This document is for the information of WHO (Headquarters and Regional Offices), GRYF members and advisers.

1 See resolution WHA68.4 on Yellow fever risk mapping and recommended vaccination for travellers, available at http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_R4-en.pdf.
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I. Background and rationale

“The Sixty-eighth World Health Assembly, in resolution WHA68.4\(^2\) requested the Director-General to establish a formal scientific and technical advisory group on geographical yellow fever risk mapping, with the participation of countries with areas at risk of yellow fever, to: (i) maintain up-to-date yellow fever risk mapping; and (ii) provide guidance on yellow fever vaccination for travellers in ways that facilitate international travel.”

This document describes background and rationale for establishment of this group as well as scope of work, functions and procedures.

Yellow Fever risk trends

Yellow Fever (YF) was originally imported into the Americas from Africa, and became widely established there. There are nowadays an estimated 200,000 cases of YF, causing 30,000 deaths\(^3\) worldwide each year, with 90% occurring in Africa\(^4\). Although most infections present few symptoms, some lead to an acute illness.

Unvaccinated travellers who visit areas in Africa during periods of epidemic activity have a 1 in 267 risk of illness and a 1 in 1,333 risk of death due to YF; the risks are likely to be lower between epidemic periods. The risk of illness and death for individuals travelling to South America is considered to be 10 times lower than it is for those travelling to Africa because viral transmission occurs in the forest canopy away from human contact, and because vaccine coverage is higher. However, travellers’ risk of acquiring YF is difficult to predict due to variations in the ecologic determinants of virus transmission and in protective behaviours, immunity profiles, and activities\(^5\).

The density and habitats of the most common mosquito vector *Aedes aegypti* has recently expanded both in urban and rural areas. This mosquito is now again infesting regions from which it was previously eradicated. YF has never been reported from Asia, but, should it be accidentally imported, the potential for outbreaks exists because the appropriate mosquito vector is present\(^6\). Most countries in Asia with high *Aedes aegypti* mosquito density are considered “receptive” for YF transmission.

There is no specific treatment for YF. Vaccination is highly recommended as a preventive measure for travellers to, and people living in, endemic countries. A single dose of YF vaccine is sufficient to confer sustained immunity and life-long protection against YF disease and a booster dose of YF vaccine is not needed\(^7\). The introduction of the YF 17D vaccine in the 1930s provided an effective preventive measure

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\(^7\) Position paper Yellow Fever vaccination Weekly Epidemiological Report No. 20, 2013, 88, 201–216, [http://www.who.int/entity/wer/2013/wer8820.pdf?ua=1](http://www.who.int/entity/wer/2013/wer8820.pdf?ua=1)
resulting in a significant decline of the disease. However, more recently, there has been a resurgence of YF due to changes in population dynamics, urbanization, deforestation coupled with other agricultural and developmental activities, climate changes and a decline in population immunity.8

**Yellow Fever risk assessment**

The scarcity of well documented and consistent methods in YF risk assessment and the changing global epidemiology of the disease emphasised the need to revise classification and standardise the geographical risk assessment for YF. For instance, in late 2007 and early 2008, the disease re-emerged in Paraguay and Argentina after more than 30 years. Furthermore, increased numbers of cases were reported from many countries in central Africa that had previously reported cases only rarely.

WHO convened an Informal Working Group on Geographic Risk for Yellow Fever to review factors important for the transmission of yellow fever virus and country-specific yellow fever information, to establish criteria for additions to or removal from the list of countries with risk for yellow fever virus transmission, to update yellow fever risk maps, and to revise the recommendations for vaccination for international travel.9 The working group met by teleconference regularly (roughly every month) from September, 2008, to May, 2010 and then on an ad hoc basis. This working group outlined four levels of yellow fever risk and classified geographical areas into four corresponding categories: endemic, transitional, low risk, and no risk (table 1). The factors identified in table 1 were adopted as the criteria for the addition or removal of countries and geographical regions in annex 1 of the International Travel and Health (ITH) publication.

The risk of YF was determined on the basis of the virus circulation in humans, non-human primates and vectors; the distribution of YF vectors and animal reservoirs; and the ecological factors.10 Within certain countries, and where data exist, it is possible to stratify areas according to the epidemiological risk of YF virus transmission.

The factors identified by the group which can provide useful information on risk of YF virus transmission were:

- Periodicity of reported human or animal YF cases (active or passive surveillance);
- Presence and distribution of mosquito vectors and non-human primate hosts involved in the YF virus transmission cycle (field research);
- Ecological factors (proxy indicators for presence, abundance, and activity of vectors and primates): Vegetation, rainfall, elevation, temperature (satellite imagery);
- Historical serological surveys of the human population;
- Detection of YF virus or antibodies in non-human primates and in vector mosquitoes (field studies).

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<table>
<thead>
<tr>
<th>Classification criteria</th>
<th>Risk for infection</th>
<th>Vaccination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endemic Areas with persistence of enzootic yellow fever virus transmission for long periods of time, where yellow fever vectors and non-human primate hosts are present, and where yellow fever infections are repeatedly reported in human beings, non-human primates, or both, where yellow fever cases in human beings were reported regularly before high yellow fever immunisation coverage was achieved, or where serosurveys (pre-vaccination era) show evidence of high levels of yellow fever virus infection</td>
<td>High</td>
<td>Vaccination recommended for all travellers aged ≥ 5 months or older</td>
</tr>
<tr>
<td>Transitional Areas bordering zones that are endemic for yellow fever with periodic evidence of virus transmission during epizootic or epidemic expansions, where yellow fever vectors and non-human primate hosts are present, and where yellow fever infections are reported in human beings, non-human primate hosts, or both (sporadic or epidemic) at long intervals and during yellow fever epizootic cases or epidemic expansions from bordering endemic areas, or where serosurveys (pre-vaccination era) show evidence of yellow fever virus infection in individuals born before the previous yellow fever virus expansion</td>
<td>Moderate to high</td>
<td>Vaccination recommended for all travellers aged ≥ 5 months or older</td>
</tr>
<tr>
<td>Low potential for exposure Areas bordering zones where yellow fever is endemic or transitional, where yellow fever vectors and non-human primate hosts are present, where no yellow fever infections have been reported in either human beings or non-human primates, and where serological or other evidence of low levels of yellow fever viral transmission in the past might exist</td>
<td>Low</td>
<td>Vaccination generally not recommended for travellers to areas with low potential for exposure; however, vaccination might be considered for a small subset of travellers whose itineraries would place them at an increased risk for exposure to yellow fever virus (e.g., prolonged travel, heavy exposure to mosquitoes, inability to avoid mosquito bites)</td>
</tr>
<tr>
<td>No risk Areas where no past or present evidence of virus circulation exists or environmental conditions are not conducive to yellow fever virus transmission</td>
<td>None</td>
<td>Vaccination not recommended</td>
</tr>
</tbody>
</table>

Criteria were defined at the 2008 and 2010 WHO consultations on yellow fever—some criteria include elements for which there is no scientific basis for definition (e.g., high levels, long intervals) and which will need interpretation by experts with experience in this disease area. Decisions regarding the use of yellow fever vaccine for travellers must consider several factors, such as a patient’s risk of infection, country entry requirements, and the potential for serious adverse events after vaccination—in the absence of such information, a conservative approach to vaccination is justified.

**Table 1:** Classifications of geographical areas, according to risk of transmission of yellow fever virus
Other WHO Groups contributing to the YF work are:

- **The Strategic Advisory Group of Experts (SAGE)**\(^{11}\) on Immunization established by the Director-General of the World Health Organization in 1999 provides guidance on the work of WHO. SAGE is the principal advisory group to WHO for vaccines and immunization. It is charged with advising WHO on overall global policies and strategies, ranging from vaccines and technology, research and development, to delivery of immunization and its linkages with other health interventions. SAGE recommendations guide the technical content of the ITH publication.

- **The Global Advisory Committee on Vaccine Safety (GACVS)**\(^{12}\), an expert clinical and scientific advisory body, established in 1999 by WHO provides independent, scientifically rigorous advice on vaccine-safety issues of potential global importance. Recommendations from this group regarding yellow fever vaccination will be brought to the attention of the Scientific and Technical Advisory Group on Geographical Yellow Fever Risk Mapping (GRYF) for its consideration and included in the ITH publication\(^ {13}\).

- **The technical unit in charge of yellow fever control.** This unit convened a group of YF experts and developed a multidisciplinary risk assessment methodology for field investigations which includes serological surveys in human and non-human primate, and assessment of vector density and infectivity\(^ {14}\). The field investigation methodology proposed aims at supporting a more systematic approach for data collection and analysis to assess YF risk in an area, and to determine appropriate vaccination strategies at national level (e.g. the need for either preventive or reactive campaigns, or the use of the vaccine in the childhood expanded programme on immunizations). This unit will work closely with the GRYF secretariat and appropriate results from field investigations and data available for vaccination coverage will be shared with the GRYF members to document the YF risk classification status and determine appropriate protective measures for travellers.

The GRYF will work in close collaboration with the technical units\(^ {15}\) responsible for the Yellow Fever Initiative and for immunization and vaccine safety.

**International Health Regulations**

YF is the only disease expressly listed in the International Health Regulations (IHR) for which countries can require proof of vaccination from travellers as a condition of entry into a country\(^ {16}\). The IHR stipulate that vaccination with a WHO approved YF

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\(^{11}\) See SAGE web pages, [http://www.who.int/immunization/sage/en](http://www.who.int/immunization/sage/en)


\(^{13}\) International Travel and Health web page, [http://www.who.int/ith/en/](http://www.who.int/ith/en/)

\(^{14}\) Yellow Fever in Africa: Estimating the Burden of Disease and Impact of Mass Vaccination from Outbreak and Serological Data, [http://apps.who.int/iris/bitstream/10665/158260/1/PMC4011853.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/158260/1/PMC4011853.pdf?ua=1)


International Health Regulations, [http://www.who.int/topics/international_health_regulations/en/](http://www.who.int/topics/international_health_regulations/en/)
vaccine\textsuperscript{17} provides protection against infection for 10 years, and that the certificate of vaccination or re-vaccination is accordingly valid for 10 years. The WHO World Health Assembly in May 2014 adopted an amendment to Annex 7 of IHR\textsuperscript{18}, which stipulates that the period of protection afforded by YF vaccination, and the term of validity of the certificate will change from 10 years to the duration of the life of the person vaccinated. This change will enter into force legally in July 2016.

The requirement of a proof of vaccination from travellers as a condition of entry into a country shall not be more restrictive of international traffic and not more invasive or intrusive to persons than reasonably available alternatives that would achieve the appropriate level of health protection. In determining whether to implement the requirement of a proof of vaccination from travellers, countries shall base their determinations upon scientific principles, available scientific evidence of a risk to human health, or where such evidence is insufficient, the available information including from WHO and other relevant intergovernmental organizations and international bodies; and any available specific guidance or advice from WHO. A country implementing a requirement of a proof of vaccination which significantly interferes with international traffic shall provide to WHO the public health rationale and relevant scientific information for it. WHO shall share this information with other countries and may, where appropriate, request that the country concerned reconsider the application of the measures.

\section*{International Travel and Health}

The WHO International Travel and Health (ITH) publication provides guidance on the full range of significant health issues associated with travel. Updated chapters and annexes are available from the WHO web site\textsuperscript{19}. The ITH country list includes YF vaccination certificate country’s requirements and WHO recommendations to travellers. Every year WHO sends a questionnaire to Member States to update this list.

ITH Annex 1 is a table listing countries with risk of YF transmission and countries requiring YF vaccination. The terms “country” and “countries” cover countries, territories and areas.

Risk of YF transmission is defined as YF being currently reported or having been reported in the past and presence of vectors and animal reservoirs representing a potential risk of infection and transmission. Annex 1 also includes yellow fever vaccination requirement for travellers having transited through the airport of a country with risk of yellow fever transmission. The new 2015 version will also include the State requirement for validity of the YF certificate, taking into account the above-mentioned amendment to Annex 7 of the IHR. Yellow Fever risk maps and vaccination recommendations are updated on a yearly basis, see graph 1.

\begin{itemize}
\item \textsuperscript{17}WHO Database for pre-qualified vaccine, http://www.who.int/immunization_standards/vaccine_quality/PQ_vaccine_list_en/en/
\item \textsuperscript{18}Vaccine Position Papers http://www.who.int/immunization/documents/positionpapers/en/
\item \textsuperscript{19}WHA 67.13 Implementation of the International Health Regulations (2005), http://apps.who.int/ebwha/pdf_files/WHA67-REC1/A67_2014_REC1-en.pdf#page=25
\item \textsuperscript{19}International Travel and Health book, http://www.who.int/ith/en/
Graphs 1 and 2 - WHO’s ITH maps of Yellow Fever vaccination recommendations, 2015 version

Yellow Fever Vaccination Recommendations in Africa, 2015

*Yellow Fever (YF) vaccination is generally not recommended in areas where there is low potential for YF virus exposure. However, vaccination might be considered for a small subset of travelers to these areas who are at increased risk for exposure to YF virus because of prolonged travel, heavy exposure to mosquitoes, or inability to avoid mosquito bites. Consideration for vaccination of any traveler must take into account the traveler’s risk of being infected with YF virus, country entry requirements, and individual risk factors for serious vaccine-associated adverse events (e.g., age, immune status).

The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. United and dashed lines on maps represent approximate border lines for which there may not be full agreement.

Data Source: World Health Organization
Map Production: International Travel and Health
World Health Organization
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Yellow Fever Vaccination Recommendations in the Americas, 2013

Venezuela (Bolivarian Republic of)
Trinidad and Tobago
Guyana
Suriname
French Guyana

Colombia
Panama
Ecuador
Peru
Paraguay
Argentina
Bolivia (Plurinominal State of)
Chile
Uruguay
Brazil

Vaccine
- Vaccination recommended
- Vaccination generally not recommended
- Vaccination not recommended

* Yellow Fever (YF) is generally not recommended in areas where there is low potential for YF exposure. However, vaccination might be considered for a small subset of travelers to these areas who are at increased risk for exposure to YF virus because of prolonged travel, heavy exposure to mosquitoes, or inability to avoid mosquito bites. Consideration for vaccination of any traveler must take into account the traveler’s risk of being infected with YF virus, country entry requirements, and individual risk factors for serious vaccine-associated adverse events (e.g., age, immune status).

The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Data Sources: World Health Organization
Yellow Fever Working Group

World Health Organization
II. Scope of work

WHO recommends YF vaccination with three objectives:
- to protect populations living in areas subject to endemic and epidemic disease;
- to protect travellers visiting the area with risk of YF; and
- to prevent international spread by minimizing the risk of introduction or re-introduction of the virus by viraemic travellers\textsuperscript{20,21}.

The work of the GRYF will focus on the last two objectives.

Protection of travellers visiting areas with risk of Yellow Fever

Vaccine should be offered to all unvaccinated travellers aged $\geq 9$ months, travelling to and from at-risk areas (table 2), unless they belong to the group of individuals for whom YF vaccination is contraindicated. In addition for travellers going to areas with low risk of YF transmission, although the vaccination is generally not recommended, it might be considered for the ones travelling for a long period to areas where they may be exposed to heavy load of mosquito bites.

Table 2 – Yellow Fever vaccination recommendations for travellers

<table>
<thead>
<tr>
<th>Yellow fever vaccination category</th>
<th>Rationale for recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommended</td>
<td>Yellow fever vaccination is recommended for all travellers $\geq 9$ months old in areas where there is evidence of persistent or periodic yellow fever virus transmission.</td>
</tr>
<tr>
<td>Generally not recommended</td>
<td>Yellow fever vaccination is generally not recommended in areas where there is low potential for yellow fever virus exposure (no human yellow fever cases ever reported and evidence to suggest only low levels of yellow fever virus transmission in the past). However, vaccination might be considered for a small subset of travellers to these areas, who are at increased risk of exposure to mosquitoes or unable to avoid mosquito bites. When considering vaccination, any traveller must take into account the risk of being infected with yellow fever virus, country entry requirements, as well as individual risk factors (e.g. age, immune status) for serious vaccine-associated adverse events.</td>
</tr>
</tbody>
</table>

Protection of vulnerable countries

Countries where the vectors and non-human primate hosts exist are vulnerable to the introduction or re-introduction of YF virus, even if the disease is not endemic.


\textsuperscript{21} Updated list of YF vaccines position paper and all key references with summary, http://www.who.int/immunization/policy/position_papers/yellow-fever/en/
Importation of the virus by an infected traveller could initiate an enzootic transmission cycle, leading to a long-term infection risk for the local population.

To prevent importation of YF virus, States may decide to require a proof of YF vaccination as a condition of entry to travellers coming from areas with risk of YF transmission (endemic or transitional). The requirement to produce a valid vaccination certificate then applies equally to all travellers coming from a country where there is a risk of yellow fever (regardless of whether or not this risk is homogeneously distributed throughout the territory).

III Functions of the GRYF advisory body

The GRYF is a formal scientific and technical advisory group on geographical yellow fever risk mapping, with the participation of countries with areas with risk of yellow fever, to:

(i) maintain up-to-date yellow fever risk mapping; and
(ii) provide guidance on yellow fever vaccination for travellers in ways that facilitate international travel.

In order to achieve the above mentioned objectives, the GRYF will advise the IHR Secretariat on:

- The definition of criteria for inclusion/exclusion of countries/areas with risk of yellow fever transmission
- The review of requests received from Members States including public health justification and scientific data to add or remove countries/areas with risk of yellow fever
- Collection, reviewing and analysing new epidemiological data on yellow fever transmission
- Proposals for revision of the list of countries/areas with risk of yellow fever transmission
- Proposal for revision of the Yellow Fever risk mapping
- Promoting the international harmonization of the Yellow Fever risk mapping
- Establishment and maintenance of a centralized updated yellow fever country database with the aim of tracking history of risk mapping status changes per country (decision making, rationale, data)

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23 See resolution WHA68.4 on Yellow fever risk mapping and recommended vaccination for travellers, available at http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_R4-en.pdf.
IV . Composition

Members
Between 10 and 20 experts will be selected taking into consideration the technical expertise, geographical representation and gender balance. Members shall be drawn from the IHR Expert Roster\textsuperscript{24} or any appropriate WHO expert advisory panels\textsuperscript{25}. The selection of an expert is made by the Director-General on the recommendation of the IHR secretariat after consultation with the Regional Directors. Members shall serve in their personal capacity and take part in the decision making process of the meeting in which they are involved. The list of members and their affiliations will be made publically available. The members’ expertise shall include the following areas of expertise: virology, entomology, veterinary public health, geographical risk mapping, epidemiology, immunization and travel medicine. Yellow Fever specific experience will be required of all members.

Duration of duty
Members of the GRYF shall be appointed to serve for a maximum period of 4 years, and will be eligible for reappointment. Their appointment, and, as appropriate, designation as Chairman, may be terminated at any time by WHO if it is in WHO’s interest.

Secretariat
The Secretariat for the GRYF will be composed of WHO staff members from HQ responsible for travel health and IHR. The Secretariat will work closely with appropriate technical units in Headquarters and Regional Office in charge of YF.

Temporary Advisers
The GRYF secretariat may decide to invite additional experts, as temporary advisers as needed. Temporary advisers provide working papers or advice to the Secretariat and take part in discussions, but not in the decision making process of the meeting to which they contribute.

Observers
Representatives from inter-governmental organizations, as well as nongovernmental organizations in official relations with WHO may be invited by WHO to participate in appropriate aspects of GRYF meetings as observers. Upon invitation of the Chair, they may present the views and policies of their organizations and contribute to the GRYF discussions. Observers will not be involved in the deliberations on adoption of decisions or recommendations of the GRYF\textsuperscript{26}.

\textsuperscript{24} International Health Regulations, article 47, http://whqlibdoc.who.int/publications/2008/9789241580410_eng.pdf
\textsuperscript{26} Internal Note: the selection of the institutions which are invited to send a representative should be based on objective and justifiable criteria.
Chair, vice chair and rapporteur
Chairman, vice chair and rapporteur shall be designated by the Assistant Director General of the responsible Cluster from among the members of the GRYF. Their designation may be terminated at any time by WHO if WHO’s interest so requires.

The Chairman’s roles shall include the following:
- to chair the meeting of the GRYF;
- to liaise with the WHO GRYF Secretariat between meetings

The vice Chair serves as chairman in the absence of the chairman.
The rapporteur is responsible for the meeting report drafting.

Country representative
The Secretariat may invite the State Party where the YF risk classification is being revised to present its views to the GRYF via a country representative.

Conflict of Interest Management
In the exercise of their functions, the members and advisers shall act as international experts serving the Organization exclusively; they may not request or receive instructions from any government or authority external to the Organization. Furthermore, the members and advisers must be free of any real, potential or apparent conflict of interest. They shall disclose all circumstances that could give rise to a potential conflict of interest in accordance with the mechanisms established by the Director-General.

To this end, members and advisers will be required to complete the WHO declaration of interest form (DoI), in order to allow the GRYF Secretariat to determine whether their participation would give rise to a real, potential or apparent conflict of interest.

If it is concluded that a declared interest is potentially significant, one of the following three options, or a combination of these options, may be considered to determine the participation level of the members and advisers:

(i) Conditional Participation: Under this option, the Responsible Officer would decide to continue the expert's involvement in the meeting or work and publicly disclose the expert's interest at the start of the meeting to all meeting participants and in the report of the meeting and/or relevant publications or work products. This approach is especially appropriate where the expert's interest is relatively minor.

(ii) Partial Exclusion: In this alternative, the Responsible Officer would limit the expert's involvement, either (a) by excluding the expert from that portion of the meeting or work where a conflict of interest has been identified and/or (b) excluding the expert from participating in the decision making process related to the development of, for example, guidelines or recommendations.

In both cases, and after consulting the Chair of the meeting (if applicable), the reported interest must also be publicly disclosed to other meeting participants and must be recorded and disclosed in the report of the meeting and/or
relevant publications or work products. Partial exclusion must be carefully monitored. It may only be used to enable other members to listen to the results of research or views held by the best-qualified experts, while bearing in mind the expert's potential bias.

(iii) Total Exclusion. In this case, the expert is excluded from the meeting or work altogether, where the nature of the conflict of interest is too significant vis-à-vis the overall objective, or where limiting the expert's involvement to only a portion of the meeting or work is not feasible (because, for example, the expert's participation in the remainder of the meeting would have little or no value). A decision to exclude an expert should always be taken in consultation with the Assistant-Director General and following consultation with the Office of Compliance, Risk Management and Ethics.

Disclosure

As stated above, if a member or adviser declares an interest that leads the Secretariat to either conditionally approve his/her participation in a meeting or to partially exclude him/her from a meeting or activity, then the Secretariat must make a public disclosure of that interest to meeting participants as well as in the final report, relevant publication or work product emanating from such meeting or activity. The WHO Responsible Officer should always consult the Chair of the meeting prior to making a public disclosure of a member or adviser's interest to other meeting participants or considering any of the measures described above27.

Public disclosure of a member or adviser’s interest does not eliminate the conflict of interest but rather mitigates it by making others aware of the interest thereby enabling them to exercise an appropriate degree of critical assessment about the views or recommendations that are made by that expert.

In disclosing the financial interest of a member or adviser, the Secretariat should either use general characterizations or ranges of amounts depending on the particular circumstance involved. In this regard, if the aggregate amount of consultancy fees from any single company exceeds USD 10,000 in a calendar year, it would be characterized as “significant”. Likewise, a shareholding in any one company in excess of 1,000 shares would also constitute a “significant shareholding”. On the other hand, less than 50 shares would constitute an “insignificant shareholding” and less than USD 1,000 in fees or income from any one company in a calendar year would be characterized as “minor income”. Regardless of the amount of shares or their value, however, the Secretariat should always disclose when an expert has a controlling interest in a company, i.e. when he/she has the ability to influence decisions taken by the company.

In meetings where relevant interests are disclosed by members and advisers, the Secretariat should prepare a summary of the DOI responses accurately characterizing each member and adviser's relevant conflicts. The Chair at the start of the meeting should then read the summary.

27 Guidelines for declaration of interests (WHO experts)
http://intranet.who.int/homes/ker/documents/coi%20guidelines%20and%20procedure%20final.doc
Public Notice and Comment
In order to enhance its management of Conflicts of Interest as well as strengthen public trust and transparency in connection with WHO meetings involving the provision of technical/normative advice, the names and brief biographies of individuals (“Published Information”) being considered for participation in such meetings are disclosed for public notice and comment.

The Published Information is provided by the experts themselves and is the sole responsibility of the individuals concerned. WHO is not responsible for the accuracy, veracity and completeness of the Published Information provided. Furthermore, in no event will WHO be responsible or liable for damages in relation to the use of, and reliance upon, the Published Information.

The comments received by WHO through the public notice and comment process are treated confidentially and their receipt will be acknowledged through a generic email notification to the sender. Comments and perceptions brought to the knowledge of WHO through this process are an integral component of WHO’s conflict of interest assessment policy and are carefully reviewed. WHO reserves the right to discuss information received through this process with the relevant expert with no attribution to the provider of such information. Upon review and assessment of the information received through this process, WHO, in its sole discretion, may take appropriate management action in accordance with its policies.

The participation of an expert in a WHO meeting does not imply that they are endorsed or recommended by the World Health Organization nor does it create a binding relationship between the expert and WHO.

The list of participating experts, a summary of relevant interests disclosed by such experts, and any appropriate mitigation measures taken by WHO relating to the management of conflicts of interests, will be reported publically in accordance with WHO practice.

V. Methods of work

Members’ participation
Members are expected to participate in most meetings. Meetings of the GRYF may take place through teleconferences, videoconferences or electronic communications. If a member misses two consecutive meetings, WHO may terminate his/her appointment as a member of the GRYF. WHO may decide to appoint a member in replacement of that member.

Agenda
The GRYF secretariat shall prepare the draft agenda, submit it to its Assistant Director General for approval after consultation with regional offices, appropriate technical units and advisory bodies (YFI, SAGE and GAVSC). The agenda shall include any subject within the terms of reference of the technical advisory group as appropriate.
Meeting frequency
The GRYF should normally meet at least once each year or upon request of the Secretariat on an ad hoc basis.

Language of deliberation
The working language is English.

Collaboration
Focal points from WHO Headquarter, regional offices and other WHO advisory bodies are consulted on issue(s) or document that should be brought to the attention of the GRYF as well as agenda items.

Country representative
The Secretariat may invite the State Party to the meeting where the YF risk classification is being reviewed to present its views to the GRYF. To that effect, the Secretariat should notify to it the dates and the agenda of the meeting of the GRYF with as much notice as necessary. The State Party concerned, however, may not seek a postponement of the meeting of the GRYF for the purpose of presenting its views thereto.

State’s request
States may submit a request to the GRYF secretariat to revise the YF risk classification. This request should be documented with a public health justification and scientific data supporting the request. On receipt of such request the GRYF Secretariat will convene on an ad hoc basis or at least annually a teleconference to review the YF risk classification and related issues. At this occasion the State will have the opportunity to provide its views to the GRYF via a country representative. Updates to the country list once approved and validated will be published on the WHO ITH web site.

Information and documentation
A report of each teleconference will be submitted by the WHO Secretariat to the Assistant Director-General of the responsible Cluster. All recommendations from the GRYF members are advise to the WHO Secretariat, which retains full control over any subsequent decisions or actions regarding any proposals, policy issues or other matters considered by the GRYF. WHO shall share the reports with Member States.

The information and documentation to which GRYF members, advisers and observers will gain access, may include confidential and proprietary information. To protect the proprietary and confidential nature of such information, all members, advisers and observers will therefore be required to sign an appropriate Confidentiality Undertaking and Copyright Assignment. GRYF members, advisers and observers shall refrain from quotation, and circulation and use of GRYF documents outside of the context of meetings or among Members and the WHO Secretariat, and for any purpose other than in a manner consistent with their responsibilities under these TOR, except as formally allowed in writing by the Assistant Director-General or her designee. GRYF members shall not purport to speak on behalf of, or represent, the GRYF or WHO to any third party.
**Vote**

Scientific questions shall not be submitted to a vote. If the members of the GRYF cannot agree, each shall be entitled to have his personal opinion reflected in the report if any; this statement of opinion shall take the form of an individual or group report, stating the reasons why a divergent opinion is held.

**Quorum**

The discussions of a GRYF meeting shall be considered as valid if at least one-third of its members are present; unless otherwise authorized by the Assistant Director General of the GRYF Secretariat.

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