The International Health Regulations (IHR) (2005) entered into force in June 2007 and are legally binding on all the WHO Member States (MS). The main purpose of this global legal framework is to prevent the international spread of disease while avoiding unnecessary interference with international traffic and trade. Under the IHR (2005), points of entry (PoE) play an important role in preventing international spread of diseases. Strengthening core capacities at all times, establishing response mechanisms to address an event including public health emergency contingency plan, and measures to be adopted during public health emergency of international concern (PHEIC) are core requirements under IHR (2005).

A regional meeting on IHR (2005) core capacities at PoE was held in Kochi, (India) to discuss progress made under the IHR (2005) at PoE in Member States, identify strengths and weaknesses and follow-up actions at national and regional levels to strengthen core national capacities at PoE.

During the meeting, it was agreed that the main areas where MS need to accelerate their efforts included advocacy, amending legislation, strengthening intersectoral collaboration and dedicating resources, both in terms of finance and human resources, and paying special attention to issues related to ground crossing points. WHO was urged to provide technical support in building human resource capacity through study tours; support development of action plans including public health emergency contingency plan; provide relevant materials for advocacy and training of staff; facilitate cross-border meetings and enhanced collaboration with other related international agencies; and mobilize resources.
International Health Regulations (2005)
core capacities at points of entry

Report of a regional meeting
26–28 June 2013, Kochi, India
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<th>Definition</th>
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<td>International Health Regulations (IHR) (2005)</td>
</tr>
<tr>
<td>ABQHO</td>
<td>Airport and Border Quarantine Health Office, India</td>
</tr>
<tr>
<td>AOT</td>
<td>Airport of Thailand Public Company Limited</td>
</tr>
<tr>
<td>APHO</td>
<td>airport health office</td>
</tr>
<tr>
<td>BSF</td>
<td>Border Security Force, India</td>
</tr>
<tr>
<td>CA</td>
<td>competent authority</td>
</tr>
<tr>
<td>CAPSCA</td>
<td>Cooperative Arrangement for the Prevention and Management of Public Health Events in Civil Aviation</td>
</tr>
<tr>
<td>DRRT</td>
<td>district rapid response team</td>
</tr>
<tr>
<td>FETP</td>
<td>field epidemiology training programme</td>
</tr>
<tr>
<td>FSSAI</td>
<td>Food Safety And Standards Authority of India</td>
</tr>
<tr>
<td>GC</td>
<td>ground crossing</td>
</tr>
<tr>
<td>ICAO</td>
<td>International Civil Aviation Organization</td>
</tr>
<tr>
<td>IDSS</td>
<td>integrated disease surveillance system</td>
</tr>
<tr>
<td>IMO</td>
<td>International Maritime Organization</td>
</tr>
<tr>
<td>LPAI</td>
<td>Land Port Authority of India</td>
</tr>
<tr>
<td>MS</td>
<td>Member States</td>
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<tr>
<td>NFP</td>
<td>national focal point</td>
</tr>
<tr>
<td>PAG</td>
<td>ports, airports, and ground crossings</td>
</tr>
<tr>
<td>PAGNET</td>
<td>Ports, Airports and Ground Crossings Network</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>--------------</td>
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</tr>
<tr>
<td>PHECP</td>
<td>public health emergency contingency plan</td>
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<tr>
<td>PHEIC</td>
<td>public health events of international concern</td>
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<td>PHO</td>
<td>port health offices</td>
</tr>
<tr>
<td>PoE</td>
<td>points of entry</td>
</tr>
<tr>
<td>RRT</td>
<td>rapid response team</td>
</tr>
<tr>
<td>SARP</td>
<td>standards and recommended practices</td>
</tr>
<tr>
<td>SARS</td>
<td>severe acute respiratory syndrome</td>
</tr>
<tr>
<td>SEAR</td>
<td>WHO South-East Asia Region</td>
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<tr>
<td>SEMEX12</td>
<td>Suvarnabhumi emergency management exercise</td>
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<tr>
<td>SSC</td>
<td>ship sanitation certificates</td>
</tr>
<tr>
<td>TS</td>
<td>technical support</td>
</tr>
<tr>
<td>WPR</td>
<td>Western Pacific Region</td>
</tr>
<tr>
<td>YF</td>
<td>yellow fever</td>
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Executive summary

The International Health Regulations (IHR) (2005) entered into force in June 2007 and are legally binding on all the WHO Member States (MS). The main purpose of this global legal framework is to prevent the international spread of disease while avoiding unnecessary interference with international traffic and trade and provide a public health response. Effective public health measures, including surveillance and response capacity at international points of entry (PoE), contribute to minimizing the risk of international spread of diseases.

A regional meeting on IHR (2005) core capacities at PoE was held between 26–28 June 2013 at Kochi, India to discuss progress made under the IHR (2005) at PoE in MS, identify strengths and weaknesses and follow-up actions at national and regional levels to strengthen core national capacities at PoE.

The specific objectives were to:

1. Review the progress in development of core capacities at PoE;
2. Identify strategies and approaches to strengthen core capacity at airports/seaports/and ground crossings (GCs) including joint designations at GCs;
3. Share case-studies depicting best practices in IHR (2005) implementation at PoE; and
4. Identify follow-up actions at national and regional levels and technical support from WHO.

A total of 35 participants from 10 Member States of WHO South-East Asia Region (SEAR) attended the meeting which included presentations from MS on the progress made, gaps and challenges and what is expected from WHO. The invited technical advisers presented examples of prevailing practices at the three PoE viz. ports, airports,
and GCs. The representative from International Civil Aviation Organization (ICAO) described how WHO and ICAO could work together to strengthen the capacity of MS to implement IHR (2005) at airports through Cooperative Arrangement for the Prevention and Management of Public Health Events in Civil Aviation (CAPSCA) project. The participants were divided into three groups: one each for ports, airports, and GCs and discussed the strengths and weaknesses in IHR (2005) implementation, strategies and approaches to strengthen core capacities at PoE in SEAR.

Under the new IHR (2005), PoE play an important role in preventing international spread of diseases. Strengthening core capacities at all times, establishing response mechanisms to address an event including public health emergency contingency plan (PHECP), and measures to be adopted during public health emergency of international concern are core requirements under IHR (2005). Member States in the Region have undertaken measures to strengthen IHR (2005) implementation at PoE, but the progress is uneven between Member States as well as across different core capacities, as exemplified by the relative lack of response mechanisms to address events due to nuclear/chemical/ radiological hazards.

During the meeting, it was agreed that the main areas where MS need to accelerate their efforts included advocacy, amending legislation, strengthening intersectoral collaboration and dedicating resources, both in terms of finance and human resources, and paying special attention to issues related to GCs.

WHO was urged to provide technical support in building human resource capacity through study tours; support development of action plans including PHECP; provide relevant materials for advocacy and training of staff; and facilitate cross-border meetings and enhanced collaboration with other related international agencies; and mobilize resources. Necessary follow-up to the recommendations will be ensured by the Regional Office.
Background

The International Health Regulations (IHR) (2005) entered into force in June 2007 and are legally binding on all the WHO Member States (MS). The main purpose of this global legal framework is to prevent the international spread of disease and provide a public health response while avoiding unnecessary interference with international traffic and trade. Effective public health measures including surveillance and response capacity at international points of entry (PoE) contribute to minimize the risk of international spread of diseases. Under IHR (2005), MS have a legal requirement for complying and establishing core capacity standards at designated PoE. IHR (2005) require Member States to develop and strengthen the core capacities at designated international 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 (PHECP). All the Member States of WHO’s South-East Asia Region (SEAR) have received extension up to 15 June 2014 for implementation of IHR (2005) core capacities, including those to be implemented at PoE.

The IHR (2005) monitoring data highlight certain gaps in achievement of core capacities at the designated PoE in Member States of the Region which primarily include:

- advocacy at national level to involve different stakeholders;
- existing legislations/acts/government orders that may not be in line with the requirements of IHR (2005);
- development of country/PoE-specific plans and guidance documents;
- training of the staff at PoE;
- strengthening cross-border collaboration; and
- resource mobilization.
Progress has been made in the areas of creating awareness and advocacy; technical support visits and organization of training for PoE staff in four MS in accordance with the recommendations made at the regional meeting on strengthening PoE in SEAR held at Colombo, Sri Lanka in June 2010. WHO provided direct support to strengthen implementation of PoE in many MS, including financial contribution, such as to Timor-Leste. At the national level, many MS have undertaken assessments and developed plans to strengthen core capacities at PoE. However, progress in this area of IHR (2005) has been relatively slow and there is a need to accelerate efforts to strengthen PoE in Member States of the Region. The issues related to strengthening IHR (2005) requirements at PoE have been discussed in the meetings held periodically to assess IHR (2005) implementation in MS, and in the Fourth Regional Meeting on the Implementation of the International Health Regulations (2005) held in December 2011 at Bangkok, Thailand, as well as the IHR Partners’ Meeting held in November 2012, at New Delhi, India, when gaps in implementation of IHR (2005) at PoE were identified. The WHO Regional Office for South-East Asia was requested to facilitate the assessment of national IHR core capacities when requested and support the development of national IHR implementation plans (especially with respect to public health legislation, surveillance and response, public health laboratory capacity, risk communication and PoE).

Since IHR (2005) came into force, there have been two biregional meetings between the South-East Asia and Western Pacific regional offices to address issues related to PoE and IHR (2005). The WHO–ASEAN meeting on public health measures at international PoE: New role under the International Health Regulations (2005) was held in November 2009 at Manila, Philippines. A total of 13 countries from the Western Pacific Region (WPR) and seven from SEAR participated in the meeting. The meeting recommended that WHO, in coordination with relevant agencies such as ICAO, provide technical support to strengthen PoE core capacities under the IHR (2005) framework; help MS implement preventive measures and information-sharing; provide support to strengthen emergency preparedness and response; and develop technical guidance on public health emergency preparedness at designated PoE. By June 2012, each MS should have at least one designated airport and port, as applicable, which will meet obligations under IHR (2005). The second meeting of technical experts from WPR and SEAR was held in February 2010, which developed a document “Guidance for public health emergency contingency planning at designated points of entry: Requirement under the International Health Regulations (2005)”.
A regional meeting on IHR (2005) core capacities at PoE was held between 26–28 June 2013 at Kochi, India, which brought representatives from SEAR together to discuss progress made under the IHR (2005) at PoE in MS, identify strengths and weaknesses as well as follow-up actions at national and regional levels to strengthen core capacities at PoE. It was perceived that this meeting would also help in developing formal and informal networks among Member States in the Region. (See list of participants at Annex I)
Objectives

The general objective of the meeting was to strengthen national capacity at PoE in accordance with the requirements of IHR (2005). The specific objectives were to:

1. review progress in the development of core capacities at PoE;
2. identify strategies and approaches to strengthen core capacities at airports, seaports, and ground crossings (GCs) including joint designations at ground crossings;
3. share case studies depicting best practices in IHR (2005) implementation at PoE; and
4. identify follow-up actions at national and regional levels and request technical support from WHO.
Dr Richard Brown, Regional Adviser, Disease Surveillance and Epidemiology, WHO Regional Office for South-East Asia, gave a brief overview of the meeting and delivered the message of Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia highlighting the significance of the meeting as exemplified by the broad participation from Member States. The South-East Asia Region has made considerable progress in the implementation of IHR (2005), particularly in the areas of strengthening surveillance systems and capacity-building to respond to public health threats. However, progress in strengthening capacities required at designated international PoE has been slow and needs extra effort, both in terms of technical and financial resources.

The Regional Director also drew attention to the challenges being faced in the implementation of IHR (2005), which mainly included the need for advocacy, capacity-building, strengthening cross-border collaboration and resource mobilization.

WHO is mandated to provide support to its Member States to strengthen core capacities at PoE. In this regard, direct technical and financial support has been extended to many Member States in our Region. This meeting was an important step in strengthening collaborative efforts and addressing the issues related to IHR (2005) implementation at PoE (See Annex 2 for full text of the message.)

Dr Daniel Lins Menucci, Technical Officer, Global Capacity, Alert and Response Department, WHO Headquarters, thanked the participants and reiterated WHO’s commitment for supporting regional initiatives. He also described the current activities being undertaken, such as supporting training, development of guidance materials and coordination and collaboration with other sectors to strengthen IHR (2005) implementation at PoE.

Dr Sujeet Singh, Deputy Director-General (International Health), Public Health Specialist, Ministry of Health and Family Welfare, Government of India and Dr LBH
Denuwara, Director (Quarantine), Ministry of Health, Sri Lanka were appointed Chairperson and Co-chairperson respectively.

Dr Singh emphasized the role of training and technical material for strengthening required capacities at PoE and stated that self-monitoring data reflected the areas where support is needed. He mentioned the steps being taken in India such as PHECP at airports and ports which had been finalized, and revision of legislation, where the approval of the Ministry of Law was awaited. Collaboration with other stakeholders had been strengthened and a nodal officer in each sector identified for liaison for IHR (2005) implementation. He noted that there was a gap in cross-border collaboration and emphasized the need to work more closely by developing informal networks.

Dr Brown provided a regional overview of the activities being undertaken in different core capacities to support the implementation of IHR (2005) in SEAR. The priority hazards in SEAR included, among others, emerging and re-emerging communicable diseases, natural disasters, increasing incidence/recognition of chemical/toxic events, and antimicrobial resistance. He also gave a brief overview of IHR (2005); how it is different from IHR (1969) (amended in 1973 and 1981); and what are the roles and responsibilities of MS. While describing the relationship between WHO Headquarters, Regional Office and MS, he stressed collective responsibility and reporting requirements. He emphasized the importance of PoE as a component of IHR (2005). The slow progress made in SEAR for development of core capacities was attributed to tight timelines, priority by the MS, funding and inherent property of some capacities requiring more time and because the responsibility lies outside MoH. All MS had been given an extension up to 15 June 2014 based on extension plans. He provided a brief overview of the activities being undertaken in different core capacities at the regional level to support implementation of IHR (2005) in Member States of the Region.

Dr Yogesh Choudhri, Temporary International Professional, Disease Surveillance and Epidemiology, WHO Regional Office for South-East Asia, recapitulated the progress made in the Region in implementing IHR (2005) including the results of assessments undertaken in the past and monitoring data of 2012 at PoE. He also outlined the main gaps and challenges which included, but were not limited to developing and formalizing effective collaboration, communication and formal plans with other sectors; strengthening communication links, undertaking detailed periodic assessments and developing and testing PHECP, emphasizing the need for WHO and MS to work collaboratively.
Dr Menucci outlined the obligations of state parties and pointed out that the focus is on the traveller, reducing the spread of disease and maintaining ports, airports, and ground crossings (PAG). He underlined the need to collaborate with others such as ICAO, International Atomic Energy Agency, and International Maritime Organization (IMO) and mentioned that some areas of IHR (2005) that are binding on MS are also internationally agreed upon with airlines/ship operators as per the ICAO Standards and Recommended Practices (SARP) and different conventions of IMO, International Air Transport Association (IATA) and ICAO. He also urged MS in SEAR to send a list of ports authorized to issue ship sanitation certificates (SSC). Currently, only four MS are issuing SSC. Regarding certification process for airports and ports, initial consultative meetings had been held, but for GC, no such certification had been planned. Various resources and guidance documents available as technical guides for implementing IHR (2005) and the benefits of joining PAGNet were also described.

Dr Rolly T Bayaban, Officer-in-Charge, Office of the Flight Surgeon and Aviation Medicine, Civil Aviation Authority of the Philippines, in his capacity as Deputy Team Leader, outlined the Cooperative Arrangement for the Prevention and Management of Public Health Events in Civil Aviation (CAPSCA) project in detail. The aim of the CAPSCA Asia–Pacific project was to bring stakeholders together, especially the aviation and public health sectors, to facilitate collaboration in the development and implementation of relevant ICAO standards and recommended practices, associated procedures and guidance material to reduce the risk of air travellers spreading influenza with pandemic potential, and similar communicable diseases. In addition, implementation of the (IHR) (2005) at PoE, in particular at international airports, is an important goal of CAPSCA. The Sixty-sixth World Health Assembly urged Member States to continue strengthening ties and intensifying collaboration with ICAO – especially with CAPSCA – to enhance preparedness and response to public health events at PoE. At present, six MS of the Region (India, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand) are members of the CAPSCA Project and there is a need to involve the remaining MS also, so that they can avail the benefits of the services being offered (See Annex IV for a detailed description).
4

Proceedings

4.1 Update on IHR (2005) implementation at points of entry

Table 1 depicts the number of designated PoE in each of the MS (except Democratic People’s Republic of Korea where seven ports, one airport, and 10 GCs have been designated as per IHR monitoring data 2012). In total, there are 107 designated PoE (39 ports, 28 airports, and 40 GCs) and six more will be added from India in the near future.

Table 1: Number and names of designated ports, airports, and ground crossings

<table>
<thead>
<tr>
<th>Member State</th>
<th>Number of designated</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ports</td>
<td>Airports</td>
<td>Ground crossings</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Bhutan</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>India</td>
<td>Nine (one more to be designated later)</td>
<td>Five (5 more to be designated later)</td>
<td>1</td>
</tr>
<tr>
<td>Indonesia</td>
<td>7</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Maldives</td>
<td>4</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Myanmar</td>
<td>1</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Nepal</td>
<td>0</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>Four each of international and national</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Thailand</td>
<td>5</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
4.2 Progress made in Implementation of IHR (2005) at ports, airports, and ground crossings in MS of SEA Region

Bangladesh

Dr Rezia Akhter Begum, Airport Health Officer, Hazrat Shahjalal International Airport, Dhaka, Bangladesh listed the designated PoE of the country as follows:

*Designated airport*: Hazrat Shahjalal International Airport, Dhaka (assessment done in 2011 and 2012)

*Designated port*: Chittagong Seaport, (assessment done in 2011 and 2012)

*Designated ground crossing*: Benapole and Jessore (bordering India) (assessment done in 2011 and 2012).

While delineating the progress made in implementation of core capacities, it was evident that there were certain common elements at all the three PoE. This included lack of appropriate legislation, absence of routine surveillance and non-existence of PHECP. However, at all the three PoE, coordination committees were constituted, meetings held to address IHR (2005) and assessments undertaken.

At the airport, medical facilities are available; however, there is no coordinator/contact point and no entry/exit control tool. No veterinary facilities are available, although a quarantine entomologist has been posted. There is no practice for submission of the health part of the aircraft general declaration by the captain/crew member to the airport authority in case of an aircraft coming from an infected area, perhaps because of lack of coordination between the health and airport authorities.

Similar observations were made regarding ports where the main findings included: absence of coordinator/contact point, existence of entry/exit control tool, availability of medical facilities, posting of plant observer and quarantine entomologist, SSCs are issued and submission of maritime declaration is practised.

As far as GCs are concerned, similar facts emerged from the assessments: the main findings included absence of coordinator/contact point for PoE, lack of entry/exit control tool. However, plant observer, veterinary officer and quarantine entomologist are posted.
Bhutan

Dr. Karma Lhazeen, Chief Programme Officer, Department of Public Health, Ministry of Health, Bhutan outlined the progress made regarding implementation of IHR (2005) at PoE in Bhutan. The following PoE have been proposed for designation in Bhutan:

Designated airport: Paro Airport (assessment done in March 2011).

Designated ground crossings: Phuntsholing (assessment done in March 2011); Gelephu (not assessed so far); and Samdrup Jongkhar (not assessed so far).

At Paro airport, an assessment undertaken in March 2011 revealed that competent authority for IHR (2005) has not been identified formally. Coordination and collaboration mechanism with other sectors is lacking, although there is good interaction at the operational level. However, no formal processes and standard operating procedures (SOP) exist, although each sector is doing its part fully or partially very well to achieve the IHR core capacities requirements.

A variety of Acts with public health implications on humans (livestock, plant quarantine, seed, forestry and nature conservation, food and custom Acts) are well developed to regulate cross-border trade and animal movement. Public health measures such as quarantine are undertaken as per executive orders. A formal coordination and collaboration mechanism, however, is lacking. Cross-border initiatives for control of communicable diseases (HIV/TB/malaria) are taken from time to time, but are not very effective in terms of implementation. PHECP has not been developed.

India

Dr. Sujeet Singh, Deputy Director-General ADG (International Health) made a presentation on the IHR (2005) implementation at PoE in India. The following PoE have been designated in India:

Airports: Five; one each at Delhi, Mumbai, Kolkata, Chennai and Tiruchirapalli. In addition, five more airports will also be designated and these include Thiruvananthapuram, Bengaluru, Hyderabad, Ahmedabad and Kochi.

Ports: A total of nine ports have been designated, including ports at Mumbai, JNPT Sheva, Kolkata, Chennai, Goa, Kandla, Kochi, Vishakhapatnam, Mandapam Camp; one more port at Tuticorin will be added soon.

Ground crossing: Amritsar ABQ ground crossing has been designated.
Out of the five designated airports, two (Mumbai and Delhi) have been assessed. Regarding progress made at airports, revision of legislative measures and identification of nodal officers for all designated airports have been undertaken. The Airport Facilitation Committee meets every month for coordination and collaboration with other sectors. Coordination/communications with immigration, customs, airport management, animal quarantine, Director-General of Health Services, and national focal point (NFP) is carried out and capacities for routine public health measures (to be undertaken at all times) are in place. Routine activities at the airports include surveillance for yellow fever (YF), provision of care and transport for sick travellers, isolation and quarantine facilities which are available at two major airports, YF vaccination services, vector control, food and water surveillance, conveyance inspection/clearance for disinfection. Training has been conducted for staff. Both airport health offices (APHOs) have fully equipped buildings and strengthening has been proposed for 10 APHOs which includes back-up hospital and laboratory facilities for routine and public health events of international concern (PHEIC). PHECP has been developed for Delhi and Mumbai. A uniform template has been developed for airports and circulated, but it has not been tested.

As far as progress made at ports is concerned, the Indian Port Health Rules have been revised to include provisions related to IHR (2005). Nodal officers for IHR have been designated at all ports. Capacities for routine public health measures (undertaken at all times) including medical care for ill travellers, vector control surveillance, food safety, and water sampling are in place. Strengthening of 10 port health offices (PHO) has been proposed in the Twelfth Plan. Regular training programmes on routine measures and training of trainers on health measures for events which may constitute PHEIC and SS inspection and issuance of Ship Sanitation Control Exemption Certificates SSCEC/SSCC have been organized. Coordination and collaboration through port trust authorities is done only in case of PHEIC.

The public health functions at GCs are covered under the Indian Aircraft (Public Health) Rules, which are under revision. The Land Port Authority of India (LPAI) established under LPAI Act, 2010 has helped in greater collaboration and coordination with other sectors. A nodal officer has been designated for IHR (2005) and is responsible for coordination and collaboration with other sectors. The designated GC – airport, border quarantine (ABQ) has not been assessed so far. Cross-border meetings for collaboration with neighbouring countries were not held at designated GC, but have been held with Bangladesh, Bhutan, Nepal and Sri Lanka on the issue of prevention of communicable diseases. Routine activities in terms of surveillance/ coordination/ communications take place at ABQ. A PHECP has been developed, but not pre-tested.
Indonesia

Indonesia has 27 international airports, 141 international ports and six GCs and 14 PoE have been designated (six international airports, one GC and seven seaports) as below:

**Airports**: Hasanudin Airport, Hang Nadim Airport, Juanda Airport, Ngurah Rai Airport, Polonia Airport, Soekarno Airport.

**Ports**: Belawan Port, Harbour Bay Port, Lagoi Port, Sekupang Port, Soekarno Hatta Port, Tanjung Perak Port, Tanjung Priok Port.

**Ground crossing**: Entikong.

Dr Zamhir Setiawan, Head of Health Quarantine and Port Health Sub-directorate, Ministry of Health, Republic of Indonesia mentioned that the country is preparing to adopt IHR (2005), as some legal matters have undergone revision and the remaining are planned to be revised (such as quarantine law, outbreak law, guidelines for implementation of surveillance system, SSCC/SSCEC Issuance, and international vaccination). All the PoE have been assessed and the main recommendations are that coordination and communication mechanisms with the authorities at other PoE abroad need to be strengthened; at most PoE, space and equipment to assess ill travellers are available, but are not adequate; and most PoE do not have adequate space to interview suspect cases or affected travellers.

Routine surveillance of people, goods and conveyances is conducted at all PoE, especially of those who come from infected countries/areas; health and quarantine documents are checked; health measures are applied to conveyances when risk factors are found (disinsect, derat, disinfect, decontaminate). Almost all 14 designated PoE mentioned above have established PHECP with authorities/stakeholders. Contingency plans are tested through tabletop exercise and field simulation on PHEIC.

Maldives

Dr Asma Ibrahim, Director, Health Protection Agency, Maldives stated that a total of eight PoE have been designated in Maldives which include four airports and four ports as below:

**Airports**: Ibrahim Nasir International Airport, Gan International Airport, Hanimadhoo International Airport, and Maamigili International Airport (private).

Draft regulations entitled “Public Health Act” are being developed and incorporate elements of IHR (2005) and in addition, draft regulations for port health have been developed. SOP for core functions at airport and port have been developed. Assessment of five PoE has been completed and the main recommendations included amendment of legislation, establishment of quarantine facility, training of staff and stakeholders. Based on the assessment, a plan of action has been developed. An IHR Committee has been established to lend support to the coordination and collaboration mechanism. As far as core capacities are concerned, surveillance includes passenger screening (yellow fever, any disease notified by IHR), ship sanitation certification and ship inspection; food inspection is done at PoE. Means of communication with NFP, Health Protection Agency (HPA), and the designated hospital exist. Although there is no specific PHECP, it is embedded in the airport emergency plan and pandemic preparedness plan (2009). Disease control measures, e.g. aerosol spraying, airport general declaration of health, vector control, risk-based inspections, and waste management functions are in place.

**Myanmar**

Dr Toe Thiri Aung, Assistant Director, Central Epidemiology Unit, Department of Health, Myanmar, made a presentation on IHR (2005) implementation at PoE in the country. The country shares its borders with Bangladesh, China, India, Lao People’s Democratic Republic and Thailand. A total of eight PoE have been designated which include:

**Airports:** Yangon International Airport (assessment done) and Mandalay International Airport.

**Port:** Yangon International Seaport (assessment done).


The progress made in implementation of IHR (2005) at each PoE was discussed. The Public Health Law (1974), Prevention and Control of Communicable Disease Law (1995), and the Law Amending the Prevention and Control of Communicable Disease Law (2011) which incorporate elements of IHR (2005), have been advocated and all stakeholders were sensitized to amended legislations.

At the airport, doctors and paramedics are trained by the regional field epidemiology training programme (FETP) except for those newly appointed. A competent authority responsible for supervision, coordination with related authorities
such as immigration, customs, police, transport and the Ministry of Science and Technology, clinics, ambulance, and quarantine facilities has been constituted. A PHECP is being developed.

Regarding sea ports, staff have been trained under various programmes such as the Field Epidemiology Traning Programme (FETP), tabletop exercise for pandemic influenza, training on risk communication and ship sanitation inspection and issuance of SSC. A competent authority has been identified and regular weekly coordinating meetings led by the Port Authority are being held. A PHECP is being developed.

Ground crossings are also in the process of implementing IHR 2005. Joint RRT training has been conducted at three GCs with Thailand. A competent authority has been identified and coordination and collaboration with other sectors is done through monthly meetings of the Border Control Committee.

Nepal

Dr Yuva Raj Pokhrel, Integrated Medical Officer, Epidemiology and Disease Control Division, Department of Health Services, Ministry of Health and Population (MoHP), Nepal mentioned that nine PoE have been designated in Nepal including:

Airport: Tribhuvan International Airport, Kathmandu (assessment done).

Ground crossings: Kakadvitta, Jhapa, Biratnagar, Morang, Birganj, Parsa, Bhairahawa, Rupandehi, Nepalganj, Banke, Dhangadi, Kailali, Mahendranagar, Kanchanpur with India and Tatopani, Sindhupalchok with Tibet/China. Five designated GCs have been assessed.

The Epidemiology and Disease Control Division (EDCD) acts as focal point for coordination and communication. In order to incorporate the provisions of IHR (2005), the first draft of a new Infectious Diseases Act has been prepared. The Food Act (1996) and Natural Calamity (Relief) Act (1992) are in place which address certain components of IHR (2005). Multisectoral coordination and consultation meetings have been conducted to develop an action plan for implementation of IHR (2005) and this incorporates elements related to PoE.

An IHR sensitization workshop for stakeholders was conducted in February 2007. Orientation of health officials from MoHP and DHS was conducted in July 2007 and
health workers trained on risk communication; but these activities were not specifically for PoE staff. The medical and public health staff at the airport coordinate and manage medical services including screening, isolation and treatment on a case by case basis. Four hospitals have been identified as isolation centres. A Nepal–India cross-border meeting on communicable diseases was held in 2012.

**Sri Lanka**

Dr LBH Denuwara, Director, Quarantine Unit, Ministry of Health informed that a total of six PoE had been designated in Sri Lanka which include:

**Airports:** Banadaranayake International Airport, Katunayake and Mattala Rajapakshe International Airport, Hambantota.

**Seaports:** Colombo Sea Port International, Hambantota Sea Port International, Galle Seaport International and Tricomalee Seaport International.

Progress in implementation of IHR (2005) was assessed and reviewed with all relevant stakeholders (port health authority, civil aviation authority, ministry of health, veterinary department, atomic energy authority) at the ministerial level, headed by the DGHS. Focal persons of epidemiology and quarantine units of the Ministry of Health have been appointed as NFPs of IHR. The country has established 24-hour health desks with medical services, with provision of limited isolation and patient transport facilities. The facilities at the Infectious Disease Hospital, which acts as an isolation centre for travellers, have been expanded and the laboratory services strengthened. In addition, enhancement of manpower, capacity-building, and contingency plans have been addressed (contingency plans have been developed at Bandaranayake International Airport and Colombo Sea Port). Migration and vaccination policy are under review to address the requirements of IHR (2005).

**Thailand**

Dr Vichan Pawun, Port Health Office (Suvarnnabhumi Airport), International Communicable Diseases Section, Bureau of General Communicable Diseases, Department of Disease Control Ministry of Public Health, Thailand, mentioned that a total of 18 PoE have been designated to implement core capacities of IHR 2005. These include:

**Airports:** – Suvarnnabhumi, Chiang Mai, Phuket and Krabi

**Seaports:** Bangkok Port, Laem Chabang, Mabtapud, Phuket and Chiang Saen.
Ground crossings: Aranyaprattet, Sadao, Padangbesar, Chiang Kong, Mae Sot, Mae Sai, Nongkhai, Mukdaharn, and Chong Mek.

The Ministry of Public Health and relevant stakeholders are committed to initiate IHR (2005) implementation since 2007. The Cabinet has endorsed the National IHR Committee and four sub-committees for building up IHR core capacities. In 2008, the National IHR Implementation Plan was developed and approved by the Cabinet, which allowed budget and resource allocations. Action plans have been implemented at the designated PoE to ensure that core capacities requirement in accordance with IHR (2005) provisions are met and are functional. In terms of legislations and regulation, the Communicable Disease Control Act has been revised and a new ministerial regulation on health documents related to IHR (2005) has been reviewed. The process for development of core capacities at the designated PoE and existing national port health system has been enhanced, and some new activities relating to IHR (2005) implementation strategy have been established, using WHO’s tools for guidance. The authorized operating team, by the jurisdictional governor, at designated PoE is a key mechanism for coordinating and mobilizing resources for the development of core capacities at PoE. Training has been conducted in SSCs, food inspection, vector control programme and highly pathogenic emerging diseases (HPED). Monitoring to assess the ability of the existing PoE structures and resources to meet the core capacity requirements at designated PoE was conducted by a team comprising representatives from various departments. This approach provides explicit mechanisms that drive the ongoing development and maintain a functioning programme to ensure public health safety. PHECP is available for all three types of PoE.

Timor-Leste

Ms Ofelia Maria do Carmo, PoE Coordinator, MoH-Timor-Leste informed that a total of three PoE have been designated in Timor-Leste and these include:

Airport: President Nicolao Lobatoe Airport (assessment done).

Port: Dili Seaport (assessment done).

Ground crossing: Batugade (1 PoE staff designated).
PoE and public health functions at PoE were established in 2011 with technical and financial support from WHO. The legislation governing PoE and IHR (2005) was approved by the Council of Ministers in December 2011 and the Government Law or Interministerial Committee Law was also approved in 2011. The two legislations mentioned are in the process of publication. A few activities have been undertaken to strengthen IHR (2005) implementation and these include: interministerial meeting and workshop, workshop to introduce main responsibilities at airport, intersectoral meeting at port with relevant sector (customs, agriculture, immigration), and meeting with airport authority. There is collaboration and coordination with staff from other ministries that have been posted at PoE, although no formal SOP/MOU exists. Medical services are provided at the port and airport. No routine surveillance is undertaken due to limited staff; joint Inspection of cargo is being undertaken. PoE staff were trained in India on ships, cargo and goods. PHECP has not been developed. Cross-border meetings and collaboration with neighbouring countries have been undertaken with Indonesia in 2011, 2012, and 2013.
### Table 2: Gaps/challenges, plan of action and areas calling for technical support

<table>
<thead>
<tr>
<th>Member State</th>
<th>Gaps/challenges</th>
<th>Plan of action</th>
<th>Technical support</th>
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<tbody>
<tr>
<td>Bangladesh</td>
<td>No disease surveillance&lt;br&gt; No routine screening&lt;br&gt; Health-care services at port and airport&lt;br&gt; HR not trained&lt;br&gt; Inadequate facilities for travellers at POE&lt;br&gt; No veterinary services&lt;br&gt; No identified training needs/modules&lt;br&gt; Finance&lt;br&gt; Stakeholders’ involvement (multisectoral collaboration)&lt;br&gt; Lack of PHECP</td>
<td>Re-assessment&lt;br&gt; Medical Officer at Point of Entry to be included in District Rapid Response Team (DRRT)&lt;br&gt; HR strengthening&lt;br&gt; Develop guidelines for surveillance&lt;br&gt; Physical infrastructure&lt;br&gt; Ambulance&lt;br&gt; Develop Public Health Emergency Contingency Plan (PHECP)</td>
<td>Consultants for technical support&lt;br&gt; Physical facilities at PoE&lt;br&gt; Technical Support for water and waste management at ports</td>
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<td>Bhutan</td>
<td>Appoint competent authority&lt;br&gt; Advocacy&lt;br&gt; Stakeholders involvement (multisectoral collaboration)&lt;br&gt; Formal processes and SOP&lt;br&gt; Cross-border initiatives&lt;br&gt; Develop plan of action and PHECP&lt;br&gt; Open and porous borders</td>
<td>Appointment of competent authority&lt;br&gt; Involve stakeholders&lt;br&gt; Formalize processes&lt;br&gt; Sensitization&lt;br&gt; Develop SOP&lt;br&gt; HR capacity-building and training&lt;br&gt; Strengthen surveillance mechanism&lt;br&gt; PHECP and event-on-board&lt;br&gt; PHEIC plan to include POE</td>
<td>HR: Training&lt;br&gt; Study tours for airports and GC&lt;br&gt; Development of SOP and formal processes</td>
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<td>Democratic People’s Republic of Korea</td>
<td>No representation at this meeting</td>
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<td>India</td>
<td>HR strengthening</td>
<td>Training facility development</td>
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<td>Advance life support ambulance</td>
<td>Strengthening manpower/equipment/facilities</td>
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<td>Coordination with food safety</td>
<td>Training PHECP testing of plans</td>
<td>E-networking</td>
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<td>Integration of PHEIC in other plans</td>
<td>Intersectoral collaboration on event management</td>
<td>Organize and support cross-border meetings</td>
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<td>Training and drill for PHECP</td>
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<td>Stakeholders involvement at level of PoE</td>
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<td>Airport: Space; food safety on aircraft; coordination with airlines</td>
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<td>SP: Uniform SOP; training; transport</td>
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<td>Organize and support cross-border meetings</td>
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<td>GC: Legislation; cross-border meetings</td>
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<td>Regional collaboration</td>
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<td>HR Training: Facility to be developed</td>
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<td>Assessments</td>
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<td>E-networking</td>
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<td>National Disaster Management System (NDMA) and early warning and response system (EWARS): Intersectoral collaboration</td>
<td>Intersectoral collaboration on event management</td>
<td>Training</td>
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<td>E-networking and communications and coordination</td>
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</table>
| **Indonesia** | Advocacy among non-health partners  
Lack of effective surveillance and response to PHEIC is not effective  
Documented policies and practices lacking  
IHR not well understood by partners  
Financial constraints | Advocacy  
Promote coordination  
Examine and revise legislation  
Strengthening surveillance at PoE  
Development of guidelines  
Development of PHECP  
Development of SOP for response at PoE | Advocacy  
Training and HR capacity development  
SOP development |
| **Maldives** | Legislation: Revision  
Inadequate supervision and monitoring  
Lack of resources: HR and facilities/equipment  
Privatization policy of port (challenges)  
Stakeholders’ involvement  
Stronger political commitment  
Waste disposal is a challenge | Plan for Public Health Emergency (PHE)  
Preparedness and Response  
Plan for regular training  
Develop SOP  
Strengthen communications  
Coordinated activities related to travel and health  
Supplies  
Occupational health of PoE workers | Finalizing legislation  
Training of staff  
Assessment of PoE |
| **Myanmar** | Human resources: Quantity and capacity  
Intersectoral collaboration  
Cross-border strengthening  
Inadequate infrastructure and medical facilities  
Country in transition (trade and travel)  
Strengthen existing vs new PoE  
Limited resources | Strengthening POE: Epidemiologist at central level  
Updating surveillance system  
Strengthening communications  
Cross-border dialogues  
Updating facilities for IPC at PoE  
Monitoring and assessment | PHECP development and testing plans  
Updating FETP manuals to include PoE  
Technical Support for capacity-building for mass health gatherings |
<table>
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<th>Member State</th>
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<tbody>
<tr>
<td>Nepal</td>
<td>Stakeholders’ involvement (multisectoral collaboration) A plan of action for strengthening core capacities needs to be developed IDSS yet to be implemented Infrastructure and human resources Legislation Porous borders Financial constraints</td>
<td></td>
<td>Development of plan Support development of infrastructure Strengthening surveillance system Financial support Capacity-building Human resources and training RRT capacity development Laboratory strengthening</td>
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<tr>
<td>Sri Lanka</td>
<td>Trained manpower Limited infrastructure SSC training Finance Stakeholders involvement Stronger political commitment Legislation Limited laboratory infrastructure</td>
<td>Widen scope of surveillance Communications and networking Training Infrastructure development Review legislation Develop SOP Multisectoral/ multidisciplinary task force PHECP updating and testing Mapping resources Needs assessment for training Screening facilities at PoE</td>
<td>Sharing of experience with other countries Finance Technical Support for expansion of basic infrastructure</td>
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</table>
Table 2 depicts the main gaps and challenges, plan of action and need for TS as presented by the representatives from Member States. The main gaps and challenges include:

- lack of political support
- need for advocacy
- revision of existing legislation
- lack of intersectoral collaboration and communications
- lack of surveillance and risk assessments
- lack of financial and human resources
- lack of cross-border initiatives to implement IHR (2005) at GC
- lack of PHECP

The main areas where national governments are investing include:

- advocacy
• strengthening intersectoral collaboration
• human resource capacity-building
• strengthening surveillance
• development of guidelines and SOP
• development and testing of PHECP.

Technical support is needed by the Member States in implementing plan of action especially related to development and testing of PHECP, development of standard operating procedures (SOP) and training of manpower.

Dr Ritu Singh Chauhan, National Professional Officer-Microbiology, WHO Country Office, India shared recent experiences of WHO supporting the Ministry of Health and Family Welfare, Government of India for strengthening PoE in line with IHR (2005) through various mechanisms. In the biennium 2012–2013 also, a number of activities were supported for PoE, including revision of port and airport health rules in accordance with IHR and contingency planning at ports and airports as well as capacity-building of PoE staff for managing a public health emergency of international concern.

The use of the contingency planning template for developing robust action plans at PoE was explained to the group. Some of the essentials of this planning process such as mapping of stakeholders (at national and local levels); addressing all IHR threats (food/chemical/radio-nuclear and zoonoses events); clearly spelling out the institutional framework at local level (with defined roles and responsibilities) for activation/deactivation of the plan; resource planning; and most importantly, communicating and periodically updating the plan, were stressed. Other Member States were encouraged to go through this exercise, as this is one of the core capacity requirements under IHR (2005).

4.3 Case-studies on prevailing practices/best practices

Airport Health Office, Indira Gandhi International Airport, New Delhi, India

Dr Sanjay Kumar, Air Port Health Officer, Airport Health Office (APHO), IGI Airport, Delhi shared his experience in establishing all-time core capacities at IGI Airport and during the severe acute respiratory syndrome (SARS) and H1N1 Influenza outbreaks.
India was already conducting activities at their international PoE for prevention of the spread of diseases like yellow fever, anthrax, plague, smallpox and glanders from foreign countries to India under the Indian Aircraft (Public Health) Rules 1954. These Rules have been revised in 2013 and now are with the Ministry of Law for approval.

IGI Airport, New Delhi is one of the busiest airports of India. Almost all the core capacities required for implementation of IHR (2005) are in place at APHO Delhi. Adequate number of trained staff and programme for inspection of conveyances and vector control are available at APHO Delhi for medical care and transport for the transfer of ill/suspected passengers. Services for provision of safe drinking water and proper waste management have been outsourced. The APHO staff conduct regular supervisory rounds for maintenance of safe drinking water and proper waste management and in case of any irregularity, the concerned agency is given feedback for improvement. There are some problems in supervision of safe food at IGI Airport, Delhi because of New Food Safety and Standards Act and Rules. Meetings of senior officers are being held at the national level to sort out the issue.

APHO Delhi has developed its PHECP and national level meetings have already been held with chemical, radio-nuclear, zoonotic and food safety experts; however, liaison at the local level needs to be established for all-hazards approach management.

The SARS outbreak in 2003 was managed in a very haphazard manner with poor intersectoral coordination and frequent stock-outs due to lack of proper training. The lessons learned from the SARS outbreak and the newly amended IHR (2005) helped APHO Delhi in the proper management of pandemic H1N1 (2009) with better intersectoral coordination due to proper training and there was hardly any shortage of stock.

**Port Health Office, Suvarnabhumi Airport, Bangkok, Thailand**

Dr Vichan Pawun, Port Health Office (Suvarnabhumi Airport), Department of Disease Control, Ministry of Public Health, Thailand presented the Suvaranabhumi Airport Emergency Contingency Plan by showing a video of the simulation exercise carried out at the airport.

Thailand has gained experience in pandemic planning and response through dealing with many international public health threats such as SARS, highly pathogenic
avian influenza, and pandemic H1N1 (2009). It was important that lessons be learned from these outbreaks so that the country is prepared to respond to a public health emergency of international concern (PHEIC).

Airport of Thailand Public Company Limited (AOT) is the leading airport business operator in Thailand. There are six airports under its responsibility, including Suvarnabhumi Airport, the busiest airport in the country, which handled 51.5 million passengers in 2012 (+9.8% from previous year), and nearly 3 million tons of cargo per year, and 76 flights per hour. Suvarnabhumi airport was selected to be the designated PoE in Thailand under IHR (2005) for the development of IHR core capacities.

PHECP and standard operating procedure are integrated in the airport contingency plan in accordance with ICAO regulations. Suvarnabhumi Emergency Management Exercise (SEMEX12) was conducted in 2012 to evaluate the airport response plan for medical emergency and communicable disease control. The AOT provided financial support for this exercise with Technical Support and other in-kind support from the Ministry of Public Health. The programme included identifying an exercise team, meeting with all relevant stakeholders within and outside the airport territory, conducting several orientation, tabletop and full-scale exercises. The approximate period of the exercise was around six months. The full-scale exercise was convened on 5 July 2012. The overall objectives of the simulation exercise were to test and validate its contingency plan on medical and communicable disease response plan. It also provided an opportunity for competent authorities to develop, conduct and evaluate an exercise based on IHR (2005) core capacities. In this exercise, the emphasis was on comprehensive integrative collaboration functions and response rather than specific technical functions. All functions involving event management at the airport were tested in this simulation, including case management on board, notification procedure, communication lines, patient transportation, passenger screening, corpse management, infectious waste management, aircraft disinfection, and risk communication. Exercise evaluation was conducted after the simulation in order to identify the areas for improvement.

The exercise was perceived to be successful, at least in terms of the clarification of roles and responsibilities of relevant stakeholders as well as validation of communications and collaborated responses. However, several areas in the plan require improvement. Response measures on the aircraft, designation of parking bay for the affected aircraft, and selection of personal protective equipment, for example, require improvement.
**Mumbai Seaport, Mumbai, India**

Dr Deepak Sule, Public Health Specialist, Port Health Organization (PHO), Mumbai presented IHR (2005) implementation at Mumbai Seaport, India. Mumbai port is one of the major ports situated on the west coast of India. The port comes under Mumbai Port Trust as an autonomous body under the Ministry of Shipping, Government of India and is governed by its trustees. It is one of the nine Indian ports designated as PoE and notified to WHO as authorized port to issue SSC and having a port health organization setup.

PHO, Mumbai is responsible for the main port of Mumbai and other intermediate and minor ports in the vicinity. Its functions include:

**Routine functions**

These are:

- clearance of:
  - ships;
  - dead body (in case of death on board);
  - imported used clothing and woollen rags;
- issuance of international certificates;
- ensuring:
  - safe environment and sanitation in and around the port area;
  - provision of safe and hygienic facilities in the port area;
  - supply of safe potable water to ships;
- facilitating provision of medical care and transport/ambulance to sick crew and travellers;
- vaccination of international travellers; and
- additional functions.
Event management

The event management activities undertaken by the PHO include:

- accidents, chemical-gas leaks on board the ship/in port area:
  - facilitating on board/in port first aid;
  - facilitating quick transfer of injured/affected; and
  - coordination with Port Trust medical unit/hospital/local hospitals.
- coordination with customs/Immigration/agent and other stakeholders;
- clearance of passenger ships:
  - deployment of additional manpower
- other major and minor emergencies:
  - coordination with national /state/local agencies as per emergency
- during PHEIC – functions as per PHECP.

Strengths of PHO

The following are the strengths of PHO:

- Exclusive organizational set-up;
- already implementing IHR provisions for the last 50 plus years;
- successfully implemented IHR 1969 screening during SARS and pandemic H1N1 (2009) outbreaks;
- nodal officer of DGHS designated for Mumbai port;
- better coordination between the health officer and most of the stakeholders; and
- statutory powers available with the health officer to implement IHR (2005).

Challenges

- many intermediate and minor ports normally covered by local health authorities with limited knowledge of IHR (2005) and their implementation;
- training needs at different levels;
- shortage of trained manpower;
- lack of regular training and updates;
• lack of uniformity in working due to long-term practice;
• infrastructure needs strengthening;
• weak data-sharing and IT linkages with other stakeholders and ports in India;
• weak e-networking/IT support channel;
• delay in implementation of legislation as per new IHR;
• limitation in dealing with radio-nuclear and chemical events; and
• implementation of statutory powers by penalties or notices is lacking.

Vector control at Marmagao Port and Goa Airport, Goa, India

Dr Ashwani Kumar, Deputy Director, Officer-In-Charge, National Institute of Malaria Research shared experiences of intersectoral cooperation for vector control within a radius of 400 metres at Marmagao Port in Goa, and Goa Airport. He highlighted how a serious mosquito menace at the port in 1998 led to systematic control of vectors with the involvement of different stakeholders. While technical inputs like training, surveillance, recommendations for action, assessment of intervention, measures undertaken and impact assessment on vectors were provided by the National Institute of Malaria Research at the port and surrounding areas, the Port Civil Engineering Department carried out desired engineering interventions like source reduction, habitat modifications and manipulations so as to deny vectors scope for breeding. The sanitary inspectors of the Port carried out surveys and biological control i.e. introduction of larvivorous fish and treatment of curing waters with recommended chemical insecticide in the harbour and port colonies. The local health authorities of the Government of Goa stepped up vector control measures in the border areas of the port, especially at the nearby slums, while the municipal authorities resorted to source reduction like removal of containers and tyres from the bordering areas of the port.

As the interventions were being implemented, concurrent impact assessment showed that adult mosquito densities and the number of malaria cases among port workers reported at the port hospital had significantly reduced over the four years of monitoring carried out every fortnight.

This exercise exemplified the need for networking of various stakeholders involved and pooling of strengths of different players to achieve sustained and environment-friendly vector control at the port. Current monitoring of immature mosquitoes from the
sample of 8845 habitats checked at the port and the vicinity showed that around 1% of the habitats harboured immature vectors in 2012–2013. This showed that the mosquito potential existed as malaria vector An. stephensi, filariasis vector Culex quinquefasciatus and dengue and chikungunya vectors Aedes aegypti and Aedes albopictus respectively emerged as adults from larval samples.

WHO had developed a draft handbook on vector control at PoE which was circulated to the participants and their feedback and contributions on their experiences, vector control case studies, if any, and relevant pictures of intervention were invited which would be duly acknowledged in the final document.

**Implementation of IHR (2005) at ground crossings: an example from India**

Dr Prabha Arora, Assistant Director-General (International Health), Ministry of Health and Family Welfare, India discussed the implementation of IHR (2005) at GCs. In India, there are many porous borders with the neighbouring countries, and these GCs are geographically, environmentally, culturally contiguous. The distances that conveyances are expected to travel are minimal compared to the distance covered in air and sea travel (at times, there is no distance due to lack of proper demarcations). The scope of managing health on board the cargo vehicles, is minimal/difficult due to porosity of borders, necessitating routine coordination with cross-border meetings. The systems of health care and the public health requirements for the passengers may be similar or differ on either side of the border. Neighbouring countries that have borders with India are: Bangladesh, Bhutan, China, Myanmar, Nepal, and Pakistan. At present, India has only one designated GC. This GC is functional at the Attari border and Attari railway station in Amritsar city of Punjab. The city has an international airport known as Guru Ram Dassji International Airport.

Land Port Authority of India (LPAI) came into force by an Act in 2010 under the Ministry of Home Affairs. It has the power to develop, manage and sanitize the facilities for cross-border movement of passengers and goods at international borders across India; provide space and facilities for health services; and animal and plant quarantine at integrated check posts. The legislative measures for GCs need to be developed based on the existing ones for airports and ports. In addition, six GCs are to be made functional during Phase 1: Raxaul (Bihar), Jogbani (Bihar), Akhaura (Tripura), Petrapole (West Bengal), Dawki (Meghalaya) and Moreh (Manipur); a further six are likely to be made functional soon in the second phase, although these may not be designated.
As LPAI is a new organization, the Border Security Force (BSF), which is the nodal agency for all coordination at the border crossings has been entrusted with the task of coordinating with all the agencies functioning at the border crossing by holding meetings every month. The BSF Commandant functions at border crossings on behalf of LPAI. Airport and Border Quarantine Health Office (ABQHO) which is primarily responsible for health-related issues including implementation of IHR (2005), is regularly invited to these meetings. Special meetings, chaired by the Airport and Border Quarantine Health Officer are held in case of public health-related issues. Cross-border meetings for collaboration with neighbouring countries are held with the customs and immigration sectors; but so far, there is no mechanism of cross-border meetings between health officials from the two countries on health matters.

So far, a draft public health contingency plan has been developed for ABQHO in coordination with other stakeholders. However, it is yet to be tested. There are manpower constraints, as the existing manpower attends to three PoE (railway, GC and airport which are situated in the city). Capacity-building of manpower in PHEIC would be required.

Legislative rules need to be framed and existing rules of aircraft and ship revisited and amended to address the needs of the land borders. ABQHO has not been assessed. Food licensing is being delegated to the Food Safety and Standards Authority of India (FSSAI) since August 2011, after the new Act came into force. However, the issue of authorizing health officers at PoE, i.e., BQHO as designated officer for licensing is still not resolved. LPAI is also improving coordination with waste management.

Medical and public health services at Attari railway station are under the jurisdiction of the Indian Railways; however, at present, the Airport Border Quarantine Health Officer is looking after medical services and response to PHEIC. There is a five-bedded quarantine facility at the border crossing. The coordination with various stakeholders needs to be enhanced. At present, the ABQHO is coordinating with various agencies viz. meeting with LPAI for establishment of border crossings for space and manpower requirements and local level meetings with vector-borne disease control and integrated disease surveillance programme. Regular meetings are held between border agencies such as BSF, LPAI, ABQHO, customs and immigration, FSSAI and waste management authorities.
Consideration should be given to establishing a joint health counter for health authority for medical services and public health functions at border crossings for coordinated actions required by the countries on either side of the border. Support from WHO is required for coordinating the efforts for developing legislative measures, and from other organizations to support implementation of IHR (2005) at PoE. Norms of joint health units for managing the public health requirements need to be developed.
PoE database

Dr Ninglan Wang, Technical Officer (PAG), WHO demonstrated the PoE database being developed at WHO Headquarters. The main purpose of this database is to store comprehensive information on the ports authorized to issue SSC. Such a database will enable the ship captains to know comprehensively about the ports they are visiting and if they can issue SSC, thereby alleviating the need for lengthy communication procedures. The database will also list other facilities that are available at the ports, including medical facilities and whether they have been designated under IHR (2005). WHO plans to pilot test this database and different Member States were urged to join the pilot testing programme.

Outbreak monitoring procedures were demonstrated through an example from avian influenza A (H7N9) virus human cases in China and the epidemiology, clinical features, laboratory characteristics, surveillance and possible scenarios that could arise from the current situation summarized by Dr Brown.

Detailed discussions were held in groups on legislation, coordination and communications, PHECP, all-hazards approach, assessment/care/isolation of affected animals, human resources development strategies and addressing gaps in PoE capacity-building, and GCs special provisions, among others. The groups listed out priority actions to be taken by the national authorities and the role of WHO in supporting those which have been captured while drawing up conclusions and recommendations.
Conclusions

Under the new IHR (2005), PoE play an important role in preventing the international spread of disease. Strengthening core capacities at all times, establishing response mechanisms to address an event including PHECP, and measures to be adopted during PHEIC are core requirements under IHR (2005). Member States in the Region have undertaken measures to strengthen IHR (2005) implementation at PoE, but the progress is uneven between Member States as well as across different core capacities as exemplified by relative lack of response mechanisms to address events due to nuclear/chemical/radiological hazards.

The single most important factor hampering the implementation of IHR (2005) at PoE is lack of advocacy, thereby resulting in lack of coordination and collaboration with different sectors that play a vital role in smooth operations at PoE including port/airport/GC authorities, border control, customs, and immigration.

Considering that health departments play a relatively minor role, effective mechanisms for multiagency communication, coordination and information-sharing, including establishment of operational links, should be preceded by sensitization and advocacy efforts. The advocacy efforts include participation of health departments in the meetings organized by other managing bodies at PoE such as the port organization, airport authorities and border and custom authorities at GC, involving other sectors in meetings hosted by health organizations, and participating in tabletop or simulation exercises.

The implementation of IHR (2005) calls for review of existing legislation/acts/Government orders, which has been carried out in most Member States who are at different stages for revising/amending/modifying their national legislation. In some cases, the issues related to PoE have not been addressed in the revised legislation, which may adversely affect implementation of IHR (2005) at PoE. Public health professionals
working at the PoE are not aware of international binding agreements which govern the airlines and maritime sectors. A mechanism for sharing information such as SARP from ICAO and relevant conventions of IMO need to be developed which can then further feed into the existing national level regulations.

Some progress has been made to strengthen capacity in airports and ports, but relatively little at land crossings. Activities that might be expected to enhance this work would include cross-border meetings, followed by joint planning to harmonize arrangements where possible. The existence elsewhere of land crossings that have been jointly designated by neighbouring countries may provide a model for this Region. Member States expressed a clear need for strengthening ties and communication links with competent authorities in other countries in order to share vital surveillance information. WHO can play a major role in developing such a system either through the competent authority or national focal point, International Health Regulations.

Implementation of IHR (2005) at PoE and the provisions thereof creates an enormous demand for additional resources which need to be mobilized to develop infrastructure and deploy adequate and trained manpower. All PoE across the Region face a shortage of manpower, as training programmes have not been undertaken due to lack of resources. This, coupled with frequent transfer of staff, leads to inadequate and frequent disruption of services. Member States felt that there is a need to undertake resource-mapping and assessment of training needs, so that appropriate training programmes may be instituted. One of the options to address this issue could be to incorporate the subject matter in the existing field epidemiology training programme. Training may also be imparted through mutual sharing of experiences and organizing study tours. In addition, it was desired that there should be training courses for other sectors for the purpose of sensitization and advocacy. WHO can play an important role on development of standardized curriculum/ materials for training which can be adapted at the local level. WHO was also urged to explore mobilization of financial resources to meet the demands at PoE.

Emergency preparedness and response plans are virtually non-existent, and where available, neither follow the all-hazards approach nor involve the relevant stakeholders. While measures for addressing PHEIC are in place, exemplified by the measures taken during pandemic H1N1 (2009), handling of an event may not always be optimum. Member States expressed the need for technical support to prepare and test PHECP.
At present, 70 ports in four Member States in the Region [India (9 ports); Indonesia (37 ports); Sri Lanka (1 port); and Thailand (23 ports)] are authorized to issue SSC and there is a need to expand this capacity in the Region. It is important that more ports be equipped, so that they perform ship sanitation inspection and issue SSC. Those who are issuing SSC need to send the list of ports to WHO.

WHO and other organizations such as ICAO, Association of Southeast Asian Nations (ASEAN), South Asian Association for Regional Cooperation (SAARC) and expert groups such as Ports, Airports and Ground Crossings Network (PAGnet) can play an important role in providing technical support/facilitate dialogue to strengthen PoE and such mechanisms need to be explored.
7

Recommendations

7.1 Recommendations for Member States

The following recommendations were made for action by Member States:

- enhance advocacy on the importance of IHR with all PoE stakeholders at national and local levels;
- ensure the inclusion of all relevant issues for PoE in a review of national legislation to comply with IHR;
- consider mechanisms to actively enhance intersectoral collaboration on PoE issues at national and local levels, including the following:
  - use of tabletop and simulation exercises;
  - advocacy for inclusion of IHR port ‘competent authorities’ as members of other PoE-related committees, and take steps to actively involve other stakeholders in any IHR-related committees/activities;
- consider measures to accelerate development of IHR core capacities at GCs, including cross-border meetings, joint assessments, cross-border planning and joint designation;
- advance planning for development of PoE should include health requirements, including infrastructure and logistics;
- ensure strengthening of manpower and logistics for PoE and IHR core capacity requirements;
- strengthen human resources for PoE based on identified needs, including:
  - undertaking a PoE training needs assessment;
  - raising issues related to PoE in the curriculum of medical training, including field epidemiology training programme; and
  - sharing experiences of PoE, hosting exchange visits;
• advocate for the inclusion of public health emergencies in existing port emergency/disaster response plans (all hazard approach), including:
  – hazard/resource mapping, risk assessment as a first step/foundation stone;
  – identification of coordination and communication mechanisms as well as contact points;
  – integration of PoE in national health surveillance and response systems;
  – linking/integration with national all-hazard preparedness and response plans;
  – development of protocols for event management, including communication; and
  – dissemination of health alerts and information for travellers; and
• send a list of ports authorized to issue SSCs to WHO and support in-service training.

7.2 Recommendations for WHO

• advocate at high level for the importance of PoE in the context of IHR, including the development and dissemination of appropriate materials such as flyers, booklets, and success stories;
• disseminate information on existing legislation, standards and procedures related to different international agreements;
• support bilateral meetings, study tours, joint assessments and joint designation of GCs;
• develop training materials (including for online training) and support delivery of training for airport, ports and GCs, including vector control;
• enhance collaboration to strengthen IHR core capacities at PoE with related international agencies;
• raise awareness of PAGNET; and
• advocate for resource mobilization.
Annex 1

Agenda

(1) Update on IHR (2005) implementation at points of entry
(2) Country experiences in strengthening public health functions at points of entry
(3) Case-studies on prevailing practices / best practices
(4) Introduction to points of entry database
(5) Strengths and weaknesses in IHR (2005) implementation at points of entry in SEAR;
(6) Strategies and approaches to strengthen core capacities at points of entry;
(7) Follow-up actions
(8) Conclusions and recommendations
Annex 2

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Opening Remarks by Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia

Distinguished participants, honourable guests, ladies and gentlemen,

I warmly welcome you all to this regional meeting on International Health Regulations (2005) core capacities at PoE. I am happy to note the presence of national focal points for implementation of the International Health Regulations (2005) at PoE and thank you all for sparing your valuable time to attend this meeting. The theme of this meeting is “Strengthening PoE under the New International Health Regulations 2005”.

This is the second meeting in the South-East Asia Region focusing on PoE, bringing together Member States from the Region and experts from the Eastern Mediterranean and the Western Pacific regions, WHO headquarters, and other partner organizations such as the ICAO. The broad participation here reflects the importance of collaborative efforts to implement the International Health Regulations (2005) at PoE. 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, irrespective of source and origin.

The main purpose of this global legal framework is to prevent international spread of disease and provide a response to a public health event of international concern while avoiding unnecessary interference with international traffic and trade. Effective public health measures including surveillance and response capacity at international PoE contribute to minimizing the risk of international spread of diseases. Under IHR (2005), MS have a legal requirement for compliance and establishing core capacity standards at designated PoE. IHR (2005) require MS to develop and strengthen the core capacities at designated international airports, ports and ground crossings by June 2012, including strengthening public health emergency preparedness and response at
designated PoE. All the MS in the South-East Asia Region have received an extension up to June 2014 for implementation of IHR (2005) core capacities, including those to be implemented at PoE.

The South-East Asia Region has made considerable progress in implementation of IHR (2005), particularly in the areas of strengthening surveillance systems and capacity-building to respond to public health threats. However, the progress to strengthen capacities required at designated international PoE has been slow and needs extra effort both in terms of technical and financial resources.

Under IHR 2005, international PoE now have new roles to play that go beyond mere border control. This new mandate has also brought out many challenges which include:

- advocacy at national level to involve different stakeholders;
- development of country/PoE-specific plans and guidance documents;
- capacity-building of the staff at PoE;
- strengthening cross-border collaboration; and
- resource mobilization.

WHO is mandated to provide support to its MS to strengthen core capacities at PoE. In this regard, direct technical and financial support has been extended to many Member States in our Region. This meeting is an important step in strengthening our collaborative efforts and in addressing the issues related to IHR (2005) implementation at PoE.
The International Health Regulations (IHR) (2005) entered into force in June 2007 and are legally binding on all the WHO Member States (MS). The main purpose of this global legal framework is to prevent the international spread of disease while avoiding unnecessary interference with international traffic and trade. Under the IHR (2005), points of entry (PoE) play an important role in preventing international spread of diseases. Strengthening core capacities at all times, establishing response mechanisms to address an event including public health emergency contingency plan, and measures to be adopted during public health emergency of international concern (PHEIC) are core requirements under IHR (2005).

A regional meeting on IHR (2005) core capacities at PoE was held in Kochi, (India) to discuss progress made under the IHR (2005) at PoE in Member States, identify strengths and weaknesses and follow-up actions at national and regional levels to strengthen core national capacities at PoE.

During the meeting, it was agreed that the main areas where MS need to accelerate their efforts included advocacy, amending legislation, strengthening intersectoral collaboration and dedicating resources, both in terms of finance and human resources, and paying special attention to issues related to ground crossing points. WHO was urged to provide technical support in building human resource capacity through study tours; support development of action plans including public health emergency contingency plan; provide relevant materials for advocacy and training of staff; facilitate cross-border meetings and enhanced collaboration with other related international agencies; and mobilize resources.

International Health Regulations (2005) 
core capacities at points of entry

Report of a regional meeting 
26–28 June 2013, Kochi, India