

Summary report on the
Fifth regional stakeholders
meeting to review the
implementation of
International Health
Regulations (2005)

WHO-EM/IHR/009/E

Cairo, Egypt
20–22 September 2016



World Health
Organization

Regional Office for the Eastern Mediterranean

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1. Introduction

The International Health Regulations (IHR) (2005) remain the key driver in national and international efforts to strengthen global health security. In accordance with World Health Assembly resolutions WHA61.2 and WHA65.23, all State Parties are required to develop, strengthen and maintain core capacities for surveillance and response to effectively prevent, detect and rapidly respond to any health threat before it becomes an international emergency. Protecting public health security through preparedness, readiness, response and recovery is a critical undertaking and must be maintained at all times and all levels.

The initial deadline for developing core capacities for IHR (2005) was 2012, with potential extensions until 2016. Although progress has been made in the World Health Organization (WHO) Eastern Mediterranean Region, these capacities have not been established in many countries. The IHR Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR (2005) Implementation (WHA 68/22 Add.1) recommended in 2014 “...to move from exclusive self-evaluation to approaches that combine self-evaluation, peer review and voluntary external evaluations involving a combination of domestic and independent experts.” A revised IHR Monitoring and Evaluation Framework was also noted by the Sixty-ninth World Health Assembly held in May 2016.

In this context, the fifth Regional Stakeholder meeting to review the implementation of IHR (2005) was organized by the WHO Regional Office for the Eastern Mediterranean in Cairo, Egypt from 20–22 September 2016. The meeting was attended by national IHR focal points from 17 Member States in the Region, members of the IHR Regional Assessment Commission (IHR-RAC), as well as representatives from the Civil Aviation Regulatory Commission, Eastern Mediterranean Public Health Network, Finnish National

Institute for Health and Welfare, Food and Agriculture Organization of the United Nations (FAO), Centers for Disease Control and Prevention (CDC), U.S. Naval Medical Research Unit No. 3 (NAMRU-3), as well as staff from WHO headquarters, Regional Office and country offices. The objectives of the meeting were to:

- appraise Member States on Regional Committee resolution EM/RC62/R.3;
- inform Member States on the new IHR Monitoring and Evaluation Framework (post-2015);
- share experiences and outcomes of the Joint External Evaluation (JEE) process;
- discuss implementation of IHR core capacities in the Region;
- present and discuss the draft global implementation plan for the recommendations of the Review Committee on the Role of the IHR (2005) in the Ebola Outbreak and Response.

The meeting was inaugurated by Dr Jaouad Mahjour, Director of Programme Management and ad-interim Regional Emergency Director, WHO Regional Office for the Eastern Mediterranean. Dr. Mahjour highlighted the importance of IHR (2005) implementation following the adoption of resolution EM/RC62/R.3 which urged Member States to conduct objective assessment of implementation of IHR (2005) with WHO support, and report annually to IHR-RAC on progress in implementing the regulations using a harmonized tool and standardized methodology. The resolution further requested the Regional Director to establish terms of reference for IHR-RAC and organize the first meeting of the Commission before the end of 2015, and to establish a regional task force to harmonize the existing tools for assessment of implementation of IHR (2005), including the GHSA assessment tool.

In accordance with resolution EM/RC62/R.3, the WHO Regional Office for the Eastern Mediterranean spearheaded global efforts to

review the existing tools and harmonize the IHR core capacity assessment tools with those of the Global Health Security Agenda (GHSA) package. The JEE tool was thus developed with input from partners. Up to September 2016, JEE has been conducted in six Member States in the Region, while the evaluation to assess IHR core capacities using JEE tools will be conducted in an additional nine Member States between September 2016 and April 2017.

2. Summary of discussions

IHR Monitoring and Evaluation Framework post-2015

Post-2015, the IHR Monitoring and Evaluation Framework includes self-assessment, JEE, after-action reviews (AARs), annual reporting and simulation exercises. The JEE is a voluntary, transparent and multisectoral exercise that can be requested by Member States, whereas annual reporting is a mandatory process that takes place regularly. JEE aims to identify Member States' capacities and identify their most urgent needs to prevent, detect and respond to public health threats, whereas AARs and simulation exercises are conducted to assess capacities to implement IHR core capacities in real-life situations. JEE is multisectoral and complements the Evaluation of Performance of Veterinary Services (PVS) implemented by the World Organisation for Animal Health (OIE).

IHR-RAC

The IHR-RAC was established in 2015 in accordance with resolution EM/RC62/R.3. IHR-RAC comprises 15 members, appointed by the Regional Director on the basis of their expertise and personal capacity to advice on implementation of IHR core capacities. The duration of the appointment is 4 years, with a possibility of renewal of one third of members for a second term. Members do not have any supervisory or

reporting role to their countries. The main tasks of the IHR-RAC are (i) assessing the implementation of IHR in the Region; (ii) advising Member States on issues related to implementation; (iii) identifying major issues and challenges to be addressed by WHO to support implementation of IHR in the Region; and (iv) reporting annually to the Regional Committee on the progress of implementation of IHR.

The IHR-RAC has met twice so far, in December 2015 and September 2016. In accordance with resolution EM/RC62/R.3, the IHR-RAC provided recommendations to Member States on issues related to implementation of IHR core capacities in the Region. The main recommendations of the IHR-RAC are:

- enhance the function of IHR national focal points;
- strengthen IHR multisectoral committees;
- establish an inventory of existing laboratory services for a network of laboratories;
- forge greater collaboration and a coordinated response to chemical and radiation emergencies;
- promote the One Health approach for detection, prevention and response to emerging diseases.

JEE in the Eastern Mediterranean Region

The purpose of the external evaluation process is to measure country-specific status and progress in achieving the targets in the JEE tool. JEE allows countries to identify the most critical gaps within their human and animal health systems to prioritize opportunities for enhanced preparedness and response, and to engage with current and prospective donors and partners to effectively target resources. Transparency is an important element in order to attract and direct resources to where they are needed most. External evaluations should be regarded as an integral part of a continuous process of strengthening capacities for

implementation of IHR (2005) which includes strong political commitment, self-evaluation and a multisectoral integrated approach.

The JEE tool contains 19 action packages grouped under four main areas: (i) preventing and reducing the likelihood of outbreak (national legislation, policy and financing, IHR coordination and communication, antimicrobial resistance, zoonotic disease, food safety, biosafety and biosecurity and immunization); (ii) detecting signals of unusual health events early (national laboratory system, real-time surveillance, reporting and workforce development); (iii) responding rapidly and effectively (preparedness, emergency response operations, linking public health and security authorities, medical countermeasures and personnel deployment and risk communication); and (iv) other IHR-related hazards and points of entry (chemical events and radiation emergencies). Each action package is populated with targets and indicators to measure capacities attained by the State Party in respective areas.

The JEE tool and process support countries to:

- determine baseline capacity for implementation of capacities required for IHR (2005);
- determine strengths, best practices, areas which need strengthening, challenges and priority actions for 19 key technical areas;
- integrate findings from other evaluations and assessments into one common evaluation platform, with internal and external expert opinion overlay;
- inform the review of national priorities and revision of existing relevant institutional plans to integrate and accommodate actions and resources needed to address gaps and needs identified;
- serve as a common platform for revision and update of cooperation plans between national authorities and internal and external partners/stakeholders, including the development of integrated, multisectoral plans;

- support internal JEE self-evaluations and monitor progress made through JEE at approximately 4–5 year intervals;
- contribute to the overall IHR Monitoring and Evaluation Framework.

The tool determines current levels of capacity in the 19 technical areas and identifies a score of 1–5 (1 indicates that implementation has not occurred; 5 indicates that implementation has occurred, is tested, reviewed and exercised, and that the country has a high level of capability for the indicator). Separate scores for human and animal sectors may be given. Most of the technical area indicator measures are descriptive and qualitative.

Representatives from Bahrain, Jordan, Lebanon, Morocco, Pakistan and Qatar shared their experiences in planning, preparation and implementation of JEE. They listed priority actions based on evaluation results, and discussed challenges and ways forward in their respective countries.

The composition and number of external evaluation team members is complex. Larger teams are logistically difficult to manage and costly; however, a multisectoral approach necessitates a relatively large group. Team size can be adjusted based on the country context and reduced by allowing experts to multi-task or by including multi-subject experts as part of the teams, when available.

More experts are needed to conduct JEE in all subject areas. It is therefore paramount to encourage experts from the Region to apply for JEE and to develop further strategies to evaluate experts' capacities. Exchange of expertise between countries should be encouraged by enhancing modalities for such support. Member States, including those in conflict, that have not gone through JEE should encourage experts to take part in external evaluations in other

countries, because the process is a valuable capacity-building exercise that can help countries implement their own JEE.

Countries in conflict require special consideration and may require adapted methodology for conducting JEE. Changes in JEE methodology must be approached with caution, however, because the strength of the tool lies in its unified methodology across countries and regions. Changes should not compromise that consistency.

There is a need to consider the timeline for implementing JEE, as the timeframe may not be sufficient in larger Member States. Working modalities of the processes, such as orientation workshops and site visits, are beneficial and important for understanding country context and putting issues into perspective.

Although JEE is voluntary, the IHR Monitoring and Evaluation Framework proposes that all countries conduct at least one external evaluation every 4 years. So far, from April to September 2016, WHO in collaboration with partners and experts, has conducted JEE in six countries in the Region on the basis of requests received from State Parties. These countries are Bahrain, Jordan, Lebanon, Morocco, Pakistan and Qatar. Nine more countries have requested to host the JEE mission between September 2016 and April 2017: Afghanistan, Islamic Republic of Iran, Kuwait, Oman, Saudi Arabia, Somalia, Sudan, Tunisia and United Arab Emirates.

Reports from JEE missions conducted so far in the Region were shared with the IHR-RAC for review. The major gaps in IHR core capacities identified during the JEEs are summarized as:

- insufficient policy, financing and regulatory framework to support the functions of IHR national focal points;

- limited multisectoral and multidisciplinary coordination and communication mechanisms to support IHR functions;
- absence of inclusive and comprehensive disease surveillance and tiered public health laboratory systems for early warning, threat detection and risk assessment;
- lack of a multi-hazard national emergency preparedness and response plan covering all IHR-related hazards;
- poor cross-sectoral mechanisms/approach to deal with emerging threat of antimicrobial resistance;
- absence of needed regulations, standards and coordination mechanisms for chemical, food and radio-nuclear emergencies.

Mapping out resources to support IHR implementation

Member States are encouraged to carry out a rigorous prioritization process with the support of WHO, IHR-RAC and partners, and to develop 5-year comprehensive national action plans for implementing IHR including a costing plan and partner/donor engagement strategy. The WHO Strategic Partnership Portal can be used to support the implementation of action plans. The Strategic Partnership Portal is a mapping tool to facilitate coordination between donors and Member States to strengthen sustainability and long-term capacity of countries to implement IHR. The GHSA Alliance on Country Assessment and IHR implementation is an open initiative that aims to facilitate information exchange and access to funding through partners. The Alliance supports WHO in conducting JEEs.

The prioritization process is challenging because Member States have a large number of competing priorities. Additional challenges include lack of high-level political commitment in countries that is not always sustained due to conflicts and financial constraints. Lack of

intersectoral collaboration is also a hurdle to Member States in implementing IHR core capacities.

Several strategies were discussed to improve the implementation of IHR core capacities in the Region including engaging multisectoral partners in the planning and budgeting of national plans to ensure ownership, continuous advocacy to guarantee the support of international agencies and donors, and identification of experts at the national level to guarantee continuity of the implementation plan. Many technical resources are available in the Region, but not always known. Therefore, mapping of available resources and developing modalities for making the resources available is needed. As countries share similar priorities, the sharing of resources and expertise is of utmost value. Technical support provided by WHO and partners is instrumental, as is their ability to link Member States with donors.

Urgent needs for implementation of IHR core capacities were summarized as:

- advocate for JEE;
- map gaps in IHR core capacities that are common to the Region in order to prioritize actions;
- support development of national plans of action to address gaps identified during the assessment;
- provide guidance on implementation of national plans of action by mapping external support and advocating for allocation of domestic support;
- monitor attainment of core capacities, preparedness and readiness measures.

Priority areas to support IHR implementation

The Ebola crisis highlighted shortcomings in the application of IHR (2005). In response, the Review Committee on the Role of the IHR (2005) in the Ebola Outbreak and Response presented 12 main recommendations and 60 supporting recommendations to the Sixty-ninth World Health Assembly in May 2016. The Health Assembly adopted decision WHA69(14) requesting the Director-General to prepare a draft global implementation plan to take forward the recommendations and, following consultations with regional offices, to submit the draft plan to the WHO Executive Board in January 2017. The main finding of the IHR Review Committee was that the world remains ill-prepared to respond to a global, sustained and threatening public health emergency. In response, the draft global implementation plan included six areas of work and a number of actions. The six areas of work are given below.

- Acceleration of country implementation of the IHR (2005): addresses recommendations 2, 3, 8, 9 and 10 of the Review Committee.
- Strengthening WHO's capacity to implement the IHR (2005): addresses recommendations 4 and 12 of the Review Committee, with the exception of sub-recommendations 12.7 and 12.8.
- Improved monitoring, evaluation and reporting on IHR (2005) core capacities: presents the Director-General's proposal to address recommendation 5 of the Review Committee.
- Improved event management, including risk assessment and risk communication: presents the Director-General's proposal to address recommendation 6 of the Review Committee.
- Enhanced compliance with Temporary Recommendations under the IHR (2005): presents the Director-General's proposal to address recommendation 7 of the Review Committee and sub-recommendations 12.7 and 12.8.

- Rapid sharing of scientific information: presents the Director-General's proposal to address recommendation 11 of the Review Committee.

The draft global implementation plan for IHR was presented and discussed. All recommendations were accepted, especially the recommendation on accelerating country implementation of IHR (2005) which should be taken forward immediately by all Member States and WHO. Accelerating country implementation of IHR needs to take into consideration gaps/weaknesses in IHR capacities identified during JEEs being carried out in Member States by WHO and other external partners. The global implementation plan for IHR (2005) also needs to have a set of indicators for measuring progress of implementation over time, cross-referenced to the relevant SDG indicators as well as the Sendai Framework for Disaster Risk Reduction (2015–2030) for improved reporting of compliance and monitoring progress.

3. Recommendations

The meeting concluded with recommendations by IHR-RAC for overarching country priority areas and WHO priority actions for accelerating the progress of IHR implementation.

To Member States

1. Ensure that the national focal point concept for IHR and the roles and responsibilities of IHR national focal points are well understood by decision-makers.
2. Ensure that IHR national focal points have the necessary capacities and authority to take action. National focal points should have easy access to the minister of health as well as to other intersectoral collaborators.

3. Establish a multisectoral IHR committee, either by building a new structure or by revitalizing a currently existing one. Mapping of current organizational structures is recommended prior to selecting the structure of the IHR committee.
4. Ensure laboratory quality systems are developed and institutionalized, and a national laboratory policy is promoted. Encourage laboratory networking and carry out an inventory of current laboratory capacities to improve understanding of how laboratories can benefit from one another.
5. Develop systems, structures and guidelines for multisectoral collaboration related to chemical and radiation emergencies. Establish channels of coordination and communication between the ministry of health and other sectors regarding chemical and radiation emergencies.
6. Enhance regional coordination and identify resources and experts that can be used in further assessments and capacity-building efforts.
7. Advocate the One Health concept among veterinarians to engage them in IHR implementation at all levels. Advocate the importance of conducting PVS assessments and making the results available.

To WHO

8. Develop an IHR acceleration plan for implementation of IHR core capacities in the Region, in line with the global implementation plan for IHR.
9. Finalize the tools for monitoring and evaluation of IHR including AARs, simulation exercises and annual reporting questionnaires. Encourage countries to conduct AARs and simulation exercises to test the functionality of IHR core capacities.
10. Support the JEE process in nine Member States in the Region between October 2016 and April 2017 and continue advocacy for

additional countries to request JEE in all countries in the Region by 2017.

11. Develop and maintain regional rosters of experts for JEE and encourage intra-country support by identifying success stories and supporting the mobilization of technical support between countries.
12. Support Member States to develop post-JEE national plans of action, review existing costing tools and advise on implementation of plans of action for IHR core capacity building following JEE.
13. Support Member States in the implementation of national plans by helping map donor support using the Strategic Partnership Portal and work with GHSA Alliance to advocate for implementation and funding plans.
14. Support Member States in the development of IHR capacities by helping implement IHR-RAC recommendations, assessing national legislation to facilitate the implementation of IHR, conducting IHR advocacy among senior and political leaders, establishing a functioning mechanism for coordination and information sharing between national stakeholders as well as analysing gaps and coordinating technical support.
15. Adapt/develop methodological approach for conducting JEE in countries in conflict, emergency or protracted crisis without compromising the consistency and uniformity of currently existing JEE tools.



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