Kingdom of Bahrain
Ministry of Health
Public Health Directorate
International Health Regulations (IHR)

مملكـــة البحـــرين
وزارة الصحـــة
إدارة الصحـــة العامـــة
اللوائـــــح الصحـــــية الدولـــــية

# National Plan of Action Implementation of the International Health Regulations 2005 (IHR) Bahrain

2011-2012

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# ***National Plan of Action for Implementation of IHR 2005***

## Introduction

The continuing increase in worldwide travel has led to an increased threat and risks that are of public health concern. Therefore, the overall purposes of health activities at international terminals are to manage health risks associated with the movement of people and goods through air, sea and land travel, and for managing the medical needs of travelers and others employed at, or visiting ports. While notification to WHO under the IHR (1969) focused only on 3 diseases (cholera, yellow fever and plague), the scope of notification under IHR (2005) is broaden to include a wide range of international public health risks such as biological, chemical, radio-nuclear and food contamination.

International Health Regulations (2005) are a set of legally binding regulation for all WHO member states which helps countries working together to prevent, protect against, control and respond to the international spread of disease while avoiding unnecessary interference with international traffic and trade. These regulations are also designed to reduce the risk of disease spread at international airports, ports and ground crossings. These regulations entered into force on 15 June 2007 and are binding on 194 countries across the world, including all World Health Organization (WHO) Member States.

World Health Organization's International Health Regulations 2005 state purpose is **"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"**, so these regulations ensure global health security.

Bahrain has recognized the importance of collective inter-sectorial action to manage health emergencies. If this fails to act, or act independently, it will result in a less than optimal response that will increase the harms to their citizens and disrupt the global economy. Compliance with the revised International Health Regulations is a critical step toward preventing this from happening. The National IHR committee, a key advocate for the regulations, should lead the way both by demonstrating its own compliance with the regulations and by championing their implementation in the country.

## Bahrain IHR Vision

The vision of the Bahrain IHR is to "**minimize the health, economic and social impact of any public health emergencies of international concern**."

It goes with the Bahrain vision 2030 "**The Bahrain Economic Vision 2030 is a long-term economic development plan that outlines the future path for the development of The Kingdom of Bahrain's Economy and Society over the coming 21 years"**. It was created

in consultation with the government, private sectors, political leaders and international bodies and was intended to cover the period 2008-2030.

The Bahrain Vision 2030 pledges to improve the Bahraini standards of living as well as reform the Government, Education, Health sectors, increase privatization, and enhance the quality of life in Bahrain. It signals aspirations for a competitive global economy driven by a thriving private sector. The Vision also underscores the role of all Bahrainis and raises incomes and quality of life for all societal segments. It therefore outlines in skeleton form what it calls forward-looking policies in such critical areas as education, health care, infrastructure and the environment. However, social security and social justice are also accorded attention, with a focus on subsidies on water, electricity, gasoline and food exclusively targeting the needy; housing support for those most in need; and a high standard of social assistance giving all Bahrainis an equal start.

And it goes with the Ministry of Health vision "**To improve the health of population in Bahrain by partnership with stakeholders, in order to provide accessible, responsive, high quality service for all through their lifetime."**

## Bahrain IHR Mission

The Bahrain IHR mission is to "**improve health protection in Bahrain, to be prepared and to respond to a public health emergency of international concern"**. It goes with Ministry of Health mission "**To ensure the provision of evidence-bases care at all levels based efficient use of resources and encouragement of personal responsibility for health."**

## Bahrain IHR strategy

The Bahrain Strategy for IHR implementation is a road map to strengthen core capacities required for effective preparedness planning, prevention, prompt detection, characterization, containment and control of emerging infectious diseases which threaten national, regional and global health security. Implementation of IHR is an important stepping stone in fulfilling many of the requirements of the revised International Health Regulations (2005).

The advent of SARS, avian influenza and H1N1 underscores the importance of emerging diseases and their impact on health and economic development. By increasing globalization of public health events and the requirements of the IHR (2005), there is clearly value in developing such a strategy for Bahrain. The scope of threats is broad and includes objectives for the short, medium-and long-term capacity needed to reduce these threats.

Within the kingdom of Bahrain, this is supported by active engagement of higher authorities and concerned stakeholders in relevant sectors. Additionally, benefiting from the best available technical support for effective implementation of IHR (2005) by establishing regional and global health regulation network was done.

**The IHR Strategy aims are:**

-To reduce the potential risks to the public's health posed by movement of persons and goods, and other trade activities with the avoidance of unnecessary interference with international traffic and trade by the year 2013.

-To prevent and Respond to International Public Health Emergencies

-To establish the legal and regulatory frameworks that specifies the roles of participating partners and stakeholders

-To ensure justification, assessment of measures and to facilitate a quick and timely response. Furthermore, regularly monitoring the progress indicators for the implementation of IHR 2005 is necessary for improvement.

-To strengthen the early warning system

-To ensure a rapid response.

-To strengthen the partnership by resource mobilization through intra -sectoral and inter-sectoral collaboration between various ministries and organization

This could be achieved through producing, implementing, exercising and harmonizing national public health actions to rapidly detecting and managing risks and public health emergencies of international concern.

**Bahrain will use the Strategy in the following ways:**

-As a strategic document to guide the development or strengthening of the national core capacities required for health protection from events.

-As a framework for the development of stronger collaboration with neighboring countries, sub regional, regional and global networks and other technical partners to build a safety net.

-As a guide to meet the core capacity requirements for surveillance and response under IHR (2005).

-As a document for national and regional advocacy for adequate, equitable and sustainable health financing arrangements (including resource mobilization and donor coordination), human resource development, and sustainable knowledge, skills and technology transfer.

-As an operational plan base for IHR implementation.

Events threats do not respect international borders. Global partnerships and the rapid sharing of data and other information enhance preparedness and evidence-based control strategies for the emerging threats with their risk analysis and management, case management, epidemiology, public health, diagnostics and verification of results, laboratory bio-safety, infection control, logistics, risk communication, and other specialty areas.

With strong political support, a commitment to the global public goods and effective public health systems, the challenge can be met.

**Bahrain IHR strategic goal**

To establish a productive planning, prevention, prompt detection, characterization, and the containment and control of any Public Health Emergencies of International Concern by 2013.

**Bahrain IHR goals and objectives are**

**Strategic Goals 1: Partnership strengthening**

Resource mobilization through intra-sectoral and inter- sectoral collaboration between various ministries and organization within the kingdom of Bahrain. This is supported by active engagement of higher authorities and concerned stakeholders in relevant sectors. To benefit from the best available technical support for effective implementation of IHR by establishing regional and global health regulation network.

**Objective:**

To inform, train and actively involve the concerned stakeholders in relevant sectors in implementing the Regulations (short to intermediate)

To ensure that higher authorities in the country understand the public health and economic benefits of implementing the revised Regulations and engage in resource mobilization activities to support their full implementation.(short term)

To establish and be an active member in the regional and global health regulation network.(long term )

**Strategic Goals 2: Strengthen National Capacity**

To conduct an analysis of the available capacities to identify the gaps and plan for improvement. Core capacity building should be strengthened in the field of national disease prevention, surveillance, control and response. Moreover, public health measures and response capacity building at designated ports of entry is required , as it has a recognized role in rapid detection and response to the risk of international disease spread.

**Objective:**

-To conduct assessment of the alert and response capacity in the country. (Short term)

-To perform gap analysis of the alert and response capacity and develop and implement national action plans to prevent, detect, and respond to public health threats (short term)

-To request WHO's technical support for national capacity building (short term)

-To train the concerned staff in the field of disease prevention, surveillance, risk assessment, control and response. (Intermediate)

-To ensure that PoE are kept free of infection or contamination, including vectors and reservoirs (long term)

-To ensure that routine measures, in compliance with IHR (2005), are in place for travelers, conveyances, cargo, goods and postal parcels (short term)

-To implement the public health contingency plan for public health emergencies at all designated PoE (intermediate)

-To ensure that designated points of entry have the capacity to rapidly implement international public health recommendations (short)
-To assess and strengthen surveillance system. (Short)

-To improve skills of public health inspectors who attend the ports. (Long)

-To establish an emergency planning compatible with IHR 2005. (Intermediate)

-To establish an educational and training plan. (Long)

-To establish a communication plan with the concerned parties. (Intermediate)

-To conduct a simulation exercises to elaborate Bahrain's emergency plan to face public health emergencies of international concern. (Long)

-To provide a feedback system about performance of concerned parties

**Strategic Goals 3: Prevent and Respond To International Public Health Emergencies**

Strengthen the early warning system to ensure rapid response. This could be achieved through producing, implementing, exercising and harmonizing national public health action to rapidly detecting and managing risks and public health emergencies of international concern.

**Objective:**

-To develop plans for surveillance and early warning for specific risks at national level (infectious, food, chemical and radio-nuclear)

-To identify and implement risk reduction strategies

Preparedness and readiness for response and containment of the threats identified in IHR (2005) including involvement of local level.

-To implemented international mechanisms for stockpiling critical supplies (vaccines, drugs, personal protective equipment (PPE) for priority threats critical supplies

-To implement the public health contingency plan for public health emergencies at all designated PoE

-To ensure that designated points of entry have the capacity to rapidly implement international public health recommendations

**Strategic Goals 4: Legal Issues and Monitoring**

Establishment of the legal and regulatory frameworks that specify the roles of participating partners and stakeholders ensure justification of Assessment of measures and facilitate quick and timely response. Furthermore, regularly monitoring the progress indicators for the implementation of IHR 2005 is necessary for improvement.

**Objective:**

-To assess national public health legislation and to adapt it in line with the IHR (2005) Regulations.

-To designate the National IHR Focal Points(NFP)

-To monitor implementation of eight core capacities through a checklist of indicators, capacity development at PoE and capacity development for the four IHR-related hazards (zoonotic and food safety (biological), radiological and nuclear, and chemical )

-To establish IHR health policy and legislations.(intermediate)

**IHR Situation analysis in Bahrain**

The Ministry of Health, Directorate of Public Health requested a mission to take place from the 28th of November to the December 2, 2010 to evaluate the progress in the IHR implementation in Bahrain. Expert from WHO/EMRO conducted this mission with coordination with Bahrain Desk Officer and NFP .Meeting with officials and field visits to relevant sectors to assess the capacities for the implementation of IHR was done. Finally the recommendation and the (POA) is formulated and submitted to NFP for implementation and follow up. The burden of epidemic borne disease and food related hazards are examined periodically and annually in order to identify the trend of these diseases and to ensure that control measures in place, however the burden of chemical and radio-nuclear hazards are not addressed adequately.

A quick situational analysis through visiting nominated ports* and all sectors concerned with IHR implementation for assessment of core capacities available and discussions with district officials to provide basic information about the existence of a particular problem, its size and impact was done. To achieve that we nominate the concerned parties and contact them by letters to cooperate with them to assess core capacity available and that required to implement IHR 2005

| Area | Str | Weaknesses | Opportunity | Threat |
|---|---|---|---|---|
| **Legislation and policy** | □ National IHR focal point for coordination of IHR related activities was designated.<br>Revision of national laws in context of IHR is started and almost not limiting | Lack of approved SOPs for the function of NFP<br>□ Lackof mandatory | Updating the public health law now<br>□ The availability of National disaster committee covering | - |
| **Surveillance** | Detection:<br>All diseases listed in Annex (2) of IHR (2005) are included in the notification forms except for small pox.<br>Notifiable disease list includes" unusual events"<br>Utilize the hospital discharge records as data source.<br>Active surveillance in place for AFP and measles.<br>Daily media scanning by public relation section<br>Reporting<br>Via well structured daily and weekly notification forms.<br>Urgent Notification by | Updated communicable disease with case definition and management still not in place<br>□ Lack of peripheral sites data management at least in term | Utilize IT facility in MOH to invent electronic reporting system. | The emerging diseases |
| **Preparedness** | □ The availability of disease specific national preparedness plan (Influenza H5N1, H1N1). | □ Lack of a national comprehensive | □ IHR (2005) implementation | □ Financial limitatio |
| **Risk communication** | □ The availability of Public relation section which is responsible for communication all the time and during | □ Lack of social mobilization approach during | Pandemic H1N1<br>□ Transparency in the country in all aspect including health | □ Delay the risk communicatio n |
| **Human reso** | Training program is available in MOH and certain budget is allocated | No training need assessment in | □ IHR (2005) implementati | Financial limitation |
| **Laboratory** | **Confirmation:** Public health lab(PHL) has the capacity to diagnose many | □ Lackof diagnostic facilities | □ IHR (2005) implementati | Financial limitation |

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| | polio and measles<br>**External quality assessment** in collaboration with UK NEQAS for microbiology and WHO for | fever and lack of availability list of collaborating center in this | | |
| **Port of entry Bahrain International Airport Khalifa Sea Port King Fahd** | The accessibility to medical service(with adequate staff and equipment) for care of ill traveler<br>The accessibility to facilities to transfer the ill traveler to appropriate medical facility<br>Availability of good services | No designation of ports for IHR implementation.<br>No application of IHR documents( yellow fever vaccine certificat | IHR (2005) implementation | Financial limitation |

**The following IHR stakeholders were identified based on IHR implementation requirements:**

Representatives from public health directorate (surveillance ,food control section, environmental section) (MOH),from Primary Health Care(MOH),from Health Promotion Section(MOH), from Drug Control Section(MOH),from National Sea Port Authority , from Civil Aviation Affairs , from animal welfare section in Ministry of Agriculture and Animal Welfare ,from private sector, from Ministry of Interior (Customs), from the media., from Legal affairs office in Ministry of Health, from Ministry of Environment., from Ministry of Foreign affairs Ministry of Industry and Commerce

**Assessment of core capacity required at the PoE at all times:**

| **Task** | **Responsible section** |
|---|---|
| 1- Assessment of the medical diagnostic facilities used to care of ill travelers at the port | Primary health care directorate and port authorities. |
| 2- Assessment of the availability of equipment and personnel for the transport of ill travellers to an appropriate medical facility. | Primary health care directorate and port authorities. |
| 2- Adequate medical staff and paramedics for care of ill travelers at the port | Primary health care directorate |
| 3-Inspection at the port<br>For communicable disease)<br>Imported food, animals, drugs.<br>Ship inspection | Public health directorate<br>Disease control section ,food control and drug control sections<br>Ministry of Municipalities and Agriculture |

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| | Affairs |
| 4- Safe environment for travelers using point of entry facilities | Public health directorate Environment health section |
| 5- Control of vectors, reservoirs in, and near points of entry | Public health directorate Environment health section |

**Assessment of core capacity required for responding to events that may constitute a public health emergency of international concern:**

| **Task** | **Responsible section** |
|---|---|
| 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; ( Bahrain Disaster plane ,Bahrain plane for Avian flu pandemic). | Public health directorate with concerned parties |
| To provide assessment of and care for affected travelers or animals by establishing arrangements with local medical and veterinary facilities for their isolation, treatment and other support services that may be required | Primary health care directorate and Ministry of Municipalities and Agriculture Affairs |
| To provide appropriate space, separate from other travelers, to interview suspect or affected persons. | Port authorities |
| To provide a place for the assessment and, if required, quarantine of suspect travelers, preferably in facilities away from the point of entry. | Ministry of health |

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| 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 | Public health directorate Environment health section and Port authorities |
| To apply entry or exit controls for arriving and departing travelers | Port authorities and Public health directorate |
| To provide access to specially designated equipment, and to trained personnel with appropriate personal protection, for the transfer of travelers who may carry infection or contamination. | Primary health care directorate and secondary health care. |

**Identification of existing resources**

Existing resources will be identified by concerned parties each in his field regarding manpower, place of work and equipment.eg. Communicable Disease Section manpower has 2 medical consultant and 8 public health specialist. Places for work: offices at the public health building. Equipments: including computers for each staff, printers, telephones, fax and cars.

# Action Plan

-Situation analysis of IHR implementation in Bahrain.
-Establish IHR committees
-Designation of the IHR focal point.
-Identify responsibilities of the committee and the IHR Focal Point.
-Formulate policies and legislation related to IHR.
-Formulate IHR strategies.
-Development of training material and conducting training
-Establish a reporting system
-Data analysis, feedback and action taken.
-Time frame for implementation of the plan.
-Monitoring of the IHR implementation in the country

## Establish IHR committees

Two IHR committees were raised, one is a higher committee from different sectors related to IHR and the other committee is the Ministry of Health committee. These committees composed of:

-Program coordinator (IHR focal officer) from Public Health Directorate
-Representatives from Primary health care directorate
-Representatives from Disease Control Section
-Representatives from Food Control Section.
-Representatives from Drug Control Section.
-Representatives from Environmental Health Section.
-Representatives from Public Health Laboratory
-Representatives from Health Education Section.
-Representatives from seaport.
-Representatives from the airport.
-Representatives from causeway.
-Representatives from Ministry of Municipalities and Agriculture Affairs
-Representatives from Ministry of Finance (Customs and Ports Affairs)
-Representative from Civil Aviation Affairs.
-Representative from Gulf Air Clinic.
-Representative from Ministry of Industry & Commerce.
-Representative from Ministry of Interior.
-Legal Advisor from the Ministry of Health

## Designation of IHR Focal Point

Public Health Directorate **designated by Minister of Health as an IHR focal point.**

**Time frame for implementation of the plan:**

## *IHR monitoring and Implementation Plan in Bahrain 2011-2012*

| Activity | Responsible | Resources | Time Started | Time Finalized |
|---|---|---|---|---|
| National IHR strategic plan implementation<br>Target:<br>-Putting a written plan. | NFP | Experts | Q4 2010 (given to WHO expert on his visit to Bahrain for review) | Q2 2011 (depend on WHO reply) |
| -Review of the plan by committee members. | IHR Committee | | Q2 2011-01-20 | Q3 2011 |
| IHR policy<br>Target:<br>-To establish a written policy. | NFP | Experts | Q4 2010 | Q3 2011 |
| Core capacity assessment tool | NFP | Experts | | |

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| Target:<br>-To establish an assessment tool for regular monitoring of the core capacities at different sectors. | | | Q4 2010 | Q1 2011 |
| Monitoring and evaluation of core capacity for IHR implementation<br>Target:<br>-To conduct an assessment (regular) for IHR core capacity at different sectors.<br>-POE, MOH, etc… | NFP | Experts | Q1 2011 | Ongoing every 6-12 months |
| Establishment of an algorithm for event reporting under IHR according to WHO recommendation.<br>Target: | NFP<br>IHR Committee | Political commitment<br>Experts | | |

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| -Algorithm established.<br>-Algorithm revised by the committee | | | Q2 2010<br>Q3 2010 | Q1 2011 |
| Establishment of IHR focal point (center) guide<br>Target:<br>-A guide established with term of reference and the functions of the center.<br>-Guide review by committee | NFP<br>IHR Committee | Experts<br>Funds<br>Human Resources | Q3 2010<br>Q3 2010 | Q3 2010<br>Q1 2011 |
| IHR awareness program<br>Target:<br>-To establish awareness plan workshops and lectures for MOH staff. | NFP<br>IHR Committee | Experts<br>Funds | Q2 2011 | Q4 2012 |

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| -Awareness for other ministries and other partners | | Human Resources | | |
| Review all country legislations related to IHR<br>Target:<br>-To collect country legislations related to IHR for all related sectors.<br>-to start review legislations | NFP<br>IHR Committee<br>Legal advisors | Political commitments<br>Experts<br>Funds<br>Human Resources | Q1 2011<br>Q1 2011 | Q2 2011<br>Q3 2012 |
| IHR website<br>Target:<br>-To request<br>-Prepare the program contents | NFP | Experts<br>Political commitments<br>Human Resources | 2010<br>Q2 2011 | -<br>- |
| Get approval of the designated NFP function<br>Target: | • NFP<br>• MOH authorities | • Political commitment | Q2 2011 | Q4 2011 |

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| Approved NPF function | | | | |
| Develop guideline for rapid detection, prompt risk assessment, notification, and response to communicable disease for all sites including PoE.<br>Target:<br>guideline development | • Disease Control Section ,surveillance group | • Experts<br>• Funds | Q3 2011 | Q3 2012 |
| Develop guideline for rapid detection, prompt risk assessment,<br>notification, and response to food related hazards for all sites including PoE.<br>Target:<br>guideline | • NFP<br>• Food Control Section | • Experts<br>• Funds<br>• Human resources | Q3 2011 | Q3 2012 |

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| development | | | | |
| Develop guideline for rapid detection, prompt risk assessment, notification, and response to chemical hazards and radio-nuclear hazards for all sites including PoE<br><br>Target:<br>guideline development | • WHO<br>• NFP<br>• Environmental<br>• Department<br>• Radiation protection consultant. | • Experts<br>• Funds<br>• Human resources | Q3 2011 | Q3 2012 |
| Develop communications plan to coordinate and manage outbreak operations and other public health events;<br>Target:<br>communications plan development | • WHO<br>• NFP<br>• IHR committee members | • Experts<br>• Funds<br>• Human resources | Q3 2011 | Q1 2012 |
| Develop preparedness, | • WHO | • Experts | | |

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| including national, local community/primary response level public health emergency response plans for all public health threats and relevant IHR hazards<br>Target:<br>Preparedness plan for biological and food hazard within 12 months. Preparedness plan for chemical and radio-nuclear hazards | • NFP<br>• IHR committee members | • Funds<br>• Human resources | Q3 2011 | Q4 2012 |
| Develop risk communication plan<br>Target:<br>Risk communication | • WHO<br>• NFP<br>• Health promotion section | • Political commitment<br>• Experts<br>• Funds<br>• Human resources | Q3 2011 | Q4 2012 |

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| plan | • Media<br>• Community leaders<br>• schools | | | |
| prepare nee d assessment for training of public health personnel (including laboratory personal) to get appropriate knowledge, skills and competencies that are critical for effective<br>implementation of the IHR;<br>Target:<br>Need assessment to be finalize within 6 months<br>Implementation of the training | • NFP | • Funds | Q2 2011 | 2013 |

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| develop a laboratory plan for identification of infectious agents and other hazards likely to cause public health emergencies of national and international concern and to including laboratories regional ,international networks.<br>Target:<br>Plan developed | • NFP<br>• Public Health Lab<br>• Environmental laboratory | • Political commitment<br>• Experts<br>• Funds<br>• Human resources | Q3 2011 | Q1 2012 |
| Monitor IHR2005 implementation in Bahrain using WHO monitoring tool.<br>Target:<br>Yearly with monitoring report to be ready be the | • NFP | • Funds<br>• Human resources | Annually | Annually Q1 |

**Monitoring of the IHR implementation in the country**

# Monitoring and Evaluation Plan

## *Status of implementation of the International Health Regulations in the Kingdom of Bahrain*

| *Status* | *Implemented* | *Not Implemented* | *Under Implementation (Date)* |
|---|---|---|---|
| • An assessment of relevant legislation, regulations, administrative requirements and other government instruments for IHR (2005) implementation. | | | |
| • A documentation that recommendations following assessment of relevant legislation, regulations, administrative requirements and other government instruments have been implemented in Bahrain. | | | |
| • A review of national policies to facilitate the implementation of IHR NFP functions and the implementation of technical core capacities. | | | |
| • Documentation that policies to facilitate IHR NFP core and expanded functions and strengthening of | | | |

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| technical core capacities have been implemented. | | | |
| • A published compilation of national IHR-related legislation. | | | |
| • To evaluate and share national experiences in terms of IHR-related laws, regulations, administrative requirements, policies or other government instruments with the global community. | | | |
| • To coordinate within relevant ministries on events that may constitute a public health event of national or international concern. | | | |
| • Standard Operating Procedures (SOP) available for coordination between IHR NFP and stakeholders of relevant sectors. SOPs should detail the Terms of Reference (ToR), roles and responsibilities of the IHR NFP, implementing structures, various administrative levels, and stakeholders in the implementation of the IHR established, and disseminated to all relevant stakeholders. Stakeholders are any groups, organizations, or systems who can help affects or can be affected by a public health event. These include relevant sectors, various levels and non-governmental organizations | | | |

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| working within State Parties | | | |
| • To establish a multisectoral, multidisciplinary committee, body or task force in place in order to address IHR requirements on surveillance and response for public health emergencies of national and international concern. | | | |
| • To test the coordination mechanisms through an actual event occurrence or through exercises and updated as needed. | | | |
| • A list of national stakeholders involved in the implementation of IHR. | | | |
| • Define roles and responsibilities of various stakeholders under the IHR. | | | |
| • To develop plans to sensitize all relevant stakeholders to their roles and responsibilities under the IHR. | | | |
| • To implement plans to sensitize stakeholders to their roles and responsibilities. | | | |
| • Establish active IHR website. | | | |

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| • Conduct updates on the IHR with relevant stakeholders on at least an annual basis. | | | |
| • Establish HR NFP. | | | |
| • Disseminate Information on obligations under the IHR to relevant national authorities and stakeholders. | | | |
| • IHR NFP provided WHO with updated contact information as well as annual confirmation of the IHR NFP. | | | |
| • NFP accessed IHR Event Information Site (EIS) at least monthly in the past 12 months. | | | |
| • At least one written NFP-initiated communication with WHO consultation, notification or information sharing on a public health event in the past 12 months. | | | |
| • Documentation of actions taken by the IHR NFP and relevant stakeholders following communications with WHO | | | |
| • Country implementation of any roles and | | | |

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| responsibilities which are additional to the IHR NFP functions. | | | |
| • Evaluate and share national experiences in terms of IHR-related laws, regulations, administrative requirements, policies or other government instruments with the global community. | | | |
| • To provide list of priority diseases or conditions for surveillance. Priority diseases are those with the highest public health significance as defined by the country and should include the diseases in Annex 2 of the IHR | | | |
| • Provide Case definitions for priority diseases. | | | |
| • Design specific units for surveillance of public health risks. | | | |
| • Estimate the proportion of timely reporting in all reporting units. | | | |
| • Analyse surveillance data on epidemic prone and priority diseases at least weekly at national and sub-national levels. | | | |

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| • Baseline estimates, trends, and thresholds for alert and action been defined for the local public health response level for priority diseases/events. | | | |
| • Reports or other documentation showing that deviations or values exceeding thresholds are detected and used for action at the primary public health response level. | | | |
| • At least quarterly feedback of surveillance results disseminated to all levels and other relevant stakeholders. | | | |
| • Evaluations of the early warning function of routine surveillance been carried out and country experiences, findings, lessons learnt shared with the global community. | | | |
| • Information sources for public health events and risks been identified. | | | |
| • Unit(s) designated for event-based surveillance that may be part of an existing routine surveillance system. | | | |
| • SOPs and guidelines for event capture, reporting, confirmation, verification, assessment and | | | |

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| notification been developed and disseminated. | | | |
| • SOPs and guidelines for event capture, reporting, confirmation, verification, assessment and notification been implemented, reviewed and updated as needed. | | | |
| • A system in place at national and/or sub-national levels for capturing and registering public health events from a variety of sources including, media (print, broadcast, community, electronic, internet etc.). | | | |
| • A local community (primary response) level reporting strategy been developed. | | | |
| • An active engagement and sensitization of community leaders, networks, health volunteers, and other community members to the detection and reporting of unusual health events been developed. | | | |
| • Implementation of local community reporting was evaluated and updated as needed. | | | |
| • Country experiences and findings on the implementation of event-based surveillance, and the integration with indicator-based surveillance been | | | |

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| documented and shared with the global community. | | | |
| • Reported events contain essential information specified in the IHR. | | | |
| • Proportion of events identified as urgent in the last 12 months has risk assessment been carried out within 48 hours of reporting to national level. | | | |
| • Proportion of verification requests from WHO has IHR NFP responded to within 24 hours. | | | |
| • Use the Decision Instrument in Annex 2 of the IHR (2005) to notify WHO. | | | |
| • Proportion of events that met the criteria for notification under Annex 2 of IHR were notified by NFP to WHO (Annex 1A Art 6b) within 24 hours of conducting risk assessments over the last 12 months. | | | |
| • Review the use of the decision instrument, with procedures for decision making updated on the basis of lessons learnt. | | | |
| • Shared globally country experiences and findings in notification and use of Annex 2 of the IHR documented. | | | |
| • Evaluate and share national experiences in terms of IHR-related laws, regulations, administrative | | | |

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| requirements, policies or other government instruments with the global community. | | | |
| • Resources for rapid response during outbreaks of national or international concern are accessible. | | | |
| • Management procedures been established for command, communications and control during public health emergency response operations? | | | |
| • A functional, dedicated command and control operations centre at the national or other relevant level. | | | |
| • Management procedures are evaluated after a real or simulated public health response. | | | |
| • Resources for rapid response during outbreaks of national or international concern are accessible. | | | |
| • Rapid Response Teams (RRT) available in the country. RRT trained in outbreak investigation and control, Infection control and decontamination, social mobilization and communication, specimen collection and transportation, chemical event investigation and management and if applicable, | | | |

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| radiation event investigation and management | | | |
| • A roster of trained RRT members is available. | | | |
| • SOPs are available for the deployment of RRT members. | | | |
| • Multidisciplinary RRT been deployed within 48 hrs from the time when the decision to respond is taken. | | | |
| • RRT submit preliminary written reports on investigation and control measures to relevant authorities in less than one week of investigation. | | | |
| • RRT mobilized for real events or through simulation exercise at least once a year at relevant levels. | | | |
| • An evaluation of response including the timeliness and quality of response been carried out. | | | |
| • Response procedures been updated as needed following actual event occurrence or an assessment. | | | |
| • Country should offer assistance to other States Parties for developing their response capacities or implementing control measures. | | | |

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| • Responsibility is assigned for surveillance of health-care-associated infections and anti-microbial resistance. | | | |
| • National infection prevention and control policies or guidelines are in place. | | | |
| • A documented review of implementation of infection control plans available. | | | |
| • SOPs, guidelines and protocols for IPC are available to all hospitals. | | | |
| • Defined norms or guidelines developed for protecting health-care workers. | | | |
| • A national coordination for surveillance of relevant events such as health-care-associated infections, and infections of potential public health concern with defined strategies, objectives, and priorities in place is available. | | | |
| • All tertiary hospitals have designated area(s) and defined procedures for the care of patients requiring specific isolation precautions (single room or ward), adequate number of staff and appropriate equipment for management of infectious risks) according to national or international guidelines. | | | |
| • The management of patients with highly infectious | | | |

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| diseases meet established IPC standards (national/international). | | | |
| • Surveillance within high risk groups is available (intensive care unit patients, neonates, immunosuppressed patients, emergency department patients with unusual infections, etc) to promptly detect and investigate clusters of infectious disease patients. | | | |
| • A monitoring system for antimicrobial resistance was implemented, with available data on the magnitude and trends as well as unexplained illnesses in health workers. | | | |
| • Qualified IPC professionals present in place at a minimum in all tertiary hospitals. | | | |
| • A compliance with infection control measures and their effectiveness been evaluated and published (available in a public domain) | | | |
| • Has a national programme for protecting health care workers been implemented (preventive measures and treatment offered to health care workers; e.g. Influenza or hepatitis vaccine programme for health care workers, PPE, occupational health and medical surveillance Programs for employees to identify potential "Laboratory Acquired Infections" among | | | |

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| staff, or the monitoring of accidents, incidents or injuries as outbreaks caused by LAIs). | | | |
| • An assessment of core capacities for the implementation of IHR been conducted (Annex 1A Article 2) and the report of the assessment shared with relevant national stakeholders. | | | |
| • A national plan to meet the IHR core capacity requirements been developed (Annex 1A Article 2). | | | |
| • A national public health emergency response plan for hazards and Points of Entry (PoE) been developed (Annex 1A, Article 6g). | | | |
| • A national public health emergency response plan(s) for multiple hazards and PoE been tested in an actual emergency or simulation and updated as needed. | | | |
| • A policy or strategy put in place to facilitate development of surge capacity. | | | |
| • A national plan was put for surge capacity to respond to public health emergencies of national and international concern. | | | |

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| • Testing the surge capacity either through response to a public health event or during an exercise, and determined to be adequate. | | | |
| • Documenting the country experiences and findings on emergency response and mobilizing surge capacity and sharing it with global community. | | | |
| • Risk and resource management for IHR preparedness. | | | |
| • A directory of experts in health and other sectors to support a response to IHR-related hazards available. | | | |
| • A national risk assessment to identify the most likely sources of urgent public health event and vulnerable populations been conducted. | | | |
| • A national resources been assessed to address priority risks. | | | |
| • A major hazard sites or facilities that could be the source of chemical, radiological, nuclear or biological public health emergencies of international concern been mapped. | | | |
| • An experts been mobilized from multiple disciplines/sectors in response to an actual public health event or simulation exercise in the past twelve months. | | | |

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| • The national risk profile and resources regularly assessed (e.g. annually) to accommodate emerging threats. | | | |
| • Plan for management and distribution (if applicable) of national stockpiles available. | | | |
| • Stockpiles (critical stock levels) for responding to the country's priority biological, chemical and radiological events and other emergencies are available and accessible at all times. | | | |
| • Stockpile management system been tested through a real or simulated exercise and updated. | | | |
| • The country contributes to international stockpiles. | | | |
| • The country evaluated and shared national experiences in terms of risk and resource management | | | |
| • Risk communication partners and stakeholders been identified. | | | |
| • A unit responsible for coordination of public communications during a public health event, with roles and responsibilities of the stakeholders clearly defined. | | | |
| • A risk communication plan including social | | | |

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| mobilization of communities been developed. | | | |
| • Policies, SOPs or guidelines disseminated on the clearance and release of information during a public health event. | | | |
| • A proportion of public health events of national or potential international concern has the risk communication plan been implemented in the last 12 months. | | | |
| • Policies, SOPs or guidelines are available to support community-based risk communications interventions during public health emergencies. | | | |
| • An evaluation of the public health communication been conducted after emergencies, including for timeliness, transparency and appropriateness of communications, and SOPs updated as needed. | | | |
| • SOPs been updated as needed following evaluation of the public health communication. | | | |
| • Accessible and relevant IEC (Information, Education and Communications) materials tailored to the needs of the population. | | | |
| • Regularly updated information sources accessible to media and the public for information dissemination. | | | |
| • Proportion of PH emergencies in the last 12 months | | | |

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| were populations and partners informed of a real or potential risk (as applicable) within 24 hours following confirmation of event was estimated. | | | |
| • Regularly updated information sources accessible to media and the public for information dissemination. | | | |
| • Accessible and relevant IEC (Information, Education and Communications) materials tailored to the needs of the population. | | | |
| • Results of evaluations of risk communications efforts during a public health emergency been shared with the global community. | | | |
| • A responsible unit been identified to assess human resource capacities to meet the country's IHR requirements. | | | |
| • Critical gaps been identified in existing human resources (numbers and competencies) to meet IHR requirements. | | | |
| • Training needs assessment been conducted and plan developed to meet IHR requirements. | | | |
| • A plan been developed to meet training needs requirements. | | | |
| • Workforce development plans and funding for the | | | |

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| implementation of the IHR been approved by responsible authorities. | | | |
| • Targets being achieved for meeting workforce numbers and skills consistent with milestones set in training development plan. | | | |
| • A strategy been developed for the country to access field epidemiology training (one year or more) in-country, regionally or internationally. | | | |
| • An evidence of a strengthened workforce when tested by urgent public health event or simulation exercise is available. | | | |
| • Specific programs, with allocated budgets, to train workforces for IHR-relevant hazards are available. | | | |
| • A training opportunities or resources being used to train staff from other countries. | | | |
| • Bio safety guidelines should be accessible to individual laboratories. | | | |
| • Regulations, policies or strategies exist for laboratory bio safety. | | | |
| • A responsible entity been designated for laboratory bio safety and bio security. | | | |
| • Bio safety guidelines, manuals or SOPs been disseminated to laboratories. | | | |

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| • Relevant staff trained on bio safety guidelines. | | | |
| • National classification of microorganisms by risk group been completed. | | | |
| • An institution or person responsible for inspection, (could include certification of bio safety equipment) of laboratories for compliance with bio safety requirements is available. | | | |
| • Bio safety procedures implemented, and regularly monitored. | | | |
| • A bio risk assessment been conducted in laboratories to guide and update bio safety regulations, procedures and practice, including for decontamination and management of infectious waste. | | | |
| • Diagnostic laboratories designated and authorized or certified BSL 2 or above for relevant levels of the health care system are available. | | | |
| • Country experience and findings related to bio safety been evaluated and reports shared with the global community. | | | |
| • Country experience and findings regarding laboratory surveillance been shared within the country and global community. | | | |

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| • Review meeting (or other appropriate method) conducted to identify Points of Entry for designation. | | | |
| • Competent authority' for each PoE been designated. | | | |
| • Designated ports (as relevant)/airports for development of capacities specified in Annex 1 (as specified in Article 20, no.1) been identified. | | | |
| • List of Ports authorized to offer certificates relating to ship sanitation been sent to WHO (as specified in Article 20, no.3). | | | |
| • Proportion of designated airports has competent authority. | | | |
| • Proportion of designated airports has been assessed. | | | |
| • Proportion of designated ports has competent authority. | | | |
| • Country experiences and findings about the process of meeting PoE general obligations have been shared and documented. | | | |
| • Proportion of designated ports has been assessed. | | | |
| • Country experiences and findings about the process of meeting PoE general obligations have been shared and documented. | | | |
| • Priority conditions for surveillance at designated PoE have been identified. | | | |

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| • Surveillance information at designated PoE been shared with the surveillance department/unit. | | | |
| • Mechanisms for the exchange of information have between designated PoE and medical facilities in place. | | | |
| • Designated PoE have access to appropriate medical services including diagnostic facilities for the prompt assessment and care of ill travellers, with adequate staff, equipment and premises (Annex 1b, art 1a). | | | |
| • Surveillance of conveyances for presence of vectors and reservoirs at designated PoE was established (Annex 1B art 2e). | | | |
| • Designated PoE has trained personnel for the inspection of conveyances (Annex 1b, art 1c). | | | |
| • Designated PoE has the capacity to safely dispose of potentially contaminated products. | | | |
| • Functioning programme for the surveillance and control of vectors and reservoirs in and near Points of Entry (Annex 1A, art 6a Annex 1b, art 1e) is available. | | | |
| • Review of surveillance of health threats at PoE been carried out in the last 12 months and results | | | |

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| published. | | | |
| • SOPs for response at PoE are available. | | | |
| • Public health emergency contingency response plan at designated PoE been developed and disseminated to key stakeholders, | | | |
| • Public health emergency contingency plans at designated PoE been integrated with other response plans. | | | |
| • Public health emergency contingency plans at designated PoE been tested and updated as needed. | | | |
| • Designated PoE has appropriate space, separate from other travellers, to interview suspect or affected persons (Annex 1B, art 2c). | | | |
| • Designated PoE provides medical assessment or quarantine of suspect travellers, and care for affected travellers or animals (Annex 1B, art 2b and 2d). | | | |
| • referral and transport system for the safe transfer of ill travellers to appropriate medical facilities and access to relevant equipment, in place at a designated PoE (Annex 1b, art 1b and 2g). | | | |
| • Recommended public health measures (article 1B | | | |

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| art 2e and 2f) be applied at designated PoE (This includes entry or exit controls for arriving and departing travellers, and measures to disinfect, 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). | | | |
| • Results of the evaluation of effectiveness of response to PH events at PoE published. | | | |
| • Coordination mechanism within the responsible government authority (ies) for the detection of and response to zoonotic events is Available. | | | |
| • National policy or strategy in place for the surveillance and response to zoonotic events is available. | | | |
| • Focal points responsible for animal health (including wildlife) been designated for coordination with the MoH and/or IHR NFP . | | | |
| • Functional mechanisms for intersectoral collaborations that include animal and human health surveillance units and laboratories have been established and documented. | | | |
| • List of priority zoonotic diseases with case | | | |

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| definitions is available. | | | |
| • Systematic and timely collection and collation of zoonotic disease data is in place. | | | |
| • Systematic information exchange between animal and human health surveillance units about urgent zoonotic events and potential zoonotic risks using is done. | | | |
| • Country have access to laboratory capacity, nationally or internationally (through established procedures) to confirm priority zoonotic events. | | | |
| • zoonotic disease surveillance implemented with a community component. | | | |
| • Timely and systematic information exchange between animal, human health surveillance units and other relevant sectors regarding urgent zoonotic events and risks is done. | | | |
| • Regular (e.g. monthly) information exchange been established on zoonotic diseases among the laboratories responsible for human diseases and animal diseases. | | | |
| • Regularly updated roster (list) of experts that can respond to zoonotic events is done. | | | |
| • Mechanism has been established for response to outbreaks of zoonotic diseases by human and animal | | | |

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| health sectors. | | | |
| • Animal health (domestic and wildlife) authorities/units participate in a national emergency response committee. | | | |
| • Operational, intersectoral public health plans for responding to zoonotic events been tested through occurrence of events or simulation exercises and updated as needed. | | | |
| • Timely (as defined by national standards) response to more than 80% of zoonotic events of potential national and international concern is reached. | | | |
| • Share country experiences and findings related to zoonotic risks and events of potential national and international concern with the global community in the last 12 months. | | | |
| • National or international food safety standards are available | | | |
| • National food laws or regulations or policy in place to facilitate food safety control are available. | | | |
| • Operational national multisectoral mechanism for food safety events is in place. | | | |
| • Decisions of the food safety multisectoral body implemented and outcomes are documented. | | | |
| • Functioning coordination mechanism been | | | |

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| established between the Food Safety Authorities, specifically the INFOSAN Emergency Contact Point (if member) and the IHR NFP. | | | |
| • The country is an active member of the INFOSAN network. | | | |
| • List of priority food safety risks is available. | | | |
| • Guidelines or manuals on the surveillance, assessment and management of priority food safety risks are available. | | | |
| • Epidemiological data related to food contamination been systematically collected and analyzed. | | | |
| • Food safety authorities report systematically on food safety events of national or international concern to the surveillance unit. | | | |
| • Risk-based food inspection services are in place. | | | |
| • Country has access to laboratory capacity to confirm priority food safety events of national or international concern including molecular techniques | | | |
| • Roster of food safety expert is available for the assessment and response to food safety events. | | | |
| • Operational plans for responding to food safety events has been tested and updated as needed. | | | |

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| • Food safety events investigated by teams that include food safety experts is available. | | | |
| • Mechanisms have been established for tracing, recall and disposal of contaminated products | | | |
| • Communication mechanisms and materials are in place to deliver information, education and advice to stakeholders across the farm-to-fork continuum. | | | |
| • Food safety control management systems (including for imported food) has been implemented. | | | |
| • Information from food borne outbreaks and food contamination has been used to strengthen food management systems, safety standards and regulations. | | | |
| • Analysis of food safety events, food borne illness trends and outbreaks which integrates data from across the food chain been published | | | |
| • Experts have been identified for public health assessment and response to radiological and nuclear events | | | |
| • National policy or plan for the detection, assessment and response to radiation emergencies is in place. | | | |
| • National policy or plan for national and international transport of radioactive material and samples and waste management, including from hospitals and | | | |

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| medical services is available. | | | |
| • Coordination and communication mechanism for risk assessments, risk communications, planning, exercising and monitoring among relevant National Competent Authorities (NCAs) responsible for nuclear regulatory control/safety, national public health authorities, the Ministry of Health, the IHR NFP and other relevant sectors is established. | | | |
| • Inventory of hazard sites and facilities using/handling radioactive sources which may be the source of a public health emergency of international concern is available. | | | |
| • Monitoring is in place for radiation emergencies. | | | |
| • Mapping of the radiological risks that may be a source of a potential public health emergency of international concern (sources of exposure, populations at risk, etc.) are done. | | | |
| • Systematic information exchange between radiological competent authorities and human health surveillance units about urgent radiological events and potential risks that may constitute a public | | | |

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| health emergency of international concern is done. | | | |
| • Scenarios, technical guidelines and SOPs for risk assessment, reporting, event verification and notification, investigation and management of radiation emergencies are available. | | | |
| • Agencies responsible for radiation emergencies participate in a national emergency response committee and in coordinated responses to radiation emergencies in place. | | | |
| • Radiation emergency response plan is available. | | | |
| • Radiation emergency response drills have been carried out regularly at national level, including requesting international assistance (as needed) and international notification. | | | |
| • Mechanism is in place for access to hospitals or health-care facilities with capacity to manage patients from radiation emergencies (in or out of the country). | | | |
| • Strategy for public communication in case of a radiological or nuclear event is present. | | | |
| • Country has basic laboratory capacity and instruments to detect and confirm presence of radiation and identify its type (alpha, beta, or gamma) for potential radiation hazards. | | | |

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| • Regularly updated collaborative mechanisms in place for access to specialized laboratories that are able to perform bioassays biological dosimetry by cytogenetic analysis and ESR, | | | |
| • Country experiences relating to the detection and response to radiological risks and events documented and shared with the global community. | | | |
| • Comprehensive list of Indicators (30 indicators) | | | |

**3/4/2011**