

Progress in Implementation of International Health Regulations (2005) - Country Profile 2012: BAHRAIN

As we approached the 5 year target date of June 2012 by which State Parties (SPs) agreed to have full implementation of the IHR core capacities, most of the Eastern Mediterranean SPs have requested a two year extension for the implementation of the IHR and have also submitted their plans of implementation to achieve full implementation by the new deadline of 15 June 2014.

In accordance with resolution WHA65.23, SPs and WHO are to ensure identification of remaining gaps and to take the necessary steps to ensure the required strengthening, development and maintenance of the core public health capacities and to report to the WHA 66 and 67 through its executive boards on progress made in IHR implementation.

For this purpose, a country profile was developed to provide an overview of the progress achieved by each SP and the way forward as reported and assessed through IHR monitoring tool; reports of IHR missions carried out to each SP to assess the core public health capacities required by the IHR; and the plans of implementation submitted by each SP to achieve full implementation of IHR capacities during the two year extension. The results of the analysis is described for each capacity of the IHR eight core capacities, capacity requirements for the Points of Entry and for the IHR four- related hazards.

IHR capacity requirements for surveillance and response

A. ACHIEVEMENTS

National legislation, policy and finance: Assessment of relevant legislation, regulations, administrative requirements and other government instruments for IHR implementation has been conducted. Review of national policies to facilitate IHR NFP functions and IHR technical core capacities have been carried out; and implementation of the outcomes of the review has been implemented.

Coordination and national focal point communication: The IHR NFP has been established and information on obligations of the NFP under IHR has been widely disseminated. National stakeholders responsible for the implementation of IHR have been identified with defined roles and responsibilities. A multisectoral body has been established to address IHR requirements and coordination and communication mechanisms among sectors on events that may constitute a PHEIC have been tested. SOPs for coordination between IHR NFP and relevant sectors have been developed. The IHR Event Information Site (EIS) is currently used as an integral part of the IHR NFP information resource; and the IHR NFP provides WHO with updated contact information and with annual confirmation of the IHR NFP.

Surveillance: specific units have been designated for surveillance of public health risks. A list of priority diseases, conditions and case definitions for surveillance is identified; and surveillance data on epidemic prone and priority diseases is analyzed weekly. Regular feedback of surveillance results is disseminated to all levels and other relevant stakeholders. Arrangements with neighboring countries to share data on surveillance and the control of a PHEIC are in place.

Specific unit for event based surveillance has been established with available SOPs. Information sources for public health events have been identified; and a system is in place for capturing public health events from a variety of sources. The decision instrument in Annex 2 of the IHR is properly used to notify WHO; and the IHR NFP responded to all verification requests from WHO.

Response: A functional command and control operations centre is in place; and resources for rapid response during public

health emergencies are accessible. Public health emergency response management procedures are established for command, communications and control and have been evaluated after a real or simulated public health response. Evaluation of the response including timeliness and quality has been carried out. Multidisciplinary Rapid Response Teams to respond to events have been established at central level with SOPs for their deployment. Case management guidelines for priority conditions are available.

Surveillance of health-care-associated infections and surveillance of anti-microbial resistance have been established. SOPs, guidelines and protocols for IPC are available to hospitals. All tertiary hospitals have designated area and defined procedures for the care of patients requiring specific isolation precautions with qualified IPC professionals. Evaluations of the infection control measures and their effectiveness are carried out regularly.

Preparedness: An assessment of the capacity of existing national structures and resources has been carried out and a national plan has been developed to meet IHR core capacity requirements. The national public health emergency response plan incorporates IHR related hazards and PoE and has been tested in actual emergency. Strategies are in place to reallocate or mobilize resources to support actions at primary response level with an adequate surge capacity to respond to public health emergencies.

A plan for management and distribution of national stockpile is available and stockpiles are accessible for responding to emergencies. Bahrain has access to experts in health and other sectors to support a response to IHR-related hazards. Bahrain contributes to international stockpiles.

Risk communication: Risk communication stakeholders have been identified; and a risk communication plan has been developed. The risk communication plan are tested and updated regularly. Updated information sources are accessible to media and the public for information dissemination. SOPs on the clearance and release of information during a public health emergency have been developed. Accessible and relevant IEC materials tailored to the needs of the population are available;

and populations and stakeholders are rapidly informed of a real or potential risk. An evaluation of the public health communication has been conducted after emergencies.

Human resources: A unit that is responsible for the development of human resource capacities has been identified; needs assessment have been conducted to identify gaps in human resources and training to meet IHR requirements. A training plan that includes human resource requirements for IHR has been developed.

Laboratory: A policy to ensure the quality of laboratory diagnostic capacities exists; and network of laboratories to meet diagnostic and confirmatory laboratory requirements is identified. External quality assessment schemes for major public health disciplines have been implemented for diagnostic laboratories. Guidelines on biosafety and biorisk at laboratories have been developed and made accessible to laboratories; and a responsible person has been designated for laboratory biosafety.

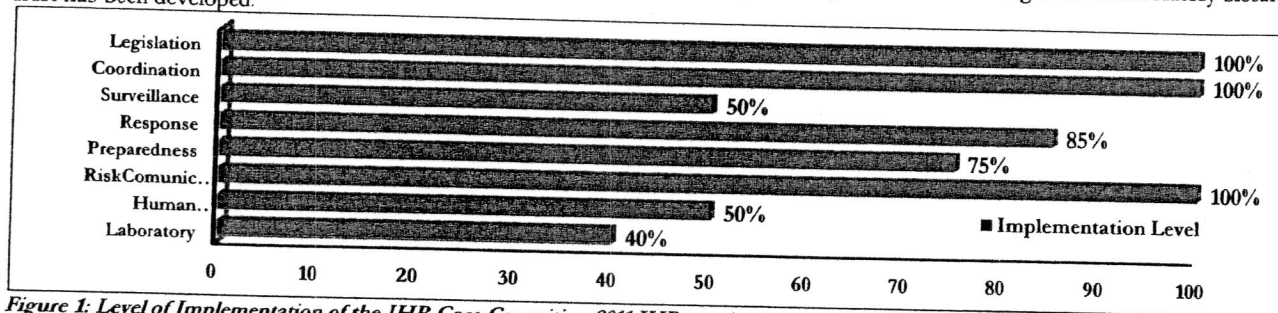


Figure 1: Level of Implementation of the IHR Core Capacities, 2011 IHR monitoring tool

B. Areas of Work: IHR Eight Core Capacities

EMRO
Support
(Date)

1. NATIONAL LEGISLATION

- Development of a national public health law based on all existing laws, provisions and other legal documents involving other sectors and institutions to facilitate IHR NFP functions and IHR technical core capacities.

2. COORDINATION AND IHR NATIONAL POINT COMMUNICATION

- Establishment of a multidisciplinary body (Task Force) to address IHR requirements on surveillance and response for public health emergencies.
- Strengthening coordination mechanisms among the different stakeholders with regular evaluation.
- Widely dissemination of information on obligations of the IHR NFP has been disseminated to relevant national authorities and stakeholders.
- Carry out an annual update on the status of the IHR implementation across all relevant stakeholders.

3. SURVEILLANCE

- Define baseline estimates, trends, and thresholds for alert and action for the primary response level for priority diseases/ events
- Enforce timely reporting from all health units at central and peripheral levels.
- Carry out evaluations of the early warning function of the indicator based surveillance.
- Develop SOPs and guidelines for event capture, reporting, confirmation, verification, assessment and notification.
- Engage the community as a source of information for capturing public health events

4. RESPONSE

- Intensify and expand training of the RRT at central and peripheral levels.
- Development of a national infection prevention and control policy and implementation of operational plans

5. PREPAREDNESS

- Assess national risk to identify potential urgent public health event, and the most likely sources of these events
- Map out national resources for IHR relevant hazards and priority risks.

6. HUMAN RESOURCES

- Expand and intensify the human resources- related activities to meet the workforce numbers and skills in line with milestones set in the training plan.
- Develop a plan to access field epidemiology training.
- Establish specific programs, with allocated budgets, to train workforces for IHR-relevant hazards.

7. LABORATORY

- Establish an inventory of public and private laboratories with relevant diagnostic capacity available.

- Establish a full biorisk management program and identify an institution or person responsible for inspection of laboratories for compliance with biosafety requirements.

IHR Capacity Requirements for the Points of Entry and the four IHR-related Hazards

A. Achievements

Points of Entry: 1 port and 1 airport have been identified as designated PoE. Assessment of the designated PoE has been conducted. Legislation and regulations have been updated and implemented at designated PoE. The list of ports authorized to offer certificates relating to ship sanitation has been identified and shared with WHO.

Priority conditions for surveillance have been identified at designated PoE. Surveillance information at designated PoE is shared with the surveillance department. The designated PoE has communications procedures established and a mechanism for the exchange of information between designated PoE and medical facilities is in place. The designated PoE have access to appropriate medical services including diagnostic facilities for the prompt assessment and care of ill travelers and with adequate staff, equipment and premises. The designated PoE have an inspection program to ensure safe environment at facilities and have a functioning programme for the surveillance and control of vectors and reservoirs in and near PoE.

SOPs for response at designated PoE are available. The designated PoE has an established and maintained public health emergency contingency plan to provide public health emergency response; have appropriate space, separate from other travelers, to interview suspect or affected persons; can apply entry or exit controls for arriving and departing travelers and other recommended public health measures.

Capacity Requirements for zoonotic events: Coordination exists within the responsible government authority for the detection of and response to zoonotic events. A focal point responsible for animal health has been designated for coordination with the IHR NFP. Bahrain has access to laboratory capacity to confirm priority zoonotic events. The community is involved in the surveillance of zoonotic diseases.

Capacity requirements for food safety events: Standards for food safety are available. National food laws and regulations are in place to facilitate the control of food safety. A coordination mechanism has been established between the food safety authorities and the IHR NFP. Mechanisms for multisectoral collaborations for food safety events are in place. List of priority food safety risks is available and guidelines on the surveillance, assessment and management of priority food safety events have been developed. Epidemiological data related to food contamination are systematically collected and analyzed. Services for risk-based food inspection is in place. Bahrain has access to laboratory capacity to confirm priority food safety events. Systematic and timely exchange of information between food safety authorities, surveillance units and other relevant sectors is in place. Operational plan for responding to food safety events has been tested in an actual emergency or simulation exercise. Mechanisms to trace, recall and dispose of contaminated products have been established; and

communication mechanisms are in place to deliver information to stakeholders. Systems for food safety control management have been implemented and information from foodborne outbreaks and food contamination has been used to strengthen food management systems, safety standards and regulation.

Capacity Requirements for Chemical events: Experts been identified for public health assessment and response to chemical incidents. National authorities responsible for chemical events have a designated focal point for coordination and communication with the ministry of health and/or the IHR National Focal Point. An inventory of major hazard sites and facilities that could be a source of chemical public health emergencies has been developed. An emergency response plan that defines the roles and responsibilities of relevant agencies is in place for chemical emergencies and has been tested through occurrence of real event or through a simulation exercise. Laboratory capacity or access to laboratory capacity has been established to confirm priority chemical events; an

Capacity Requirements for radio-nuclear events: Experts been identified for public health assessment and response to radiological and nuclear event. National plans for the detection, assessment and response to radiation emergencies has been developed. A functional coordination and communication mechanism between relevant sectors has been established. A focal point has been designated by the national authorities responsible for radiological and nuclear events for coordination and communication with the ministry of health IHR NFP. A system for monitoring of radiation emergencies and for informing exchange between relevant sectors is in place. A system for systematic information exchange between radiological competent authorities and human health surveillance units about urgent radiological events and potential risks is in place. A radiation emergency response plan has been developed; and radiation emergency response drills have been carried out. Bahrain has to access health facilities with capacity to manage patients with radiation emergencies is in place; and access to laboratory capacity to detect and confirm the presence of radiation and identify its risk.

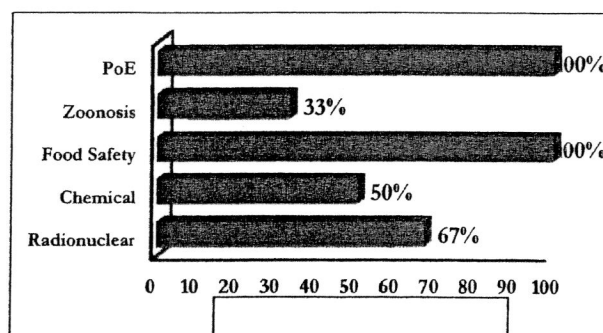


Figure 2: Level of Implementation of IHR capacity requirements for the PoE and the IHR four-related hazard, 2011 IHR monitoring tool

B. Area of Work: IHR Capacity Requirements for the Points of Entry and IHR four- Related HazardsEMRO
Support
(Date)**1. IHR requirements for the Points of Entry (PoE)**

- Implementation of the outcomes of assessment of relevant legislation and regulations for IHR implementation
- Conducting an in depth of legislation applied at PoE.
- Establish a joint designation of PoE for core capacity development between countries.
- Review surveillance of health threat at designated PoE.
- Evaluate the effectiveness of response to public health events at PoE.

2. IHR requirements for the four IHR- related Hazards**2.1 ZOOONOSIS**

- Develop a national policy and guidelines for the surveillance and response to zoonotic events.
- Establish intersectoral collaborations that include animal and human health surveillance units and laboratories.
- Animal health laboratory should be supported with enough budget, equipments and supplies to assist in building capacities needed for zoonotic disease control
- Establish a system for systematic and timely collection of zoonotic data and exchange of information between animal surveillance units, laboratories, human health surveillance units and other relevant sectors.
- Establish a roster of experts that can respond to zoonotic events.
- Establish a mechanism for timely response to outbreaks of zoonotic diseases by human and animal health sectors.

2.2 CHEMICAL

- Development of manuals and SOPs for chemical event surveillance, alert and rapid assessment and strengthen coordination mechanisms with relevant sectors for surveillance and response.
- Development of a list of priority chemical events/syndromes that may constitute a PHEIC.
- Development of manuals and SOPs for chemical event case management and control.
- Establishment of a system for information exchange between appropriate chemical units, surveillance units and other relevant sectors about urgent chemical events and potential chemical risks.
- Establishment of an adequately resourced Poison Centre.

2.3 RADIONUCLEAR

- Development of national policies, strategies or plans for national and international transport of radioactive material and samples.
- Development of SOPS and guidelines for risk assessment, reporting, confirmation and notification, investigation and management of radiation emergencies
- Establishment of a mechanism to access health facilities with capacity to manage patients of radiation emergencies.
- Establishment of mechanism to access specialized laboratories to perform specialized radio-nuclear laboratory testing.



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Division of Communicable Diseases
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