World Health Organization

SIXTY-FIFTH WORLD HEALTH ASSEMBLY **A65/17 Add.1**
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Implementation of the International Health Regulations (2005)

Report on development of national core capacities required under the Regulations

Report by the Secretariat

1. In January 2012, the Executive Board at its 130th session noted a report on implementation of the International Health Regulations (2005).[1] In response to members' requests, the Secretariat undertook to prepare an update for the Sixty-fifth World Health Assembly on progress towards implementation of the Regulations, major obstacles to full implementation and the Organization's plans for providing support to States Parties.

2. According to Articles 5.1 and 13.1 of the Regulations each State Party shall develop, strengthen and maintain as soon as possible but no later than five years from the entry into force of the Regulations for that State Party, respectively: the capacity to detect, assess, notify and report events in accordance with the Regulations; and the capacity to respond promptly and effectively to public health risks and public health emergencies of international concern, respectively. Considering that the Regulations entered into force on 15 June 2007, as provided in Article 59, it is intended that core capacities required under the above-mentioned Articles 5 and 13 should be in place by 15 June 2012.[2] The Regulations indicate that extensions will be granted following a request from the State Party that includes a justification for the extension and an implementation plan. In September 2011 the Secretariat communicated to all States Parties and National IHR Focal Points regarding the approaching deadline and provided them with an outline of proposed procedures for obtaining an extension and a template for extension requests. These documents are posted on the password-protected web site for National IHR Focal Points and included as annexes to the document "Information to States Parties regarding determination of fulfilment of IHR Core Capacity requirements for 2012 and potential extensions".[3] A reminder was sent to National IHR Focal Points and Permanent Missions at the time of the 130th session of the Executive Board, and a further reminder is planned at the time of the Sixty-fifth World Health Assembly. After 15 June 2012 the Secretariat will provide information on those States Parties that have obtained extensions using the secure web site.

[1] See document EB130/2012/REC/2, summary record of the ninth meeting.

[2] There are exceptions to this target date, arising from the dates on which the Regulations entered into force for the States Parties concerned. These exceptions are: India, current target date 8 August 2012; Liechtenstein, current target date 28 March 2017; Montenegro, current target date 5 February 2013; and United States of America, current target date 18 July 2012.

[3] See http://www.who.int/ihr/legal_issues/ihr_core_capacity_2012/en/index.html (accessed 26 April 2012).

3. This report provides further analysis of the status of implementation in States Parties of national core capacities under the International Health Regulations (2005). It also identifies the major obstacles to full implementation and sets out the Secretariat's plans to support States Parties that have not yet achieved full implementation. The report takes into account a number of data sources, including the following: annual reports of States Parties submitted for inclusion in the reports by the Secretariat to the Sixty-fourth and Sixty-fifth World Health Assemblies,[1] responses received from the self-assessment questionnaire for monitoring implementation,[2] as well as regional reports prepared for a consultation between officers at headquarters and IHR Regional Officers held in Lyon in February 2012. As at 4 April 2012, 156 of 194 States Parties (80%) had reported to WHO.[3]

PUBLIC HEALTH BACKGROUND

4. Countries in all regions continue to face a wide range of public health events, which are recorded in WHO's Event Management System.[4] The System is used to record information, key operational decisions about disease events and actions taken during outbreaks that may be of international concern. It is not intended to be an exhaustive database of all outbreaks worldwide. The largest number of events recorded in the Event Management System over the past few years have been attributed to infectious hazards (influenza, dengue, chikungunya, imported measles and yellow fever). Many countries face recurring epidemics such as cholera, cerebrospinal meningitis, measles, dengue and viral haemorrhagic fevers. Wild poliovirus continues to circulate in some regions. An increasing proportion of events were food-safety related (of infectious or toxic origin) or involved zoonoses (influenza and rabies). Food safety is increasingly seen as an essential public health issue in some regions but the limited amount of information available makes it difficult to evaluate food safety-related problems and issues fully. Environmental factors also contribute to much of the disease burden. Two events recorded in the Event Management System were associated with radionuclear hazards.

IMPLEMENTATION MECHANISMS

5. States Parties are taking forward the implementation of the International Health Regulations (2005) through a variety of forums, including subregional integration initiatives such as MERCOSUR (the Common Market of the South) in the Americas, the European Commission, and regional strategies such as the Integrated Disease Surveillance and Response strategy in the African Region and the Asia Pacific Strategy for Emerging Diseases.

6. The Asia Pacific Strategy for Emerging Diseases, which involves the South-East Asia and Western Pacific regions, was initially developed in 2005 in order to confront emerging threats and promote public health security through preparedness, prevention, early detection and rapid response to emerging diseases and other public health events. The Strategy was revised in 2010, taking into account the achievements of the previous five years and the lessons learnt in confronting the emergence of avian influenza H5N1 and responding to pandemic influenza A (H1N1) 2009. Although it continues to place priority on emerging infectious diseases, the revised Strategy has an extended scope with eight focus areas: surveillance, risk assessments and response; laboratories; zoonoses;

[1] Documents A64/9 and A65/17.

[2] Sent to National IHR Focal Points annually for reporting on progress made in the development of core capacities. Also available online for States Parties at https://extranet.who.int/ihrportal/report.aspx?id=68 (accessed 26 April 2012).

[3] Numbers of reporting States Parties and percentages of reporting Parties per region are current as at 4 April 2012.

[4] Epidemic alert and verification: summary report 2006. *Weekly Epidemiological Record,* 2007, **82**(13):111–116.

infection prevention and control; risk communication; public health emergency preparedness; regional preparedness, alert and response; and monitoring and evaluation. A bi-regional workplan for the Strategy has also been developed to guide the development of national plans and to underpin the work of the regional offices.

7. At subregional level, efforts to reinforce core capacities have traditionally focused on the establishment and strengthening of subregional surveillance mechanisms for communicable diseases; laboratory networks; response mechanisms to specific risks; cross-border activities and points of entry-related initiatives; and the assessment and revision of national legal frameworks. Regional partners have been identified with defined roles and responsibilities to assist in implementation of the International Health Regulations (2005), including the deployment of regional multidisciplinary teams of experts, especially to assist with advocacy, assessment, capacity-building, monitoring and response.

OVERVIEW OF PROGRESS TO DATE

8. As reported previously,[1] much progress has been made in the building of all capacities (see paragraphs 18 to 42 below for a detailed regional analysis). Data from States Parties in 2011 show consistent improvement in the following core capacities: surveillance and detection of, and response to, food safety-related and zoonotic events. Generally, the International Health Regulations (2005) have been used to strengthen the role of the health sector. States Parties have identified public health preparedness work at points of entry, although still a challenge, as an opportunity to attract the attention of other sectors for the general implementation of the Regulations. Most reporting States Parties have passed legislation to implement the Regulations. Progress has also been made in strengthening capacity in the area of zoonotic diseases, with many States Parties establishing coordination mechanisms between animal and human health sectors to support detection and response in relation to zoonotic events. Achievements have also been notable in laboratory capacity, infection control, and risk communication. Monitoring and evaluation is a new focus area for national and regional capacity development, with an emphasis on country ownership and use of data for programme improvement.

CHALLENGES TO IMPLEMENTATION

9. A number of common challenges have been identified across all regions and are discussed briefly below. Some reflect gaps at the national level that will require greater focus by individual States Parties; others have emerged as common to all States Parties within a particular region. Certain gaps require support and intervention by external parties at the international level.

Financial and technical resources

10. It has proven challenging to characterize the short-term benefits of implementation and the return on investment for donors. It is difficult to measure and demonstrate directly the benefits of the International Health Regulations (2005) in terms of their health and economic impact. Resource mobilization for implementation faces a number of challenges, including dealing with the unpredictability of funding gaps for national workplans; providing assistance in technical areas without adequate support, and responding to the fact that some States Parties have no donor or partner to support them; generating support for the costs of human resources; aligning donor priorities with country needs; and attracting new partners. Underlying these challenges is a lack of national resources

[1] Documents A62/6, A63/5 and A63/5 Add.1, A64/9, A64/10 and A64/10 Add.1.

and a lack of core funding for the programme. The Organization's current financial situation means that it has limited capacity and human resources for the work that needs to be done for the implementation of the International Health Regulations (2005) globally.

11. Many States Parties are in the process of developing or updating national workplans. Effective implementation of these plans will require significant, sustainable financial investment on the part of national governments, as well as external support from donors and partners, throughout the coming years.

High-level political ownership

12. Successful implementation of the Regulations requires governmental commitment; it also depends on the mobilization of a number of sectors and actors that must take responsibility for compliance in their areas. Greater political leadership and oversight at the national level are also needed.

Legislative and regulatory mechanisms

13. The assessment and revision of legislation related to the Regulations require specific expertise and considerable person-hours. Many States Parties are still in the process of carrying out these activities.

Empowerment of National IHR Focal Points

14. Overall, National IHR Focal Points are insufficiently empowered and lack resources to perform their work, as noted by the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009.[1] They need authority for reporting, both within and beyond the health sector, mechanisms to ensure timely notification or verification to WHO as required, and stronger links to public health functions in other sectors and at points of entry. At the same time, States Parties need continuing guidance on the functions of Focal Points.

Awareness and advocacy efforts beyond the health sector

15. Much work has been accomplished in the area of awareness raising, including through meetings of National IHR Focal Points, the annual training course on the Regulations (the distance learning "IHR-i course"), and advocacy with many sectors during country assessments. However, awareness of the International Health Regulations (2005), of the key rights and obligations of States Parties across all sectors, and among donors and partners, remains insufficient. In addition to the high turnover of staff assigned to Regulations-related activities (and of National IHR Focal Points), experiences recorded by many States Parties show that there is a perception that the Regulations constitute a new discipline and not a tool for institutionalizing key public health functions and public health preparedness mechanisms; or that the Regulations are exclusively a responsibility of the health sector. Undertaking high-level advocacy efforts to promote the Regulations as a framework for national and global health security and the national action plans as a tool to mobilize and make better use of resources continues to be challenging. In addition, in some States Parties the overlapping across ministries of responsibilities for surveillance, response and preparedness results in poor coordination

[1] Document A64/10 Add.1.

and a lack of timely and systematic information sharing, and contributes to the uneven performance of surveillance and response mechanisms.

Human resources

16. Particularly large gaps exist in human resources. The recruitment, training and retention of staff across the eight core capacity areas remain a challenge throughout many regions. High turnover of staff within the health sector, including in the institutions designated as National IHR Focal Points, is hampering efforts to build sustained human resource capacity. In some States Parties with small populations and limited government capacity, it is common for one person to have to perform a range of duties, with multiple responsibilities. Despite the fact that insufficient human resources constitute a significant barrier to capacity building, donor funds often cannot be used to support salaries of staff at the national level.

Availability of guidance in local languages

17. The implementation process for the Regulations and day-to-day operations are greatly hampered by language barriers. In regions in which English is not the working language, translations of guidelines, documents, and training are urgently needed. Lack of language resources constitutes a serious impediment to the elaboration of context-specific training materials, case studies, and illustrative examples. The fact that WHO guidance documents, official communications, and tools are not all translated into the six official languages – largely as a result of resource constraints – continues to be a major obstacle to a common understanding of the provisions of the Regulations globally.

REGIONAL PROGRESS TO DATE AND PLANNED ACTIONS

African Region

18. Thirty-seven of the 46 States Parties (80%) have reported to WHO on the development of core capacities. Eight States Parties did not report on their core capacity status through the States Parties questionnaire in either 2010 or 2011, six States Parties have not carried out assessments and nine do not have plans for development of the core capacities required by the International Health Regulations (2005). Priority will be given to all the States Parties concerned.

19. Across the Region, surveillance systems have been improved and response capacities increased. The implementation process has also raised awareness of the need for increased capacity to respond to all types of hazard under the Regulations, including food safety-related, chemical or radionuclear events. This improvement includes a better awareness of the need to foster interaction between the different information-sharing and communications mechanisms of the responsible sectors. Regional analysis has revealed gaps and weaknesses in capacities related to legislation, preparedness, risk communication and human resources; and in the detection of, and response to (i) food safety-related, chemical and radionuclear events and (ii) public health emergencies, including at points of entry. Implementation of the International Health Regulations (2005) continues to compete with other priorities in the Region and to struggle against shortages in staff, funding and inadequate infrastructure. Lack of capacity in human resources across all areas of the Regulations is a barrier to implementation.

20. High priority will be given to tackling the gaps mentioned above in the regional plan. This will be achieved through the planning undertaken for subregional activities, during which individual States Parties will be also prioritized. Technical support will include field missions and regional and

subregional workshops for specific capacities. Emphasis will be placed on strengthening capacities in respect of: detection and response to radionuclear, food-safety related and chemical events or emergencies; legislation; risk communication; and public health preparedness and response. The capacities of States Parties to detect and respond to public health emergencies of international concern at points of entry will also be strengthened. At the same time, States Parties will need continuing support to strengthen or maintain their surveillance capacities to ensure timely detection, notification and reporting, laboratory-quality assurance, as well as biosafety and biosecurity best practices, outbreak response for, and coordination and empowerment of, National IHR Focal Points and human resources. The mapping of unmet needs and resources will help to support States Parties' efforts to mobilize resources for dealing with the gaps.

21. Support to WHO intercountry support teams for central, west, east and southern Africa – based in Libreville, Ouagadougou and Harare – will continue. Subregional organizations and intercountry surveillance networks need support in order to contribute to the attainment of goals for the Regulations in the Region. Special attention needs to be given to small islands in the Region.

Region of the Americas

22. Twenty-eight of the 35 States Parties (80%) have reported to WHO. At least 30 have conducted planning activities and have developed or updated plans. The following core capacities and areas have been identified as critical: human resources, preparedness, detection and response to chemical and radionuclear events and emergencies, and prevention, detection and response in relation to public health emergencies at points of entry.

23. In June 2011 the regional component of the Global Outbreak Alert and Response Network was established.

24. Access to WHO collaborating centres that can contribute to intersectoral preparedness should be increased (e.g. the WHO Collaborating Centre for Prevention, Preparedness and Response to Chemical Emergencies at Companhia Ambiental do Estado de São Paulo (CETESB) Sao Paulo, Brazil).

25. States Parties in the Caribbean subregion face challenges posed by unique geographical and demographic factors, as well as those stemming from limited resources. Mechanisms to maximize the benefits of viable subregional approaches need to be explored continuously; the Caribbean Public Health Agency may play a critical role in this. A priority in the Caribbean subregion will be the implementation of the IAEA–PAHO partnership project on strengthening the national infrastructure for radiation safety and security of radioactive sources in the Caribbean Community States.

26. Strengthening the leadership of national authorities in Central America while negotiating with subregional integration initiatives and multiple donors and partners is a priority.

27. Bilateral cooperation and the sharing of experiences among States Parties in South America will be promoted, in view of the heterogeneity of the capacities of States Parties in the subregion as well as the substantial progress on intersectoral collaboration made by certain States Parties. Similarly, the Regional Office for the Americas should promote the sharing at global level of the innovative approaches of some States Parties in the subregion in areas covered under the Regulations. A specific challenge will be the FIFA World Cup and Summer Olympics that Brazil will host in 2014 and 2016, respectively. These events should be taken as an opportunity to accelerate preparedness in the subregion.

South-East Asia Region

28. All 11 States Parties in the Region (100%) have reported to WHO. The main gaps concern detection and response capacities in relation to specific human health hazards, namely, chemical and radionuclear events.

29. Capacity building in surveillance and laboratory diagnosis are priorities for all States Parties. Considerable work needs to be undertaken to strengthen capacities in order to ensure resilience against chemical and radionuclear hazards. The strengthening of capacities at points of entry is also a high priority for many States Parties. Although significant progress has been made, this area continues to pose a challenge for States Parties with large numbers of designated ports and airports. Priority is also being given to supporting implementation in the more resource-constrained States Parties, including those with limited human resources. As in the Western Pacific Region, this work is guided by the workplan of the Asia Pacific Strategy for Emerging Diseases (2010).

30. In smaller States Parties, capacity strengthening for the International Health Regulations (2005) is constrained by a number of factors, including limited human resources and what appears to be a higher cost of implementation than elsewhere, compounded in some cases by insufficient financial and technical support. It is therefore important to prioritize regional support, focus on the inclusion of smaller States Parties in regional networks and seek innovative solutions, such as twinning projects.

European Region

31. Forty-four of the 55 States Parties (80%) have reported to WHO. Self-reported data show that the main weakness lies in the area of human resources.

32. Capacities at points of entry and those for risk communication need to be strengthened in all States Parties. The International Health Regulations (2005) need to be better integrated into generic national preparedness activities and plans. Multisectoral coordination and coordination between points of entry and the national level need to be improved. In particular, States Parties in the eastern part of the Region will benefit from awareness-raising activities for senior officials within the health sector and beyond in order to increase political commitment to IHR implementation of the Regulations. The relevant legislation also needs to be reviewed and operationalized in order to be relevant for day-to-day work. States Parties need to be encouraged to share and publish best practices.

33. Support will be given for the preparedness core capacity and for dealing with mass gatherings in the Region (e.g. Summer Olympic and Paralympic Games in London in 2012, and the Winter Olympic and Paralympic Games in Sochi, Russian Federation in 2014).

Eastern Mediterranean Region

34. Eighteen of the 22 States Parties (82%) have reported to WHO. Regional analysis shows that there is a delay in the development of national action plans, a lack of national frameworks that fulfil the wide scope of the International Health Regulations (2005) and a prevailing political instability in many States Parties in the Region.

35. The main weaknesses concern the following capacities: chemical event management and human resources, together with capacities at points of entry. Technical gaps have also been identified in the following core capacities and areas: event-based surveillance, response, preparedness, risk communication and laboratory (including biosafety and biosecurity); and the detection of and response to zoonotic, food safety-related, chemical and radionuclear events and emergencies.

36. The gaps mentioned above will be given high priority in the regional plan. This will be achieved through planning for subregional activities, during which individual States Parties will be also prioritized.

37. Technical support planned to be provided after 15 June 2012 includes advocacy missions and regional and subregional workshops for specific capacities. The Secretariat is working with States Parties in the Region to increase transparency and establish mechanisms for information sharing, using the framework of the Regulations. Coordination between key partners will be strengthened for detecting and responding to food safety-related, zoonotic, chemical and radionuclear events and emergencies.

38. Support is needed for the development of exercises to test and validate plans for building core capacities to implement the Regulations. Efforts are under way to improve liaison between national veterinary and national public health services.

Western Pacific Region

39. Eighteen of the 35 States Parties (67%) have reported to WHO. Good progress has been made in the following core capacities and areas: surveillance, response, coordination and risk communication, and detection of and response to zoonotic events. A number of areas require improvement, including preparedness and points of entry capacity. There is also a need to strengthen public health event and emergency management for non-infectious disease hazards.

40. Technical core capacities and areas selected as indicators that need to be strengthened as a priority include: indicator-based surveillance, risk assessment capacity, public health laboratory services, health emergency risk communication, public health emergency preparedness (including pandemic influenza preparedness, the establishment of an emergency operational centre in the health ministries, better defining of the functions of the National IHR Focal Point, public health emergency contingency planning for designated points of entry), regional surveillance and response capacity (including strengthening the Global Outbreak Alert and Response Network), and monitoring and evaluation capacity. Priority States Parties have been identified where further national efforts and external support are required. These States Parties are developing and implementing their updated workplans for managing emerging diseases and public health events and emergencies. As in the South-East Asia Region, this work is guided by the workplan of the Asia Pacific Strategy for Emerging Diseases (2010). The newly established monitoring and evaluation system under the Strategy reflects the need to build capacities for the implementation of the Regulations; in this context, it places a strong emphasis on meeting Member States' accountability requirements and learning needs.

41. Increased technical and financial support is required from WHO, donors and partners in facilitating development and implementation of national workplans. It is also vital for international assistance to be provided in a coordinated and consistent manner.

42. The development of the global monitoring tool for core capacities under the Regulations presents a significant challenge for the Pacific island States Parties. A tailored or adapted approach for the use of the tool and for capacity development is vital. This approach may include a Pacific-wide syndromic surveillance system, laboratory capacity strengthening through laboratory networking, and access to regional and international capacity in chemical and radionuclear emergency management.

Next steps

43. **Strengthening country ownership and work with States Parties in support of development.** WHO will continue to advocate for plans that are sustainable and will support health sectors to adopt multisectoral approaches. The Secretariat will provide support to States Parties that request an extension in finalizing their plans for establishing core capacities under the Regulations. WHO will provide further guidance on the roles and responsibilities of National IHR Focal Points.

44. The Organization will support States Parties in making critical assessments of the ways in which regional and subregional networks can assist them in implementing the International Health Regulations (2005). These networks and economic and technical subregional integration mechanisms need to be engaged in the implementation of regional strategies and national plans in ways that avoid duplication of effort and competition for funding.

45. **Increasing advocacy and awareness.** WHO will continue to build a sound evidence base in support of implementation, including through the development of outcome indicators and costing tools.

46. Communication will be improved to provide a clearer definition of the benefits of implementing the Regulations, including the benefits of event management at country level. Strengthened communication will also help to raise awareness of the importance of involving other sectors in implementation, especially with respect to their rights and obligations, roles and responsibilities and related legal frameworks. WHO will tailor its advocacy efforts as required by specific audiences (partners, donors and other stakeholders) and specific hazards (for example, those posed by chemical or radionuclear events). The Secretariat will support States Parties that are building operational links with other sectors.

47. **Strengthening resource mobilization.** The first step towards strengthening resource mobilization will be to map existing needs and gaps, based on national implementation plans that will be available after June 2012 for States Parties that request an extension. In the same way, partners will be engaged in mapping their potential contributions to technical and financial support. WHO will also assist the matching of technical and financial resources to technical areas of work and country needs.

CONCLUSION

48. The first deadline for implementation of the International Health Regulations (2005) – 15 June 2012 – is drawing near and States Parties are providing more detailed information in their implementation plans, including highlighting the capacities that are most in need of strengthening. The Secretariat will therefore be able to provide a more detailed analysis that matches needs with support, and will continue to support States Parties in monitoring their progress. The Secretariat will also develop a plan for providing States Parties that request the two-year extension, with support for specific action plans for the period 2013–2014.

49. The Secretariat will consider the best mechanism to agree on indicators for the evaluation of country status, as required for the June 2014 deadline.

ACTION BY THE HEALTH ASSEMBLY

50. The Health Assembly is invited to note this report.

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