World Health Organization
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Revision of the International Health Regulations: progress report

Report by the Director-General

The International Health Regulations (IHR) are being revised in accordance with a resolution adopted by the Health Assembly in 1995 (WHA48.7). The purpose of the revision is to adapt IHR to the present volume of international traffic and trade and take account of current trends in the epidemiology of communicable diseases, including emerging disease threats. This progress report is submitted for the Board's information.

1. A group of international consultants met in December 1995 and considered methods to improve the utility and effectiveness of the Regulations in view of the public health and economic consequences of recent outbreaks of infectious diseases of international importance. They determined that the principles upon which the Regulations are based remain valid but that significant revisions would be required to meet current and future challenges posed by infectious disease threats.

2. The consultation proposed that the Regulations should provide for the immediate reporting of a number of defined clinical syndromes. This would facilitate the rapid recognition and reporting of outbreaks of new or unusual infectious diseases. Immediate notification of syndromes would normally be followed later by a report on the specific disease involved after confirmation of the diagnosis. By expediting the notification of syndromes, international awareness of rapidly evolving infectious disease threats would be improved. Another major recommendation was that the Regulations should be revised to include provisions designed to limit or prevent the introduction of inappropriate or unnecessary control measures that could affect international trade and transportation.

3. The governments of all Member States were invited to designate an official focal point for liaison with WHO on the IHR revision. Over 80 Member States have now done so. All interested intergovernmental and nongovernmental organizations were also invited to designate focal points for this purpose and several have done so.

4. The Committee on International Surveillance of Communicable Diseases will be responsible for finalizing the draft revised IHR for submission to the Health Assembly. The members of this Committee have been selected, have confirmed their acceptance and have been appointed by the Director-General, in accordance with the Regulations for this Committee which stipulate a maximum of seven members. The members were chosen both

for their expertise in the field of public health (covering such aspects as administration, entomology, food hygiene, bacterial and viral diseases) and to ensure a wide geographical representation.

5. To assist the Committee in preparing the revised IHR, a small working group was set up to advise on the provisions to be included in the revised IHR, in the light of the principal recommendations of the consultation in December 1995. The composition of the working group is based on the need for expertise in public health and quarantine matters, disease surveillance, international cooperation in public health, communicable diseases including foodborne diseases and vector control, as well as experience in the application and administration of the existing IHR. It includes international experts and present and former WHO staff members. The group is organized on an informal basis, with participation modified according to needs as the revision process progresses.

6. The informal working group of experts met twice in 1996 and three times in 1997 and formulated the concepts on which the revised IHR will be based and on the structure of the IHR document. In renewing IHR, the original fundamental principle - to ensure maximum security against the international spread of diseases with minimum interference with world traffic and trade - will be retained. Furthermore, many of the public health provisions of the current IHR which remain valid at the present time, will be included in the revised IHR. However, important changes are proposed under the revised IHR, involving a new approach to mandatory notification as well as a major alteration in the structure of IHR, as follows:

(a) Notification

In accordance with recommendations from the consultation in December 1995, the revised IHR will require immediate reporting of a number of defined clinical syndromes that are of international importance. This will facilitate timely notification, which would normally be followed by specific disease reporting once the diagnosis has been confirmed. It will also provide for reporting of disease outbreaks of unknown origin where a potential hazard to international travel or trade is observed. The syndromes, which will be notifiable only where an international public health threat is involved, include haemorrhagic fever, acute respiratory, acute gastrointestinal and acute neurological syndromes as well as a category covering other undefined syndromes of presumed infectious origin. The precise definition of the syndromes, to ensure appropriate levels of sensitivity and specificity for reporting purposes, is the subject of international consultation at the present time.

(b) Structure of the revised IHR

The proposed structure for the revised IHR will take the form of:

- a framework document containing (i) general principles on appropriate public health measures and (ii) legal provisions relating to the operation and amendment of IHR and incorporating by reference the technical annexes (see below); and

- a series of annexes describing technical provisions and specific requirements, which - because of the reference in the framework part to the annexes - will form an integral part of IHR.

In addition, there will be operational guidelines to accompany IHR and assist in their application.

Thus, the IHR framework will stipulate in general terms appropriate measures that should be taken, for example, for the management and control of syndromes or diseases subject to the Regulations; to eliminate or reduce animal hosts or vectors of disease subject to the Regulations; to disinsect aircraft leaving an airport in an area where mosquito-borne disease occurs, using internationally approved procedures. In all such instances, the technical details of the measures to be taken will be described in full in the annexes. The annexes will be subject to regular review and will be updated as necessary. Thus, this new structure for IHR will provide basic regulations of a generic nature which should remain valid for many years. At the same time, the specific public health measures contained in the annexes can be modified rapidly according to changing needs and new

knowledge. The intention is to ensure longevity of IHR together with adaptability of the specific technical provisions. It is envisaged that, if the Health Assembly agrees to delegate to the Executive Board the necessary authority, the annexes could be revised upon approval of the Executive Board after having been considered by the Committee on International Surveillance of Communicable Diseases or other appropriate expert committee.

7. The draft text of the revised IHR was completed in September 1997 for distribution to Member States later in the year. The operational guidelines are being completed and will include illustrative case scenarios describing the measures to be taken. They will also indicate inappropriate measures, with an explanation of why they should not be taken. The syndromic approach to notification is being field-tested in a limited number of selected countries from each WHO region. Information seminars were planned in each region for the participating countries in October-November 1997. Country visits by WHO staff will be arranged as necessary during the field tests. The draft IHR will be revised in the light of the experience gained during these field tests.

8. The Committee on International Surveillance of Communicable Diseases will be convened after completion of field testing and any necessary revision of the draft IHR. It is foreseen that a meeting of the Committee will take place in 1998 and its recommendations submitted to the Health Assembly in 1999. Progress reports are published every six months in the *Weekly Epidemiological Record*. Information on the revision was provided to the Global Policy Council in July 1997.

ACTION BY THE EXECUTIVE BOARD

9. The Board is invited to note the progress report. The report could be provided to the Health Assembly in 1998, if the Board so wishes.

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