Information to States Parties regarding
determination of fulfilment of IHR Core
Capacity requirements for 2012 and
potential extensions

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Acronyms

ADG  Assistant Director General
APSED  Asia Pacific Strategy for Emerging Diseases
DPC  Disease Prevention Control
IDSR  Integrated Disease Surveillance and Response
IHR  International Health Regulations (2005)
IHRMT  International Health Regulations Monitoring Tool
NFP  National Focal Point
MoH  Ministry of Health
NGO  Non-governmental organization
PHEIC  Public Health Emergency of International Concern
PoA  Plan of Action
PoE  Points of entry
SOP  Standard operating procedure
SWOT  Strengths, weaknesses, opportunities and threats analysis
WR  WHO Representative
WHA  World Health Assembly
WHO  World Health Organization
WHO CO  WHO Country Office
I. Introduction

1.1. Purpose of this document
This document is for States Parties who would like information and WHO guidance in determining whether they have met or will meet (by the deadline of June 2012) their national core capacity requirements in Annex 1, and whether to seek an extension\(^1\).

1.2. Brief overview of IHR (2005)
The International Health Regulations 2005 (IHR) are an international legal agreement binding on 194 States Parties, including 193 WHO Member States\(^2\). States Parties are required to develop, strengthen and maintain minimum national core public health capacities and as such, should have developed and been implementing plans of action to ensure that the core capacities required by the IHR are present and functioning throughout their territories by June 2012.

The IHR are binding on States Parties as a whole, not only on one or more specific ministries such as the Ministry of Health. In order for the IHR to be fully operational, there is a need to empower IHR NFPs to carry out their functions.

Actions to empower the NFPs include, among others:
- Establishing a clear, specific mandate for the implementation of all NFP functions.
- Providing authority, resources, policies, procedures, knowledge and training to communicate with all levels of their governments and with WHO, on behalf of their governments as necessary.
- Establishing coordination and communication mechanisms among all relevant ministries, departments, and sectors including Points of Entry.

A number of obligations and rights have been defined within the IHR. See Appendix 1 for a more detailed summary of States Parties provisions.

1.3. Dates and Timelines
The IHR specify a timeline for the establishment of national core capacities based on the entry into force of the IHR for a State Party, and must be - "as soon as possible but no later than five years from the entry into force....." (Articles 5, 13). For the vast majority of countries\(^3\), the relevant timeline is indicated below:

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\(^1\) Requests for extension for 2014 are beyond the scope of this guidance document and will be addressed separately.
\(^2\) This number does not include South Sudan, which recently became the 194th Member State of WHO; in general, new Member States of WHO have a 12-month period to notify rejection of, or reservation(s) to, the IHR.
\(^3\) The time frames for the States Parties which made reservations to the IHR (USA and India) are slightly later, as is the case for Montenegro which became a Member State (and State Party after the IHR entered into force).
II. Determining the fulfilment of national core capacity requirements in accordance with IHR (2005)

The obligations of States Parties are to meet all the requirements of Annex 1. The ultimate determination regarding fulfilment of national core capacity requirements for 2012 lies with each of the individual States Parties.

While all of the Annex 1 requirements must be met, it is reasonable and appropriate for each country to prioritize some of the requirements based on its own public health needs, resources available, infrastructure and other considerations. States Parties may use any applicable approaches, methodologies, or tools they choose to make this decision, provided they have reliable data/evidence to be confident that all core capacity requirements in Annex 1 have been met. To facilitate the decision-making by States Parties, the WHO Secretariat is proposing the use of the IHR Monitoring Tool (IHRMT) as one of the tools to measure the fulfilment of core capacity requirements of the IHR.

III. Operationalization of Annex 1 of the IHR (2005)

Annex 1 of the IHR is generalized and function oriented. To support States Parties in the implementation and the monitoring of IHR core capacities, WHO carried out technical consultations to:
• Further define, clarify and standardize the national core capacities described in Annex 1,
• Provide guidance and indicators to States Parties for their monitoring of progress in IHR core capacity development,
• Provide a means to report (though 20 indicators) on progress of the States Parties in the implementation of IHR to the World Health Assembly (WHA) in accordance with Article 54 of the Regulations.

The IHR Monitoring Framework (see Appendix 3 for details of the framework) defines eight core capacities which reflect the operational meanings of the capacities required to detect, assess, notify and report events; and to respond promptly and effectively to public health risks and potential public health emergencies of international concern, as stipulated in Articles 5, 13, and Annex 1. In accordance with the broad scope of the IHR, these apply across all IHR relevant hazards (biological/infectious, zoonotic, food safety, chemical, radiological, other)\(^4\), and require States Parties to have the ability to address such risks and events nationally (domestically) and report them internationally (as required).

For Points of Entry, under Articles 20.1 and 21.1 "State Parties shall designate the airports and ports that shall develop the capacities provided in Annex 1", and "may designate ground crossings that shall develop" these capacities. Article 19 provides States Parties must "identify the competent authorities at each designated point of entry in its territory". See Appendix 4 for details. The differences between ports authorized to issue ship sanitation certificates, and points of entry designated by a State Party to strengthen, develop and maintain capacities as described in Annex 1 of the IHR, are outlined in Appendix 5 of this document.

The IHR Monitoring Framework can facilitate measurement of levels of attainment of the required IHR capacities for 2012 using the data collected through the States Parties Questionnaire (also referred to as IHR Monitoring Tool, or IHRMT in this document). While this was primarily designed to track progress made in developing national core capacities, it may also be used in conjunction with other data sources to assess the status of achievement of national core capacity requirements.

**IV. Recommended steps in deciding if core capacity requirements are met, and whether to request an extension\(^5\)**

The following steps are proposed for States Parties to consider in the decision making:

\(^4\) This does not imply the establishment of separate vertical programmes for individual hazards particularly if the generic capacities developed under IHR such as event-based surveillance are sufficient to address all public health risks.

\(^5\) The steps recommended in this document apply to request for extension until 2014 only. Consideration of requests for extension after 2012 will be dealt with in other documents to be developed.
**Step 1: Review of the National Action Plan (or equivalent) for strengthening IHR core capacities and the results of the IHR Monitoring Tool, together with information from other sources including but not limited to:**

- Status of implementation of the National IHR Action Plan (or equivalent) as well as action plans for individual Points of Entry designated to establish the core capacity as detailed in Annex 1;
- Latest national data on IHR core capacity development from the web-based IHRMT which can be used to assess quickly the real-time status of IHR core capacity development;
- Outcome of assessment/monitoring conducted using tools developed to assess and monitor IHR national core capacity development (See Appendix 6 for list of WHO IHR relevant tools and links), including Assessment Tool for Core Capacity Requirements at Designated Airports, Ports and Ground Crossings.
- Other sources of information, e.g. relevant regional tools, other national data, sub-regional and regional assessments, reports, statistics etc.
- Country context information: public health needs, resources available, infrastructure and other considerations.

A practical and standardized way of judging if national core capacity requirements as outlined in Annex 1 have been met, is to consider the achievement of the 20 WHA indicators in the IHRMT as illustrated in Appendix 7, together with the specific IHR capacity requirements Annex 1 of IHR (Appendix 2).

The primary issue to consider is whether, based on the individual country specificities, the existing capacities fully achieve the functions required by the IHR, including in Annex 1. In making the determination on whether to seek an extension or not, a State Party may wish to make a judgement that achieving a certain proportion of the attributes under each of the WHA indicators in each core capacity is sufficient to detect and respond to public health risks/events, including events that may constitute public health emergencies of international concern. This means that while a State Party may not achieve 100% of all attributes in the IHR Monitoring Framework, it may nevertheless determine that it has met the core capacity requirements, based on a review of all necessary information, including national/sub-national assessment data, reports, statistics, and other relevant national data.

Countries would however continue to work towards achieving and maintaining 100% of attributes in all core capacities.

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6 A level of achievement that assumes infrastructures and organizational capacities are in place to achieve desired outcomes.
7 A set of specific elements or characteristics that reflect the level of performance or achievement of a specific indicator.
8 This acknowledges the possibility of a “herd immunity” effect, whereby achieving a good proportion of each capacity allows the country to build generic capacity to a threshold that could detect and respond to public health risks/events, including events that may constitute public health emergencies of international concern, as required by the IHR irrespective of the origin and meet the requirements of Annex 1.
Step 2: Consultation with relevant sectors wherever necessary and approval by appropriate authorities

- Discussions on relevant data with line ministries and other stakeholders, and consensus on whether IHR core capacities have been fulfilled, and whether to request extension in relation to specific core capacities or hazards which would then be addressed in the action plan
- Approval by MOH (or other appropriate authorities) and decision made whether to request extension and if so, what the extensions should cover.

Step 3: Development of IHR implementation plan or equivalent (for extension period) and dissemination to relevant stakeholders

- Thematic review of current capacity status, and recommendations for actions at national level
- Development of implementation plan for IHR core capacities to meet the 2014 deadline, if a decision has been made to request extension
- Dissemination to relevant sectors and potential donors and partners for advocacy and resource mobilization

*It is important to note that each designated Point of Entry has to meet IHR core capacity requirements. Capacities at Points of Entry should be addressed in the overarching National IHR Implementation Plan.*

Step 4: Report and request for extension as needed

- Submit formal request for extension to WHO with a justified need and an implementation plan no later than 15 June 2012 (See Appendix 8, 9 and 10 for the Assistant Director General of the Health Security and Environment Cluster of WHO (ADG/HSE) letter to States Parties, and the template and procedures for seeking extensions)
- Submit annual States Parties Questionnaire by August 2012

Step 5: Follow up actions

States Parties that have requested extensions should:

- Continue to monitor and develop IHR core capacities
- Regularly update National Plan of Action
- Request support by WHO and/or other agencies if needed

States Parties that have indicated that they have met their IHR core capacity obligations should:

- Continue monitoring IHR core capacities
- Consider request for an extension if there is a relevant change in the status of IHR core capacities
- Document and share best practices with other States Parties

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9 Submitting the annual States Parties Questionnaire by the 15th of June 2012 will help States Parties carry out a real time assessment of the status of capacity development and is strongly encouraged. However, States Parties that are unable to do so should submit by August 2012
• Support countries that have yet to meet 2012 obligations

Flow Chart for Decision-Making on Extensions

The WHO Secretariat through its Headquarters, Regional Offices as well as Country Offices stands ready to provide support and assistance as needed to States Parties in their decision-making process.

V. Flow chart for action

The following chart illustrates in time sequence actions to be taken, including assessment of IHR core capacities, development and implementation of National Plan of Action, monitoring of IHR core capacities and reporting to the World Health Assembly. States Parties could use it as a reference for actions to be taken at different stages in IHR implementation and fulfilment of IHR core capacity requirements.
IHR Enters into Force
15th June 2007

States Parties must have assessed existing national capacity for Surveillance, response and at PoE

Develop National Plan of Action for strengthening IHR Core Capacities for Surveillance, response and at PoE

Assess using IHR Protocol, PoE Protocol, sub-regional/regional tools or other tools

15th June 2009

No

Yes

No

Yes

Develop PoA

Implement PoA and Monitor progress

PoE Assessment Checklist

15th June 2012
Countries must have minimum Core Capacities in place

States Parties uses WHO guidance for MS along with their judgment based on their national, subregional, regional or other guidance, to determine fulfilment of the IHR

Request extension based on justification and implementation plan

Yes

No

Support other MS and share best practices

Annual reporting to WHO

Note: The web based IHR Monitoring Tool accessible to NFPs through the IHR Portal (http://extranet.who.int/ihrportal) provides real time assessment of IHR core capacities, and can be used to track country progress on core capacity development.
VI. Appendices

Appendix 1: States Parties Provisions

To facilitate the identification or location of State Party provisions in the IHR (2005) on particular key subjects, the articles and annexes may be organized by subject matter in the following ten categories:

A. General provisions (purpose and scope; principles; transparency, promptness and non-discriminatory implementation of health measures; general requirements) (Arts. 2, 3, 42, 44.1)

B. Responsible authorities including National IHR Focal Points (NFPs) and competent authorities (in particular Arts. 4 and 22, and Annex 7.2(f))

C. Notification and reporting of events to WHO (Arts. 5.1-.2, 6.1-.2, 7, 8, 9.2, 10.1-.2 and 46, and Annex 1)

D. Public health response (Arts. 13.1, 13.5, and 46, and Annex 1. See also articles and annexes listed under section E below.)

E. Public health emergencies of international concern (PHEIC), temporary recommendations and related national capacities (see articles and annexes listed under sections C and D above and Arts. 10.3, 12, 13.4, 15, 17, 18, 43, 48-49, and Annex 1)

F. Points of entry (international ports, airports and ground crossings) (Annex 1B, Arts. 19-23)

G. International goods, containers and container loading areas (Arts. 23.1(b), 33-35, 41)

H. Conveyances (international aircraft, shipping, ground vehicles) and conveyance operators (Arts. 23.1(b), 24-28, 35, 37-39, 41, 43, and Annexes 3-5, 8 and 9)

I. International travellers (persons): applying health measures and traveler protections (including human rights) (Arts. 3.1, 23, 30-32, 35-36, 40, 43, 45, Annexes 6 and 7)

J. National core capacity requirements (surveillance, response and designated points of entry) (Arts. 5.1, 13.1, 19(a), 20.1, 21, and Annex 1)

Appendix 2: Core Capacity Requirements at national, intermediate, and community level and for designated points of entry

The IHR have defined certain functions as national core capacity requirements for surveillance and response at the national, intermediate and community and/or primary public health response (peripheral) levels, and for designated points of entry. While the IHR do not generally say how the capacities specified in Annex 1 are to be established, or the methodology of measurement and assessment, the Regulations do specify the functional capacities that must be established. These are detailed below (Annex 1 A and B)
I. General obligations

- Unless otherwise specified, the terms in Annex 1 have the same meanings as defined in the rest of the IHR, including Article 1 (Definitions). Hence the broad scope of the IHR, in light of the definitions of event, disease, public health risk and health measure, applies here as well.
- States Parties must implement their "plans of action to ensure that these core capacities are present and functioning throughout their territories..." (Annex 1A)
- All States Parties must develop, strengthen and maintain the capacity to:
  - "detect, assess, notify and report events in accordance with these Regulations, as specified in Annex 1." (Article 5.1), and
  - "respond promptly and effectively to public health risks and public health emergencies of international concern as set out in Annex 1" (Article 13.1)
  - collaborate as provided (Article 44.1, Annex 1A) and
  - to carry out all activities concerning designated airports, ports and ground crossings as required in Annex 1

II. Specific obligations (Annex 1A):

At the local community level and/or primary public health response levels

<table>
<thead>
<tr>
<th>Surveillance, assessment and reporting</th>
<th>Control / Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) to detect events involving disease or death above expected levels for the particular time and place in all areas within the territory of the State Party; and (b) to report all available essential information <strong>immediately</strong> to the appropriate level of healthcare response.</td>
<td>(c) to implement preliminary control measures <strong>immediately</strong></td>
</tr>
</tbody>
</table>

For the purposes of this Annex, **essential information includes** the following: clinical descriptions, laboratory results, sources and type of risk, numbers of human cases and deaths, conditions affecting the spread of the disease and the health measures employed;

At the intermediate public health response levels

<table>
<thead>
<tr>
<th>Surveillance, assessment &amp; reporting</th>
<th>Response / control</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) to confirm the status of reported events (b) to assess reported events immediately and, if found <strong>urgent</strong>, to report all essential information to the national level.</td>
<td>(a) upon confirmation of the reported events, to <strong>support or implement additional control measures</strong></td>
</tr>
</tbody>
</table>

For the purposes of this Annex, the **criteria for urgent events include** serious public health impact and/or unusual or unexpected nature with high potential for spread.

At the national level, the capacities

<table>
<thead>
<tr>
<th>Assessment, notification &amp; reporting</th>
<th>Response / control</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) to assess all reports of urgent events <strong>within 48 hours</strong>; and (b) to notify WHO <strong>immediately</strong> through the National IHR Focal Point when the assessment indicates the</td>
<td>On <strong>a 24 hour basis:</strong></td>
</tr>
<tr>
<td></td>
<td>(a) to determine rapidly the control measures required to prevent domestic and international spread; (b) to provide support through specialized staff, laboratory analysis of samples (domestically or through collaborating centres)</td>
</tr>
</tbody>
</table>
and logistical assistance (e.g. equipment, supplies and transport);
(c) to provide on-site assistance as required to supplement local investigations;
(d) to provide a direct operational link with senior health and other officials to approve rapidly and implement containment and control measures;
(e) to provide direct liaison with other relevant government ministries;
(f) to provide, by the most efficient means of communication available, links with hospitals, clinics, airports, ports, ground crossings, laboratories and other key operational areas for the dissemination of information and recommendations received from WHO regarding events in the State Party’s own territory and in the territories of other States Parties; and
(g) to establish, operate and maintain a national public health emergency response plan, including the creation of multidisciplinary/multisectoral teams to respond to events that may constitute a public health emergency of international concern

III. Annex 1 B

<table>
<thead>
<tr>
<th>At all times</th>
<th>For responding to events that may constitute a PHEIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) to provide access to (i) an appropriate medical service including diagnostic facilities located so as to allow the prompt assessment and care of ill travellers, and (ii) adequate staff, equipment and premises;</td>
<td>(a) to provide appropriate public health emergency response by establishing and maintaining a public health emergency contingency plan, including the nomination of a coordinator and contact points for relevant point of entry, public health and other agencies and services;</td>
</tr>
<tr>
<td>(b) to provide access to equipment and personnel for the transport of ill travellers to an appropriate medical facility;</td>
<td>(b) to provide assessment of and care for affected travellers or animals by establishing arrangements with local medical and veterinary facilities for their isolation, treatment and other support services that may be required;</td>
</tr>
<tr>
<td>(c) to provide trained personnel for the inspection of conveyances;</td>
<td>(c) to provide appropriate space, separate from other travellers, to interview suspect or affected persons;</td>
</tr>
<tr>
<td>(d) to ensure a safe environment for travellers using point of entry facilities, including potable water supplies, eating establishments, flight catering facilities, public washrooms, appropriate solid and liquid waste disposal services and other potential risk areas, by conducting inspection programmes, as appropriate;</td>
<td>(d) to provide for the assessment and, if required, quarantine of suspect travellers, preferably in facilities away from the point of entry;</td>
</tr>
</tbody>
</table>
(e) to provide as far as practicable a programme and trained personnel for the control of vectors and reservoirs in and near points of entry.

(e) to apply recommended measures to disinsect, derat, disinfect, decontaminate or otherwise treat baggage, cargo, containers, conveyances, goods or postal parcels including, when appropriate, at locations specially designated and equipped for this purpose;

(f) to apply entry or exit controls for arriving and departing travellers; and

(g) to provide access to specially designated equipment, and to trained personnel with appropriate personal protection, for the transfer of travellers who may carry infection or contamination.

Appendix 3: The WHO Monitoring Framework

This comprises of a checklist and indicators, a States Parties questionnaire and an online tool. The monitoring framework developed, represents a consensus of technical expert views drawn globally from WHO Member States, technical institutions, partners, the WHO Secretariat and subject matter experts. The framework is based on concepts that have been successfully applied in monitoring capacity development activities.

The tools developed as part of the IHR Monitoring Framework (checklist, indicators and questionnaire) were based on existing regional and sub-regional tools and strategies worldwide such as the Asia-Pacific Strategy for Emerging Diseases (APSED) in the Western Pacific Region and South-East Asia Region; the Integrated Disease Surveillance and Response strategy (IDSR) in the African region; the Emerging Infectious Diseases (EID) Strategies in the Americas, the European Region and Eastern Mediterranean Regions. Sub regional strategies and tools such as the MERCOSUR tool were also consulted.


The IHR Monitoring Tool: The global tool for monitoring IHR Core Capacity implementation is the States parties Questionnaire. This annual data collection form is sent to all IHR-NFPs and data is collated in the online version of the SP Questionnaire (accessible to NFPs through the IHR Portal http://extranet.who.int/ihrportal).

The IHR Web Based Tool (online version of the SP Questionnaire) allows the online collection of standardized information about progress made in core capacity development.

Eight operational core capacities were defined and are described in the IHR Monitoring Framework:

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10 The process of maintaining regular overview of implementation of activities, with routine and continuous tracking of implementation of planned activities and the overall performance of the system.

Core capacity 1: National legislation, policy and financing
Core capacity 2: Coordination and National Focal Point (NFP) communications
Core capacity 3: Surveillance
Core capacity 4: Response
Core capacity 5: Preparedness
Core capacity 6: Risk communication
Core capacity 7: Human resources
Core capacity 8: Laboratory

The core capacities for Ports, Airports and Ground Crossings, stated in Annex 1B, include:
- Core capacities at all times: assessment and medical care, staff and equipment; equipment and personnel to transport ill travellers; trained personnel for inspection of conveyances; ensuring a safe environment (e.g. water, food, waste); and trained staff and a programme for vector control.
- Core capacities for responding to events that may constitute a public health emergency of international concern (PHEIC): among others, a public health emergency contingency plan and the application of recommended measures to disinsect, disinfect, and decontaminate baggage, cargo, goods, etc.

The IHRMT checklist operationalizes Annex 1 and defines 20 indicators to measure country progress in the building of the 8 core capacities, PoE and Hazards using the achievement of distinct functions (attributes), that reflect the level of performance or achievement of a specific indicator and measures the progress made towards the attainment of an individual core capacity.

In developing operational indicators for measuring the status of development of the IHR core capacities, the following criteria were applied:
1. Relevance to the IHR: The indicators and the attributes that make up each indicator must be relevant in developing capacities to detect, assess, report, notify, verify and respond to public health events of national or international concern.
2. Coverage: The indicators and attributes reflect systems establishment at the national, intermediate, and peripheral levels.
3. The scope of application in relation to the IHR relevant hazards: Biological (infectious, zoonotic and foodborne) chemical, radiological and nuclear hazards.
4. The quality of the function or service: quality refers to compliance with national and international standards and procedures applied;
5. The timeliness of application of functions and services;
6. The documentation and dissemination of practices.

The 20 WHA indicators are listed in Appendix 7.
## Appendix 4: Summary of IHR Core Capacity Requirements at each Designated Point of Entry

<table>
<thead>
<tr>
<th>Designated PoE name</th>
<th>Core capacities at all times (9.2)</th>
<th>Core capacity for responding to public health emergencies (9.3)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coordination and communication (9.2.1.3)</td>
<td>Public health contingency plan (9.3.1.2)</td>
</tr>
<tr>
<td></td>
<td>Medical services (9.2.1.7)</td>
<td>Appropriate place for interview (9.3.1.3)</td>
</tr>
<tr>
<td></td>
<td>Transport of ill travellers (9.2.1.8)</td>
<td>Medical assessment and quarantine (9.3.1.5)</td>
</tr>
<tr>
<td></td>
<td>Inspection program (9.2.1.9)</td>
<td>Entry and exit control (9.3.1.6)</td>
</tr>
<tr>
<td></td>
<td>Vector surveillance and control (9.2.1.10)</td>
<td>Transfer of infected travellers (9.3.1.7)</td>
</tr>
<tr>
<td></td>
<td>Inspection of conveyances (9.2.1.11)</td>
<td></td>
</tr>
</tbody>
</table>

### Ports

### Airports

### Ground crossings

### Note:

9.1.1.4 Please indicate whether a ‘Competent authority’ has been identified for the designated PoE.

9.2.1.3 Please indicate whether the designated PoE has communications procedures established as required by the IHR in Annex 1.

9.2.1.7 Please indicate whether the designated PoE has access to appropriate medical services including diagnostic facilities for the prompt assessment and care of ill travellers and with adequate staff, equipment and premises (Annex 1b, 1a).

9.3.1.2 Please indicate whether the designated PoE has an established and maintained public health emergency contingency plan to provide public health emergency response including a coordinator and contact points for relevant points of entry, public health and other agencies and services.

9.3.1.3 Please indicate whether the designated PoE has appropriate space, separate from other travellers, to interview suspect or affected persons (Annex 1b, 2c).

9.3.1.5 Please indicate whether the designated PoE can provide medical assessment or quarantine of suspect travellers, and care for affected travellers or animals (Annex 1b, 2b and 2d).

9.3.1.6 Please indicate whether the designated PoE can apply entry or exit controls for arriving and departing travellers and other recommended public health measures.

9.3.1.7 Please indicate whether the designated PoE has access to specially designated equipment, and to trained personnel (with appropriate personal protection), for the transfer of travellers who may carry infection or contamination available at designated PoE.
Appendix 5: Questions and Answers on authorized ports and designated points of entry

I. Ports authorized to issue ship sanitation certificates
   (Main IHR Articles 20, 27 and 39; Annexes 3, 4, 5 and 8)

1. What is an authorized port?

   • This is a port which is authorized to issue internationally recognized IHR ship sanitation certificates (SSC) that conform to the model certificate in IHR Annex 3, and which provides the related inspection and control services required for the certificates.

2. What is the procedure by which a port is authorized to issue ship sanitation certificates (SSC)?

   • It is up to each State Party to determine which ports located within its territory are authorized to issue a SSC.
   • There is no time frame within which such ports must be authorized - i.e States began authorization of their ports upon entry into force of the IHR in 2007 and continue to do so on an ongoing basis. Similarly, States can remove the authorization of a port at any time, and must inform the WHO when they do so.
   • States do not have any obligations to authorize a minimum or specific number of ports. However, in light of the reliance of international ship traffic upon the regimen based on these certificates, it is important that a sufficient number of authorized ports are available globally within reasonable distances of the world's major shipping routes.

3. How are the WHO and the maritime community informed of which ports are authorized to issue SSCs? Is that information publically available?

   • The IHR require each State Party to send to WHO the list of ports in its territory that are authorized to issue SSCs; these should be submitted via the National IHR Focal Point (NFP). The State Party must also inform WHO of any modifications to its list (additions or deletions).
   • WHO publishes, and updates on a regular basis, the list of ports authorized to issue SSC. This list is available on the WHO Web site at: www.who.int/ihr/ports_airports/portslanding/en/index.html

4. What are the possible consequences if a port that is not on the list of ports authorized to issue SSC nevertheless issues a SSC, or if a port issues a SSC that does not conform to the model in Annex 3 of the IHR (2005)?
• The validity of a SSC issued by a port that is not included on the authorized list of ports may be challenged by a subsequent port, and any SSC that does not conform to the model in Annex 3 of the IHR may also be challenged. Such challenges may entail economic consequences associated with delays in granting free pratique and procedures required to obtain a valid certificate.

II. Designated points of entry
(Main IHR articles 19, 20 and 21; Annex 1)

1. What is a designated point of entry?

• A designated point of entry refers to a port, airport and potentially a ground crossing that is designated by a State Party to strengthen, develop and maintain the capacities described in Annex 1 of the IHR:
  
  o The capacities at all times concerning access to medical services for prompt assessment and care of ill travellers, a safe environment for travellers (e.g. water, food, waste), personnel for inspection and vector control functions; and
  
  o The capacities to respond specifically to events which may constitute a public health emergency of international concern.

2. How many points of entry should a State Party designate?

• The IHR do not specify a particular number of designations of points of entry to develop these capacities. The IHR make clear that the designation and development of ports and airports are part of the core requirements for States Parties and are essential elements for their fulfilling the public health purpose and objectives of the IHR including the role for designated points of entry in national emergency response plans. To achieve these objectives, States Parties need to designate, at a minimum, one airport and one port (depending upon the geographical context of the State Party). For larger countries and those with high levels of international traffic, the Secretariat would strongly encourage the designation of additional points of entry.

3. Is there a time frame to designate a point of entry?

• The IHR provide that the time frames applicable to development of the other core capacities under Annex 1, also apply to development of the core capacities at designated points of entry. The first target date for establishment of these capacities at designated points of entry is also 15 June 2012\(^{12}\).

4. Can extensions be obtained for capacities at points of entry?

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\(^{12}\) The time frames for the States Parties which made reservations to the IHR are slightly later; the time frames for WHO Member States who became members after the IHR entered into force in 2007 also have later time frames.
If the capacities are not fully established in all designated points of entry by the deadline, States Parties can obtain an extension according to the procedures described in the letter from the Assistant Director-General sent to all States Parties in September 2011.

5. Can additional points of entry be designated and develop these capacities after the above time frames?

- The time frame for initial designation and capacity establishment should not restrict States Parties from continuing to designate and develop these capacities at additional points of entry as the national and international contexts evolve over time. In such cases, States Parties should advise WHO of the additional points of entry where they have determined to develop the required capacities for designated points of entry and when the capacities have been achieved.

6. Can a designation of a point of entry be withdrawn?

- Designations of points of entry may be withdrawn at any time, taking into consideration the need for States Parties to have a minimum of one designated airport and one designated port (depending upon the geographical context of the State Party). States Parties should advise WHO of any change to a point of entry's designation.

III. **Main differences between a port that is authorized and a designated point of entry**

1. What are the main differences between *authorization* and *designation* of a port?

- An *authorized* port requires only the specific capacities for inspecting/controlling potential public health risks on ships and the issuance or extension of the relevant ship sanitation certificate. In contrast to designated points of entry, there is no timeframe for authorization and establishment of these capacities, and therefore requests for extensions are generally not relevant (unless the port is also designated for all Annex 1 capacities as indicated below).

- A *designated* point of entry requires a broader range of capacities to be developed and available at designated ports. Designation applies to ports and airports (and potentially ground crossings). A specific timetable for the development of the capacities is provided, with the possibility of extensions on request.

- Example of difference: There is no IHR requirement for an *authorized* port to provide access to an "appropriate medical service including diagnostic facilities located so as to allow the prompt assessment and care of ill travellers", whereas that is one of the capacities that must be provided by a *designated* point of entry at all times.

2. Can an authorized port also be a designated point of entry?
• Yes, if the authorized port has been also designated by a State Party to strengthen, develop and maintain the capacities at port facilities described in IHR Annex 1.

3. Can a port designated as a point of entry to develop IHR Annex 1 capacities also be authorized to issue ship sanitation certificates?

• A designated port that has developed all the capacities described in Annex 1 may not be generally authorized to issue Ship Sanitation certificates. Even though designated ports need to have specified capacities relating to inspections, health measures and certificates under the IHR, any such authorization is at the discretion of the State Party where the port is located.

Appendix 6: Available tools to assess IHR national core capacity development

To support States Parties, WHO, with technical partners has developed global and regional specific tools addressing the capacities required by the IHR. These could be consulted in making the decision about meeting core capacity requirements. These tools, guidance and other publications are available on the WHO IHR website:  
http://www.who.int/ihr/elibrary/en/index.html. A summary of the tools, are highlighted below.

I. WHO Assessment Tools

A number of generic and specific assessment tools have been developed to support countries in assessing the status of implementation of IHR core capacities. These include, but are not limited to:

• Protocol for the assessment of national communicable disease surveillance and response systems - guidelines for assessment teams -2010  
(http://www.who.int/ihr/publications/who_hse_ihr_201007/en/index.html). This document proposes guidance to States Parties on the assessment of their national IHR core capacities for surveillance and response, in accordance with Annex 1A of the IHR.

• Desk Review and Planning guide (being finalized after field testing)
Some countries may choose to carry out the in-depth assessments, and some to use the annual self-reporting IHR States Parties monitoring questionnaire for assessment/monitoring. The desk review and planning guide is an intermediary tool which identifies gaps and strengths, permits the development of robust plans, while validating the quality of the States Parties Reports, within a short timeframe. This guide can be used by countries that have not yet conducted an assessment of existing national structures and resources to meet the minimum requirements using the IHR Assessment Protocol, IHR Monitoring Tool (IHRMT) or other assessment or monitoring tools. It can also be used by countries that wish to rapidly develop their plans, advocate for, and mobilize resources for development of IHR core capacities.
• Points of Entry: Assessment tool for core capacity requirements at designated airports, ports and ground crossings
  (http://www.who.int/ihr/ports_airports/PoE_Core_capacity_assessment_tool.pdf)
This tool is intended to support States Parties in determining existing capacities and capacity needs at points of entry with reference to Article 20.1 and Annex 1B. It also addresses communication/collaboration structure between competent authorities at PoE and the National IHR Focal Point and health authorities at national, intermediate and local levels, as per in Annex 1a of the Regulations. It applies to individual designated Points of Entry.

Each designated Point of Entry needs to be assessed individually with the results to provide a necessary basis for monitoring IHR implementation at Points of Entry at country, regional and global levels. Individual assessment is also necessary to provide the basis (justification) for decisions on which designated Points of Entry may need an extension. To serve this purpose, see the WHO Assessment Tool for Core Capacity Requirements at Designated Airports, Ports and Ground Crossings (available at http://www.who.int/ihr/ports_airports/PoE/en/index.html). Please also see Appendix 4 for a summary of national capacity requirement at each designated PoE, for the consideration of Member States to provide more information on IHR core capacity requirements at each designated PoE.

II. Other assessment, implementation and planning tools

IHR Publications

Toolkit for implementation in national legislation - Questions and answers, legislative reference and assessment tool and examples of national legislation - 2009
http://www.who.int/ihr/Toolkit_Legislative_Implementation.pdf
This toolkit provides guidance on the implementation of the IHR in national legislation.

Toolkit for implementation in national legislation: The National IHR Focal Point (NFP) - 2009
http://www.who.int/ihr/NFP_Toolkit.pdf
This toolkit provides guidance on NFP-related IHR requirements in national legislation.

IHR (2005): a brief introduction to implementation in national legislation - 2009
http://www.who.int/ihr/Intro_legislative_implementation.pdf
This document provides a brief introduction to legislative implementation of the IHR to assist countries in initiating these processes.

This document gives a brief description of the International Health Regulations, summary of Member States’ key obligations, opportunities and benefits, as well as of WHO tasks and responsibilities.

Securing global health: IHR implementation course
(http://www.who.int/ihr/training/ihrcourse/en/index.html)
This on-the-job and face-to-face course aims at developing IHR implementation capacities and efficient international collaboration.
**Online briefings:** [https://extranet.who.int/ihr/training/](https://extranet.who.int/ihr/training/)

**WHO guidance for the use of Annex 2** of the International Health Regulation (2005) - decision instrument for the assessment and notification of events that may constitute a public health emergency of international concern - 2010  

The purpose of the WHO guidance on Annex 2 is to help national authorities to use the decision instrument in assessing public health

**Laboratory Assessment Tool** (being finalized)

This document offers guidance and questionnaires to assess laboratories and the national laboratory system. The intended audience of the document is any stakeholder performing laboratory assessments: national health authorities, multilateral agencies, Non-Governmental Organizations (NGOs), laboratory managers, etc. This document does not intend to replace laboratory assessment tools that could have been developed by specific disease control programmes or initiatives. It is based on the internationally recognized standards and good practices governing laboratory services but does not take into account specific national norms or regulations. It is well aligned with the laboratory section of the Protocol for the assessment of national communicable disease surveillance and response systems - guidelines for assessment teams - 2010.

**Table Top Exercise Manual** (being finalized after field testing)

This manual provides guidance to countries on how to validate their IHR plans through exercises, focusing on table top exercises. It addresses the IHR core capacities, hazards and points of entry. Exercises allow the identification of which actions are working and which need to be improved. The functioning of certain procedures, mechanisms and processes may also help the States Parties in making the determination whether the country has met their core capacities requirements.
Appendix 7: Main IHR articles relevant for IHR core capacity development, WHA indicators and summary table of core capacities achieved for all hazards
(Note: In accordance with the broad scope of the IHR (2005), the capacities listed apply for all IHR relevant hazards (infectious, zoonotic, food safety, chemical, radiological and others), and to all territories and all levels of the States Parties.)

I. Main IHR articles and WHA indicators to determine the status of achievement of IHR core capacities
The table below lists selected articles and text of IHR (2005) that are related to IHR core capacity requirements, and with the 20 WHA indicators in the IHRMT. In considering whether relevant core capacity requirements are met, MS may use the IHRMT to show attainment of relevant indicators, together with other relevant national data to judge whether the specific indicators have been achieved or can be achieved by 15 June 2012.

<table>
<thead>
<tr>
<th>IHRMT - WHA Indicators</th>
<th>% of attainment of IHRMT indicators</th>
<th>Other relevant national data</th>
<th>Actions/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legislation, laws, regulations, administrative requirements, policies or other government instruments in place are sufficient for implementation of IHR.</td>
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<tr>
<td>A functional mechanism is established for the coordination of relevant sectors in the implementation of the IHR.</td>
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<td>IHR NFP functions and operations are</td>
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</table>

Selected articles and texts of IHR (2005) in relation to core capacity requirements for IHR implementation (in the order of appearance in the IHR (2005)) Other pertinent articles can be found in Appendix 1 (States Parties Provisions)

Article 1 Definitions (please refer to IHR (2005) for the full list of definitions under Article 1)
“disease” means an illness or medical condition, irrespective of origin or source, that presents or could present significant harm to humans;
“event” means a manifestation of disease or an occurrence that creates a potential for disease;
“public health emergency of international concern” means an extraordinary event which is determined, as provided in these Regulations:
(i) to constitute a public health risk to other States through the international spread of disease and
(ii) to potentially require a coordinated international response;
“public health risk” means a likelihood of an event that may affect adversely the health of human populations, with an emphasis on one which may spread internationally or may present a serious and direct danger;

Article 4 Responsible authorities
1. Each State Party shall designate or establish a National IHR Focal Point and the authorities responsible within its respective jurisdiction for the implementation of health measures under these Regulations.
2. National IHR Focal Points shall be accessible at all times for communications with the WHO IHR Contact Points provided for in paragraph 3 of this Article. The functions of National IHR Focal Points shall include:
(a) sending to WHO IHR Contact Points, on behalf of the State Party concerned, urgent communications concerning the implementation of these Regulations, in particular under Articles 6 to 12; and
(b) disseminating information to, and consolidating input from, relevant sectors of the administration of the State Party concerned, including those responsible for surveillance and reporting, points of entry, public health services, clinics and hospitals and other government departments.

Article 5 Surveillance
1. Each State Party shall develop, strengthen and maintain, as soon as possible but no later than five years from the entry into force of these Regulations for that State Party, the capacity to detect, assess, notify and report events in accordance with these Regulations, as specified in Annex 1.
2. Following the assessment referred to in paragraph 2, Part A of Annex 1, a State Party may report to WHO...
on the basis of a justified need and an implementation plan and, in so doing, obtain an extension of two years in which to fulfill the obligation in paragraph 1 of this Article. In exceptional circumstances, and supported by a new implementation plan, the State Party may request a further extension not exceeding two years from the Director-General, who shall make the decision, taking into account the technical advice of the Committee established under Article 50 (hereinafter the “Review Committee”). After the period mentioned in paragraph 1 of this Article, the State Party that has obtained an extension shall report annually to WHO on progress made towards the full implementation.

3. WHO shall assist States Parties, upon request, to develop, strengthen and maintain the capacities referred to in paragraph 1 of this Article.

4. WHO shall collect information regarding events through its surveillance activities and assess their potential to cause international disease spread and possible interference with international traffic. Information received by WHO under this paragraph shall be handled in accordance with Articles 11 and 45 where appropriate.

Article 6 Notification
1. Each State Party shall assess events occurring within its territory by using the decision instrument in Annex 2. Each State Party shall notify WHO, by the most efficient means of communication available, by way of the National IHR Focal Point, and within 24 hours of assessment of public health information, of all events which may constitute a public health emergency of international concern within its territory in accordance with the decision instrument, as well as any health measure implemented in response to those events. If the notification received by WHO involves the competency of the International Atomic Energy Agency (IAEA), WHO shall immediately notify the IAEA.

2. Following a notification, a State Party shall continue to communicate to WHO timely, accurate and sufficiently detailed public health information available to it on the notified event, where possible including case definitions, laboratory results, source and type of the risk, number of cases and deaths, conditions affecting the spread of the disease and the health measures employed; and report, when necessary, the difficulties faced and support needed in responding to the potential public health emergency of international concern.

Article 7 Information-sharing during unexpected or unusual public health events
If a State Party has evidence of an unexpected or unusual public health event within its territory, irrespective of origin or source, which may constitute a public health emergency of international concern, it shall provide to WHO all relevant public health information. In such a case, the provisions of Article 6 shall apply in full.

Article 8 Consultation
In the case of events occurring within its territory not requiring notification as provided in Article 6, in particular those events for which there is insufficient information available to complete the decision instrument, a State Party may nevertheless keep WHO advised thereof through the National IHR Focal Point and consult with WHO on appropriate health measures. Such communications shall be treated in accordance with paragraphs 2 to 4 of Article 11. The State Party in whose territory the event has occurred may request WHO assistance to assess any epidemiological evidence obtained by that State Party.
exported or imported:
(a) human cases;
(b) vectors which carry infection or contamination; or
(c) goods that are contaminated.

Article 10 Verification
1. WHO shall request, in accordance with Article 9, verification from a State Party of reports from sources other than notifications or consultations of events which may constitute a public health emergency of international concern allegedly occurring in the State’s territory. In such cases, WHO shall inform the State Party concerned regarding the reports it is seeking to verify.
2. Pursuant to the foregoing paragraph and to Article 9, each State Party, when requested by WHO, shall verify and provide:
   (a) within 24 hours, an initial reply to, or acknowledgement of, the request from WHO;
   (b) within 24 hours, available public health information on the status of events referred to in WHO’s request; and
   (c) information to WHO in the context of an assessment under Article 6, including relevant information as described in that Article.
3. When WHO receives information of an event that may constitute a public health emergency of international concern, it shall offer to collaborate with the State Party concerned in assessing the potential for international disease spread, possible interference with international traffic and the adequacy of control measures. Such activities may include collaboration with other standard-setting organizations and the offer to mobilize international assistance in order to support the national authorities in conducting and coordinating on-site assessments. When requested by the State Party, WHO shall provide information supporting such an offer.
4. If the State Party does not accept the offer of collaboration, WHO may, when justified by the magnitude of the public health risk, share with other States Parties the information available to it, whilst encouraging the State Party to accept the offer of collaboration by WHO, taking into account the views of the State Party concerned.
immediate application of international control measures.
3. WHO shall consult with the State Party in whose territory the event is occurring as to its intent to make information available under this Article.
4. When information received by WHO under paragraph 2 of this Article is made available to States Parties in accordance with these Regulations, WHO may also make it available to the public if other information about the same event has already become publicly available and there is a need for the dissemination of authoritative and independent information.

**Article 12 Determination of a public health emergency of international concern**

1. The Director-General shall determine, on the basis of the information received, in particular from the State Party within whose territory an event is occurring, whether an event constitutes a public health emergency of international concern in accordance with the criteria and the procedure set out in these Regulations.
2. If the Director-General considers, based on an assessment under these Regulations, that a public health emergency of international concern is occurring, the Director-General shall consult with the State Party in whose territory the event arises regarding this preliminary determination. If the Director-General and the State Party are in agreement regarding this determination, the Director-General shall, in accordance with the procedure set forth in Article 49, seek the views of the Committee established under Article 48 (hereinafter the “Emergency Committee”) on appropriate temporary recommendations.
3. If, following the consultation in paragraph 2 above, the Director-General and the State Party in whose territory the event arises do not come to a consensus within 48 hours on whether the event constitutes a public health emergency of international concern, a determination shall be made in accordance with the procedure set forth in Article 49.
4. In determining whether an event constitutes a public health emergency of international concern, the Director-General shall consider:
   (a) information provided by the State Party;
   (b) the decision instrument contained in Annex 2;
   (c) the advice of the Emergency Committee;
   (d) scientific principles as well as the available scientific evidence and other relevant information; and
   (e) an assessment of the risk to human health, of the risk of international spread of disease and of the risk of interference with international traffic.
5. If the Director-General, following consultations with the State Party within whose territory the public health emergency of international concern has occurred, considers that a public health emergency of international concern has ended, the Director-General shall take a decision in accordance with the procedure set out in Article 49.

**Article 13 Public health response**

1. Each State Party shall develop, strengthen and maintain, as soon as possible but no later than five years from the entry into force of these Regulations for that State Party, the capacity to respond promptly and effectively to public health risks and public health emergencies of international concern as set out in Annex 1. WHO shall publish, in consultation with Member States, guidelines to support States Parties in the development of public health response capacities.
2. When requested by WHO, States Parties should provide, to the extent possible, support to WHO-coordinated response activities.
preventing or promptly detecting its recurrence.

2. Temporary recommendations may include health measures to be implemented by the State Party experiencing the public health emergency of international concern, or by other States Parties, regarding persons, baggage, cargo, containers, conveyances, goods and/or postal parcels to prevent or reduce the international spread of disease and avoid unnecessary interference with international traffic.

3. Temporary recommendations may be terminated in accordance with the procedure set out in Article 49 at any time and shall automatically expire three months after their issuance. They may be modified or extended for additional periods of up to three months. Temporary recommendations may not continue beyond the second World Health Assembly after the determination of the public health emergency of international concern to which they relate.

Article 18 Recommendations with respect to persons, baggage, cargo, containers, conveyances, goods and postal parcels

1. Recommendations issued by WHO to States Parties with respect to persons may include the following advice:
   – no specific health measures are advised;
   – review travel history in affected areas;
   – review proof of medical examination and any laboratory analysis;
   – require medical examinations;
   – review proof of vaccination or other prophylaxis;
   – require vaccination or other prophylaxis;
   – place suspect persons under public health observation;
   – implement quarantine or other health measures for suspect persons;
   – implement isolation and treatment where necessary of affected persons;
   – implement tracing of contacts of suspect or affected persons;
   – refuse entry of suspect and affected persons;
   – refuse entry of unaffected persons to affected areas; and
   – implement exit screening and/or restrictions on persons from affected areas.

2. Recommendations issued by WHO to States Parties with respect to baggage, cargo, containers, conveyances, goods and postal parcels may include the following advice:
   – no specific health measures are advised;
   – review manifest and routing;
   – implement inspections;
   – review proof of measures taken on departure or in transit to eliminate infection or contamination;
   – implement treatment of the baggage, cargo, containers, conveyances, goods, postal parcels or human remains to remove infection or contamination, including vectors and reservoirs;
   – the use of specific health measures to ensure the safe handling and transport of human remains;
   – implement isolation or quarantine;
   – seize and destruction of infected or contaminated or suspect baggage, cargo, containers, conveyances, goods or postal parcels under controlled conditions if no available treatment or process will otherwise be successful; and
   – refuse departure or entry.

Article 19 General obligations

Each State Party shall, in addition to the other obligations provided for under these Regulations:
(a) ensure that the capacities set forth in Annex 1 for designated points of entry are developed within the timeframe provided in paragraph 1 of Article 5 and paragraph 1 of Article 13;
(b) identify the competent authorities at each designated point of entry in its territory;
1. States Parties shall designate the airports and ports that shall develop the capacities provided in Annex 1.

2. States Parties shall ensure that Ship Sanitation Control Exemption Certificates and Ship Sanitation Control Certificates are issued in accordance with the requirements in Article 39 and the model provided in Annex 3.

3. Each State Party shall send to WHO a list of ports authorized to offer:
   (a) the issuance of Ship Sanitation Control Certificates and the provision of the services referred to in Annexes 1 and 3; or
   (b) the issuance of Ship Sanitation Control Exemption Certificates only; and
   (c) extension of the Ship Sanitation Control Exemption Certificate for a period of one month until the arrival of the ship in the port at which the Certificate may be received.

Each State Party shall inform WHO of any changes which may occur to the status of the listed ports. WHO shall publish the information received under this paragraph.

Article 21 Ground crossings

1. Where justified for public health reasons, a State Party may designate ground crossings that shall develop the capacities provided in Annex 1, taking into consideration:
   (a) the volume and frequency of the various types of international traffic, as compared to other points of entry, at a State Party’s ground crossings which might be designated; and
   (b) the public health risks existing in areas in which the international traffic originates, or through which it passes, prior to arrival at a particular ground crossing.

2. States Parties sharing common borders should consider:
   (a) entering into bilateral or multilateral agreements or arrangements concerning prevention or control of international transmission of disease at ground crossings in accordance with Article 57; and
   (b) joint designation of adjacent ground crossings for the capacities in Annex 1 in accordance with paragraph 1 of this Article.

Article 22 Role of competent authorities

1. The competent authorities shall:
   (a) be responsible for monitoring baggage, cargo, containers, conveyances, goods, postal parcels and human remains departing and arriving from affected areas, so that they are maintained in such a condition that they are free of sources of infection or contamination, including vectors and reservoirs;
   (b) ensure, as far as practicable, that facilities used by travellers at points of entry are maintained in a sanitary condition and are kept free of sources of infection or contamination, including vectors and reservoirs;
   (c) be responsible for the supervision of any deratting, disinfection, disinsection or decontamination of baggage, cargo, containers, conveyances, goods, postal parcels and human remains or sanitary measures for persons, as appropriate under these Regulations;
   (d) advise conveyance operators, as far in advance as possible, of their intent to apply control measures to a conveyance, and shall provide, where available, written information concerning the methods to be employed;
   (e) be responsible for the supervision of the removal and safe disposal of any contaminated water or food, human or animal dejecta, wastewater and any other contaminated matter from a conveyance;
   (f) take all practicable measures consistent with these Regulations to monitor and control the discharge by ships of sewage, refuse, ballast water and other potentially disease-causing matter which might contaminate the waters of a port, river, canal, strait, lake or other international waterway;
   (g) be responsible for supervision of service providers for services concerning travelers, baggage, cargo, containers, conveyances, goods, postal parcels and human remains at points of entry, including the conduct of inspections and medical examinations as necessary;
   (h) have effective contingency arrangements to deal with an unexpected public health event; and
   (i) communicate with the National IHR Focal Point on the relevant public health measures taken pursuant to these Regulations.

2. Health measures recommended by WHO for travelers, baggage, cargo, containers, conveyances, goods,
postal parcels and human remains arriving from an affected area may be reapplied on arrival, if there are verifiable indications and/or evidence that the measures applied on departure from the affected area were unsuccessful.

3. Disinsection, deratting, disinfection, decontamination and other sanitary procedures shall be carried out so as to avoid injury and as far as possible discomfort to persons, or damage to the environment in a way which impacts on public health, or damage to baggage, cargo, containers, conveyances, goods and postal parcels.

Article 23 Health measures on arrival and departure
5. Any medical examination, medical procedure, vaccination or other prophylaxis which involves a risk of disease transmission shall only be performed on, or administered to, a traveller in accordance with established national or international safety guidelines and standards so as to minimize such a risk.

Article 44 Collaboration and assistance
1. States Parties shall undertake to collaborate with each other, to the extent possible, in:
   (d) the formulation of proposed laws and other legal and administrative provisions for the implementation of these Regulations.

Article 46 Transport and handling of biological substances, reagents and materials for diagnostic purposes
States Parties shall, subject to national law and taking into account relevant international guidelines, facilitate the transport, entry, exit, processing and disposal of biological substances and diagnostic specimens, reagents and other diagnostic materials for verification and public health response purposes under these Regulations.

Article 59 Entry into force; period for rejection or reservations
3. If a State is not able to adjust its domestic legislative and administrative arrangements fully with these Regulations within the period set out in paragraph 2 of this Article, that State shall submit within the period specified in paragraph 1 of this Article a declaration to the Director-General regarding the outstanding adjustments and achieve them no later than 12 months after the entry into force of these Regulations for that State Party.

ANNEX 1
A. CORE CAPACITY REQUIREMENTS FOR SURVEILLANCE AND RESPONSE
B. CORE CAPACITY REQUIREMENTS FOR DESIGNATED AIRPORTS, PORTS AND GROUND CROSSINGS

ANNEX 2
DECISION INSTRUMENT FOR THE ASSESSMENT AND NOTIFICATION OF EVENTS THAT MAY CONSTITUTE A PUBLIC HEALTH EMERGENCY OF INTERNATIONAL CONCERN
II. Summary Table of **Core capacities achieved for all hazards**

<table>
<thead>
<tr>
<th>Core Capacity</th>
<th>Biological (infectious) Y/N</th>
<th>Zoonosis Y/N</th>
<th>Food Safety Y/N</th>
<th>Chemical Y/N</th>
<th>Radio-nuclear Y/N</th>
<th>CC in place to detect and respond to PHE for all IHR relevant hazards?</th>
<th>Actions to be taken if any</th>
</tr>
</thead>
<tbody>
<tr>
<td>CC1. Legislation and Policy</td>
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<td>CC2. Coordination and NFP Communications</td>
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<td>CC4. Response</td>
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<td>CC5. Preparedness</td>
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<td>CC6. Risk Communications</td>
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<td>CC8. Laboratory</td>
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<td>Points of Entry</td>
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</tbody>
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*Note: This does not imply the establishment of separate vertical programmes for individual hazards particularly if the generic capacities developed under IHR such as event-based surveillance are sufficient to address all public health risks.*
Appendix 8: Assistant Director General of the Health Security and Environment Cluster of WHO (ADG/HSE) letter to States Parties

Dear National IHR Focal Point,

Re: 2012 Target date for establishing national core capacities as set out in the International Health Regulations (2005) and the procedure for obtaining an extension

One of the provisions adopted by the World Health Organization (WHO) Member States in their revision of the International Health Regulations (2005) (IHR or Regulations) is the obligation for all States Parties to the Regulations to ensure that national core capacities outlined in Annex 1 of the Regulations are in place within five years of entry into force of the IHR for that State Party; for all but three State Parties the date for implementation of national core capacities is 15 June 2012 (see Enclosure 1). These capacities are focused on two areas; firstly public health surveillance and response throughout the territory and secondly for public health actions at Points of Entry designated to establish and maintain such capacity.

Ensuring public health preparedness is a continuous process, however, when negotiating the Regulations WHO Member States set themselves a target date for achieving the IHR national core capacities and, because this target is challenging, they also included provisions to allow the target date to be extended.

The IHR indicate that any request for extension is based on the initiative of the State Party and I am writing now, several months before the target date, to encourage the relevant authorities in each State Party to evaluate the extent to which the required national core capacities have been achieved, and subsequently should the State Party consider it necessary, to initiate a request for a two-year extension to the target date.

To facilitate the process for requesting the two-year extension to the 2012 target date there are a number of enclosures with this letter that include:

1. enclosure 1: IHR provisions relevant to the request for extension to the 2012 target date for establishment of IHR national core capacities;
2. enclosure 2: Outline of the proposed procedures to be followed by States Parties in order to obtain the two-year extension to the 2012 target date for establishing IHR national core capacities;
3. enclosure 3: Suggested template for the request for extension to the 2012 target date for establishing IHR national core capacities.

The WHO Secretariat looks forward to working with all States Parties over the coming year to ensure that all those requiring an extension can complete the procedures in compliance with the IHR before the target date.
Appendix 9: Suggested template for the request for extension to the target date for establishing IHR national core capacities

The IHR do not make any specific requirements for the request to the WHO Secretariat other than it contains both a justification for the request for extension and an implementation plan. The following template is provided solely to facilitate the request process and States Parties are free to use it, amend it or report using a different format should they so wish. Whatever form of request is used the inclusion of the justification and the implementation plan is mandatory.

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The government of <<Country name>>, a State Party to the International Health Regulations (2005) (IHR or Regulations), wishes to report to the WHO IHR Contact Point for <<WHO Region>> that <<Country name>> requests an extension to the Regulations.

The justification for our request is that more time is needed to ensure adequate capacity in the following areas:

[insert specific justification]

An implementation plan to achieve the national core capacities described in Annex1 of the Regulations is enclosed.

The government of <<Country name>> will report to WHO annually on the progress achieved.

Appendix 10: Outline of the proposed procedures to be followed by States Parties in order to obtain the two years extension to the target date for establishing national core capacities

The IHR define the requirements for obtaining an extension to be:

• A request to the WHO Secretariat containing a justification for the two years extension to the 2012 target date;
• An implementation plan (as referred to in Articles 5 and 13) to ensure that the core capacities are in place by the end of the two years extension period.

The IHR do not make any specific requirements regarding the contents of the implementation plan that must be included in the request for extension to the WHO Secretariat. It is possible, therefore, that existing national plans remain relevant for submission as the implementation plan. For example:

• A comprehensive National IHR Action Plan encompassing the core capacities detailed in Annex 1 that many States Parties have already developed on the basis of the capacity assessment described in paragraph 2. of Annex 1 (and which were due to be completed by 15 June 2009), or
• Plans of action referred to in Annex 1A. Core capacity requirements for surveillance and response; and/or
• Plan(s) of action for individual Points of Entry designated to establish the core capacity
detailed in Annex 1B. Core capacity requirements for designated airports, ports and ground
crossings.

To facilitate the formulation of the request for extension, States Parties are encouraged to
consider the following items while considering the format and contents of any implementation
plan being submitted.

• Areas of capacities to be addressed, including the description of current status and analysis of
gaps identified;
• Planned action, described as numbered objectives and their constituent activities, each
including start and completion dates as well as estimated cost;
• Identification of resource requirements, including planned investment from national funding
sources, any resource gaps, and plans for resource mobilization.

There are a number of technical resources available on the WHO website and from WHO
Regional Offices to support States Parties in their efforts to assess the core capacities and
develop the implementation plan in order to inform their decision on whether or not to request
the two years extension to the target date. Similarly, individual WHO Regional Offices might
propose mechanisms to States Parties in their Region to support this decision making process.

The request and the implementation plan(s) should be sent by the National IHR Focal Point
(NFP) to the WHO IHR Contact Point at the appropriate WHO Regional Office.

In order to avoid falling out of compliance with the Regulations in relation to the national
capacity obligations, the WHO Secretariat encourages all States Parties wishing to obtain an
extension to complete the process before 15 June 2012.

After receiving the request for the two years extension, accompanied by the justification and
implementation plan, the WHO Secretariat will inform the State Party via the NFP that the
extension has been obtained and indicate the new target date for the completion of the capacities.
Extensions will be for a period of two years usually starting from the current target date of 15
June 2012.

States Parties obtaining an extension will be reminded of the obligation to provide annual reports
on the progress made towards full implementation of the implementation plan to achieve the core
capacity required.

Further reminders of this process will be sent to States Parties six (6) months before and again
one (1) month before the target date.