

IHR Core Capacities at Points of Entry

*Report of a Regional Meeting
Colombo, Sri Lanka, 14-16 July 2010*



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Executive summary

The International Health Regulations (IHR) (2005) require countries across the globe to develop and strengthen the core capacities at international points of entry (PoE) such as airports, ports, and ground crossings by June 2012, including strengthening public health emergency preparedness and response at designated PoE through the development of a public health emergency contingency plan. The Disease Surveillance and Epidemiology Unit (DSE) at the South-East Asia Regional Office (SEARO) of the World Health Organization (WHO) has the mandate to assist Member States to reduce the risk of emerging diseases, facilitate early detection and response to outbreaks, improve preparedness and provide support to develop sustainable capacities at PoE. In order to accomplish this, WHO-SEARO organized a Regional Meeting on IHR Core Capacities at Points of Entry in Colombo, Sri Lanka from 14 to 16 July 2010. The meeting was attended by port and airport health officers and public health experts from nine Member States of the South-East Asia Region (SEAR) (except Bangladesh and Timor-Leste), two temporary advisors, IHR and Communicable Diseases Surveillance and Response (CSR) focal points from WHO Country Offices in Bangladesh, India, Indonesia, Nepal, and Sri Lanka and the Eastern Mediterranean Regional Office (EMRO), and technical experts from WHO Headquarters and the International Civil Aviation Organization. The objectives of the meeting were:

- To review the current status of core capacities at PoE including assessment of strengths and weaknesses.
- To identify strategies and approaches to strengthen core capacity at ports, airports and ground crossings (PAG).
- To help countries undertake a needs assessment and identify areas of improvements and key activities at the national level.
- To identify follow-up actions at the national and regional level and the role of WHO.

The meeting involved presentations and group work on current capacities existing at various PoE, including strengths and weaknesses, and

the role of WHO and Member States to develop and strengthen the core capacities. The third objective was achieved through a hands-on training-cum-exercise session where participants learnt the basics of assessments of the PAG. The meeting was followed by a workshop on ship sanitation control and exemption certificates for the port health officers.

During the course of discussion it emerged that Member States in SEAR have undertaken measures to strengthen IHR (2005) implementation but the focus has largely been on development of communicable diseases surveillance and response systems at community and national level. The development of core capacities at PoE is comparatively lacking largely due to lack of awareness, advocacy and adequate training. However, the countries are in a good position to build or strengthen the core capacities at PoE due to a combination of factors which include a functioning national focal point on IHR, experience gained during SARS and Pandemic (H1N1) 2009 and organizational setup at PoE. The ports have functioning systems for quarantine and airports have managed to act as screening points to prevent international spread of diseases; the same cannot be said for ground crossings, where much effort is needed. The PoE in Member States have primarily acted as control quarantine isolation points for incoming traffic, which was the guiding principle of IHR (1969); a paradigm shift was needed to address the PoE and IHR (2005) issues. Some of the Member States in SEAR have developed national guiding or operational plans for strengthening the core capacities at PoE, but none of them have standard operating procedures (SOPs) for implementing core capacities. In addition, the focus for development of core capacities is on communicable diseases, and the all-hazard approach envisioned under IHR (2005) is lacking.

1. Introduction

The International Health Regulations (2005) entered into force in June 2007 and are legally binding on all the WHO Member States. The main purpose of this global legal framework is to prevent and provide a public health response to the international spread of disease while avoiding unnecessary interference with international traffic and trade. Effective public health measures and response capacity at international points of entry (PoE) contribute to minimizing the risk of international spread of diseases. The IHR (2005) require Member States to develop and strengthen the core capacities at designated international ports, airports, and ground crossings (PAG) by June 2012, including strengthening public health emergency preparedness and response at designated PoE through the development of a public health emergency contingency plan.

While considerable progress has been made to strengthen surveillance and response capacity in Member States, the development of core capacities at PoE as mandated under IHR (2005) is comparatively lacking. Strengthening public health measures and response capacities at PoE requires a multiagency approach and strong partnerships involving agencies such as aviation/ maritime industry, private organizations, the international community, and countries sharing common borders. There is an urgent need to improve common understanding about IHR (2005) among national and international agencies operating at PoE, and identify the way forward in strengthening PoE work.

In 2007, IHR assessments conducted in countries in the South-East Asia Region (SEAR) revealed that strengthening of PoE would need development of guidance (norms and standards), assigning and training human resources, ensuring supplies and equipment and developing strategic linkages.

Since IHR (2005) came into force, there have been two biregional meetings between SEARO and WPRO to address issues related to PoE and IHR (2005). The first meeting, *WHO-ASEAN Meeting on Public Health Measures at International Points of Entry: New role under the International Health Regulations (2005)* was held in November 2009, in Manila, Philippines. A total of 13 countries from the Western Pacific Region (WPR)

and 7 from SEAR participated in the meeting. The meeting recommended that WHO, in coordination with relevant agencies such as the International Civil Aviation Organization (ICAO), provide technical support to strengthen PoE core capacities under the IHR (2005) framework; help Member States implement preventive measures and information sharing and provide support to strengthen emergency preparedness and response; and develop technical guidance on public health emergency preparedness at designated PoE. By June 2012, each Member State should have at least one designated airport and port, as applicable, which will meet obligations under IHR (2005). The second meeting was held in February 2010, and was attended by technical experts from WPR and SEAR; a document, *Guidance for Public Health Emergency Contingency Planning at Designated Points of Entry: Requirement under the International Health Regulations (2005)* was produced.

In a SEAR meeting held in Bangladesh in February 2010 between national IHR focal points where all 11 Member States participated and deliberated on common issues, the participants sought WHO support in building national capacity at PoE and assistance to appropriately review and revise the existing legislations. The Disease Surveillance and Epidemiology Unit (DSEU) workplan outlines that support be provided to countries in their effort to strengthen implementation of IHR (2005) including core capacity requirements at PoE.

In order to review progress made under IHR (2005) at PoE, and to agree on priority areas to strengthen surveillance and response (S&R) at PoE, the Regional Meeting on IHR Core Capacities at Points of Entry was organized in Colombo, Sri Lanka, 14-16 July 2010. This meeting proposed to bring the Member States together to identify current strengths and weaknesses, to present the planning document and identify follow-up actions at national and regional level to strengthen core capacities at PoE.

2. Objectives of the meeting

General objective

To strengthen national capacity at points of entry in accordance with the requirements contained in IHR (2005).

Specific objectives

- To review the current status of core capacity at PoE including assessment of strengths and weaknesses.
- To identify strategies and approaches to strengthen core capacity at airports/ports/ ground crossings.
- To help countries undertake a needs assessment and identify areas for improvement and key activities at national level.
- To identify follow-up actions at national and regional level and role of WHO.

The meeting was jointly organized by WHO-SEARO and the WHO Country Office for Sri Lanka. The participants included nominated professionals from Member States, observers and representatives from international organizations and the Ministry of Health, Sri Lanka, WHO staff from SEAR and WHO headquarters, and external experts. The meeting included presentations from Member States and other participants, panel discussions and group work. The presentation on the assessments tool for points of entry included a hands-on-demonstration. Following the conclusion of the meeting, many participants also attended a training workshop on ship sanitation and inspection.

3. Opening session

Dr S. Settinayake, Acting Deputy Director General, Public Health Services, Ministry of Health, Sri Lanka in his capacity as Chief Guest inaugurated the meeting. Dr Firdosi R. Mehta, WHO Representative for Sri Lanka, delivered the message of Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia. Dr Mehta said this meeting on IHR core capacities was one of the first of its kind, addressing specifically the IHR core capacities at PoE. The challenges of Pandemic (H1N1) 2009 indicated that there were many intricacies and practicalities that had to be discussed. It was fortunate that colleagues from headquarters and other regional representatives were present at this meeting. This was an important area and it was urged the meeting would result in concrete actions.

The South-East Asian Region had made considerable progress in the implementation of IHR areas such as strengthening surveillance systems and

building capacity to respond to public health threats. However, there was a need to strengthen these capacities at designated international points of entry. The participation of Member States from South-East Asia, the Eastern Mediterranean and WHO headquarters and other partner organizations reflected the importance of collaborative efforts to implement the International Health Regulations (2005) at points of entry.

The Regional Director hoped that the issues of ensuring points of entry compliance with IHR (2005), better preparedness and building technical capacity with human and financial resources would be addressed. (For the complete text of the message, see Annex 1).

In the globalized world, infectious diseases spread far and wide within a short period of time via international travel and trade. A health crisis in one country can affect livelihoods and economies in many parts of the world. Nomination of office bearers

Dr. A.J.M.J.B. Walalawela, Director – Quarantine, Ministry of Health Sri Lanka and Dr. Femmy Kawangun Bawolem, Chief of Port Health Office, Ministry of Health, Indonesia, were appointed Chairperson and Co-chairperson, respectively.

4. Nomination of Office bearers

Dr A. J. M. J. B Walalawela, Director – Quarantine, Minister of Health, Sri Lanka and Dr Femmy Kawangun Bawolem, Chief of Port Health Office, Ministry of Health, Indonesia, were appointed Chairperson and Co-chairperson, respectively.

5. Business session

International Health Regulations (2005): A paradigm shift and obligations related to PoE and progress in SEAR

Even though many diseases have emerged in the last decade, it was outbreak of SARS in 2002 that made a major impact on the health-care system all over the world and had significant social and economic repercussions. New diseases are emerging and there are many uncertainties

which need to be dealt with. It has become evident that the public health threats affecting mankind have to be addressed with shared responsibility. The new IHR (2005) came into force on 15 June 2007. This is a legally binding document for the Member States that signed it and sets the rules for international health. Now the shift is towards all-hazard threats and not just diseases, and there is more focus on containment at source.

The 2007 to 2009 were devoted to planning and assessment of IHR; 2009–2012 is the implementation period. The aim for SEAR was that there should be at least one designated port, airport and land crossing in each country (as applicable) that would have all the core capacities listed under the IHR. This has to be done by 2012.

WHO is mandated to support Member States in becoming IHR compliant by June 2012. Member States should be able to identify, assess, assist and inform WHO of any potential Public Health Emergency of International Concern (PHEIC). Containment at source is the most effective measure to prevent a potential PHEIC from becoming global. The importance of limiting unnecessary health-based restrictions on travel at PoE was also highlighted. The aim is to keep ships sailing, planes flying and transport running between countries.

The role of WHO under the new IHR, benefits and values of IHR (2005), expected obligations related to PoE in international travel, prevention and containment, early warning and response, routine and emergency core capacity requirements, were discussed.

Discussions

- Designation of ports, airports and ground crossings: Some countries felt that all international PoE should be designated as otherwise it defeats the very purpose of IHR (2005), while others felt it was more realistic to designate only important PoE (e.g. planes with a potential PH threat on board could be transferred/redirectioned to the designated PoE) and focus country efforts on developing these PoE to meet the requirements of the IHR.
- The requirements at PoE include not only screening and quarantine but also provision of safe food and drinking water, maintaining hygiene and good sanitation, being free from

vectors, and having other facilities to reduce health risks to international travelers.

- Exit screening was being given a low priority and most countries were concentrating on entry screening only.
- If there is a public health threat on board, delay or diversion of a plane at the PoE can impact the whole travel network, affecting other countries and creating a domino effect. This impact has to be taken into consideration while planning for such measures.
- There were still issues in dealing with International Civil Aviation Organization (ICAO) and International Maritime Organization (IMO) while implementing IHR at PoE; and coordination mechanisms need to be in place with these organizations.
- The Cooperative Arrangement for the Prevention of Spread of Communicable Diseases (CAPSCA), at its fourth steering committee meeting held in Kuala Lumpur in June 2010, introduced business continuity management; which covered airlines and airports and related services. It also provides directions towards issues related with points of entries under IHR (2005) obligations.

Public health measures taken at international borders during early stages of pandemic influenza A (H1N1) 2009: preliminary results

Towards the end of 2009, WHO, the Centers for Disease Control and Prevention (CDC) and the Hamburg Port Health Center collaborated with ICAO and industry partners to conduct a multi-sector survey of border health measures used during the early stages of Pandemic (H1N1) 2009. This survey was conducted by the IHR Coordination Department to study the response during Pandemic (H1N1) 2009 at PoE between 20 April and 31 July 2009. The survey aimed to obtain information about the measures applied, perceived effectiveness, resource requirements, and the impact on international travel and transport.

- The presentation depicted the overview of results (preliminary analysis) of the survey and it showed that information was provided to travelers mostly by website and hand-outs on arrival, with too much focus on entry procedures rather than on exit

ones. The presentation talked about border measures taken by health authorities, change in requirements for declarations of health by aircraft, ships, trains and buses, before and during the Pandemic (H1N1) 2009; entry screening methods, isolation of suspected/ confirmed cases, quarantine of close contacts, changes in strategy and perceived impact of entry screening and the way forward.

- Fifty six of 193 (29%) WHO Member States responded to the survey, although only 17 responded to the longer version of the questionnaire. EMRO and AFRO did not participate in the survey.
- 91% of countries provided health information at PoE.
- The proportion of countries conducting entry screening increased from 32% before the 2009 pandemic to 61% during the early stages of the pandemic. Only 5% of countries reported having conducted exit screening; 91.6% of those Members States who responded thought that they were able to delay entry of the virus in their countries. During the presentation it was mentioned that China had detected 14 cases per million population screened. Most other countries had much lower detection rates. In the case of China, the detection rate was high because of their past experience and because these public health measures are now routine (post-SARS).
- Nearly half of responding countries issued travel advisories recommending avoidance of travel to affected areas. While no countries reported canceling flights or ship routes to affected areas, 4% stopped the entry of people and 11% stopped the entry of animals or animal products from affected areas; 9% of countries reported having refused free pratique (defined as permission for a conveyance to enter a port to embark or disembark, to discharge or load cargo or stores).

Discussions

- Screening: Of 34 countries who had some sort of entry screening, only 15 had facilities for isolation. These countries used quarantine for suspected cases. The other countries that did not confirm the infection also did not use quarantine

isolation effectively. It is not clear whether they did not use it or whether they were not prepared well enough to use it. Entry screening has a limited role but is considered effective in specific instances such as delaying the entry of a pathogen into the country. But self-screening yielded more positive cases as compared to other entry screening measures such as temperature monitoring.

- Only four countries had laboratory support available at the airport or port. We still do not know if conducting laboratory tests at the PoE has any advantages considering the limited efficacy of the laboratory test kits. Precise information was not available regarding the time taken for testing at the PoE. But it is generally perceived that in international travel, holding a passenger for more than two hours is likely to result in a lost connection. Any test that takes more than two hours to report back the results is not likely to be acceptable.
- Contact tracing: Regarding contact tracing, the proximity guidelines (those persons two rows in front and two rows in the back) were explained and recommended considering that droplet transmission covers 1 to 1.5 metres. The PoE functions include detection, identification of contacts and informing the national health surveillance system. Usually there are no resources at PoE to do contact tracing; also, many contacts go unidentified.

Response at the PoE has to be comprehensive, including efficient entry and exit screening, facilities for quarantine and isolation, and linkages with national surveillance and response systems. The countries that had routine public health measures before the pandemic had fewer problems in implementing measures, and preparedness was the key.

6. Presentations on country experiences

Strengthening of PoE: Experiences from EMRO

The Eastern Mediterranean Region (EMR) is a diverse region including 21 Member States with long-standing conflicts, massive movement of populations (76 million internally displaced persons), porous international

borders, and different levels of health systems development resources, and economic disparities. Many activities here undertaken at the time of Pandemic (H1N1) 2009 but these did not focus on core capacities at PoE only, but rather were an integral part of IHR activities. The presentation was based on a self-assessment monitoring and evaluation tool developed at EMRO; WHO was not involved in the monitoring in the countries assessed themselves and reported and EMRO aggregated and summarized the data. Challenges in the region included economic disparities, lack of understanding of the importance of partnerships and intersectoral collaboration, lack of transparency and sharing of information, a shortage of health workforce, and training needs.

A decision was made to establish an IHR Unit in EMRO and the unit's agenda was to map the authorized points of entry and assess IHR core capacities.

Discussions

All 11 countries of the South-East Asia Region have completed the self-evaluation M &E tool and sent to the IHR department of WHO headquarters with a copy to SEARO, but the analysis results are not available yet.

The questionnaire for monitoring IHR core capacities is divided into 13 sections, which include the 8 core capacities at PoE and 4 hazards. Individual questions are grouped; by components and indicators. PoE covered under Core Capability 9 and has 3 components: general obligations, surveillance, and response. More self-assessment by countries needs to be done, and more details of all the elements required will be available in the future.

Asia Pacific Strategies for Emerging Diseases (APSED) recommendations on strengthening PoE under IHR 2005

Asia Pacific strategies for emerging diseases (ED) are vital because many of these diseases originate in this region; APSED was jointly developed by WPRO and SEARO to address emerging infections. During the "APSED Beyond 2010" country consultations were conducted. Many countries expressed the need for inclusion of PoE public health work in the next APSED in order to strengthen links between PoE roles and the existing

surveillance systems for emerging infectious diseases and other public health events. A biregional meeting was held in Manila during the first week of July 2010 and strategies for 2011–2015 were finalized and support to APSED was extended by another five years.

The process of development of APSED has given in detail: its objectives, special areas that need considerations, upgrading of laboratories and the importance of laboratory networking, surveillance, risk assessment and response logistics, zoonoses, biosafety, public health emergency preparedness, functions of the national IHR focal point, clinical case management and the implementation of strategies at national level These included:

- Promoting the new role of PoE under the IHR (2005) with advocacy and sensitization to both routine measures and emergency public health measures
- Using existing tools and guidelines to strengthen public health measures, including strengthening cross-border collaboration
- Encouraging PoE participation in the existing national disease surveillance and response systems and in public health emergency planning
- Strengthening intercountry, regional and international partnerships and networking on managing PoE public health events and PHEIC.

Country experiences and lessons learned from Pandemic (H1N1) 2009 response at PoE and strengthening of PoE – Indonesia

The first confirmed case of H1N1 in Indonesia was reported on 16 June 2009; by September 2009, 1097 cases were detected and there were 10 deaths. The cumulative number of cases in Indonesia by provinces and age group were presented.

There are 48 port health offices and strengthening of core capacity at PoE has been carried out. Emergency planning is being completed in Indonesia and assessments are being done. Targets have been stipulated by the Ministry of Health.

A 90-day training programme for port authorities has been developed and is being used in Indonesia. This information could be shared with other countries. The training was designed by the Ministry of Health, Indonesia, and WHO funded the first training which focused on IHR core capacities at PoE.

Country experiences and lessons learned from pandemic H1N1 Pandemic (H1N1) 2009 response at PoE and strengthening of PoE – Thailand

Thailand has 64 PoE, 18 of which are designated for IHR core capacities development. During the recent pandemic, thermal scanners were used only at some major airports, ports and ground crossings. It was observed that this did not work for ground crossings. Thermal scanning was accepted for screening during SARS. Even though they were aware that technically thermal scanners were ineffective, they were used as a symbolic gesture for confidence building and to show that efforts were being made to prevent the disease from entering the country.

CDC evaluated the use of thermal scanners and recommended not using them for influenza; the same conclusion was reached by Public Health authorities in United Kingdom. WHO had recommended not using scanners but they were used by many countries for detection of cases. During SARS it was reasonable to use the thermal scanner because one of the first symptoms of SARS was high fever, but this was not the case for H1N1. Thermal scanners can be used if the resources are available and one is prepared to put up with it for a long period of time. If resources are limited it would be better to use them, for example to purchase ventilators and other critical care equipment.

Strengthening PoE – Airports Bhutan

Bhutan has one airport and about 200 passengers come and go every day, which is manageable from a public health perspective. Ground crossings are with neighbouring India and points of entry have been identified, but the most strategic ones have yet to be identified. Vector control measures are in place at major ground crossings, but emergency response plans at ground crossings are needed. Public health measures during Pandemic (H1N1) 2009 were in place, with very good cooperation from everyone

concerned. A quarantine facility was available. A multi-hazard emergency response plan is under consideration.

It was suggested that ground crossings should not just be a crossing point but have cross-border collaborations with other MoUs if feasible. There was already a MoU with the Government of West Bengal but this had to be built further.

In times of emergency, check points in Bhutan are closed under a common understanding with India. Bhutan has its own medical screening and immigration requirements, which are being currently revised.

Strengthening public health functions at PoE New Delhi–India

Before IHR (2005) came into force there were some measures undertaken as per the IHR (1969) in India. With the SARS outbreak these measures were intensified. As experience was gained, more measures were started as per IHR (2005).

The main objective was to have surveillance and response at all times and during public health emergencies and in India 11 ports and 5 airports have this 24-hour facility. Core capacities were available at all times at ports and airports and ground crossings to respond to events; isolation and quarantine are available at designated PoE (5 airports); and specific measures to deal with communicable diseases event were available. India also had an isolation facility at Indira Gandhi International airport.

Acts and regulations related to IHR were being revised in India.

Available manpower, routine functions at PoE, surveillance and response measures and preparedness for PHIEC and entry screening, and a health screening card that passengers have to fill at some ports, PHIEC strategy and challenges, were described. Infrastructure development, strengthening of conveyance surveillance, vector control, disinfection of aircraft, and the PHEIC plan were outlined in detail.

Contact tracing was carried out for co-travelers from three rows front and back, although the WHO guidelines is two rows. In a big airplane, an additional row increases the number of contacts by 20. The Ministry of

Health in India wanted the three row rule and the health authorities at the airport implemented it.

For disinfection measures, WHO guidelines have been incorporated. Disinfection of aircraft is not done routinely. Disinfection is done only when the aircraft requires it or when the aircraft has a suspected case, and this can be carried out by major airports in India.

In India, there were cross-border understandings in matters such as what type of screening needs to be done, what drugs need to be given, and treating of patients who cross the border for HIV/TB, malaria and vector-borne disease treatment. This has to be expanded to fit into the IHR (2005) compliance.

Activities to prevent Pandemic (H1N1) 2009 Democratic People's Republic of Korea (DPRK)

In DPRK all citizens get free medical care. DPRK has 12 provinces and 208 districts/counties in which there is good public health-care system and epidemic control facilities. Rapid response teams for communicable diseases have been established at central, provincial, district and county level. Good laboratory testing capacity, quarantine measures and emergency epidemic control systems are in place. Actions taken for Pandemic (H1N1) 2009 at PoE including surveillance, management and response.

Although DPRK was successful in responding effectively to the pandemic, lack of laboratory capacity to support prompt detection and immediate response and limitations in medical monitoring of the travelers and taking proper measures were seen as major constraints. This requires the development of an appropriate surveillance and response systems at PoE.

Twenty-eight confirmed cases of Pandemic (H1N1) 2009 were detected at PoE.

Country experiences and lessons learned from Pandemic (H1N1) 2009 response at PoE – Myanmar

As of 6 July 2010, there were 138 confirmed cases of Pandemic (H1N1) 2009 reported in Myanmar; there were localized small outbreaks that were contained immediately. There were no deaths and no wide spread transmission in the community.

Myanmar has two international airports, in Yangon and Mandalay, one port in Yangon, and six major ground crossings. The H1N1 infection was controlled mainly by risk communications to the public using television, printed material and other media, and intensified surveillance in the community and health-care facilities. There was political commitment and guidance from the National Health Committee, and thermal screening and health checks were carried out at the airports, ports and ground crossings.

Country experiences and lessons from Pandemic (H1N1) response at PoE- Nepal

There is only one international airport in Kathmandu, Nepal. The country is bordered by China in the north and India in the east, west and south. Borders are very porous. There were ten quarantine posts in major land crossings that were temporarily established during Pandemic (H1N1) 2009 for screening purposes only. Health screening was established at the international airport and is also available at major land crossings between Nepal and China and India. Usually these posts are manned by Department of Livestock staff (for animal screening) only.

There was screening for fever at the airport during the pandemic and passengers were provided with information to report back if symptoms developed. While screening at the airport was effective, at border crossings it was not cost effective. Case detection was made difficult at borders due to the difficult geographic terrain of Nepal. The surveillance system was not sensitive enough to detect outbreaks. Policies and legislation need to be developed utilizing a multisectoral approach. Information sharing, surveillance and response also needed to be strengthened. Involvement of the private sector is considered important.

Country experiences and lessons learned from Pandemic (H1N1) 2009 response at PoE – Maldives

Maldives has two IHR-designated international airports and four international seaports. Larger passenger vessels were allowed only at Malé port. Human resource capacity-building was required at both airports and seaports. Entry screening was done. Laboratory samples from humans and animals were sent to Bangkok. The national influenza pandemic preparedness plan has been updated. Environmental control measures were in place but capacity is limited. Inspection was done regularly for potable water and at eating establishments at the PoE.

There was daily reporting of communicable diseases; guidelines for case management were available; emergency medicines were stocked at all health facilities; risk communications were conveyed through video, leaflets and posters. A national task force on IHR has been established and a public health bill was being discussed in parliament, which could soon be adopted as an Act.

Country experiences and lessons learned from Pandemic (H1N1) 2009 response at PoE and strengthening of PoE – Sri Lanka

Sri Lanka has one designated international airport in Katunayake which has an average of 6500 arrivals daily. There are three ports, in Colombo, Galle and Trincomalee. Colombo port is designated under IHR (2005).

The actions taken during the Pandemic in April 2009 included - passenger screening, filling up of health declarations from passengers coming from infected countries, installation of two thermal scanners and having a medical officer on duty 24 hours/day were instituted at the airport. Suspected passengers were sent to the Infectious Diseases Hospital in Colombo, which was the main quarantine station, and has a 150-year history for handling disease outbreaks.

Many challenges had to be faced. The non-health staff who had varied education levels and awareness had to be educated separately. Additional health staff that was mobilized were not prepared to handle emergencies. Relief staff lacked basic facilities including availability of PPE. There was also difficulty in coordinating with other service providers at the

airport; health staff were afraid to transport suspected and ill passengers; quarantine of suspected passengers was difficult; and there was difficulty in disinfection of aircraft as staff did not know how to do it. All these issues need to be addressed in the future.

Panel Discussion

Panelists: (1) Dr Daniel L. Menucci
(2) Dr Avdesh Kumar
(3) Dr Jarnail Singh
(4) Dr Warulup Tankanakul

It was stated that we should have a common understanding of IHR and that points of entry are also points of exit, and thus should be viewed as points of exchange. IHR scope and purpose raises important questions related to PoE such as how to give the best protection to our populations; how committed the authorities are and how to do it in a best possible way; and how to best look points of entry as part of overall national surveillance and response systems. There is a need to identify a focal point for PoE in countries. The key actions that are needed include:

- Ensure an intersectoral approach and balance public health measures that are in place with key international traffic and ensure appropriate coordination.
- Create awareness of IHR for other partners.
- Identify best ways to use the human resources in the country and to specify roles and responsibilities of the human resources at the PoE.

Strengths and weaknesses at POE

Even though the IHR has lasted from 1969 to 2005, the mindset of people is still on border control and quarantine. We need to open up our minds and look at PoE as points of exchange where travel and entry of goods can be facilitated, while keeping everything functioning smoothly.

Strengths

- The biggest strength is that the IHR (2005) enabled Member States to strengthen their infrastructure at PoE and were able to

handle public health emergencies like Pandemic (H1N1) 2009 effectively. PoE is one place where one can bring about behavioural change.

Weaknesses

- Increased travel and trade pose a huge challenge at airports ports and ground crossings.
- A legal framework is needed. The Port Health Officers in Thailand have successful experience dealing with emergencies, especially after SARS. They have been empowered to do their job and the local law can be adjusted according to the IHR (2005) by changing the rules of the ministry.
- Core capacities like physical infrastructure in terms of hospitals, laboratories and trained manpower need to be developed, or strategic linkages.
- Networking and coordination with multiple stakeholders is a huge challenge.
- IEC and risk communication are another area where a lot of work still needs to be done.
- Documentation of best practices needs to be carried out.
- Hazards like food safety and chemical, nuclear and radiological aspects need further attention. There is a lack of experts on chemical/nuclear and radiological disasters.
- Financial resources are needed.
- When there is a plan for any public health emergency with international concern at PoE, think about deactivation and channeling of the resources, as most countries have limited resources. Most of the time, deactivation is at the peak of the pandemic or epidemic. By that time community spread has already taken place and there is no point in having any measures at PoE. At this stage resources will be needed to care for people at high risk and who are sick.

General comments

- Critical staff and functions such as safe water, food and hygiene and sanitation at the airports are integral part of any prepared news plan.
- Points of entry of one country are points of exit for another country. This needs to be kept in mind while setting up designated posts at borders.
- De-boarding a passenger has ethical and financial issues. Airlines do not like to carry sick passengers as this would pose more problems for them, but they also do not prefer to refund the tickets. Airlines offer a wide variety of choices in purchasing air tickets and these should be encouraged.
- A crew member of a ship being transferred from the airport to the ship carries only a maritime ID. There is no passport or visa. If she/he is not allowed to board the ship there would be a problem as the crew member will have no visa if the ship leaves without them. This has to be considered in planning.
- Where vaccinations were considered, none of the countries had provided vaccines to a cruise liner. There was no national policy to provide vaccines to crew members travelling to other countries. This necessitates thinking globally when planning preparedness.
- The plans for PoE should be developed with attention to how to do risk assessment, risk management, and risk communication. An example is the IATA database, where problems are anticipated and action taken to prevent any consequences.
- Even though 100% efficacy cannot be maintained, a mechanism to promote voluntary declarations should be found. Voluntary declaration can be made effective through intensive education efforts and behavior change. Rather than PoE, the focus should be on exit screening coupled with epidemiological intelligence.
- IHR focuses on containment at source. In this context, the PoE is a relatively small issue. The aim is to stamp out new, emerging diseases which can spread rapidly in a country. The importance of having a unified national focal point for disease surveillance

and rapid response and early warning with links to the PoE is very clear. But this link is still very weak. Efforts should also be focused on “hot spots”—for example countries that are bordered by more than one country. If there is an outbreak of disease in one country the other countries are immediately going to be affected, and intercountry and interregional collaborations to address ground crossings are crucial.

- Airlines should be involved from the beginning of planning or implementation of plans. Airlines have been cooperative whenever they have been requested to change flight schedules during a medical emergency.
- Disease can spread through cargo and containers. It would not be near the PoE and can be away from the port area. The loading points of cargo that comes from inland and goes out of the country and cargo coming through ships to a loading point could be about 15 to 20 kilometers from the PoE. These loading points, although not technically at PoE, should come under the IHR regulations.

ICAO roles and the Cooperative Arrangement for the Prevention of Spread of Communicable Disease through Air Travel (CAPSCA)

ICAO is a UN specialized agency dealing with global aviation. The Convention on International Civil Aviation governs the entire civil aviation industry and procedures. The standards and recommended practices (SARP) as set in this code are promulgated by national civil aviation authorities in their own legislation, and every standard must be complied with.

In 2002 during SARS, the airports were deserted. There were panic reactions, no preparedness plans and no harmonization at airports and in international travel. In 2005 with H5N1, WHO had meetings with ICAO and together developed preparedness plans. To take this forward the Cooperative Arrangement for the Prevention of Spread of Communicable Disease through Air Travel (CAPSCA) was formed. It was launched in September 2006 in order to facilitate implementation of ICAO guidelines, evaluation of international airports and for training of personnel, taking into

account that the aviation sector may again be hit badly. It was considered essential to have a harmonized preparedness plan that will give protection and inspire confidence in travellers. All CAPSCA guidelines are available in the WHO, IATA and ICAO websites.

Discussion

On the issue of whether the public health community overreacted to H1N1 and whether the overreaction was evaluated, it was mentioned that evaluations done in WPRO and elsewhere indicated that measures put in place by some of the states were excessive. They created problems in the free flow of passengers and trade. For example the quarantine of people who had just come into contact may not have been necessary. The authorities also did not know when to stop the measures.

WHO had guidelines on disinsection. The guidelines have three initiatives. (1) Chemical safety for new products; (2) efficient testing for products to give licenses, mainly focused on aircraft; and (3) vector control at PoE. Some work has been done with IATA, ICAO and the United States on nonchemical methods which can be used in disinsection but it is not yet approved. Under IHR (2005), WHO is supposed to provide the countries with a list of areas with risk of transmission of particular vector-borne diseases. Two meetings were held last year for these topics and focused on mosquitoes and insects in aircraft and malaria, yellow fever and chikungunya. Areas of risk within the countries are being identified and the old list is being revised.

ICAO regulations mention meetings of passenger facilitation committees every month in which the PHO has to be present, but most of the time they are not invited for these meetings. The facilitation committee requires all the authorities at the airport to be present at these meetings, and they should be formally invited. In the past, those who work in public health were not aware of the link between the public health and transport sector, for public health preparedness. All the countries should consider the need for change, and how to integrate public health and the transport sector in their preparedness plans. If this coordination is not done, as is currently the case in some countries, there will be more than one group at the airport doing similar functions.

7. Group discussions

Participants were divided into three groups, one each for those working ports, airports and ground crossings.

The following topics were discussed:

- Role of PoE health authorities including health and quarantine officers, prior to an emergency and emergency planning, at PoE.
- How to ensure partnerships with other agencies (enforcement, aviation and maritime authorities) at national and international level, and the private sector operating at ports and airports.
- How to ensure links between various officials and effective communication with the national focal point for IHR.
- How to ensure collaboration in the SEA region and with WPRO and EMRO.
- How to ensure communication at the regional level and with headquarters and other agencies during an emergency.

8. Group presentations

Group discussion on airports, ports, and ground crossings

India has 12 major ports and many minor ports. Though Kandla is a major port, it lacks basic facilities. IHR have been implemented for the last 40 years. Screening was carried out effectively during SARS and Pandemic (H1N1) 2009. The present set-up was conducive to implement the new IHR (2005) requirements. Among the weaknesses are lack of uniformity in work, manpower, training and infrastructure, as well as statutory powers for implementation and lack of awareness regarding the importance of health in trade and economics.

When there is a public health event of concern, every port health team does an enhanced surveillance of all ships as per the IHR. Based on the document of maritime information of health, ships will either be allowed direct entry without inspection or be inspected when coming in from suspected areas, if there is death of crew or animals on board, on

suspected infections/diseases. Sanitation, food and water safety, vector control, and air quality control are part of PoE routine. The port health authority is an important coordinator for public health emergencies at ports. Legislation and policy are lacking for new diseases. At seaports, it is not only a person that could carry infection, but also the carrier or containers itself. All this needs to be considered in building core capacity.

During routine hours

- As per Article 22 of IHR, the airport health officer (AHO) should coordinate with different stakeholders such as civil aviation, airport authorities, customs, immigration, security officials, and service providers, including medical service providers. They should have regular meetings, which will ensure that everybody is aware of the AHO and his/her responsibilities at the airport.
- The port health officer (PHO) should supervise and monitor all these functions and co-ordinate between all the stakeholders who are involved in various activities such as vector control, food safety, and chemical safety, etc.
- Training of stakeholders is the responsibility of the PHO.
- PHO should ensure proper communication with the national focal point and state health authorities if there is any disease outbreak or increasing problems in vector control, so that proper action can be taken. Coordination should be ensured with local authorities such as municipal authorities, veterinary department, quarantine authorities, agricultural ministry for animal and plant related diseases, district, state and national health authorities (for laboratory support and surveillance), other agencies at port such as the private sector, transport staff local container freight stations and freight terminals. At the port level, every port has to have a joint sanitary committee for surveillance and rapid response. Good coordination with vector control experts for newer knowledge and training and assessment of the prevalent situation at each port on a regular basis needs to be carried out.
- Prepare public health emergency plans and coordinate them to incorporate the plan in actions by stakeholders. The PHO should conduct mock exercises periodically.

During an emergency

- Call an emergency meeting with the coordination group and apprise them and discuss what action needs to be taken.
- Be in touch with the national focal point and ministry of health to convey what actions are needed due to the public health emergency.
- Be in touch with the airport authorities to convey requirements, such as what screening needs to be done.
- Train staff and stakeholders immediately to let them know what actions are being taken and why, so that they can communicate with the passengers if questions are asked.
- Make an assessment of the workforce available and what is needed, and designate responsibilities for other officers as well.
- Effective communication during emergencies is important both at the national and international level. PHO should be connected with the focal point, ministry of health or other national-level authorities such as Ministry of Communications and Broadcasting etc. All types of communication, either face-to-face meetings or by email, should be in place.

Partnerships

- The airport has a large number of partners such as the civil aviation authority and airport management. Various other service providers – people who provide food, water and sanitation - have a tendency to completely ignore health activities and need to be trained properly. Coordination with airlines is important when there is a suspected case among the passengers. If possible we need to have airline data for better facilitation. Coordination is also needed with the maritime industry and border security agencies.
- Coordinate with the agencies dealing with animal, plant and human quarantine.
- Coordinate with municipal agencies, especially for vector control. According to IHR, in addition to the airport premises,

the 400-metre periphery surrounding it also needs to be treated for vector control.

- Partnership with other ministries and departments can be done through the national focal point. The Ministry of Shipping, India is developing a web-based interface called the port community system to interlink customs, port health, port state control, port users, shipping agents and container terminals, to facilitate movement of ships without hindrance by various regulatory authorities. It is not implemented yet but is being tested.

Intercountry and interregional collaboration

During the Pandemic (H1N1) 2009 countries were not aware of what the other countries in the region were doing. There should be a mechanism for this; a common health-related website giving a complete list of offices, a email system, database related to manpower, contingency plans, and reporting of events of public health emergencies should be in place.

- There should be direct contact or MoU between countries and regions. Exchange of information between the AHO of one country and another should be available at least through the intercountry websites. Direct links with other ports for ship sanitation-related measures need to be developed. Under IHR, all the ship sanitation certificates and any control measures have to be applied at one port and followed up at the next port. Ports of countries should share surveillance information through a secure web site for the vectors and infectious diseases situation at the PoE to help the next port to be prepared.
- Partnerships with transport companies and other agencies such as FAO, the International Red Cross and the security and industrial sectors are needed.
- Building trust, transparency, and good human relations backed by the necessary MoU is crucial.
- Collaboration with WHO for funds and intercountry collaboration is required.

- The Association of South East Asian Nations (ASEAN) and Bay of Bengal Initiative for Multisectoral Technical and Economic Cooperation (BIMSTEC) can contribute.

Legal implementation of IHR in SEAR with focus on experience in India

IHR (2005) stipulates that each country has to assess its own legal system to determine if the existing rules and regulations are in compliance. Article 54 of IHR requires Member States as well as the Director-General of the WHO to report to the World Health Assembly (WHA) on the status of IHR implementation. In 2009, a questionnaire was sent to all Member States to assess the compliance of existing legislation, administrative requirements, and regulations in Member States to monitor the progress. Out of the 11 countries, 9 Member States participated in the survey. The findings and status of implementation in relation to these countries were presented. The Indian legal situation, acts related to health, operational framework (consisting of the focal points and acts that were revised with regulations for IHR compliance) were explained.

A brief description of the Indian Epidemic Diseases Act of 1897 was given. This Act will be replaced by the new PHEIC Bill which is now under process at the Ministry of Law and Justice before approval by Cabinet and Parliament for final gazette notification. Justification for the new Public Health Emergency Bill was presented.

Options for public health interventions at PoE and human resource capacity building at an international airport

The presentation summarized all the discussions on measures to strengthen core capacities at airports. Points of entry play an important role in the response to the international spread of diseases through early detection, coordination, public health measures taken and clear decision-making after assessment of the situation. Intervention strategies at PoE depend on the type of public health emergency. It could be infectious (known viral and bacterial) or new (such as SARS and H1N1); or related to chemicals and radiation. An intervention strategy should be in place at all times and during emergency. The goals are to delay the spread and outbreak peak, reducing number of cases, and getting a lead time to plan and prepare response.

Guidance for public health emergency contingency planning at designated points of entry : Requirement under the IHR regulations 2005

The presentation briefly explained the background and purpose of the guide which dealt with PHE management planning fundamentals. The guide described the process, key considerations, steps and structure of a plan to assist development of PoE emergency preparedness plans by Member States.

The participants were requested to work in groups to assess the utility of this guiding document to help the MS prepare emergency preparedness and response plans at PoE.

Group work presentations

The group presentations outlined strategies to strengthen core capacities at PoE in Member States. A group was constituted for each type of PoE (ports, seaports, and ground crossings), and they presented strengths and weaknesses in different Member States and suggested means to strengthen the core capacities at PoE. Although there were common issues related to each type of PoE on such as capacity building, development of standard operating procedures (SoPs) and emergency preparedness plans on each PoE presents challenges of its own. The main findings and recommendations included:

- All the countries had some form of health infrastructure and a legal framework at airports and ports, but not at ground crossings (due to past experience with public health emergencies such as SARS and Pandemic (H1N1) 2009); some action has been taken to strengthen core capacities.
- Each PoE had a different work load. It was proposed that there should be an analysis to link the workload and the status of performance to the risks at each PoE.. A data base is available with IATA with all the details and capacities available at airports, which can be used to undertake risk assessments. Although there is no standard indicator, it was felt that countries as identify a few PoE that combined together would cover 90% of

international traffic. Ever-increasing traffic requires ongoing efforts to develop core capacities.

- There is a need for assessment at PoE in order to strengthen the existing measures in most Member States. It was suggested that WHO support the assessment and ensure follow-up based on this assessment.
- Training of workforce with short - and long-term courses, development of training curriculum and training modules are needed.
- There is a lack of guidelines and contingency planning. Member States have some routine plans to deal with PH hazards at airports but their documentation is lacking. These plans include elements of emergency measures, but formal plans for emergency preparedness and response have not been developed. WHO will provide technical and financial support to strengthen routine and develop emergency plans. WHO will be requested to provide support to MS to develop MoUs and SOPs for implementation of PH measures. There is a need for development of guidelines for vector control, disinfection, sanitation, food, and quarantine. WHO will be requested to provide technical advice and funding to develop guidelines as and when required by the countries. Contingency planning teams are not in place in most countries and need to be established.
- Links with hospitals and laboratories are weak and need to be strengthened.
- IEC facilities at PoE are a weak link in efforts to combat PH hazards.
- WHO should play a lead role in developing strategies for international collaboration to share data and interact with other Member States through PAGnet or a regional website. For bilateral cooperation on IHR, WHO could support meetings with at the request of Member States.
- WHO will be requested to provide technical advice and financial support when requested by the Member States.

- There are wide variations between the countries as far as implementation of IHR (2005) at land crossings is concerned. Some countries had strong IHR and national focal points, along with WHO-provided guidance and necessary support to implement PH measures at land crossings. However, it was seen that the land crossings are not equipped well enough compared to airports and ports, and are a weak link in preventing the international spread of diseases.
- Article 21 of IHR (2005) advocates for countries to make into multilateral and bilateral agreements. WHO is preparing guidelines in this regard and will likely include experiences and lessons learned with bilateral agreements. As each ground crossing presents a unique scenario, the experiences from different countries would help to decide what considerations are to be used for managing public health risks and help decide whether the crossing point needs to be designated or not.
- A standard monitoring and evaluation system should be in place for all countries, to be used as benchmark. Member States can add more indicators to assessment tools to assess their progress.
- The number of PoE regionally and country-wise was available, but the total number of PoE handling international trade and travel was not available. This information was available with IATA and needs to be included in PAGnet.

Some of the immediate next steps to develop core capacities at ports include development of contingency plans and training of staff, strengthening physical infrastructure and transport, improving communications links and ensuring legal backup. MS will request assistance from WHO to conduct training and provide equipment and software, such as video conferencing facilities for each country. Data-sharing is required, along with development of linkages with the national surveillance system and international collaboration with other Member States.

Assessments of PoE: Using WHO assessment tool (WHO document on core capacity assessments at PoE)

A short video {IHR Edit (Final Version blue WHO HQ)} on the global picture of the 2009 pandemic, the purpose of IHR (2005) and the

development of core capacities was shown. The video focused on the role played by state authorities and WHO for the development of core capacities (both routine and emergency) at designated PoE; necessary actions by countries; communication and coordination with other national stakeholders; and vector control. Core capacities are needed not only for communicable diseases but include all public health risks. The core capacity checklist containing three major parts (communications and coordination, routine capacities and capacity for public health emergencies) has been posted on WHO website.

The presentation was followed by a group exercise on the use of a spread sheet for assessment. This is a tool that can be used by the authorities themselves to suggest areas of improvement. The spreadsheet brings out the strengths, weaknesses and feedback for future improvement based on the total score, and makes suggestions for specific areas for improvement. While an 80% score was adequate, improvements can be made to achieve a higher score even if it is not 100%.

The checklist, when used in conjunction with other qualitative indicators (such as those used in Thailand), was felt to be of immense help in monitoring progress in implementation of IHR core capacities.

Dr Sujeet Kumar asked whether the focus can be on WHO support for the deficient areas mentioned by the Member States so that they can work on those areas. Training was one area that was identified as weak.

9. Training workshop on ship sanitation and inspection

Following the meeting a training workshop on ship sanitation and inspection was held. The meeting was facilitated by Dr Daniel Menucci and Dr Wang Ninglan.

IHR (2005) create obligations for ships' masters and for competent authorities at PoE. The master of a vessel must always have a valid ship sanitation certificate on board and the competent authority is entitled to demand to see a vessel's current certificate. Furthermore, Member States must send WHO a list of ports that are authorized to issue Ship Sanitation Control Certificates and Ship Sanitation Control Exemption Certificates.

WHO has developed detailed guidelines to assist competent authorities with ship inspections and the implementation of the new regime.

10. Conclusions and recommendations

Under the new IHR (2005), PoE are an important component of prevention of the international spread of disease and should not be seen as a barrier. Strengthening PoE as per the new IHR (2005) and sound public health policies and practices will improve international travel and trade. Countries of the Region have undertaken measures to strengthen IHR (2005) implementation at PoE, but the effort has been focused on preventing infectious diseases entering into the country rather PoE developing them as per the requirements of IHR (2005). This is largely due to lack of awareness advocacy and training. Emergency preparedness and response plans are virtually non-existent, and where available do not follow the all-hazards approach nor involve the relevant stakeholders.

At the end of meeting, the participants agreed that:

- Strengthening PoE core capacities under the new IHR framework will contribute to regional and global health security, and such efforts should be part of joint efforts in managing acute public health threats. PoE should be viewed as important sentinel points (both entry and exit) and it will contribute to early detection, reporting and information-sharing about infectious diseases and other public health threats.
- There is a need to establish a clear decision-making mechanism so that evidence-based, balanced and adapted public health measures can be implemented at PoE. PoE should ensure that border measures are in compliance with WHO recommendations under the IHR framework.
- Effective mechanisms for multiagency communication, coordination and information-sharing, including operational links between PoE authorities and the national IHR focal points, need to be established.
- Strengthening and implementing PoE public health emergency preparedness and response measures is a priority, in ways that

are of regional and international common interests, the existing “Guidance for Public Health Emergency Contingency Planning at Designated Points of Entry: Requirement under the International Health Regulations (2005)”, needs to be adapted.

- There is a need to identify and share best practices in strengthening public health response capacity at international POE, including advance and practical arrangements of health services, and preparation for specific border health management measures.
- The implementation of IHR (2005) at PoE involves not only the potential PHEIC but also ensuring that routine measures and contingency planning are in place at all times. In order to accomplish that, more quarantine hospitals are being established and more equipment (such as thermal scanners) are being put in place, but this might create surplus infrastructure. The port health authority should not get involved in every activity but should make strategic linkages with national health systems to respond to any PH event. Designating a large number of PoE is going to be very difficult, and this aspect has to be looked into practically.

The following recommendations were made during the meeting:

Recommendations for Member States:

- Compile a list of all international PoE in the countries, and designate and make assessments of PoE.
- Strengthen core and develop emergency PH preparedness plans.
- Create awareness among different stakeholders regarding IHR (2005).
- Identify competent authorities to implement PH measures at PoE.
- Create and maintain multilateral cooperation.
- Address legislative issues.
- Sustain financial support and undertake fundraising.

Recommendations for WHO-SEARO

- Create awareness and undertake advocacy for implementing core capacities as required under IHR (2005) at PoE in Member States.
- Assist the Member States in implementation of IHR core capacities by strengthening their capacities at the country levels.
- Develop and update appropriate guidelines and tools for assessment, monitoring and evaluation of PoE by the countries.
- Assist the Member States in doing comprehensive assessments at PoE.
- Provide technical support to test emergency preparedness and response in Member States.
- Develop training material for developing human resource capacity at PoE and provide technical support to Member States to undertake trainings of staff.
- Update Member States on the global and regional progress through information-sharing platforms (e.g. PAGnet).
- Assist the Member States in cross-border collaboration and liaison with the international partners and resource mobilization.

11. Closing remarks

All participants acknowledged the workshop's efforts and its usefulness in enhancing wider awareness related to IHR (2005) and obligations related to PoE. Awareness on ship inspection and issuance of ship sanitation certificates under the IHR (2005) framework was raised. During his closing remarks, the chairperson expressed that the objectives of the meeting were achieved. The meeting reviewed current status of PoE, identified strengths of core capacities, helped Member States to assess themselves and improve, identified follow-up actions at national and regional levels, and the role of WHO.

Annex 1

Message from Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia Region

The theme of this meeting is “Strengthening Points of Entry under the New International Health Regulations”. This is the first meeting in the South-East Asian Region focusing on points of entry bringing together Member States from South-East Asia and experts from the Eastern Mediterranean and the Western Pacific regions, WHO headquarters, and other partner organizations such as the International Civil Aviation Organization. The broad participation here reflects the importance of collaborative efforts to implement the International Health Regulations (2005) at points of entry. These regulations, better known as IHR (2005), entered into force in June 2007. They provide a legal basis for reporting, notification, information-sharing, consultation, verification, and determination of public health emergencies of international concern (PHEIC), irrespective of source and origin.

The emergence of new infections and re-emergence of infections previously thought to be controlled have changed the face of public health across the world. Both SARS and Pandemic influenza (H1N1) 2009 clearly demonstrated how infectious diseases can spread fast and far in a short period. The International Health Regulations cover a wide range of events other than infectious diseases which may constitute a PHEIC.

The South-East Asian Region has made considerable progress in implementation of IHR (2005), particularly in strengthening surveillance systems and in capacity-building to respond to public health threats. However, there is also a need to strengthen capacities required at designated international points of entry. This Region presents unique challenges in the areas of emerging infectious diseases and other public health risks. Home to nearly a quarter of the world’s population, the South-East Asian Region has in the last decade seen several outbreaks of infectious diseases such as SARS, H5N1, dengue, Nipah virus and plague. The last year has been momentous for public health and brought out the strengths and weaknesses of public health efforts in the world and our Region. IHR

(2005) has proven to be a very valuable framework to facilitate international collaboration for timely information-sharing and mobilization of expertise and other resources to respond to public health emergencies.

The relentless efforts of the national IHR focal points have allowed us to detect and respond collectively to public health emergencies of international concern.

Under the new regulations, international points of entry now have new roles to play that go beyond mere border control. Building on the experience so far gained, there is a need to strengthen emergency preparedness and response capacities at points of entry including airports, ports and ground crossings. This new mandate has also brought out many questions:

- How can we ensure that points of entry comply with their obligations under IHR (2005)?
- How can we be better prepared to respond to these threats at designated points of entry?
- How can we build technical capacity and ensure human and financial resources to meet our obligations and make it sustainable in the long run?

This meeting is an important step towards addressing these issues. I am very pleased that such a distinguished group is gathered here to discuss these questions and help us identify ways to move forward. I wish you fruitful deliberations and every success in achieving the objectives of this important meeting.

Annex 2

Agenda

Wednesday, 14 July 2010

0800 – 0900 **Registration**

0900 **Agenda I: Opening Session**

- National Anthem (Sri Lanka)
- Lighting of Oil Lamp
- Welcome Address and RD's speech by Dr. Firdosi Rustom Mehta, WHO Representative to Sri Lanka
- Objectives of the Meeting by Dr. Yogesh Choudhri, Medical Officer, Disease Surveillance and Epidemiology, WHO SEAR
- Address by the Chief Guest – Dr. S. Settinayake, Deputy Director General of Public Health Services, Ministry of Health, Sri Lanka
- Vote of Thanks
- Appointment of Chair and Co-chair
- Administrative announcements

1015 - **Agenda II: Update on IHR (2005) in relation to PoE**

International Health Regulations (2005): a paradigm shift and obligations related to PoE and progress in SEAR region

Dr. Yogesh Choudhri, DSE/SEARO

Survey of public health measures at international PoE in response to H1N1; global and SEARO

Dr. Daniel L. Menucci, Technical Officer WHO/HQ

Agenda III: Country experiences in strengthening public health functions at PoE

1045 – 1700 *Strengthening of PoE: Experiences from EMRO*

Dr. Ali Reza Mafi EMRO.

*Asia Pacific Strategies for Emerging Diseases (APSED)
recommendations on strengthening PoE under IHR 2005 -*

Dr. Sampath Krishnan, CDS Focal Point, WHO/SEARO

*Country experiences and lessons learned from pandemic H1N1
2009 response at PoE and strengthening of PoE – **Indonesia and
Thailand***

*Strengthening PoE – Airports **Bhutan***

*Strengthening Public Health Functions at PoE New Delhi– **India***

Activities to prevent pandemic new influenza (H1N1)

- Democratic Republic of Korea (DPRK)

1300

*Country experiences and lessons learned from pandemic (H1N1)
response at POE – **Myanmar / Nepal / Maldives / Sri Lanka***

Panel Discussions followed by questions and clarifications

Thursday, 15 July 2010

0830

Summary of Day 1

0840

**Agenda IV: International Partnerships in strengthening public
health functions at POE**

*ICAO role and cooperative arrangement for the prevention of
spread of communicable disease through air travel (CAPSCA) –*

Dr. Jarnail Singh, Civil Aviation Authority of Singapore

*Introduction of group discussions – **Dr. Yogesh Choudhri***

*Group work for inter-country collaborations and international
partnerships and cooperation*

Group Presentations - Airports

*IHR 2005 core capacities at PoE, seaports: India strengths and
weaknesses - **Dr. S. Senthil Nathan, Port Health Officer,
Kandla, India***

Group presentation - Ports

Group presentation – Ground crossings

- 1300** **Agenda V: Capacity Building at PoE**
Legal Implementation of IHR in SEAR with focus on India experience - Dr. Avdhesh Kumar, Assistant Director General (International Health), Ministry of Health, India
Options for public health interventions at PoE and human resource capacity building at an international airport – Dr. Sujeeth Kumar Singh, Airport Health Officer, Indira Gandhi International Airport, Delhi
- 1545** **Agenda VI: Communication, coordination and information sharing at country level**
Guidance for Public Health Emergency Contingency Planning at designated Points of Entry : Requirement under the IHR regulations 2005 – Dr. Yogesh Choudhri
- Friday, 16 July 2010**
- 0830** **Summary of Day 2**
- 0840** *Group presentations: strategies and approaches to strengthen core capacities at PoE*
- 1015** **Agenda VII: Monitoring and Evaluation**
Presentation: WHO document on core capacity assessments at PoE – Ninglang Wang, Technical Officer, WHO HQ
Introduction of group discussions (breakout session) monitoring and evaluation: gaps and strategies to monitor and evaluate
Group exercise on using WHO checklist
Group presentations
- 11.00** **Agenda VIII: Role of WHO: Conclusions and follow-up actions**
- 1120** *Conclusions and follow-up discussions*
- 1220** *Closing remarks*
- 1330 – 1600** *Workshop on ship sanitation certificate*

Annex 3

List of participants

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The International Health Regulations, or IHR (2005), require countries across the globe to develop and strengthen the core capacities at designated international points of entry (PoE) such as airports, ports, and ground crossings by June 2012. This includes strengthening public health routine and emergency preparedness and response at designated PoE. In order to review progress made under IHR (2005) at PoE, and to agree on priority areas to strengthen surveillance and response at PoE, a Regional Meeting on IHR Core Capacities at Points of Entry was organized in Colombo, Sri Lanka, on 14-16 July 2010. This meeting brought Member States together to determine current strengths and weaknesses, and identify follow-up actions at national and regional level to strengthen core capacities at PoE. This report summarizes the deliberations of the meeting and outlines the responsibilities of the Member States and the role of WHO in meeting the obligations of IHR (2005).



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