INTERNATIONAL HEALTH REGULATIONS (IHR) ASSESSMENT FOR HUMAN HEALTH

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International Health Security ... 1980 - 2015

- HIV/AIDS
- Tchernobyl
- Plague
- Ebola / Marburg
- NvCJD
- Nipah
- Anthrax
- SARS
- Meningitis
- Cholera
- Chemical spills
- Avian Flu
- MERS CoV
May 1995, decision to revise IHR

May 2005, adoption of IHR (2005)

June 2007, entry into force of IHR
International Health Security
IHR(2005), a paradigm shift

From control of borders to containment at source

From diseases list to all threats

From preset measures to adapted response
Purpose of the IHR (2005)

"to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade"
“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 (…), the capacity to detect, assess, notify and report events in accordance with these Regulations… and ... the capacity to respond promptly and effectively…”

IHR (2005), articles 5 and 13
Timelines
Depend on both National and Global Efforts

Event onset

Median 15 days

WHO Alert

Median 7 days

Verification

12-24 hrs

Mobilisation within 24-72 hrs

Risk assessment

Intervention

Event detection

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Two main areas for implementation

► **Global** "event" management
  - Global information system
  - Coordination of international response

► **National** core capacity requirements
  - National surveillance and response systems
  - Capacity at points of entry
    (Ports, airports, ground crossings)
IHR: A Global System for Information Sharing

- Notification
- Reports
- Consultation
- Verification

National IHR Focal Point
(One per State Party)

Event Information Site (EIS)

WHO IHR Contact Point
(One per WHO Region)

Global Capacities, Alert and Response

World Health Organization
Core Capacity Requirements (national, intermediate and local)

Annex 1

8 Core Capacities
- Legislation and Policy
- Coordination
- Surveillance
- Response
- Preparedness
- Risk Communication
- Human Resources
- Laboratory

Potential hazards
- Infectious diseases
- Zoonotic events
- Food safety
- Chemical events
- Radiological events

Events at Points of Entry
Timeline for implementation

15 June 2007
IHR 2005 enters into force. States Parties agree on 5 year timeframe for implementation of core capacities

2014
Possibility for further 2 year extension, however not automatic.

Deadline for implementation of core capacities.
Two year extension granted on submission of plan of action
Tools for monitoring IHR Implementation

- Checklist of Indicators
- States Parties Questionnaire
- Online IHR Monitoring Tool
  - Data collected once a year — self reported
  - Can be updated at any time
  - Data collected through IHR NFP
  - WHO Facilitated process
- To access the IHRMT online tool please go to the IHR Portal at http://extranet.who.int/ihrportal
IHR Monitoring: 20 WHA Indicators

1. Legislation, laws, regulations, administrative requirements, policies or other government instruments in place are sufficient for implementation of IHR.

2. A mechanism is established for the coordination of relevant sectors in the implementation of IHR.

3. IHR NFP functions and operations are in place as defined by the IHR (2005).

4. Indicator based, surveillance includes an early warning function for the early detection of a public health event.

5. Event based surveillance is established.

6. Public health emergency response mechanisms are established.

7. Infection prevention and control (IPC) is established at national and hospital levels


9. Priority public health risks and resources are mapped.

10. Mechanisms for effective risk communication during a public health emergency are established.

11. Human resources available to implement IHR core capacity requirements

12. Laboratory services are available to test for priority health threats

13. Laboratory biosafety and laboratory biosecurity (Biorisk management) practices are in place.

14. General obligations at PoE are fulfilled.

15. Effective surveillance and other routine capacities is established at PoE.

16. Effective response at PoE is established

17. Mechanisms for detecting and responding to zoonoses and potential zoonoses are established.

18. Mechanisms are established for detecting and responding to foodborne disease and food contamination.

19. Mechanisms are established for the detection, alert and response to chemical emergencies.

20. Mechanisms are established for detecting and responding to radiological and nuclear emergencies.
Global Achievement of core capacities 2014
Key achievements in IHR implementation

- Establishment of National IHR Focal Points (24/7)
- Increased transparency in reporting events, using early warning systems more systematically
- Better communication and collaboration between animal and human health sector (lessons learnt from H5N1 applied to H7N9)
- Coordinated collective efforts of countries and partners to build capacities (e.g. APSED, IDSR)
- Establishment of Emergency Response coordination structures
- Better international mechanism to share information for rapid response
Key impediments to IHR implementation

- Insufficient authority/capacity of IHR National Focal points
- Implementation of IHR considered as the sole responsibility of Ministries of Health
- Limited national financial and human resources investment, high staff turnover
- Insufficient awareness of other sectors
- On-going complex emergencies/conflict
- Specificity of small islands States Parties and Overseas territories
- Focus on extensions rather than expansion of capacities
- IHR «implementation» understood as rigid and legal process with not enough operational implication, and not enough learning from experience
- Limited international solidarity to support weakest countries in building their capacities
Rec 5 for States Parties action:

- Operational approach & practical solutions to surveillance, laboratories → early warning alert and response systems/laboratory networks
- Risk approach to prioritise health threats, capacity gaps and identify priority points of entry for designation and capacity building

Rec 7: Move from checklist approach to a more action-oriented approach to periodic evaluation of functional capacities

- Methodologies that can assess quality and functional performance & systematic review of SPs and regions response to disease outbreaks
- SPs urgently to strengthen self-assessment system, implement in-depth review of diseases outbreaks
Way forward –WHO action

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Process for developing an improved IHR M&E framework is proposed for discussion at WHO governing bodies (regional committees 2015)
Thank you

www.who.int/ihr