Implementation of the International Health Regulations (2005) in the African Region

Francis Chisaka Kasolo,[i] Jean-Baptiste Roungou,[i] Florimond Kweteminga Tshioko,[i] Benido Impouma,[i] Ali Ahmed Yahaya,[i] Nathan Bakyaita,[i] Peter Gaturuku,[i] Zabulon Yoti,[i] Isabelle Nuttal,[ii] Stella Chungong[ii] and Florence Fuchs[ii]
Corresponding author: Florimond Kweteminga Tshioko, e-mail: tshiokok@who.int

SUMMARY—The International Health Regulations (IRH, 2005) are a legally binding international instrument for preventing and controlling the spread of diseases internationally while avoiding unnecessary interference with international travel and trade. Under the IHRs that were adopted on 23 May 2005 and entered into force on 15 June 2007, Member States have agreed to comply with the rules therein in order to contribute to regional and international public health security.

Obligations also include the establishment of IHR National Focal Points (NFP) defined as a national centre designated by each Member State, and accessible at all times for communication with WHO IHR Contact Points. Furthermore, Member States were requested to designate experts for the IHR roster, enact appropriate legal and administrative instruments and mobilize resources through collaboration and partnership building.

The Fifty-sixth session of the WHO Regional Committee for Africa called for the implementation of the IHR in the context of the regional Integrated Disease Surveillance and Response (IDSR) strategy considering the commonalities and synergies between IHR (2005) and the IDSR. They both aim at preventing and responding to public health threats and/or events of national and international concern.

This document discusses the issues and challenges and proposes actions that Member States should take to ensure the required IHR core capacities are acquired in the WHO African Region.

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The International Health Regulations (2005), hereafter referred to as "the IHR" or " the Regulations", are a legally binding international instrument for preventing and controlling the international spread of diseases while avoiding unnecessary interference with international travel and trade. Under the IHR that came into force on 15 June 2007, Member States have agreed to comply with the rules to contribute to regional and international public health security.

Resolutions WHA58.3[1] and WHA61.2[2] on IHR called upon Member States to develop, strengthen and maintain minimum national public health core capacities to detect, assess, notify and report events,[3] and respond promptly and effectively to public health risks and emergencies of international concern[4] and collaborate[5] in carrying out all activities concerning designated airports, ports and ground crossings.

Since the IHR came into effect in June 2007, Member States have been supported to assess the IHR minimum capacities as set forth in Annex 1 of the Regulations. In addition, support was provided for the development and implementation of plans of action to meet the deadline of 15 June 2012.

The African Region faces a number of public health threats from epidemic- and pandemic-prone diseases, natural and man-made disasters, and chemical and poisoning events. For example, between 2010 and 2011 a total of 201 public health events were reported to WHO by 38 Member States. In response to these events, WHO provided support to Member States to implement a series of preventive and control measures including support for establishing a network of centres of excellence for disease surveillance and response, laboratories, and for food and drug regulation. In addition, cross-border collaboration between Member States and partners in line with IHR Article 44 on collaboration and assistance was strengthened.

By the full implementation deadline of 15 June 2012, 43 out of the 46 Member States of the WHO African Region had conducted core capacity assessment in line with IHR requirements. None of the countries had fully implemented their national IHR plans. Compared with other WHO regions, the African Region's performance was below average for most of the IHR core capacities.[6]

Issues and challenges

All Member States in the WHO African Region missed the set deadline of 15 June 2012 for the attainment of the minimum IHR core capacities required under International Health Regulations (2005). The main reasons for this include inadequate allocation of human and financial resources, unpredictability of funding for IHR national plans, loss of highly trained and skilled health personnel including members of the national IHR Focal Points.

Coordination and collaboration between the health sector and other related government departments responsible for the points of entry, zoonotic events, food safety and chemical and radiation events remain weak. This has resulted in

i WHO Regional Office for Africa, Brazzaville, Congo
ii WHO, Geneva, Switzerland

a fragmented approach in implementing the IHR and the failure to implement the concept of "One Health" in a number of Member States.

The National IHR Focal Points who are expected to play a critical role in coordination of the relevant national sectors and act as link to the WHO IHR Contact Point have insufficient capacities to support IHR implementation. Most of these national IHR Focal Points do not have the means to communicate regularly with the relevant sectors including providing notification to WHO of potential public health emergencies.

In the African Region, IHR implementation is supposed to occur in the context of the Integrated Disease Surveillance and Response strategy (IDSR). Despite the revision of the IDSR strategy to incorporate IHR provisions, most countries have not fully implemented this strategy, resulting in weakness in systematic collection, analysis, interpretation and notification of public health events of international concern as required under IHR (2005).

Member States in the WHO African Region continue to have weak laboratory capacities for the diagnosis of chemical, biological and radiation events. Laboratory capacity is particularly poor at subnational and district levels, resulting in delays in the confirmation and monitoring of public health events that have the potential for international spread.

The majority of Member States in the WHO African Region have neither designated points of entry nor implemented the ship sanitation inspection procedures and the new ship sanitation control certificate. The personnel at points of entry are not always trained and often lack the necessary equipment and infrastructure for detecting, reporting and responding to public health events.

Most of the Member States have not updated their legal framework to incorporate IHR (2005) provisions. Furthermore, when implementing additional measures related to a public health event of national or international concern, most Member States do not systematically seek WHO advice and guidance as required under Article 43 on additional health measures. This has led to inadequate compliance and varying interpretation of IHR requirements regarding diseases such as yellow fever and cholera. In the case of yellow fever, differences in interpretation of vaccination requirements have resulted in unjustified denial of entry for certain travellers arriving at points of entry.

With regard to cholera, the majority of Member States affected by cholera outbreaks have been subjected to embargoes by neighbouring countries on items such as food products, and needless restrictions on the movements of their people. Actions set forth in World Health Assembly resolution WHA64.15 (2011) on cholera have not been fully implemented and in some cases countries

are not referring to the WHO statement related to international travel and trade as it relates to cholera.

Member States often do not notify or report outbreaks of public health events within 24 hours as required by IHR for fear of the economic consequences. This has led to delays in the implementation of appropriate interventions to control the possible national and international spread of these events.

Actions proposed

Member States should request a two-year extension to enable full implementation of IHR core capacities by 2014 in line with Article 5 of the Regulations on strengthening surveillance and resolution WHA65.23[7] on IHR implementation.

Member States should conduct a needs assessment, map unmet needs and use the identified gaps to mobilize resources in line with Article 44 on collaboration and assistance. Furthermore, Member States should take the lead and ownership of the implementation process and allocate adequate human and financial resources to support IHR implementation.

Member States should clearly define the roles and responsibilities of each sector and partners, promote the concept of "One Health" and set up coordination and multisectoral collaboration mechanisms within the country such as information sharing and joint planning, implementation, monitoring and evaluation of activities.

Member States should provide the IHR Focal Points with adequate means of communication and establish mechanisms of retaining members of the IHR National Focal Points in order to ensure timely verification and notification of public health events to the WHO IHR Contact Point.

Member States should assess and revise, where necessary, national legislation to comply with IHR requirements. Furthermore, Member States should build capacity for correct interpretation and appropriate application of legal provisions in IHR in close collaboration with WHO.

Member States should provide to WHO any new evidence regarding areas where the risk of yellow fever transmission is present so that WHO can update its determination of areas where disinfection and other vector control measures are needed for conveyances arriving from such areas, in compliance with the IHR provisions regarding yellow fever vaccination requirements and recommendations as stipulated in Annex 6 on vaccination, prophylaxis and related certificates, Annex 7 on requirements concerning vaccination or prophylaxis for specific diseases as well as the provisions of Article 23 on health measures on arrival and departure and Article 31 on health measures related to entry of travellers.

Member States should facilitate access to essential supplies, specifically to yellow fever vaccine and other vaccines to be developed, and also facilitate the availability of financial resources for emergencies. Special attention should be paid to Small Island States.

Countries should implement Article 2 on the purpose and scope of IHR as well as actions related to trade embargoes as contained in resolution WHA 64.15 on cholera and the WHO statement related to international travel and trade to and from countries experiencing cholera. In addition, Member States should not impose embargoes on food or food products nor restrict movements of people from countries affected by cholera. Member States should enhance their surveillance systems and notify WHO, within 24 hours, of any public health event of national and international concern in line with the roles and obligations of Member States in relation to surveillance and reporting of events/conditions as contained in Article 64 of the WHO Constitution and IHR Articles 5–11 on surveillance, notification, information sharing, verification and reporting of public health events to WHO.

Member States should continue strengthening their public health laboratory capacities at all levels and sectors by fully implementing actions set forth in resolution AFR/RC58/R2 entitled *Strengthening public health laboratories in the WHO African Region: a critical need for disease control.* Subregional networks and reference laboratories should be established. Likewise, capacity to detect and respond to chemical and radiation emergencies should be strengthened.

Member States should equip designated points of entry and recruit personnel to develop, strengthen and maintain core capacities on a routine and emergency basis including contingency plans to respond adequately to public health emergencies. In addition, Member States should share with WHO the lists of ports designated and authorized to undertake ship sanitation inspection and issue ship sanitation control certificates.

Regional and subregional social, economic and political organizations such as the African Union, Economic Community of Central African States, East African Communities, Economic Community of West African States, Southern African Development Community, Indian Ocean Community and others should play a critical role in awareness building and advocacy among countries and include IHR in the agenda of the various forums. In addition, they should support and encourage collaboration among Member States in order to facilitate resource mobilization and sharing of experiences in line with Article 44 of the Regulations on Collaboration and Assistance.

References

1. Resolution WHA58.3. Revision of the International Health Regulation, 2005.
2. Resolution WHA61.2. Implementation of the International Health Regulations (2005), 2008.
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5. WHO. International Health Regulations (2005), second edition, Annex 1A, Article 44.1, Geneva, Switzerland, 2005.
6. WHA 65.17 add. 1.
7. Resolution WHA65.23. Implementation of the International Health Regulations (2005), 2012.