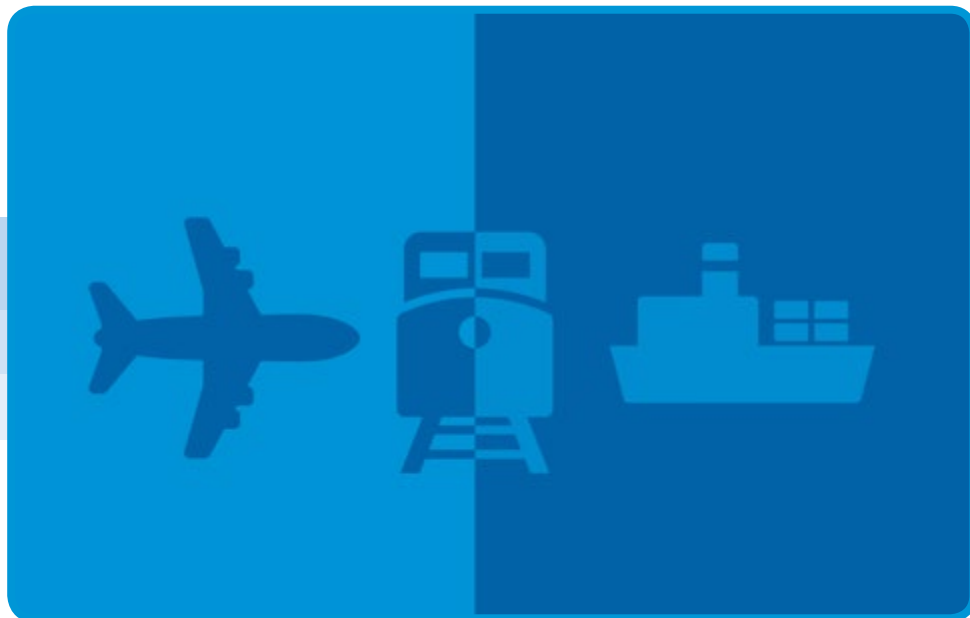


Meeting Report

REGIONAL MEETING TO STRENGTHEN IHR (2005) CORE CAPACITIES AT DESIGNATED POINTS OF ENTRY



2–4 November 2016
Xiamen, China

WORLD HEALTH ORGANIZATION

REGIONAL OFFICE FOR THE WESTERN PACIFIC

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MEETING REPORT

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DESIGNATED POINTS OF ENTRY

Convened by:

WORLD HEALTH ORGANIZATION
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NOTE

The views expressed in this report are those of the participants of the Regional Meeting to Strengthen IHR (2005) Core Capacities at Designated Points of Entry and do not necessarily reflect the policies of the conveners.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for Member States in the Region and for those who participated in the Regional Meeting to Strengthen IHR (2005) Core Capacities at Designated Points of Entry in Xiamen, China from 2 to 4 November 2016.

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Keywords:

Legislation as topic / Public health / Travel / Regional health planning / Universal precautions

SUMMARY

A Regional Meeting to Strengthen IHR (2005) Core Capacities at Designated Points of Entry (PoE) was held in Xiamen, China from 2 to 4 November 2016. The meeting was attended by 56 participants from 14 countries and areas in the Western Pacific Region, including observers from the Food and Agriculture Organization of the United Nations (FAO), Mekong Basin Disease Surveillance (MBDS), Ministry of National Health Services, Regulations and Coordination of Pakistan, World Organisation for Animal Health (OIE), General Administration of Quality Supervision, Inspection and Quarantine (AQSIQ) of China, WHO staff members and temporary advisers.

Globally, the International Health Regulations, or IHR (2005), set out the core capacity requirements for designated PoE, including the development and maintenance of public health emergency contingency plans at designated international airport(s) and port(s). At the regional level, preparedness for public health emergency response at PoE is included in the *Asia Pacific Strategy for Emerging Diseases*, or APSED. Effective public health measures and emergency response at international PoE contribute to national, regional and global health security.

Since IHR (2005) entered into force in June 2007, significant progress has been made in strengthening routine public health functions and public health emergency response at PoE in the Region. However, in light of recent experiences with Ebola virus disease and Middle East respiratory syndrome (MERS), risk-based border measures need to be further strengthened to respond to public health emergencies of international concern (PHEIC) at the country level.

Experiences and lessons shared by Member States reminded participants that health security threats are inevitable. PoE play an important role in responding to health security threats, but border measures have limitations. The achievable goal of border measures has shifted from control or exclusion of health security threats at PoE to risk management at the source (based on risk assessment as part of wider national and international responses to health security threats). The role of PoE needs to be repositioned to manage health security threats in our highly connected world.

Through discussion, participants recognized that risk communication and application of exit measures based on risk assessment may contribute to better management of health security threats.

At the end of meeting, the participants agreed to maintain and strengthen IHR (2005) core capacities, including those at designated PoE, strengthen multisectoral coordination, and support the role of the National IHR Focal Point in international information sharing, collaboration and cooperation. Innovative approaches such as exit measures and risk communication will be strengthened in Members States to minimize the international spread of disease and threats.

1. INTRODUCTION

1.1 Meeting organization

A Regional Meeting to Strengthen IHR (2005) Core Capacities at Designated Points of Entry was organized in Xiamen, China from 2 to 4 November 2016. The meeting was co-organized by the WHO Regional Office for the Western Pacific and the General Administration of Quality Supervision, Inspection and Quarantine (AQSIQ) of China. For the first time, the meeting brought together representatives of the border health and public health sectors. It aimed to take a closer look at the role of PoE and identify new and innovative approaches, such as exit measures and risk communication, throughout the travel process.

1.2 Meeting objectives

The objectives of the meeting were:

- 1) to review overall progress in the development and implementation of core capacities at designated PoE as required under IHR (2005);
- 2) to share Member States' experiences and lessons learnt on strengthening PoE public health emergency preparedness and response, including those related to MERS and Ebola;
- 3) to discuss and analyse the gaps between public health threats and public health measures, and explore innovative measures to minimize international spread of infectious diseases; and
- 4) to discuss, identify and agree on strategic directions and priority actions for PoE preparedness for public health emergency response in Member States.

2. PROCEEDINGS

2.1 Opening session

During the opening session, Mr Han Jingyi, Xiamen Municipal Government, discussed the importance of IHR (2005) and how it supports trade, travel and tourism. Vice-Minister Chen Gang, AQSIQ, described China's remarkable achievements in IHR (2005) compliance and the importance of promoting global health security. Dr Li Ailan, WHO Regional Office for the Western Pacific, reminded participants that the Asia Pacific region faces global and regional health security threats, and while border measures have limitations, they still have a unique role in the highly connected world.

2.2 Plenary 1: Implementing IHR (2005): progress and challenges

2.2.1 Implementing IHR (2005): progress and challenges (Dr Frank Konings, WHO Regional Office for the Western Pacific)

The Region remains vulnerable to health security threats. It is tested by real-world events and collective actions are needed. Preparedness and response systems have been strengthened through APSED and IHR (2005). New and updated global and regional developments to manage health

security threats include the draft global strategic plan for IHR and the *Asia Pacific Strategy for Emerging Diseases and Public Health Emergencies* (APSED III). The important role of PoE in managing public health emergencies was introduced in APSED (2010) and expanded upon in APSED III under Public Health Emergency Preparedness (Focus Area 1). APSED III covers the IHR Monitoring and Evaluation Framework, which has four components, including Joint External Evaluation (JEE). JEE also includes a dedicated technical area for PoE. Moving forward, APSED III will be used to update and guide national action plans and coordinate initiatives and multisectoral efforts, including for PoE. There is a need to strengthen political commitment for investment in human and financial resources required to advance the implementation of IHR.

2.2.2 Global situation update from International Civil Aviation Organization (Dr Ansa Jordaan, ICAO)

Aviation plays a major role in connecting people and goods. Approximately 3 billion passengers travel by air annually, and current trends indicate that this number is expected to double by 2030. While air transport's ability to connect the world delivers many benefits to Member States and societies, that same global connectivity has the potential to rapidly disseminate diseases internationally.

ICAO and WHO are carrying out the Collaborative Arrangement for the Prevention and Management of Public Health Events in Civil Aviation (CAPSCA) programme, together with other international partners, to assist countries with implementation of the IHR and public health-related aviation regulations. CAPSCA's objective is to improve preparedness planning and the ability to deliver a prompt, multisectoral collaborative response to public health events.

A survey conducted by ICAO in August 2016 indicated that Member States needed more support to implement the IHR and public health-related aviation regulations. Support required include capacity-building, training of personnel, providing detailed risk assessment guidance, providing assistance with review of preparedness plans and testing plans by means of table-top exercises, and joint physical exercises.

Member States also suggested the following measures to facilitate implementation of the regulations: closer and more operational collaboration and communication among WHO, ICAO and the International Aviation Transport Association (IATA); harmonization of regulations; standardization of procedures across the world; and the availability of experts to provide technical assistance with implementation.

The potential role that ICAO can play in managing public health emergencies was also briefly introduced by using Zika as an example. Member States were encouraged to join the CAPSCA programme if they were not already members (www.capsca.org).

2.2.3 Global situation update on IHR (2005) and PoE guidance (Dr Ninglan Wang, WHO headquarters)

The IHR Monitoring and Evaluation Framework was briefly reviewed. An overview was provided of the status of global IHR PoE core capacity development based on IHR monitoring results, particularly the indicators related to PoE overall scoring, status of self-assessment at designated POE, and status of public health emergency contingency planning at designated airports, ports and ground crossings globally and for Western Pacific Region.

A brief update on the WHO publication of PoE-related guidance and tools, as well as learning programmes, was provided. Newly published technical guidance – *Handbook for Management of Public Health Events on Board Ships*, *Handbook for the Management of Public Health Events in Air Travel*, and *Vector Surveillance and Control at Ports, Airports, and Ground Crossings*, which are being published in other five United Nations languages – were further elaborated. Participants were encouraged to disseminate guidance to operational-level users in their respective countries.

2.3 Panel discussion: Stocktaking of public health events and the role of PoE

2.3.1 Role of PoE in health security: Reflecting on the past to inform the future (Dr Li Ailan, WHO Regional Office for the Western Pacific)

Participants were reminded that health security threats are inevitable. Points of entry play an important role in responding to health security threats, but border measures have limitations. The role of PoE needs to be repositioned to manage health security threats in a rapidly changing world. What lessons have we learnt and what is the documented value of PoE measures? WHO-recommended PoE measures were presented in a table. Temporary recommendations were issued for the following health security threats: pandemic H1N1 (e.g. no border closure and travel restriction); poliomyelitis (e.g. travel restriction measure in Pakistan); MERS (e.g. border screening not recommended); Ebola (e.g. exit screening in Western Africa recommended); and Zika (e.g. no travel and trade restriction, but health information and travel advice to pregnant women). Several observations were made following these events: (1) PoE play a dynamic role in responding to PHEIC; (2) exit measures may play increasingly important roles; (3) health information and advice to travellers and use of new technology need to be strengthened; (4) there is a need for risk-based, balanced decision-making for border interventions; (5) regional and international communication, coordination and collaboration are important.

2.3.2 Panel discussion

Panellists from Cambodia, China, Japan, the Lao People's Democratic Republic, Mongolia and Papua New Guinea discussed the following three questions about the role of PoE in responding to health security threats:

- 1) What do you think about role of PoE in managing PHEIC under IHR? How can we make PoE functional?
- 2) What are effective public health measures at PoE from previous events? Do these still function in our interconnected world in terms of preventing or limiting international spread of diseases?
- 3) What do you think about the shift from control of borders (original IHR) to containment at the source (IHR [2005])? Are there any measures to reach this goal?

2.4 Plenary 2: Innovative approaches to exit measures

2.4.1 Experiences with exit measures during the Ebola outbreak in West Africa (Dr Lisa Rotz, United States Centers for Disease Control and Prevention [US CDC])

The 2014–2016 West Africa Ebola epidemic was the largest Ebola epidemic recorded to date. The bulk of the epidemic occurred in Liberia, Sierra Leone and Guinea, and ultimately resulted in over 28 000 confirmed or suspected cases and over 11 000 deaths. In August 2014, the WHO International Health Regulations (IHR) Emergency Committee declared the Ebola outbreak a public health

emergency of international concern (PHEIC). As a result, the committee recommended implementation of exit screening in the affected countries along with comprehensive and coordinated international response support to help control the outbreak and prevent further international spread.

The US CDC deployed teams in August 2014 to all three countries to help implement exit screening programmes at international airports to prevent people with symptoms consistent with Ebola or known exposure from travelling.

The following efforts helped establish the exit screening safeguards, which also allowed commercial airlines to maintain safe operations, thus keeping open essential transportation pipelines for health care and other vital resources to and from the affected countries:

- identifying major stakeholders and partners;
- establishing service agreements (e.g. ill passenger transport and medical evaluation options);
- developing support materials and operating protocols;
- increasing staff resources;
- providing training;
- procuring supplies (e.g. noncontact temperature reading devices, personal protective equipment); and
- establishing programme monitoring and reporting capabilities.

Screening efforts included: 1) pre-travel community messaging to discourage travelling when ill; 2) temperature screening for all people entering the airport; 3) when possible, limiting terminal access to confirmed departing passengers and airport staff; 4) illness and exposure questionnaires completed by all travellers and reviewed by medical or public health staff; 5) provision of Ebola educational materials to arriving and departing travellers; and 6) in some locations, additional temperature checks immediately before boarding the airplane.

People with fever or other illness symptoms or possible exposure to Ebola during primary screening were not allowed to board a plane. (If screening for fever occurred outside the airport, febrile people were not allowed to enter the terminal.) Those identified were sent for additional on-site secondary screening by medical staff and either cleared for boarding or referred for off-site medical or public health evaluation before rebooking the flight.

Between August 2014 and January 2016, approximately 300 000 travellers were screened in Liberia, Guinea and Sierra Leone (<http://www.cdc.gov/mmwr/volumes/65/su/su6503a9.htm>). During this time, none of the travellers who were denied boarding for fever or other illness symptoms were subsequently reported to have been diagnosed with Ebola. Of the travellers who were permitted to travel after secondary screening, none were known to have developed Ebola-compatible symptoms during travel or to have been later diagnosed with Ebola. The four cases of Ebola that were exported to other countries through air transportation (United States: 2 cases, United Kingdom of Great Britain and Northern Ireland: 1 case, Italy: 1 case) occurred in travellers who did not report unprotected exposure, and therefore were not identified during pre-departure screening, and became ill after they arrived at their destination.

Implementing exit screening requires extensive resources, partner coordination, planning and training. This IHR capacity should be integrated and supported within other national emergency response planning efforts. Public health authorities should set realistic goals for exit screening and should consider criteria and timelines for activation and de-activation.

2.4.2 Experiences with exit measures in New Zealand (Ms Sally Gilbert, Ministry of Health New Zealand)

Under the IHR (2005), responses to health security threats must be proportionate to the risk, evidence-based and not unnecessarily interfere with international travel and trade.

Exit measures may be appropriate if a PHEIC originates within New Zealand and/or the WHO recommends exit measures for people leaving New Zealand. Overseas governments may ask the New Zealand Government to implement exit measures.

A range of exit measures may be considered:

- health advice and alerts
- travel restrictions
- vaccination certificates
- self-health monitoring and illness reporting
- contact tracing
- screening
- medical assessment
- isolating infectious/contaminated cases (refusing travel)
- quarantining exposed travellers (refusing travel).

Case Study 1: Pandemic Influenza

During the pandemic, anyone who felt unwell was asked to delay or cancel plans to travel overseas. This advice was available through media, websites (Government and travel industry) and advertising, and at points of departure. Airport staff looked for people displaying symptoms, and airlines refused to carry obviously unwell travellers. Anyone who postponed or cancelled travel because they were unwell was allowed to cancel or re-book their travel at no additional cost.

The New Zealand Government received requests from two Pacific island country governments for screening of departing travellers. Travellers were asked about their health at check-in and public health nurses were stationed in the departure lounges to observe and question travellers, including transit passengers. Any symptomatic travellers were refused travel.

Case Study 2: Ebola

New Zealand had no cases of Ebola, so exit measures were designed to prevent the onward travel of high-risk travellers. Travellers from affected countries were identified pre-arrival or self-reported on arrival. The travellers were screened, and high-risk travellers were to be strongly discouraged from further international travel (but no high-risk transit passengers arrived in New Zealand).

New Zealanders supporting the response in affected countries were provided with advice prior to travel and agreed to be quarantined upon their return including no international travel. Others travelling to affected countries from New Zealand were advised via information on Government and airline websites that anyone travelling to an affected country would be screened upon their return; that high-risk travellers would be quarantined; that international travel was strongly discouraged; and that details of high-risk travellers would be provided to the National Focal Point(s) at the next point(s) of entry.

In conclusion, exit measures need to be based on evidence and risk, and on WHO recommendations and advice. Exit measures should be applied as early as possible. Applying exit measures at the point of exit is most disruptive to travellers, airlines/shipping companies and sea/air ports. Effective exit measures require strong relationships between the health authorities and border stakeholders before an event. Information exchanged within the region (via National Focal Points) ensures other states understand the measures and promotes consistency. For further information, please see: <http://www.health.govt.nz/publications/responding-public-health-threats-international-concern>.

2.4.3 Experiences with exit measures in China (Dr Xue Yonglei, AQSIQ, China)

China's experiences with previous public health emergencies such as SARS and influenza A(H7N9) were presented. It was shared that exit control measures in affected countries can be a low-cost and highly efficient way to prevent the spread of infectious diseases globally. The governments of affected countries should issue announcements and carry out risk communication to citizens and travellers to make them aware of infectious disease-related symptoms (so that they can avoid unnecessary international travel). If vaccination is available, people who want to travel abroad should be vaccinated in advance. At the same time, the competent authority at the PoE should take steps to minimize the international spread of diseases by implementing exit control measures, including: health declarations, temperature screening, suspect case management, health measures such as disinfection, disinsection to the exit conveyance, and informing the competent authority at destination about the suspect case and so on.

2.4.4 Overview of innovative approaches to border measures (Dr Zheng Jianning, WHO Regional Office for the Western Pacific)

The presentation explored the shift from focusing almost exclusively on measures at PoE aimed at blocking the importation of cases, to a strategy of proactive risk management, including a set of "core capacity requirements" that all Member States must meet in order to detect an event early and stop it at its source. Global health security is a collective aspiration and mutual responsibility. There was an analysis of the limitations of the main border measures based on the experiences with public health emergencies at PoE. Exit control at the source and risk communication to travellers are more effective way to secure maximum protection against international spread of diseases. They provide innovative approaches to border measures to travellers. The whole trip management of public health threats start with providing pre-travel information for target travellers and end with post-travel monitoring until the end of their incubation period under the surveillance of different stakeholders and partners. Collaboration with partners and stakeholders is essential to minimize international spread of diseases and other threats.

2.5 Plenary 3: Innovative approaches to risk communication for travellers

2.5.1 Hong Kong SAR (China), Malaysia, the Philippines and Viet Nam

Countries and areas presented their approaches to risk communication during recent experiences with public health threats. Multiple channels were used including mass media, websites, banners/posters, flyers, social media, advertising, meetings, in-cabin announcements, training of border stakeholders and hotlines. For example, Hong Kong SAR (China) shared its recent experiences with Zika. At airports, measures were taken at the departure and arrival areas and staff were briefed. Additionally, measures were taken at cruise terminals. Special attention was paid to travellers going to the Olympics and Paralympics. Viet Nam described how risk communication was one of the main components of its preparedness and response plan for Ebola virus disease.

2.5.2 Risk communication innovations for better-informed travellers (Ms Joy Caminade, WHO Regional Office for the Western Pacific)

Outbreaks and public health emergencies in recent years – including SARS, A(H7N9), MERS, Ebola, yellow fever and Zika – have increased the profile of risk communication as a public health response. Though various approaches and innovations have been put in place to address the communication needs of travellers in the context of health emergencies, they are usually one way in nature with less engagement and consideration for risk perception. Most of the approaches are geared for inbound travellers at PoE. The coordination mechanism for messaging across sectors is sometimes unclear. New media and technologies are not used optimally.

Risk communication strategies at PoE would entail a paradigm shift from messaging on travellers' personal protection to promoting responsible citizenship and collective protection. This would mean promoting dialogue and conversation, cultivating multisectoral accountability, maximizing all forms of media, including social media, and approaching communication in a more humane way. Risk communication strategies should be able to address the information needs of travellers not only upon entry into a country, but all throughout the travel cycle, including at the time of exit.

2.6 Plenary 4: Group feedback

Three groups each discussed two scenarios designed to explore innovative border measures: exit measures and risk communication. The groups identified what measures could be taken, how feasible the measures were, and what would be needed to implement the measures in their countries.

What are possible measures to prevent departures?

- Enhancing communication and coordination mechanism – within the country and with country of destination.
- Informing travel agents/airlines not to sell tickets to affected travellers and provide ticket refunds and re-bookings at no additional costs.
- Putting in place quarantine measures (voluntary home or hospital quarantine, health monitoring, etc.) and providing these services for free.
- Coordinating with the National IHR Focal Point and Embassy on the appropriate action; special requirements of the country of destination.
- Including exit measures as part of public health preparedness in national plans.

However, it was mentioned that mostly countries have no legal basis to stop the travel; only the airlines can prevent them.

What are feasible exit measures in your country?

- Set up functional information sharing, communication and collaboration mechanisms.
- Strengthen surveillance and response measures.
- Provide timely information to the public (health education).
- Conduct risk assessment of travellers and carry out appropriate advice or measure.
- Offer travel insurance to cover cost of delaying travel.

2.7 Plenary 5: PoE decision-making and communications

2.7.1 Risk assessment-based decision-making for border health measures (Dr Chin Kei Lee, WHO Representative Office for China)

There is a “menu” of border measures to be implemented to prevent/reduce infectious disease transmission. However, there are often no “pre-set” measures, and hence a decision-making mechanism needs to be installed. In the context of border measures, and in line with the IHR, the decision made needs not only to consider health threats, but also to balance the effects with travel, trade and tourism. Perception of the threats, in addition to the real magnitudes, is also important. To illustrate, the benefits of border measures were balanced against the costs and feasibility of implementing them. It is also essential to develop and advocate these mechanisms before the outbreak during “peace” time.

2.7.2 Risk communication at PoE (Ms Joy Caminade, WHO Regional Office for the Western Pacific)

Risk communication strategies at PoE have shown some limitations as applied in previous outbreaks and emergencies. Most often, risk communication at PoE is not integrated in existing national plans, and in some instances, there is some disconnect with public health measures. There is also limited capacity and resources in using new technology and new media to reach travellers. Messaging is most often geared towards travellers entering a country, with minimal information shared at other stages of the travel cycle.

Risk communication strategies at PoE could include: integration of risk communication in the national public health emergency plan; implementation of risk communication as part of other public health measures, not as a stand-alone approach; and coordination of risk communication efforts with other sectors.

Risk communication strategies at PoE would entail a paradigm shift from messaging on travellers' personal protection to promoting responsible citizenship and collective protection.

3. CONCLUSIONS AND RECOMMENDATIONS

3.1 Conclusions

- 1) Member States recognized the importance of IHR (2005) in managing global health security threats while supporting travel, trade and tourism. Member States have made progress in building IHR (2005) core capacities at PoE over the past years, but they need to be further strengthened, assessed and improved, including as part of the APSED III implementation.
- 2) A review of the role of PoE in responding to emerging disease outbreaks and public health emergencies identified mismatches between the threats faced and some measures taken over the past 10 years. Actions at PoE played an important role in preparing for and responding to these health threats, but they have limitations and cannot alone stop the international spread of disease in our highly interconnected world.
- 3) Health security threats, especially emerging infectious diseases, are inevitable. The achievable goal of border measures has changed from control or exclusion to managing risks at the PoE based on risk assessments as part of wider national and international responses to health security threats. National, regional and international communication, coordination and collaboration remain vital for sharing practices and expertise, and encouraging international consistency.
- 4) The role of PoE in managing health security threats needs to be re-positioned and recognized as being dynamic. As part of preparedness, PoE measures should be part of national and PoE public health emergency response plans, which include tailored measures applicable not only to entry but also to exit.

- 5) Border health measures that may contribute to better management of health security threats include:
 - a) risk communication mechanisms to ensure travellers are better informed about any public health risks prior to, during their travel and at their destination, including how to prevent, identify, manage and report symptoms of concern; and
 - b) application of exit measures, when needed, to mitigate the risk of international spread of disease, which must be evidence-based, specific to the threat, and proportionate to the risk.

3.2 Recommendations

3.2.1 Recommendations for Member States

- 1) Member States are encouraged to continue to maintain and strengthen IHR (2005) core capacities at designated PoE, strengthen multisectoral coordination, and support the role of the National IHR Focal Point in international information sharing, collaboration and cooperation, including as part of APSED III implementation.
- 2) Member States are encouraged to review functional capacities at PoE by using the components of the IHR (2005) Monitoring and Evaluation Framework, including exercises, after action reviews and JEE.
- 3) Member States are encouraged to strengthen decision-making mechanisms for border health measures using evidence- and risk-based approaches to prepare for and respond to future health security threats.
- 4) Member States are encouraged to ensure that risk communication mechanisms are in place to provide travellers with information about public health risks prior to and during travel and at their destination, including how to prevent, identify, manage and report symptoms of concern.
- 5) Member States are encouraged to explore, identify, plan for and practise innovative border health exit measures that are evidence-based, specific to the threat, and proportionate to the risk, including setting achievable goals and realistic expectations.

3.2.2 Recommendations for WHO

- 1) WHO is requested to continue to provide technical support to Member States to maintain and further strengthen IHR (2005) core capacities to manage health security threats at designated PoE, including as part of APSED III implementation.

- 2) WHO is requested to encourage and provide support to monitor and review PoE functions in line with the IHR (2005) Monitoring and Evaluation Framework, including exercises, after action reviews and JEE.
- 3) WHO is requested to further strengthen and incorporate PoE considerations in the regional system for timely information sharing, collective risk assessment and coordinated response for public health emergencies; and support the role of the National IHR Focal Point including maintaining the National IHR Focal Point contact list.
- 4) WHO is requested to encourage and provide support to Member States to explore, implement and review innovative border health measures, including those related to exit measures and risk communication for travellers.

ANNEX 1

List of Participants, Temporary Advisers, Observers, Consultant and Secretariat

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ANNEX 2

Programme of Activities

Day 1 –Wednesday, 2 November 2016

| | |
|----------------------|--|
| 08:30 – 09:00 | Registration |
| 09:00 – 10:00 | Opening session Welcome and opening remarks - <i>Mr Han Jingyi, Member of the Leadership of Xiamen Municipal Government</i> - <i>Mr Chen Gang, Vice Minister, General Administrative of Quality Supervision, Inspection and Quarantine of the People's Republic of China (AQSIQ)</i> - <i>Dr Li Ailan, Regional Emergency Director (RED), WHO Health Emergency Programme (WHE), WHO Regional Office for the Western Pacific (WHO/WPRO)</i> Self-introductions Overview of objectives and agenda - <i>Dr Frank Konings, WHO/WPRO</i> Nomination of Chair, Co-Chairs and Rapporteur - <i>Dr Li Ailan, WHO/WPRO</i> Administrative announcements - <i>Dr Frank Konings, WHO/WPRO</i> Group photo |
| 10:00 – 10:30 | <i>Coffee break</i> |
| 10:30 – 12:00 | Plenary 1: implementing IHR (2005): progress and challenges |
| 10:30 – 10:50 | Implementing IHR through APSED for Health Security - <i>Dr Frank Konings, WHO/WPRO</i> |
| 10:50 – 11:10 | Global situation update from International Civil Aviation Organization - <i>Dr Ansa Jordaan, International Civil Aviation Organization (ICAO)</i> |
| 11:10 – 11:30 | Global situation update on IHR (2005) and Points of Entry (PoE) guidance - <i>Dr Ninglan Wang, WHO Headquarters (WHO/HQ)</i> |
| 11:30 – 12:00 | Questions and clarifications |
| 12:00 – 13:00 | <i>Lunch</i> |
| 13:00– 17:00 | Panel discussion: Stocktaking of public health events and the role of PoE |

13:00– 15:00 Reflecting on the past to inform the future: a decade of experiences with PoE
- *Dr Li Ailan, WHO/WPRO*

Panel members:

- Cambodia
- China
- Japan
- Lao, People's Democratic Republic
- Mongolia
- Papua New Guinea

15:00 – 15:30 *Coffee break*

15:30 – 17:00 Panel discussion: Stocktaking of public health events and the role of PoE
- *cont'd*

17:30 – 19:30 **Welcome reception**

Day 2 –Thursday, 3 November 2016

8:30 – 8:45 **Summary of Day 1**

8:45 – 10:00 **Plenary 2: Innovative approaches to exit measures**

8:45 – 9:00 Experiences with exit measures during the Ebola outbreak in West-Africa
- *Dr Lisa Rotz, United State Centers for Disease Control and Prevention*

9:00 – 9:15 Experiences with exit measures in New Zealand
- *Ms Sally Gilbert, Ministry of Health New Zealand*

9:15 – 9:30 Experiences with exit measures in China
- *Dr XueYonglei, AQSIQ, China*

9:30 – 9:45 Overview of innovative approaches to border measures
- *Dr Zheng Jianning, WHO/WPRO*

9:45 – 10:00 Questions and clarifications

10:00 – 10:30 *Coffee break*

10:30 – 12:00 **Plenary 3: Innovative approaches to risk communication for travellers**

10:30 – 10:45 Hong Kong, China

10:45 – 11:00 Malaysia

11:00 – 11:15 Philippines

11:15 – 11:30 Viet Nam

11:30 – 11:45 Risk communication innovations for better-informed travellers
- *Ms Joy Caminade, WHO/WPRO*

11:45 – 12:00 Questions and clarifications

| | |
|----------------------|---|
| 12:00 – 12:15 | Introduction to Breakout Sessions - <i>Dr Frank Konings, WHO/WPRO</i> |
| 12:15 - 13:15 | <i>Lunch</i> |
| 13:15 - 15:00 | Breakout Session 1: Innovative approaches to exit measures |
| | Group work |
| 15:00 – 15:30 | <i>Coffee break</i> |
| 15:30 – 17:00 | Breakout Session 2: Innovative approaches to risk communication for travellers |
| | Group work |

Day 3 – Friday, 4 November 2016

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|----------------------|---|
| 8:30 – 8:40 | Summary of Day 2 |
| 8:40– 9:30 | Plenary 4: Group feedback |
| 8:40 – 9:00 | Breakout Session 1: Innovative approaches to exit measures |
| 8:40 – 8:50 | - Group 1 |
| 8:50 – 9:00 | - Group 2 |
| 9:00 – 9:20 | Breakout Session 2: Innovative approaches to risk communication for travellers |
| 9:00 – 9:10 | - Group 1 |
| 9:10 – 9:20 | - Group 2 |
| 9:20 – 9:45 | Questions and clarifications |
| 9:45 – 10:15 | <i>Coffee break</i> |
| 10:15 – 11:15 | Plenary 5: PoE decision-making and communication |
| 10:15 – 10:45 | Risk assessment based decision-making for border health measures - <i>Dr Chin Kei Lee, WHO/China</i> |
| 10:45 – 11:15 | Risk communication at PoE - <i>Ms Joy Caminade, WHO/WPRO</i> |
| 11:15 – 12:00 | Plenary 6: Conclusions and Recommendations |
| | Closing Session |

12:00– 13:00

Lunch

13:00– 17:00

Field Visit

- Gaoqi International Airport, Xiamen
- Wutong Ferry Terminal, Xiamen

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