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Assessment and monitoring of the implementation of the International Health Regulations (2005): meeting the 2016 target

Introduction

1. The 68th World Health Assembly discussed and endorsed the report of the International Health Regulations (2005) (IHR) Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation *(1)*, as well as several reports on the outbreak of Ebola virus disease, including the report of the Ebola Interim Assessment Panel *(2)*. Among the concerns raised by the Panel and in the Health Assembly was the reliability of the self-assessments conducted by Member States on their implementation of the national capacity requirements for IHR. The Panel noted that "This leaves these countries at high risk, and increases the risk for the international community".

2. Among the diseases of immediate concern to global health security in this context, the Health Assembly, in the context of the discussion on IHR, discussed the Middle East respiratory syndrome coronavirus (MERS-CoV), first identified in Saudi Arabia in 2012 and currently circulating widely throughout the Arabian Peninsula; the new cases of Ebola that were still occurring in west Africa at that time; avian influenza virus A(H5N1) and A(H9N2), which continues to spread in birds, reassorting with other avian influenza viruses that are endemic in various parts of the world, and which is causing infections in humans in Egypt; and polio, in particular the implementation of recommendations for countries currently exporting wild poliovirus and for polio-affected countries not exporting wild poliovirus.

3. The IHR impose obligations on Member States to develop and maintain core public health capacities for surveillance and response, including at points of entry, in order to detect early, assess, notify and report to WHO events covered by their provisions, and to make a tailored response to local situations on the ground and with the advice of the IHR Emergency Committee. During the Health Assembly, Member States acknowledged that the current threats to global health security have demonstrated an inadequate level of preparedness, and stressed the need to accelerate the implementation of the IHR and strengthen existing public health capacities. Member States also highlighted the role of WHO in continuing to provide the required technical support to Member States but noted that a different strategic approach needs to be considered to address the current challenges.

4. This paper describes the limitations of the current mechanism for monitoring IHR implementation and the gaps identified in Member States capacities for implementation. It proposes a new approach for assessment and monitoring of the development and maintenance of the required capacities for and compliance with the IHR.

Monitoring of implementation of IHR capacities for surveillance and response

5. The World Health Assembly decided (resolution WHA61.2), in accordance with paragraph 1 of Article 54 of the IHR, that States Parties and the Director-General should report to the Health Assembly on the implementation of the Regulations annually. For this purpose, a monitoring framework was developed.

6. The monitoring framework includes a checklist, indicators and self-assessment questionnaire. It involves the assessment of implementation of eight core capacities, and the development of capacities at points of entry and for IHR-related hazards, notably infectious, zoonotic, food safety, chemical, radiological and nuclear hazards. The monitoring process is not intended for use as a tool to rank the performance of countries or to compare performance between countries. Rather, it is intended as a tool to

assist individual countries to monitor progress towards meeting the core capacity requirements and to address any gaps identified.

7. Results obtained from the 2014 IHR self-assessment questionnaires indicated a regional implementation level of 72% *(3)*, with many countries having met many of the IHR requirements. However, during the missions carried out to countries of the Region in late 2014 to assess national preparedness and response to a potential importation of Ebola, many critical gaps were identified in countries related to the preparedness and response capacities. This finding included countries that had previously reported having met the obligations under the IHR by the first or second deadline.

8. In the majority of countries, the main gaps identified were the absence of a fully operational national coordination structure and also of an emergency operating centre within the Ministry of Health. The incident command and control chain was either absent or had major structural gaps, with no standard operating procedures for event management and alerts. National plans for Ebola were not perceived as an integral part of the national public health plan for preparedness and response to epidemics/emergencies and lacked a multisectoral approach and standard operating procedures. Drills and simulation exercises to test the existing Ebola plans had not been conducted. An early warning mechanism for enhanced detection and response to any suspected case was either not functioning or absent, and event-based surveillance was not yet formalized. The human resources capacity for surveillance and analysis of data was inadequate. Multidisciplinary rapid response teams for investigation and outbreak response at the different administrative levels were not available and field investigation of disease outbreaks was limited.

9. In the majority of countries, a national infection prevention and control programme with a defined structure, roles and responsibilities, plan of action and budget was not in place. The following were also not in place in most countries: procedures for safe medical waste management and the management of blood and body fluid spills; a national programme of occupational safety; a laboratory quality management system, including standard operating procedures for specimen handling, inactivation and diagnosis; protocols or guidelines on safe collection, transportation and shipment of specimens; a biorisk laboratory management system; and a biosafety level 3 facility for handling emerging dangerous pathogens and glove boxes for handling and inactivation of suspected samples. Ebola communication strategy, including risk communication and social mobilization, was very weak and a comprehensive Ebola risk communication plan as an integral part of a national risk communication plan was lacking.

10. With regard to points of entry, in most countries, public health contingency plans with functioning standard operating procedures were not in place, and coordination between the different stakeholders for points of entry and with the national system was lacking. Standard operating procedures for early detection, assessment of and response to cases were also not in place, while communication with the air travel sector, including airline companies, regarding potential cases was weak with a lack of clear arrangements for tracing contacts. Designated spaces to isolate sick passengers and to interview contacts were often not available, while capacity to undertake entry screening measures, if required, was very limited. Ground crossings were poorly equipped and had limited capacities to control movement of people adequately.

Monitoring the compliance with IHR

11. The World Health Assembly has previously urged Member States (resolution WHA61.2) to ensure that the contact details of the centre designated as the National IHR Focal Point are complete and up to date to facilitate the communication between national focal points and WHO contact points on a 24 hour basis. Member States are annually confirming the designation of IHR national focal points. However, 24 hour accessibility is not being maintained.

12. The Secretariat has provided guidance on proposed functions for national focal points. However, in most countries the functions have not been put in place. Where available, they are neither regulated nor widely disseminated among the relevant stakeholders to facilitate implementation of the IHR.

13. Member States are required to notify WHO of all public health events that are assessed as possibly constituting international concern within 24 hours of assessment by using the decision instrument provided in Annex 2 of the IHR. The notification must be followed by ongoing communication of detailed public health information on the event. Generally in the Region, the early notification to WHO and comprehensive reporting of such events is not well maintained. WHO is mandated to support the risk assessment of such events and to respond to them within the framework of the IHR, either directly or through coordinating mobilization of the required support. However, implementation of this mandate could be impeded by absence of or delay in notification and sharing of comprehensive information about such events.

14. Countries have often shown reluctance to share information related to public health events occurring in their territory that may constitute a public health event of international concern (PHEIC) as such events may have political and socioeconomic implications. The World Health Assembly therefore identified the need for an “alert” phase under the IHR. This phase would precede the declaring of a PHEIC and is intended to encourage Member States to notify WHO early and to share information. The early investigation and rapid response to such events that would result from an alert phase might help to avoid the conditions for declaring a PHEIC. The Secretariat is currently developing criteria to define and trigger the alert phase.

15. Member States are required to collaborate with each other in the detection, assessment of and response to events by providing the necessary technical cooperation, logistical support and financial resources for the implementation of the IHR in accordance with Article 44. The provision of such support is not currently being provided in the context of an agreed system or maintained.

16. In response to the perceived threat posed in the context of Ebola, many Member States implemented public health measures, such as a travel ban, which exceeded the Temporary Recommendations *(4)* made by the WHO Director-General in public health emergencies of international concern and which were not consistent with the conditions laid out in Article 43 of the Regulations. These additional measures had negative implications for travel and trade for the countries affected by Ebola.

New approach for the assessment and monitoring of IHR

17. The decision to grant a further extension for establishing the national public health capacities required under the IHR is made by the Director-General, taking into account the technical advice of the IHR Review Committee. The Committee convened on 13–14 November 2014 to advise the Director-General on: 1) requests from States Parties for second extensions (2014–2016); and 2) how to better strengthen and assess IHR core capacities in the short and long term.

18. The IHR Review Committee, in its report *(1)* (recommendation 7), recommended the Secretariat to “develop through regional consultative mechanisms options 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”. The Executive Board at its 136th session and the 68th World Health Assembly approved implementation of the recommendation.

19. The Ebola Interim Assessment Panel, in its report *(2)*, stated that “WHO should propose a thorough but prioritized and costed plan to develop the core public health capacities for all countries in respect of the International Health Regulations (2005). This plan should be put to donor agencies, Member States and other stakeholders for funding. To propose this plan WHO will need reliable information about the current situation in each country. This requires some form of peer review or other external validation. At

present only self-assessment is used. It is in the countries' own interest to have a thorough and objective analysis; the Panel recommends that ways to do this be explored".

20. On this basis it is proposed to establish the IHR Regional Assessment Commission (IHRRAC) as an independent body to oversee the implementation of IHR in the Region, with the following terms of reference:

a) review implementation of the IHR in the Region and verify data obtained through the IHR self-assessment tool;
b) identify strategic priority activities at the level of Member States to implement IHR; and
c) identify major issues and challenges to be addressed by WHO to support Member States in the Region to meet their obligations;
d) report annually to the Regional Committee on the progress of IHR implementation in the Region.

21. It is also proposed to establish a regional IHR Task Force (IHRTF) comprising experts from WHO and other partner agencies to ensure harmonized implementation of policies, strategies and plans established in line with the recommendations of the IHRRAC with the following terms of reference:

a) gather evidence required for strategic decisions of the IHRRAC;
b) support the implementation of the IHR national and regional plans;
c) advise the Regional Director and the IHRRAC on the way forward; and
d) advocate for implementation of the IHR and engage with partners who will enhance the achievement of global health security.

22. WHO will serve as the Secretariat for the IHRRAC and will continue to:

a) assess implementation of the IHR upon the request of Member States and the IHRRAC;
b) communicate relevant information to the IHRRAC and Member States; and
c) guide States Parties and provide the required support for implementing the IHR.

23. Member States will:

a) continue to complete the annual self-assessment IHR monitoring questionnaire;
b) report to the IHRRAC on the progress of IHR implementation in their territory; and
c) implement the recommendations of the IHRRAC to meet IHR obligations.

Methodology of work under the new approach for IHR assessment and monitoring

24. The Secretariat will take the lead in supporting Member States in the assessment, monitoring and implementation of the IHR. Upon the voluntary request of Member States and the request of the IHRRAC, the Secretariat will carry out missions to Member States to assess IHR implementation.

25. A progress report on the implementation of the IHR in each Member State will be developed based on each assessment visit and shared with the IHRRAC.

26. Member States are encouraged to evaluate and document their response to public health events that have occurred in their countries. Simulation exercises should be conducted to further review and enhance the national capacity for surveillance and response.

27. The IHRRAC will meet once a year during the annual meeting of IHR regional stakeholders, where Member States shall present the progress in implementing IHR. The IHRRAC will review all available documentation/reports provided by Member States and identify priority activities to be carried

out by each State Party to strengthen and further maintain their national public health capacities based on the available reports.

28. The secretariat, with the advice of the IHRTF, will develop a regional plan of action, including short-term and long-term priority activities, based on available progress reports and documentation and in line with the recommendations of the Regional Committee, the Executive Board and the World Health Assembly to support IHR implementation in the Region.

29. The regional plan of action will be shared with global and regional technical partners and donors to engage them in its implementation.

30. The IHRRAC may meet on ad hoc basis to discuss urgent IHR-related issues, upon the request of the Regional Director.

31. The IHRRAC, with the support of the Secretariat, will develop and submit to the Regional Committee on an annual basis a progress report on IHR implementation in the Region, based on results obtained from the IHR self-assessment tool, country progress reports on IHR implementation and country reports on IHR-related issues. The feedback of the Regional Committee will be submitted to the Executive Board and World Health Assembly.

Tools to support the assessment and monitoring of IHR implementation

32. The following existing tools will be used for the assessment and monitoring of IHR implementation:

a) A roster of IHR experts will be formed from the Eastern Mediterranean Region and other WHO regions in the different specialties of legislation, surveillance, laboratory, points of entry, food and chemical safety, radiation safety and risk communication. These experts will support WHO to carry out IHR assessments.
b) The IHR assessment protocol will be used for carrying out IHR assessment in Member States. WHO guiding documents will also be used as supporting documents.
c) The IHR self-assessment questionnaire will continue to be used on an annual basis. Results obtained through these self-assessments will be verified during the assessment visits.

33. In addition, the following tools will be developed to support the assessment and monitoring of the IHR:

a) a template to guide reporting of progress on IHR implementation;
b) a list of key performance indicators to evaluate implementation of the IHR;
c) standard operating procedures and scenarios to carry out simulation exercises and drills to evaluate implementation of the IHR;

34. The Secretariat will continue to carry out strategic activities that apply to all States Parties in order to support them in meeting their obligations.

Action by the Regional Committee

35. The Regional Committee is invited to consider the proposed establishment of the IHR Regional Assessment Commission and Regional IHR Task Force, their functions and methodology of work.

References

1. Implementation of the International Health Regulations (2005): report of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation. Geneva: World Health Organization; 2015 (A68/22 Add.1; http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_22Add1-en.pdf, accessed 17 September 2015).
2. Ebola Interim Assessment Panel: first report of the Panel. Geneva: World Health Organization; 2015 (A68/25; http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_25-en.pdf, accessed 17 September 2015).
3. Global Health Observatory (GHO) data IHR core capacities implementation status 2014, WHO Eastern Mediterranean Region. (http://www.who.int/gho/ihr/monitoring/region_eastern_mediterranean/en/, accessed 17 September 2015).
4. IHR Emergency Committee regarding Ebola: WHO statements on Ebola. Geneva: World Health Organization; 2014-2015 (http://www.who.int/ihr/ihr_ec_ebola/en/, accessed 17 September 2015).