? It's a difficult decision, and it's an ongoing decision. In the United States, whether it's at a State level or a national level, the discussions are the same.

It's the same when we're talking about Alaska and Florida. Those same, exact arguments are going to come up again and again and again.

I'm sorry. Just to add one more comment about GOARN. While the teams were intended to be sort of like SWAT teams: you know, you go in, stamp out the disease, and leave. They have, in essence, operated that way. However, much to the surprise, I think, of the people that are closely involved in the GOARN was the realization that by employing or using national counterparts as part of the GOARN team, there were actually unintended, almost indirect results and some capacities were left behind – not in all cases – but there have been... much to my surprise, there have been improvements in epidemiological outbreak, investigation capacity, in the sociological dimensions of an outbreak... a whole bunch of little sorts of things that were spread out by the GOARN teams in these epidemics. Not all of them. But it's kind of interesting to see that it was an unintended but real result of a SWAT team approach to things.

HR: Ron, just for the record, it's just being recorded, what is GOARN?

RS: I'm sorry. GOARN: G-O-A-R-N. The Global Outbreak Alert and Response Network.

Just a brief word, the WHO is the secretariat, but is not a WHO program. It is a network of 130 institutions – CDC is a member – and they're non-governmental. *Médicins Sans Frontièrs* is a member, as well as governmental, some academic institutions around the world that just offer up people, resources, mobile laboratories... whatever it takes to accumulate rapid resource for WHO deployment.

The GOARN team is deployed under the WHO nice blue flag, the umbrella, the nice blue flag, but it is not a WHO program

The WHO strategy to deal with epidemic events, or epidemic and pandemic disease actually involves both approaches. One side, we want to strengthen and improve mechanisms like GOARN, like the old detection or verification system, and the old alert and response operation platform to enable the organization to respond even better and quicker to requests for assistance in dealing with outbreaks. In that, GOARN has proven over the years, really a wonderful tool, so there's no question about it.

At the same time, we recognize that there is a need to develop local capacities, because that’s' where the detection takes place first of all, but also because SWAT teams coming into the country sometimes face some more difficulties: language, culture, different foods and this sort of thing. Having local capacity there can facilitate even external teams quite a bit. It's one or the other. Anyway, WHO is committed to work with member States to improve their Public Health structure and systems. It's part of the mandate. There is no question.

By the way, there is a third strategy, which is to deal with specific threats, known threats. That involves also preparedness and prevention and maybe risk reduction or vulnerability reduction to some of this. That's where you would put influenza, or viral _______ fevers, or meningitis, or cholera, or other specific problems.

These are the three strategic approaches to the problem. The issue is, with IHR, is we have worked globally, member States, WHO, the international community, in developing this capacity for many years. Lots of money has been invested, and I think a lot will continue to be invested in future before we get good systems everywhere.

Getting good systems is not in just investing in Public Health structure or part of Public Health structure. It's broader than that. It only evolves with the overall development of a country. There is only so much you can do to external investment. It's the reason, at the same time, of development of the whole national system.

The problem with the IHR is that we have a short timeframe. We have some things we want national systems to develop. We are not going to... there's no way we can be able to improve the overall system by 2012 so that it can deliver this everywhere. That's why the idea of focusing on core function, on key elements that should be everywhere comes about.

There is a discussion on this. Many people feel nervous about the idea that you only work on part of the system, that you don’t see this as developing an overall laboratory network and surveillance capacity and response capacity in the whole Public Health system, and if you go on, it's the whole health system. There is a reluctance to do that. But I think it's not possible. It's not possible in the timeframe of the IHR. It's not possible given the fact that many countries have serious important structural weaknesses. It's not possible because I don’t think we can mobilize the resources required to actually do that.

The trade-off could be that you focus on some specific elements, make sure that they are there and they are working, because there is a commitment to do that. But at least WHO will continue anyway to work on the overall development of a national system for Public Health, because that’s our mandate. There's no way we can avoid that. It might be a two-speed process, but it has to be ____ at.

Just before we continue, just to remind you, we're scheduled to end at 4:00. How many of you have to leave before then for airports and so forth? What I'd like to do is just... I'm going to bring the conversation back to where we were, but I'd like to say a couple of things about next steps just before we... Have you got about two or three minutes? Okay.

It's the intention of the Organizing Committee to attempt to put together a Web publication quickly which reflects the proceedings of this workshop. To do that, we're going to be sending to each of the national presenters a version of what we think you said based on our recordings and interpretations and so forth. We will send your text only to you. We won't end the US text to China and the Chinese text to the United States initially, so you can verify the text, add, elaborate, correct. If there are points of special sensitivity in your country, then you can adjust as appropriate, so you're not caught out with your political masters or whatever. We will attempt to get those out quickly. The people who are going to do this, as you do, have other responsibilities as well, but we will try to do this quickly with the view to getting a Web publication out hopefully before the end of the years that covers the proceedings. It's not a promise, but the quicker you can respond, the quicker we can get that done.

The second thing we hope to do as a follow up to this activity is to have some of the researchers and academic people who are associated with this process, we will be writing journal articles for medical journals, for international law journals, for federalism journals and so forth, reflecting our particular interests and expertise. On that, there's probably a somewhat slower timeline. I don't think we'll all be in referee journals by the end of the year, unless we happen to own the journals as well.

The third thing is more of a question mark. What we have wondered about is whether coming out of this overall process we could develop learning materials that might be useful to you and your colleagues at home, but also to government, Public Health officials in other countries, in other parts of the world. We have asked our colleagues in the WHO to reflect on whether they think there are ways we can be useful in that respect. We are not sure what the answer is. We're not sure what answer they will give us, or what we might conclude on our own, but we would welcome advice from any or all of you. If you have ideas that you think we might pursue based on the collective work that all of us have put in the last couple of days, and in the run up and the preparations for this event, they would be very welcome.

That, at least for the moment, is the follow up: the proceedings, some journal articles, and then possibly some learning materials. I'll ask Kumanan and David or Ron if they want to add to that.

Also about the presentations, we will ask each of you individually whether it would be okay for us to put those on the Website.

I've said that. At least, if I haven't, I think it was implicit. But that's fine.

Does anyone have any questions about this particular aspect so we can let our American colleagues make their airplanes and so forth? You're better off walking home! [laughter] Yes, Dr. Lazzari?

I just perhaps wanted to add a few points from the WHO point of view, at least my point of view, because we're going to have to take this discussion back to Geneva and have some reflection on it with the rest of the group. I'll try to make it very quick.

The feeling I have is that the discussion, clearly I liked some essential points in trying to implement IHR. One is that IHR challenges everybody – it's not just developing countries, it's not just rich countries – in very different ways. It might be different. Some places might not have the resources. Others might have more problems of too many resources and how to organize and coordinate them, but it does challenge everyone. As has been already said, the solutions might be different from place to place.

I think the final interpretation would be a mixture of the universal IHR requirements, which are the same for everyone, the local realities, the resources, the capacity, the governance at local level, but also the experiences of countries. I think SARS in Canada, I think anthrax in the US, I think perhaps plague in India will very much dictate how IHR is going to be implemented.

This might lead to tension, discussion, and maybe changes. For example, what happened in France that has been presented in the discussion of where the focal point should be, it could lead to important changes in the way governments will be structured, and mechanisms might be revised and established. All this is progress. All this is positive.

I think we also need to expand – and that goes back to the suggestion you made, the whole knowledge base about IHR – beyond the usual suspects, beyond the people who have been involved in the process, or have to be involved in IHR because of their profession. Particularly, I think we need to filter the IHR concepts and requirements down to the peripheral level. We have involved in every country the people who are going to become the actual real implementers of the IHR.

I think – and it came out from many of your suggestions – WHO has to play the role to provide...

[Start of Side 7]

...so there is a lot of work that is required.

I also think – and it came out of many of the presentations – that everything that revolves around travels, travellers, borders, points of entry, goods, is going to be a major challenge, and it's something that really would require a lot of work.

I have three points for follow up which are more related to WHO, what I think we should do. One is that we will have, even if the text of the IHR does not address Federal States, thinking about implementation we will have to consider how this applies to the special situation of Federal States and maybe get some guidance there as well. I think if we try to do that, many of you might be involved in reviewing this, and we will try to use your experience, expertise, and knowledge of the situation, and also how you are involved in the thinking about your country to provide some guidance about this.

I think we do need an advocacy strategy for IHR that, as I said before, has to be touching on different sectors, but also different levels in government and institutions. This may go in very many different ways. I think we have to think as an organization with colleagues and partners how best to do that.

I think what definitely came out of the discussion is that we have this important dual role. One is the technical guidance I mentioned, but the other one – and it was strong, I think, in the presentation made by the colleague from Sénégal – in the support to capacity building in-country, as well as in the development of human resources for implementation and ________tion, including perhaps looking at new profiles that might be required for IHR. I'm thinking particularly of a file of managers for Public Health emergencies of people who have the broad expertise and knowledge to be able to tackle all the different aspects that dealing with a Public Health emergency is a ______ of concern involved.

This, and I think Bruce has other points, but these are some of the take-home message I got from this meeting, and I think it's been very interesting, for me at least, to listen to all your experiences and the way you're trying to adapt the IHR to your local realities.

Thank you. If there's no one else who wants to comment on the follow up, we'll just continue the conversation. David, you were going to make some remarks.

This is continuing the conversation about resources and financial assistance with regards to, particularly core capacity building and the IHR. Some of my earlier remarks were an attempt to explain foreign policy thinking in the United States about the allocation of resources, but it's not just a problem with donor countries like the United States with regards to these specific issues.

One of the problems that I have encountered at virtually every meeting that I go to on the IHR with regards to building core surveillance and response capacity is the need for a significant amount of resources to help developing countries engage in this. Even with the recognition that the primary financial responsibility lies with each individual state, it's been clear since the very beginning of this revision process that there is a need for significant financial assistance to help developing countries do that.

The problem is identifying where that money is going to come from, particularly in a global health context in which you have had enormous increases in the amount of money available for global health projects, both from governments and non-governmental organizations, very little of which, I'm told by Public Health experts who work on this, contribute to building core capacities for surveillance and response. It's either for purposes of buying anti-retrovirals, or it's a vertical, disease-specific project.

Even in a context where you have enormous amount of new money flowing into global health, very little of it seems to be addressing the needs identified by the IHR. I think there is a significant and urgent need to identify those resources, calculating roughly how much is required, and then thinking about creating some types of financing mechanisms. Otherwise, that aspect of the IHR will go unanswered. I think that's one of the biggest achilles heels of this as a sustainable matter.

I agree with what David says. What are the examples in India to be faced? A lot of our external funding has been for capacity building, so that definitely is an area which is very important.

Regarding the avian influenza, the country was going through a transition and luckily we were pushing for the ______ plans, both from the animal husbandry side as well as from the health side. These were already... well in time. Suppose the outbreak had hit is in, say, October or November. We finalized it around December. India would not have been prepared to tackle that avian influenza outbreak. We did not have _PP. We did not _____ _____ forever(?), because it would have wandered the field. We did not have Tamiflu. Now, the _____ _____ provided over 20,000 doses, but that was inadequate because used almost 100,000 to 200,000 doses in the field. If at that time it had happened, then it would have become endemic in that area in respect to many more statistics, and probably we'd be still fighting it.

I think a similar thing has happened in Indonesia where initially they did not have Tamiflu, and they did not have any protection for the healthcare workers to go into the field and do stamping(?) out of patients. I think later on Australia did help a lot in doing that, but I think that delay of an initial few months has made it endemic in that area.

I think we have to look at it in those areas also.

(?)

It may also be useful, while we need to identify the resources available, would it not be useful to look at where it may be happening already, and look at what is working, where there is good capacity building that's working across the world?

Okay. Of course we thought about this a bit in _____ with ___, and the logical process would be to identify what actually the requirements are in more operational and organizational terms in countries. Then, as you know, the IHR calls for assessments to be conducted in ever country to see if this capacity is there at present or not. It's only after you conduct these assessments based on theses sorts of requirements that we have to still clearly refine, that you could do some costing. No country's starting from scratch. Many of these things already exist and might not require a major investment.

Some might require a major investment, you know, labs and things like that. And only at that point, really, you could make a cost for implementing the IHR. How this could be covered, that's also been the object of a lot of discussion. There were talks about a global fund for IHR implementation. But global funds are not really popular nowadays with major donor agencies, so there might be other mechanisms and such. There's been quite a lot of talk also about mobilizing resources for avian flu that has led to some sort of unique system.

But in defence, I think it will be very difficult, if not even impossible, to estimate today what will be the cost of implementing the IHR based on the tests and the requirements. I think it will be a very difficult exercise, and we'd have to really start making estimates based on very superficial knowledge of the situation. At least that's the feeling I have.

We were committed to ending by 4:00. I imagine that some of the members of the organizing committee may want to make some final remarks, but before we do that, can I ask if any of you want to make any final remarks on any aspect at all of the last two days? This is your last chance. Going, going, gone. Okay.

Ron, did you want to say anything final? David?

Two words. Thank you.

Dr. Wilson will make the last few remarks. Let me just say that I appreciate the cooperation of the Public Health agency of Canada, and David, for your support as we were developing this. This project originated with Kumanan and myself. But let me also say that Kumanan and I have done almost no work. Chris, over here, has turned out to be the doer, so I'd like to make special thanks to you Chris for your prodigious efforts in helping us to pull this off. I'd like to thank all of you for coming. I look forward to working with you as we move some of the products from this process to market, so to speak. Have a safe trip home. Again, if you have any logistical questions, or questions about other things, please let us know and I'll turn it over to Kumanan for the final remarks.

Thank you. A few final thank you's on behalf of the organizing committee. I'd like to thank all of our funders. We had several different sources off support, and the Public Health Agency has provided us with support, IDRC for providing the room...

HL: And some money!

KW: And some money. ...The Canadian International Development Agency, Canadian Service for Health Research also provided support.

I'd also like to thank Paddik(?) and Dido – I don't think she's here, but she saved us that first night – and the translators for all of their hard work. Thank you very much, and thank al of you for coming such a long way.

[End of Recording]