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Progress report on implementing the International Health Regulations (2005)

1. In 2007 WHO developed a tool to guide State Parties in the implementation of the obligations contained in the International Health Regulations 2005 (IHR).[1] The tool identified strategic areas of work for IHR implementation and identified national, international and WHO institutional capacities that are vital to successful implementation of the Regulations.

2. This report reviews the progress in Member States of the WHO Eastern Mediterranean Region towards fulfilling their obligations and commitments to implementing the IHR. It updates the information presented to the fifty-ninth Regional Committee for the Eastern Mediterranean in 2012, focusing on the status of national core capacities according to strategic area of work.

Fostering partnerships

3. State Parties continue to strengthen their collaboration with international organizations, UN agencies, nongovernmental organizations and with WHO collaborating centres and other centres of excellence to scale up the implementation of the Regulations. Mechanisms to maximize collaboration with existing networks such as International Food Safety Authorities Network, Global Foodborne Infections Network and PulseNet for technical cooperation need to be developed. In addition, collaboration with the International Maritime Organization, Strategic Approach to International Chemicals Management of the United Nations Environment Programme, Radiation Emergency Medical Preparedness and Assistance Network (REMPAN) and World Organization for Animal Health (OIE) needs to be further strengthened.

4. Mechanisms for of coordination and collaboration between neighbouring countries need to be strengthened to facilitate the implementation of IHR. As well, mechanisms to facilitate the provision of technical, financial and logistical support, including the sharing of experiences between State Parties in the Region, need to be further strengthened and expanded.

Strengthening national disease prevention, surveillance, control and response systems and public health security in travel and transport

5. According to the provisions of Articles 5 and 13 and Annex 1 of the IHR, State Parties should have assessed their core capacities for surveillance and response, including at designated points of entry, by 15 June 2009. In addition, they should have developed a national IHR action plan for attaining core capacities by 15 June 2012 and institutionalized the mechanisms to maintain them after that date. National plans of action have been developed by all State Parties in the Region except Somalia. However, of the 21 State Parties that were obligated to meet the first deadline of June 2012, only the Islamic Republic of Iran has implemented its plan of action for meeting the IHR obligations. The remaining State Parties obtained a two-year extension for meeting the IHR requirements by June 2014, with the exception Somalia which has not submitted the requirements for extension. It is anticipated that a considerable number of State Parties in the Region will request further extension to meet the IHR core capacities by June 2016. WHO will continue to work with State Parties to agree on the criteria for further extension.

[1] *International Health Regulations (2005) - Areas of work for implementation*. Geneva: WHO, 2007 Available at: http://www.who.int/ihr/finalversion9Nov07.pdf (accessed 15 July 2013).

6. Data collected through the 2012 IHR self-assessment tool show that the regional implementation level of capacity requirements is 66%, which is slightly lower than the global implementation level of 67%. The data also show that – with some variability – State Parties in the Region are making fair progress in developing a number of core capacities, notably those for surveillance, response and zoonotic events, but relatively little progress in the capacities for preparedness, points of entry, chemical events, radiological events and human resources.

7. State Parties continue to review the status of IHR implementation, identify gaps in capacity requirements with the support of WHO and update their national plans accordingly. Efforts are being made to enhance related capacities for surveillance and response, including for staff development. However, high staff turnover within the health sector, which extends to the institutions of the IHR national focal points, hampers the ability of State Parties to build sustained IHR capacity. Such challenges impede the efforts and investments being made by State Parties with the support of WHO and by other partners

8. All State Parties except Somalia have identified designated points of entry that must have core capacities in place and have notified these to WHO. In-depth assessments of designated points of entry were carried out in 12 State Parties. Out of the 318 designated points of entry in the Region, the competent authority has been identified in 272 points of entry and contingency plans have been developed in only 187 points of entry.

9. According to provisions of Articles 20, 27 and 39 and Annexes 1 and 3 of the IHR, each State Party is required to send to WHO a list of all of its ports, including all of its applicable administrative areas or territories, authorized to issue: the Ship Sanitation Control Certificate; the Ship Sanitation Control Exemption Certificate only, and/or the extension of the Ship Sanitation Control Exemption Certificate. As of June 2013, only 11 State Parties of the Region shared the list of their 90 ports that are authorized to issue ship sanitation certificates. State Parties need to update and share the list of authorized ports regularly with WHO in order to avoid any delay or interference with international shipping. Furthermore, requirements for effective surveillance and response at points of entry need further attention.

Strengthening the management of specific risks

10. All State Parties in the Region have established programmes addressing diseases with serious public health impact for which a single case, irrespective of context, requires immediate notification to WHO, and diseases that have demonstrated potential to cause serious health impacts and to spread rapidly across borders, as per Annex 2 of the IHR. However, programmes for other events of potential international public health concern are not comprehensively addressed in most State Parties. The recent emergence of a novel coronavirus, the Middle East respiratory syndrome coronavirus (MERS-CoV), has highlighted the existing challenges in the early detection and notification of events of international concern by national IHR focal points.

11. Establishment of event-based surveillance and rapid response teams at the different administrative levels, surveillance for health care-associated infections and for antimicrobial resistance, and enhancement of laboratory quality management systems all remain challenges in countries of the Region

12. Coordination and communication between the different IHR related sectors and with the national IHR focal point has been improved due to the establishment of multisectoral coordination mechanisms; however, such mechanisms need further strengthening with clear identification of roles and responsibilities of each sector. Furthermore, mapping out potential hazards and development of national preparedness and response plans based on the all-hazards approach, including those at points of entry, need to be considered in most of the State Parties in the Region.

Sustaining rights, obligations and procedures; and conducting studies and monitoring progress

13. Several State Parties reviewed the provisions of the Regulations and harmonized national provisions accordingly within the legal and normative framework. Nevertheless, a challenge remains for countries in approving and enforcing the revised norms and laws. To that end, State Parties are reviewing and adapting their legislation to facilitate implementation of the IHR.

14. According to provisions of Article 4 of the IHR, State Parties have to designate or establish national IHR focal points accessible at all times for communication with the WHO IHR contact point. To that end, all States Parties in the Region except Somalia have either submitted their designation and annual national focal point confirmation or updated their national focal point contact details. However, the roles and responsibilities are not yet identified in all State Parties. Furthermore, IHR national focal points lack the authority to communicate information related to public health emergencies to WHO in a timely manner.

15. Some efforts have been made to increase awareness and understanding of the roles and obligations of the national IHR focal points. Further work is needed in the area of increasing awareness of IHR and the critical role of the national IHR focal point, combined with political commitment of high-level national officials.

16. The Event Information Site for national IHR focal points began operating on 15 June 2007. This site allows for timely sharing of more comprehensive public health event-related information. All State Parties except Somalia currently have active access to the Event Information Site, for a total of 69 persons. This number includes the national IHR focal points and other persons designated by the national focal points to access the site.

17. According to provisions of Article 47 of the IHR, State Parties are recommended to nominate experts for the IHR roster of experts. As of June 2013, the IHR roster of experts includes 428 experts, 27 of whom were nominated by 11 State Parties in the Region.

18. The IHR monitoring framework is a questionnaire developed by WHO to assist State Parties in monitoring progress in implementing the IHR core capacities. In 2012, all State Parties in the Region except Somalia completed the questionnaire and shared it with WHO.