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**Progress report on national core capacities for implementation of the International Health Regulations: meeting the 2016 deadline**

**IHR timeline and extension**

1. The five-year target date for implementing the International Health Regulations (2005) following their entry into force in 2007 passed in 2012. Of the 21 States Parties in the WHO Eastern Mediterranean Region, only one (Islamic Republic of Iran) declared its readiness to meet the obligations by June 2012. Nineteen (19) other States Parties in the Region obtained a two-year extension to fully achieve the core capacity requirements by 15 June 2014 and one State Party did not comply with the requirements for extension.

2. The June 2014 deadline has also passed. Seven (7) States Parties indicated their readiness to meet the obligations (Bahrain, Jordan, Morocco, Oman, Qatar, Saudi Arabia and United Arab Emirates), and the 13 remaining States Parties in the Region requested a second extension and submitted a new implementation plan to WHO.

3. In accordance with Articles 5(2) and 13(2) of the Regulations, the IHR Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR implementation convened on 13–14 November 2014 to advise the Director-General on: 1) requests from States Parties for second extensions (2014–2016) for establishing the core capacities to detect and respond to events as specified by Annex 1 of the IHR; and 2) how to better strengthen and assess IHR core capacities over the short term and long term.

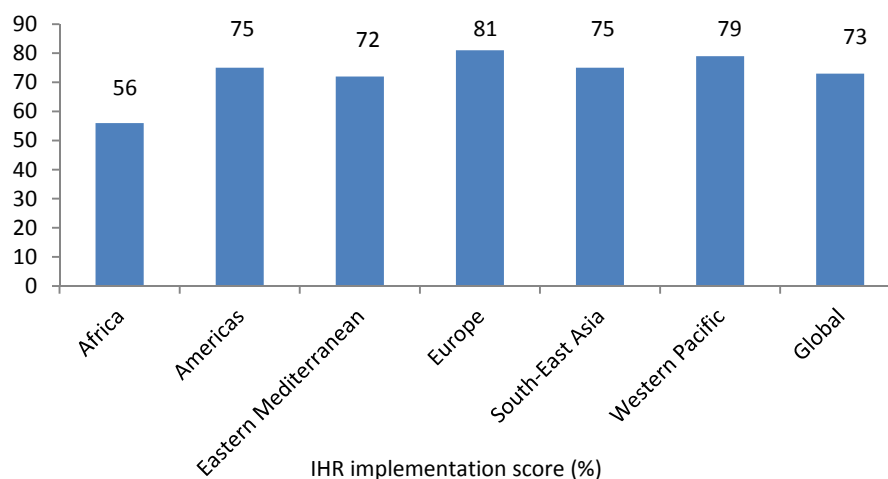
4. The Review Committee considered the variable factors between the different extension requests, such as the number of core capacities requested for extension, the completeness of proposed implementation plans and any exceptional circumstances and challenges to full implementation of the IHR cited by States Parties in their requests. Such challenges included financial, economic or public health issues, long-running emergencies, internal or external political issues and natural disasters. The second extension was granted for States Parties requesting the extension as per the recommendations of the Review Committee.<sup>1</sup>

**Progress in implementation of the International Health Regulations (2005)**

5. WHO monitors implementation of the Regulations and reports the results annually to the World Health Assembly using the IHR monitoring (self-assessment) tool. Results generated from this tool indicate that the regional implementation level of core capacity requirements was 72% in 2014, slightly higher than the 70% level achieved in 2013. The regional implementation level in 2014 was slightly lower than the global implementation level of 73% (Fig. 1).

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<sup>1</sup> 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. Sixty eight World Health Assembly, A68/22 Add.1: [http://apps.who.int/gb/ebwha/pdf\\_files/WHA68/A68\\_22Add1-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_22Add1-en.pdf)

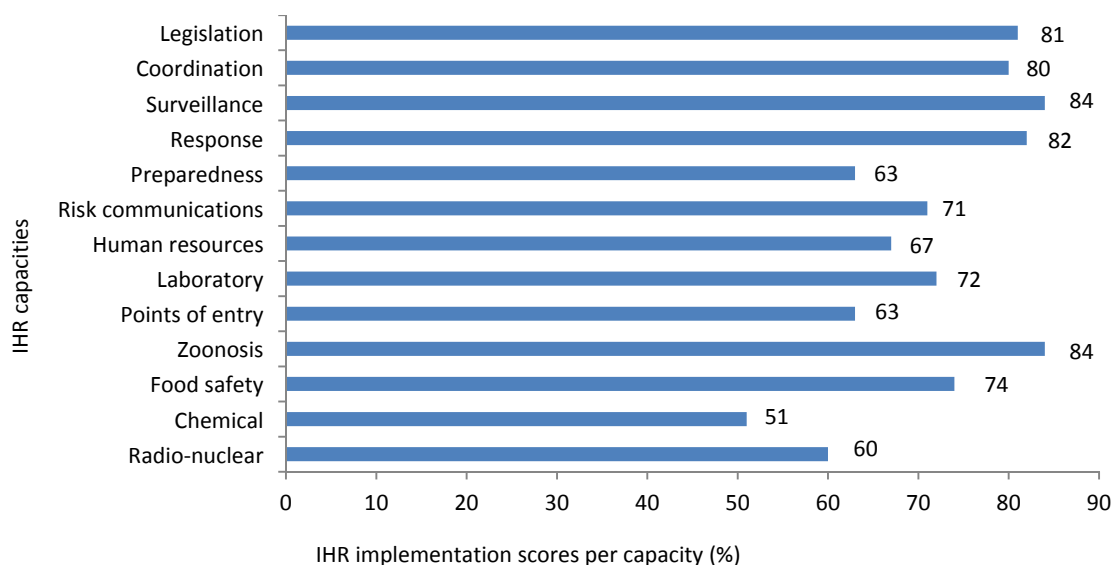


**Fig. 1. Implementation level of IHR capacities by WHO region, 2014**

Source: Global health observatory data repository: International Health Regulations (2005) monitoring framework. Geneva: World Health Organization; 2014 (<http://www.who.int/gho/ihr/en/>, accessed 23 June 2015).

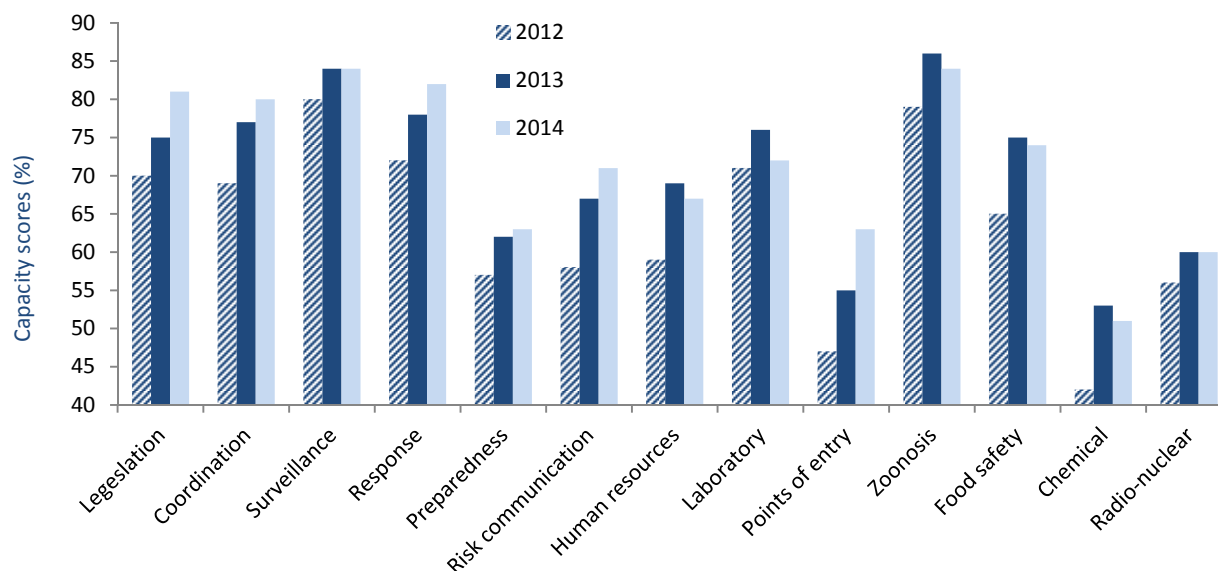
6. Overall, States Parties are making good progress in surveillance, laboratory, risk communication, legislation, coordination and food safety. However, capacities for preparedness, human resources, points of entry and for handling chemical and radio-nuclear events remain low (Fig. 2).

7. A comparison of the regional IHR implementation level per capacity between 2012 and 2014 indicates that progress was made in 2013 relative to 2012; however, data for 2014 show little improvement. Moreover, IHR implementation scores for the capacities of human resources, laboratory, zoonosis and surveillance and response to chemical events in 2014 are lower than their implementation scores in 2013 (Fig. 3).



**Fig. 2. International Health Regulations (2005): level of core capacity implementation (%) in the Eastern Mediterranean Region, 2014**

Source: Global health observatory data repository: IHR core capacities implementation status, WHO Eastern Mediterranean Region. Geneva: World Health Organization; 2014 (<http://www.who.int/gho/ihr/en/>, accessed 23 June 2015).



**Fig. 3. International Health Regulations (2005): level of core capacity implementation (%) in the Eastern Mediterranean Region, 2012–2014**

Source: Global health observatory data repository: International Health Regulations (2005) monitoring framework. Geneva: World Health Organization; 2012, 2013 and 2014 (<http://www.who.int/gho/ihr/en/>, accessed 23 June 2015).

8. The Ebola virus disease outbreak in West Africa has confirmed that countries with poor preparedness and response capacities are extremely vulnerable to any risk, and the importation of Ebola into such areas can quickly lead to wide-scale social and economic challenges. Considering this scenario, the 61st session of the WHO Regional Committee for the Eastern Mediterranean issued resolution EM/RC/61/R.2 in which it urged States Parties to urgently undertake a comprehensive assessment of their capacity to deal with a potential importation of Ebola virus disease. Accordingly, the Regional Office carried out missions to all countries of the Region to assess their national capacity for preparedness and response to Ebola including at points of entry.

9. IHR capacities for legislation, multidisciplinary communication and coordination, surveillance, preparedness, response, risk communication, human resources, laboratory and points of entry for Ebola virus disease were assessed during the missions using a regionally adapted assessment checklist. Information collected from the missions was not consistent with information reported by countries through the IHR monitoring tool.

### Notification and sharing of information on public health events

10. Under IHR, States Parties are required to carry out an assessment of public health events occurring within their territories utilizing the decision instrument provided in Annex 2 of the Regulations, and then to notify WHO of all qualifying events within 24 hours of such an assessment.

11. States Parties are generally reluctant to share information related to public health events of potential international concern that might have negative political and socioeconomic implications. The insufficient capacity of most national IHR focal points and the lack of legislation to support the functions of the national focal points have led to delays by States Parties in notifying WHO and providing comprehensive information about public health events of potential international concern, in accordance with Article 6 of the IHR. For example, although several countries in the Region have detected suspected cases of Ebola virus disease, most of the suspected cases were not notified to WHO. Had any of the suspected cases been confirmed, international response would have been delayed as a result of the delay in notification. Furthermore, urgent IHR communications from national focal points to the IHR contact points in the WHO Regional Office are not maintained within

the time-frame specified under IHR. Such communications include reporting of public health risks outside the State Party's territory that may cause international disease spread, in accordance with Articles, 8, 9 and 11, and responding to requests for verification of reports of public health events occurring in countries, in accordance with Article 10 of IHR.

12. Under the IHR, WHO is requested to provide to State Parties timely updates on acute public health events of international importance while respecting the sensitivity and potential confidentiality of such information. To that effect, WHO has developed a web-based event information site for secure communications with national IHR focal points. All national focal points in the Region have access to the information site, in addition to other officials designated by the focal points. However, only officials from ministries of health have been designated, and officials from other relevant sectors do not have access to the site. Coordination between the national IHR focal points and other relevant national sectors is insufficient in most countries of the Region, hence the sharing of information posted on the site with relevant officials in other sectors is not well established, nor is the sharing of relevant information from other sectors with the national IHR focal points. Between January 2014 and July 2015, 75 public health events were posted on the website from 50 countries. The majority of these events concerned infectious diseases. Of the 75 events, 13 occurred in 12 countries of the Region and involved cases of Middle East respiratory syndrome (Egypt, Islamic Republic of Iran, Jordan, Kuwait, Oman, Qatar, Saudi Arabia, Tunisia, United Arab Emirates and Yemen), poliomyelitis (Syrian Arab Republic), yellow fever (Sudan) and avian influenza (H9N2) (Egypt).

### **Trade and travel**

13. Some State Parties implemented measures, such as closing borders, denial of entry visas for passengers travelling from the Ebola-affected countries to other countries and suspension of airline flights to/from the affected countries, which have had the potential to significantly interfere with international traffic. Reports on such measures were recorded involving 4 States Parties in the Region. Only one State Party provided WHO with the public health rationale and relevant scientific information for implementing such measures as required under Article 43 of the IHR. WHO sought to obtain the public health rationale for implementing these additional measures from the other three States Parties; however no response was received.

14. 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 ship sanitation certificates. As of June 2015, only 12 State Parties of the Region have shared the list of their 110 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.

### **Yellow fever vaccination**

15. The World Health Assembly in resolution WHA67.13 adopted the updated Annex 7 of the IHR, of which single dose of yellow fever vaccine is sufficient to confer sustained immunity against yellow fever disease. Vaccination against yellow fever may be required of any traveller leaving an area where the Organization has determined that a risk of yellow fever transmission is present. Requiring the certificate from travellers is at the discretion of each State Party. Sudan is the only country in the Region with risk of yellow fever transmission.

16. The following countries require yellow fever vaccination certificate from travellers over 9 months or one year of age arriving from countries with risk of yellow fever transmission and for travellers having transited more than 12 hours through an airport of a country with risk of yellow fever transmission: Afghanistan, Bahrain, Djibouti, Egypt, Islamic Republic of Iran, Iraq, Jordan, Libya, Oman, Pakistan, Saudi Arabia, Somalia and Sudan. The validity of the yellow fever vaccination certificate was reported by these countries to be for 10 years in Djibouti, Iraq, Pakistan

and Somalia; and for life in the remaining countries except Afghanistan, which has not reported on the validity of the required certificate.

### **Conclusions and the way forward**

17. The IHR constitute the most important and powerful international legal framework for strengthening global health security including the development of health systems and other capacities. Full implementation of IHR is a critical step for reducing the impact of emerging, re-emerging and other public health emergencies including those of international concern. Recent experience with the Ebola virus disease outbreak underscores the importance of this step.

18. The IHR Review Committee, in its report, concluded that the work to develop, strengthen and maintain the core capacities under the IHR should be viewed as a continuing process for all countries and that the implementation of the IHR should now advance beyond simple “implementation checklists” to a more action-oriented approach to periodic evaluation of functional capacities. The Review Committee recommended to 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”. Such a mechanism is necessary to ensure full implementation and sustainability of IHR capacities beyond 2016.

19. Next steps for Member States are as follows.

- Implement recommendations of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation.
- Support the establishment of a regional external mechanism to assess, monitor and support the implementation of IHR beyond 2016.
- Establish linkages with programmes for patient safety, strengthening human resources for health, health information system management and emergency preparedness and response.
- Evaluate the response to public health events and improve response mechanisms accordingly; document best practices and share them widely with other States Parties, academic institutions and other stakeholders at regional and global levels.
- Facilitate and participate in subregional initiatives to share experience and enhance cross-border collaboration.
- Establish twinning and networking programmes with other States Parties and with technical institutions to enhance national IHR capacities.
- Establish on-the-job training to overcome the high turnover among human resources and enhance capacity of human resources.
- Prioritize capacity-building efforts based on vulnerability assessment and mapping of hazards.