IHR and the Core Capacity Requirements for Points of Entry

Dr Luo Dapeng

5th Meeting of CAPSCA Asia Pacific (CAPSCA-AP)

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Outline of presentation

- International Health Regulations (IHR) 2005
- Asia Pacific Strategy for Emerging Diseases (APSED)
- Current Status of implementation of Points of Entry (POE) in the Region
- WHO IHR assessment Tool for Core Capacity requirement at POE
- WHO guide for public health emergency contingency planning at POE
Why the IHR(2005)?

In today’s world, diseases travel fast and no single country can protect itself on its own...

Acknowledging this, the 193 WHO Member States unanimously adopted a new version of the International Health Regulations (IHR)...

“...the world to translate the new code of the Regulations into the reality of greater international public health security...”

Dr Margaret Chan, WHO Director-General
What are IHR (2005)?

- **A global legal framework** for protecting international public health security
- Represent the joint commitment for **shared responsibilities** and **collective defence** against disease spread
- **Legally binding** for 194 countries since June 2007
“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” – Article 2
IHR(2005): a paradigm shift

From control of borders to (also) containment at source
From diseases list to all acute public health threats
From preset measures to adapted and real-time response
**8 Core Capacities**

- Legislation and Policy
- Coordination
- Surveillance
- Response
- Preparedness
- Risk Communications
- Human Resources
- Laboratory

**Potential hazards**

- Infectious
- Zoonosis
- Food safety
- Chemical
- Radio nuclear

**Events at Points of Entry**

**IHR 2005 - National Core Capacity Requirements**
Designating POE...

• **Factors to be considered when designating:**
  
  – Volume and frequency of international travellers and traffic
  
  – Population density in and around the POE
  
  – Public health risks (risk analysis of the route used for travellers)
  
  – Existing facilities and capacities to manage public health risks
  
  – Others...
IHR 2005 Core Capacity Requirements for Designated POE

• Designation of POE under IHR (2005)
  – Designation of international airport(s) and port(s) – mandatory (“shall”)
  – Designation of ground crossing(s) – optional (“may”)

• Two types of the IHR core capacities required:
  – At all times: *routine public health functions*
  – Responding events that may constitute a *public health emergency of international concern (PHEIC)*
Routine Public Health Functions

- Access to appropriate medical services for assessment and care of ill travelers
- Inspection of conveyances – including ship sanitation and aircraft inspection
- Safe environment for travelers – potable water, safe food, public washrooms, waste disposal services
- Vector and reservoir control
Responding to PHEIC events

- Establishment and maintenance of a public health emergency contingency plan (PHECP)
- Arrangements with existing facilities for assessment, quarantine, isolation and treatment services, as needed
- Arrangements and updated guidelines for applying recommended measures – disinfection, deratting, disinsection, decontamination
- Preparation for entry or exit controls
Two Focuses

► Prevention (routine)
- Access to medical service
- Transport of ill travellers
- Inspection of conveyances
- A safe environment for travellers
- Control of vectors / reservoirs

► Emergency Preparedness and Response
- Public Health Emergency contingency plan
- Arrangement for treatment and isolation
- Arrangement for interview / quarantine
- Apply specific control measures
• IHR (2005) entered into force in 2007

• APSED serves as a roadmap to guide all countries in the regions towards meeting the IHR (2005) core capacity requirements, thus ensuring regional and global health security.
APSED Five Strategic Objectives

1. Reduce the risk of emerging diseases
2. Strengthen *early detection*
3. Strengthen *rapid response*
4. Strengthen effective preparedness
5. Build technical *partnerships*
Structure of APSED (2010)

Vision
An Asia Pacific region prepared to mitigate the risk and impact of emerging diseases and other public health emergencies through collective responsibility for public health security.

Goal
To build sustainable national and regional capacities and partnerships to ensure public health security through preparedness planning, prevention, early detection and rapid response to emerging diseases and other public health emergencies.

Objective 1
Reduce risk

Objective 2
Strengthen early detection

Objective 3
Strengthen rapid response

Objective 4
Strengthen effective preparedness

Objective 5
Build sustainable partnerships

Focus Areas
- Surveillance Risk Assessment and Response
- Laboratories
- Zoonoses
- Infection Prevention and Control
- Risk Communications
- Public Health Emergency Preparedness
- Regional Preparedness, Alert, and Response
- Monitoring and Evaluation
APSED (2005) 8 Focus Areas

1. Surveillance and Response
2. Laboratory
3. Zoonoses
4. Infection Control
5. Risk Communication

APSED (2010) 8 Focus Areas

1. Surveillance, Risk Assessment and Response
2. Laboratory
3. Zoonoses
4. Infection Prevention and Control
5. Risk Communication
7. Regional Preparedness, Alert and Response
8. Monitoring and Evaluation

POE Preparedness
POE public health emergency preparedness

• *Emergency planning:*
  – Developing, exercising and maintaining a PHECP at designated POE

• Improving “*readiness*”
  – An ongoing, continuing process for capacity building...
  – Examples: link with Emergency Operation Centre (EOC), risk assessment capacity
Where are we in terms of meeting IHR (2005) requirements at POE?
Global Core Capacity 2010

- Legislation: 18% Level 3, 18% Level 2, 10% Level 1, 10% Level <1
- Coordination: 28% Level 3, 15% Level 2, 59% Level 1, 10% Level <1
- Surveillance: 11% Level 3, 21% Level 2, 76% Level 1, 10% Level <1
- Response: 9% Level 3, 41% Level 2, 23% Level 1, 10% Level <1
- Preparedness: 11% Level 3, 59% Level 2, 22% Level 1, 10% Level <1
- Risk Communication: 14% Level 3, 54% Level 2, 17% Level 1, 10% Level <1
- Human Resources: 10% Level 3, 57% Level 2, 17% Level 1, 10% Level <1
- Laboratory: 9% Level 3, 47% Level 2, 34% Level 1, 10% Level <1

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Figure 72: Designated PoE can apply recommended public health measures as required in the IHR as of 2010

- Globally, over 60% of countries report that their designated PoEs can apply recommended public health measures as required in the IHR, with the percentage ranging from 50% for SEAR to 70% for WPR.

- Over 55% of countries in all regions report that their designated PoE can provide assessment and quarantine of suspect travellers and care for affected travellers or animals.
Overview of Designated POEs (till 21 Oct, 2011)

Designated PoE

AFRO, 188
AMRO, 129
EMRO, 73
EURO, 284
SEARO, 19
WPRO, 431
Key Issues in the WPR

- Need for prioritization of POE designation
- Utilization of the existing national and local public health systems and services to support POE public health functions (e.g. vector control)
- Only 50% of designated POE having a public health emergency contingency plan (PHECP) developed
- Communications and collaboration with the National IHR Focal Point vital
- Collective efforts for a regional mechanism that benefits all
What are the Core Capacities We are Looking for in Conformity with IHR?
International Health Regulations (IHR)

Ports, airports and ground crossings

While international travel and trade bring many health benefits linked to economic development, they may also cause public health risks that can spread internationally at airports, ports and ground crossings through persons, baggage, cargo, containers, conveyances, goods and postal parcels.

The IHR (2005) provide a public health response in the form of obligations and standing or temporary non-binding recommendations in ways that avoid unnecessary interference with international travel and trade.

States Parties to the IHR (2005) must strengthen public health capacities at designated airports, ports and ground crossings in both routine circumstances and when responding to events that may constitute a public health emergency of international concern.

IHR authorized list of ports
List of ports and other information

PAGNet
About PAGNet

Guidance, advice and tools
Assessment tool for core capacity requirements at designated airports, ports and ground crossings

The tool presents capacities expected in place

A) Core capacity requirements for coordination, communication of event information and adoption of measures (in regard to activities concerning designated airports, ports and ground crossings, according to annex 1A)

This first part is for assessing the establishment of a communication/coordination structure between competent authorities at points of entry, and with the National IHR focal point, and health authorities at the national, intermediate and local levels, some of the requirements in Annex 1A of the Regulations.

<table>
<thead>
<tr>
<th>Core Capacities</th>
<th>MEASURE OF COMPLIANCE</th>
<th>Stage of Implementation (Note: not applicable)</th>
<th>Description of Implementation of Core capacities under a law or regulations (e.g. programs, plans and procedures) or organizational change (e.g. creation of new entities, etc.)</th>
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<tbody>
<tr>
<td>1. International communication link with competent authorities at other points of entry</td>
<td>Daily, Weekly, Annually</td>
<td>Ensure that the competent authority at each point of entry has a contact person at each other point of entry, with the authority at the national level, for rapid and effective communication.</td>
<td>The competent authority at other points of entry will provide relevant information to the competent authority at the national level, and vice versa.</td>
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<td>2. National communication link between competent authorities at Health authorities at local, intermediate and national levels</td>
<td>Daily, Weekly, Annually</td>
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B) Core capacity requirements for designated airports

1) At all Times (Routine)

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<td>1. Access to medical and diagnostic facilities</td>
<td>Daily, Weekly, Annually</td>
<td>Ensure that the competent authority at each point of entry has a contact person at each other point of entry, with the authority at the national level, for rapid and effective communication.</td>
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<td>2. Key information regarding medical and diagnostic facilities</td>
<td>Daily, Weekly, Annually</td>
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II - For responding to events that may constitute PFHEC3 (Emergencies)

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<td>1. Public health contingency plan</td>
<td>Daily, Weekly, Annually</td>
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Moving from \textit{pandemic influenza response planning} towards \textit{generic public health emergency contingency planning (PHECP)}
WHO Guide on PHECP

- Purpose and scope of POE emergency planning
- Guiding principles and key planning consideration
- Recommended structures
- Recommended steps to develop a PHECP for a designated POE
Key Planning Considerations

“The considerations with the most impact on success or failure of a response”

1. Communication
2. Relationships
3. Command & Control Structures
4. Decision Support / Making
5. People & resources
6. Interoperability of Plans

7. Additional Planning Considerations
   - Risk profile (national, local, POE)
   - Policies & Legislation (national, local)
   - Mandatory requirements of other bodies eg. ICAO
Strategic relations...
Operational relations...

- **Points of Entry**
  - Mechanisms for command, communication and coordination:
    - Event communication
    - Collaborative investigation
    - Coordinated response (e.g. screening, examination)

- **Arrangements**:
  - Quarantine
  - Conveyance inspection
  - Vector control
  - Disinfection, disinsection, etc.

- **Hospitals and facilities**

- **Public health authority: National Surveillance and Response system**

- **National IHR Focal Point**
Example: Command and Control Structure...
Recommended Steps to Developing a PHECP

“Develop a plan that is realistic & sustainable for the POE taking into account existing and surge capacity, requirements and resources available”

1. Establish a planning team
2. Prepare for Planning phase
3. Initiate the planning phase
4. Write the plan
5. Review the plan
6. Test the plan
7. Stakeholder sign-off
8. Publish and communicate
9. Brief and train required personnel
10. Schedule regular exercises
11. Review, update and maintain as required
Operational response section

- Command & Control Structures
  - Who is accountable
- Roles & responsibilities
- Formal alert codes or phases (if used)
  - Different response postures / actions
- Initial actions or protocols
  - Who does what, when
  - Decision making process -
- Activation / Deactivation / EOC
  - Triggers
- Border measure / intervention decision matrix
  - Thresholds / triggers
Recommended Structure of a PHECP

POE Operational Response

- The EOC

- EOC Manager & team functions
  - Operations
  - Logistics
  - Planning & Intelligence
  - Liaison & Communications
  - Administration & Finance
  - Technical Advisory Teams
  - Public Health official
Supporting information (Annexes)

• Contact information / lists
• Maps of operational areas
• Standard Operating Procedures (SOP’s) / Protocols
  – Activating and staffing the EOC
  – Reporting & briefing templates
  – Single inbound / multiple inbound aircraft
  – Managing suspected and infected travelers
  – Reconfiguration of operational areas
  – Quarantine and processing process
  – etc.

• EOC / team Task Folders
• Forms & Templates
• Risk assessment & technical assessment
• Other plans / linked protocols, policies
Thank you