World Health Organization

SIXTY-SIXTH WORLD HEALTH ASSEMBLY **A66/16**
Provisional agenda item 15.1 **5 April 2013**

Implementation of the International Health Regulations (2005)

Report by the Director-General

1. The Executive Board at its 132nd session noted an earlier version of this report, as well as the related report on the criteria for extensions in 2014.[1] The primary focus of this report is to provide an update on progress made in taking forward the recommendations of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009,[2] as requested in resolution WHA64.1. This report also takes into account information provided by States Parties on the implementation of the Regulations and describes the Secretariat's related support activities, in line with the annual reporting mechanism established under resolution WHA61.2. In addition, it contains sections on the proposed monitoring of national core capacities and the development of criteria for future extensions, as requested in resolution WHA65.23.

RECOMMENDATIONS OF THE REVIEW COMMITTEE

Recommendation 1 (Accelerate implementation of core capacities required by the IHR)

2. In order to take forward this country-led recommendation, the Secretariat, at all levels of the Organization and in line with existing, revised or adapted regional strategies and mechanisms, continues to intensify its support to States Parties and has been able to attract some donor interest and targeted funding for this purpose in a number of key fields related to the International Health Regulations (2005).

3. The Secretariat has continued its substantial efforts in support of States Parties, both in terms of technical cooperation and the provision of advice. In addition, a significant degree of support in relation to the International Health Regulations (2005) has been directed towards human resources development. This has been provided by means of on-going training on implementation of the Regulations undertaken in several key areas, including the following: points of entry, laboratory strengthening, biosafety and biosecurity, field epidemiology, implementation in national legislation, together with the assessment, management and communication of risk. These training initiatives have been made possible as part of a concerted effort to develop extensive guidance materials in each of these key areas, including their translation into other official languages of the Organization.

4. With regard to implementation of the Regulations at points of entry, missions to assess country capacity have been conducted in several regions of the Organization with the technical support of the

[1] See documents EB132/15 and EB132/15 Add.1, and the summary record of the ninth meeting of the Executive Board at its 132nd session, section 3.

[2] See document A64/10.

Secretariat. Consultations, training, meetings and workshops have been held to further develop competencies and guidance. These efforts have included a learning programme covering the inspection of ships and the issuance of ship sanitation certificates and the provision of advice for the management of public health events occurring on ships and in air travel.

5. In the area of laboratory strengthening, the Secretariat has supported the enhancement of laboratory quality systems through the development of guidelines, provision of external quality assessment, organization of training sessions, workshops and on-site missions to all WHO regions. A guidance document on Laboratory Quality Stepwise Implementation is being finalized and will provide day-to-day advice for public health laboratories on their quality system implementation. Together with FAO and OIE, the WHO Secretariat is also responsible for the implementation of the IDENTIFY project. This project strives to strengthen laboratory capacities for detecting pathogens that are a threat to human and animal health in regions where the risk of emerging human and/or animal diseases is highest, such as the Congo basin in central Africa and countries in southern and South-East Asia. Capacity building takes the form of direct support to individual institutions, support to governments to provide a suitable regulatory framework and support for the development and strengthening of laboratory networks within and across the public health and animal health sectors. In the context of the Pandemic Influenza Preparedness Framework, special attention has been given to building influenza surveillance and laboratory capacity in developing countries (see also Recommendations 11 and 14 below). In addition, support continues to be provided for the implementation of systems for laboratory biorisk management at the national level, including through training of trainers. Most recently, in the Eastern Mediterranean Region, two subregional meetings were held on laboratory capacities in line with the requirements of the International Health Regulations (2005).

6. In the specific area of implementation of the Regulations in national legislation, in the past 18 months the Secretariat has supported and conducted seven subregional workshops involving the African Region, the Region of the Americas, the European Region, the Eastern Mediterranean Region and the South-East Asia Region. The workshops were designed to provide countries with the necessary tools and guidance to assess and, where necessary, revise existing national legislation in order to further facilitate the full and efficient implementation of the Regulations. Support in this area continues to be provided through country-specific missions and other means of communication, including teleconferences, IT-supported interactive sessions and individual exchanges with countries on specific legal issues.

7. Many of these training initiatives and workshops have involved the use of table top exercises. The public health scenarios that are explored in this way develop the relevant staff competencies for implementation of the Regulations, reinforce understanding of organizational roles and obligations, test plans and procedures and foster cooperation, coordination and information-sharing between sectors, administrative levels, organizations and agencies. These exercises have been conducted at the national and regional levels in a number of regions.

8. In addition, the global training course on the International Health Regulations (2005) received a positive independent external evaluation in September 2012 and continued to generate a high level of interest among national public health professionals. The course is in the process of being adapted to the regional context, including through the translation of key course materials into the Russian language. Furthermore, based on the material developed for this course, an "IHR training toolkit for epidemiologists" is currently being designed to allow relevant training institutions (such as Field Epidemiology Training Programmes and schools of public health) to include IHR modules into existing and future training.

9. The Secretariat has continued to strengthen its ties and intensify collaboration with other international organizations and agencies (i) to accelerate the establishment of core capacities under the Regulations, and (ii) to enhance the response to public health events. This cooperation includes work with the following: ICAO, especially through the ICAO's Collaborative Arrangement for the Prevention and Management of public health events in Civil Aviation; IAEA, in response to the continuing after-effects of the emergency at the Fukushima nuclear plant in Japan; and other joint initiatives, including one with UNICEF in the area of behavioural and social interventions. The Secretariat has continued to provide significant support to the strengthening, assessment and planning of national core capacities development under the Regulations. In support of this effort, which has involved States Parties in the African, South-East Asia, European and Eastern Mediterranean regions, the Secretariat has undertaken assessment missions and desk audits to identify gaps and facilitate countries' work (i) to draw up action plans and (ii) to implement those plans over the next two years.

10. Subregional cooperation initiatives, including surveillance networks and economic integration mechanisms, have continued to be important partners in tailoring approaches to meeting the core capacity requirements so that they match the context of specific groups of States Parties – for example, those in the Pacific setting.

11. In order to provide new impetus for implementation activities, the Secretariat conducted regional meetings of stakeholders in the WHO regions. These meetings brought together participants from the subregional, regional and global levels – stakeholders, partners and traditional and non-traditional donors – in order to support implementation of the International Health Regulations (2005), providing a forum for sharing details of experiences and challenges. The meetings highlighted the important work that has been done and the achievements recorded since the Regulations entered into force and the specific priority areas for strengthening national core capacities. The meetings also served to reinforce the roles and responsibilities of national, regional and global partners in improving and maintaining core capacities, in providing technical and financial support and in fostering intersectoral collaboration within countries and collaboration between countries. During the meetings, gaps, vulnerabilities and priorities were mapped, as well as existing partner and network support. The meetings were an opportunity to advocate further for the strengthening of capacities under the Regulations and to generate technical, bilateral and funding support. The majority of these meetings took place in 2012. The meeting for States Parties in the European Region, however, was held in February 2013 in order to coincide with a related meeting organized by the European Union. Such coordination further fostered cooperation between the European Union and WHO and provided efficiency savings for States Parties and the Organization.

Recommendation 2 (Enhance the WHO Event Information Site)

12. The Event Information Site for National IHR Focal Points began operating on 15 June 2007. In Recommendation 2, the Review Committee advised the Secretariat that it should enhance the Event Information Site to make it an authoritative resource for disseminating reliable, up-to-date and readily accessible international epidemic information. The Review Committee's view was that States Parties should be able to rely on the Site as a primary source of information on epidemiological status, risk assessment, and response measures. Following the recommendations of the Review Committee and the results of the Event Information Site user survey, the Secretariat elaborated the criteria for the redesign of the Site with the aim of allowing for timely information-sharing of more comprehensive event-related information.[1] Work to develop the Site is under way with the release date scheduled for

[1] See document A65/17.

the first quarter of 2013. The new Site will use upgraded underlying technology, allowing it to adapt more readily to future requirements. The new Site will be easier to use, will have more powerful search capabilities and will enable the Organization to expand the information available to users about ongoing public health events. The new technology will set the foundation for new features to be deployed rapidly in evolving situations. In parallel to the technology update, the Secretariat is working to increase the volume of event-related information communicated through the Site. The risk assessment process has been refined and standardized to ensure that the high quality of information products can be maintained over time and across all acute public health events.

Recommendation 3 (Reinforce evidence-based decisions on international travel and trade)

13. In late 2009 and early 2010, WHO was involved in preparing and conducting a survey on public health measures taken at international borders during the early stages of pandemic (H1N1) 2009. The results, and an analysis thereof, were published in the WHO's *Weekly Epidemiological Record* in May 2010.[1]

14. Following the extensive review of the current and historical evidence for areas at risk of yellow fever transmission, undertaken by a WHO-led informal working group, countries where the strength of existing evidence remains questionable have been encouraged and supported to design and implement new studies in order to better define the level of risk. In this connection, with the support and participation of interested States Parties, the Secretariat will continue detailed evaluations of areas of risk for transmission of yellow fever. The Secretariat has published guidelines for testing the efficacy of insecticide products used in aircraft,[2] with the aim of harmonizing testing procedures to allow objective comparisons to be made between different products.

15. Building on experience acquired during pandemic (H1N1) 2009, the Secretariat has been monitoring reports of travel and trade measures applied during major public health events and emergencies, including the following: the nuclear emergency at Fukushima, the outbreak in Europe of *Escherichia coli* in 2011 and certain outbreaks of viral haemorrhagic fever in Africa in 2012. In a few instances, where reported measures could be perceived as excessive, national authorities have been contacted by the Secretariat to confirm the implementation of these measures and requested to reconsider, as appropriate. The Secretariat is currently preparing standard operating procedures for monitoring international travel and trade measures during public health events and emergencies. It is anticipated that a draft of the procedures will be available in 2013.

Recommendation 4 (Ensure necessary authority and resources for all National IHR Focal Points)

16. The Review Committee concluded in its report that some National IHR Focal Points lack the authority to communicate information related to public health emergencies to WHO in a timely manner; its recommendation to strengthen the role of the Focal Points was primarily directed to States Parties. The Secretariat is undertaking a number of activities to complement and support States in following up on this recommendation. In order to increase awareness and understanding of the critical role played by a country's Focal Point, it is planned to produce a short video and brochure tailored to

[1] Public health measures taken at international borders during early stages of pandemic influenza (H1N1) 2009: preliminary results. *Weekly Epidemiological Record* 2010; 85: 186–194. Available at http://www.who.int/wer/2010/wer8521.pdf (accessed 20 March 2013).

[2] *Guidelines for testing the efficacy of insecticide products used in aircraft.* Geneva, World Health Organization, 2012.

high-level officials and non-health sectors of government, explaining the National IHR Focal Point function and the Review Committee's findings. On the basis of the findings of external studies of the process for assessment and notification of public health events by Focal Points, a web-based tutorial for notification assessment under the International Health Regulations (2005) has been developed, field tested and provided to the staff of National IHR Focal Points. The tutorial invites all Focal Points to work through the steps of the assessment process for a number of fictitious event scenarios. Focal Points are subsequently provided with the responses proposed by an expert panel, as well as the relevant explanations. New scenarios will be published at regular intervals on a continuing basis. Finally, it is planned to hold a technical consultation on event notification, verification and exchange of event information under the Regulations with the aim of revising the WHO's guidance to deal with the concerns raised in the Review Committee's report.

Recommendation 5 (Strengthen WHO's internal capacity for sustained response)

17. The Secretariat's work to operationalize the Emergency Response Framework was given impetus by the Executive Board in January 2012 and the Health Assembly in May 2012.[1] The Framework clarifies WHO's roles and responsibilities in emergency response in order to provide a common approach for WHO's work across all emergencies, including natural disasters, conflict, disease outbreaks, food contamination, chemical spills or radionuclear incidents. The Framework further provides an overarching organizational policy structure to take forward this recommendation.[2]

18. In December 2011, the Secretariat reorganized its structures in respect of the following key Regulations-related functions at headquarters: (1) alert and response operations; (2) technical support for the development of national core capacities for implementing the Regulations; and (3) the assessment and monitoring of progress in implementing and applying the Regulations. The technical teams responsible for carrying out these functions maintain headquarters' capacity to detect the public health risks posed by epidemics and other threats, to assess those risks, to communicate information about them, and to mount an appropriate response, including organizing and maintaining global strategic stockpiles for preparedness and response. These teams continue to coordinate closely with technical programmes on specific health hazards, including infectious diseases, zoonoses and threats to food safety or environmental health. The Secretariat coordinates the response to such risks at all levels of the Organization. This effort takes the form of risk assessment, communications, operations, logistics and technical support; as necessary, it can also involve cooperation with technical partners from the Global Outbreak Alert and Response Network. A strategy to address logistics, human resource development, logistics networking to share and coordinate capacity, and development of logistics capacity is also being developed in order to provide support to Member States in preparedness and response operations.

Recommendation 6 (Improve practices for appointment of an Emergency Committee)

19. The Secretariat's conflict of interest policy for experts was significantly revised in July 2010, before the Review Committee had presented its findings. As experience is gained in the application of this revised policy, it will be reviewed for further improvement and refinement. The Secretariat is also in the process of establishing the Compliance, Risk Management and Ethics team in the Office of the Director-General. With a view to further strengthening the procedures for appointing members of future Emergency Committees, a new personal information form was developed that requires experts being

[1] See resolutions EB130.R14 and WHA65.20.

[2] See also document A66/27, progress report D.

considered for placement on the International Health Regulations (2005) Roster of Experts to disclose information that allows the Secretariat to make an initial high-level assessment of conflict of interest. This requirement was applied to all candidates under consideration for appointment to the Roster, as well as to those already included on the Roster. All personal information forms are reviewed by the Secretariat and follow-up action is taken, as appropriate. Any information that might constitute evidence of the existence of a conflict of interest is included in the database for the Roster. It is important to underscore that prior to the appointment of an expert from the Roster to any Committee under the Regulations, a more detailed conflict of interest assessment is undertaken that takes into account the mandate of the relevant Committee and any changes or developments in the individual expert's information.

20. The Roster has been revised in order to broaden the spectrum of expertise among future Emergency Committee members. Eleven new areas of expertise have been added and a number of existing categories have been subdivided to provide increased specificity. As a result, the total number of areas of expertise has been increased from 53 in 2009 to 79 in 2013. The details of the Secretariat's technical focal points for the various categories of expertise are regularly updated and new nominations of experts for both existing and new areas of expertise are continuing. Geographical and gender balance are systematically reviewed in respect of experts under each category, which has led to new nominations for some of the categories. As a result, some 200 new experts have been put forward since the Review Committee made its recommendations.

Recommendation 7 (Revise pandemic preparedness guidance)

21. The Secretariat is currently revising its pandemic influenza preparedness and response guidance. The new guidance will be based on a multisectoral, all-hazards risk-management approach and includes generic components essential to all public health emergencies, while also maintaining influenza specificity. The outcome of discussions on pandemic influenza phases has been incorporated into the revised guidance. A risk-based approach is emphasized, and flexible planning and risk management at country level is encouraged. The guidance is being peer reviewed and comments from the review are being taken into account prior to finalization.

Recommendation 8 (Develop and apply measures to assess severity)

22. Gauging the severity of an influenza pandemic – a critical component of overall pandemic risk assessment – is an important consideration for the Secretariat and its Member States in planning for and responding to the next pandemic. In rethinking an approach to pandemic severity, WHO has considered lessons learnt during the 2009 (H1N1) pandemic. WHO faced many challenges in assessing the severity of the pandemic at the global level. Four major difficulties were identified: (1) reliable data were not available in the first four to six weeks, even from countries with well-developed health infrastructures; (2) not all countries, and in particular those with fewer resources, have national systems for laboratory and disease surveillance of influenza; (3) factors not related to disease affected the calculation of indicator variables (e.g. hospitalization rates were strongly influenced by national protocols, making comparisons between countries difficult); and (4) communication about the severity of the pandemic was an overarching consideration as multiple audiences, including the general public, scientists and policy-makers, had to be accommodated. A new approach to assess pandemic severity in the future has been developed to provide the best description of the event using available information, often from disparate settings, and to provide information that will help hitherto unaffected countries respond to the pandemic when it occurs. The new severity framework, which includes a basket of indicators with an agreed list of data-sets, will be proposed for testing during seasonal influenza outbreaks in a variety of settings before its finalization.

Recommendation 9 (Streamline management of guidance documents)

23. WHO's Guidelines Review Committee sets the standards for guidance documents, supports technical teams in their development, ensures consistency across the Organization, and oversees clearance. During the last two years the Committee's membership has been expanded in order to be strengthened; this has included the direct participation of WHO regional offices. These changes have enabled the WHO Handbook for Guideline Development to be revised, updated and published.[1] To strengthen the use of evidence in WHO guidance documents, the Cochrane Collaboration has been admitted into official relations with WHO.[2] With regard to dissemination of information products in public health emergencies, in 2011 the Secretariat established a dedicated team, under the leadership of an experienced medical editorial manager, to facilitate the development of timely relevant information products from the relevant technical programmes. The team supports these programmes with the planning, editing and clearance of publications, and will be an integral element of the Secretariat's involvement in public health emergencies.

Recommendation 10 (Develop and implement a strategic, Organization-wide communications policy)

24. The global communications strategy (based on the results of the 2012 stakeholder perception survey, external and internal evaluations and analysis of inputs from stakeholders related to WHO reform) is currently being developed in consultation with regional communications offices. Regional communications strategies are also in various stages of development. These will be integrated into the global strategy before final review begins. The Secretariat is also developing standard operating procedures and increased organizational capacity for emergency communications. The Secretariat has carried out a qualitative analysis, including more than 30 interviews with experts both inside and outside the Organization, in order to identify lessons learnt and determine ways of improving communications in future emergencies. A first draft of the standard operating procedures has been prepared. These procedures, and other experience which the Secretariat has gained from recent emergencies, was used to train a first cadre of emergency communications specialists from across the Organization in March 2013. This Emergency Communications Network will be deployed for all communications in emergencies, both within WHO offices and in the field, when needed, in line with the Organization's Emergency Response Framework WHO's internal staff development and learning programme to increase the Organization's ability to communicate in emergencies was broadened to include crises communications as a core module. This programme targets all staff including WHO technical staff and Heads of WHO Country Offices who are likely to have to communicate in and support Member States to communicate during a health emergency. The development of brand standards to harmonize the content, form and style of communications across the Organization began with the 2012 perception survey and is a priority project for the period 2013–2014. Finally, a dedicated, proactive, social media team has been put in place by headquarters to serve as the front line for intelligence-gathering, dissemination of information and reputation management.

[1] *WHO handbook for guideline development*. Geneva, World Health Organization, 2012. Available at http://www.who.int/kms/guidelines_review_committee/en/ (accessed on 20 March 2013).

[2] Resolution EB128.R16.

Recommendation 11 (Encourage advance agreements for vaccine distribution and delivery)

25. Resolution WHA64.5 requested the Director-General, inter alia, to implement the Pandemic Influenza Preparedness Framework[1] and to report on progress on a biennial basis. The first such report is to be submitted to the Sixty-sixth World Health Assembly in 2013,[2] and was discussed at the Executive Board at its 132nd session.[3] It includes information on advance agreements for vaccine distribution and delivery.

Recommendation 12 (Establish a more extensive global, public-health reserve workforce)

26. The Review Committee report recognized that the Global Outbreak Alert and Response Network serves as the primary mechanism for the Secretariat to support Member States during public health events, and that the Network is used to coordinate international response with technical institutions. The Review Committee further indicated that WHO's capacity to prepare and respond in a sustained way to any public-health emergency is severely limited by chronic funding shortfalls. The Steering Committee of the Network considered the Review Committee's recommendations, together with the findings of an independent evaluation of the Network's performance. Working groups were set up to perform the following functions: strengthen capacity to coordinate and respond to large-scale events and emergencies; support regional leadership and capacity to respond to requests from Member States for support with outbreak preparedness and response; develop procedures for specific diseases and threats; and support preparedness and training in outbreak response. WHO has conducted regional meetings, training courses, and workshops to develop regional response capacities, and engage additional technical institutions and partners in the Global Outbreak Alert and Response Network. In order to ensure that appropriate experts are available for the assessment of, and response to, public health events, communications and coordination between the Network and technical networks have been strengthened. The networks concerned include: field epidemiology training programmes and networks; the Global Infection Prevention and Control Network; the WHO Emerging and Dangerous Pathogens Laboratory Network; the ePORTUGUÊSe network; International Food Safety Authorities Network (INFOSAN); and the FAO/OIE Crisis Management Centre for Animal Health. WHO has coordinated the support and international deployment of partners in the Global Outbreak Alert and Response Network, together with experts in major outbreak responses and emergencies, including viral haemorrhagic fever outbreaks, and major cholera and dengue outbreaks.

Recommendation 13 (Create a contingency fund for public-health emergencies)

27. In response to this recommendation, the Secretariat has carried out an exercise to map existing contingency funds for public-health emergencies within WHO, and an analysis of lessons learnt in the area of funding. On the basis of this assessment, a proposal was presented to the Executive Board at its 130th session in January 2012.[4] The proposal concerned the creation of a contingency fund to strengthen the Organization's response to outbreaks and to ensure that response teams can be operational quickly. During the discussions, Board members were in general supportive of the concept

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[1] See also Recommendation 14.

[2] Document A66/17.

[3] Document EB132/16.

[4] See document EB130/5 Add.6.

of establishing a contingency fund, and suggested that consideration be given to establishing a reserve for outbreaks within future programme budgets, starting with the Programme budget 2014–2015.[1]

Recommendation 14 (Reach agreement on sharing of viruses and access to vaccines and other benefits)

28. In May 2011, the Health Assembly adopted resolution WHA64.5, Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits. The Pandemic Influenza Preparedness Framework, including its annexes, was adopted by the Health Assembly in the resolution.

Recommendation 15 (Pursue comprehensive influenza research and evaluation programme)

29. In November 2009, more than 90 researchers, donors, public health and policy officials from 35 countries joined forces with the Secretariat to develop a proposed research agenda in order that knowledge gained could improve public health decision-making for prevention and control of influenza. This research agenda is structured around the following five public health needs: (1) to reduce the risk of emergence of pandemic influenza; (2) to limit the spread of epidemic/pandemic influenza; (3) to minimize the impact of seasonal and pandemic influenza; (4) to optimize the treatment of patients with influenza; and (5) to promote the application of modern public health tools. In November 2011, a review of the progress was undertaken to: (i) collate the knowledge and progress attained since the launch of the agenda; (ii) interpret or apply the knowledge for improved influenza prevention and control; and (iii) highlight remaining gaps and revise recommendations, as required. Twenty academic groups performed literature reviews on a selection of key areas of research of the agenda. More than 4000 scientific papers have been published since 2009 and some of the research gaps identified at the early stage of the pandemic are about to be filled.

MONITORING IMPLEMENTATION OF THE REGULATIONS

30. States Parties have continued to provide information to the Secretariat on implementation of the Regulations, using both the WHO proposed format for the submission of the States Parties' annual report and corresponding tools based on a monitoring framework developed by the Organization to address the national capacity requirements set out in Annex 1 of the Regulations. The annual reporting process involves assessing the development of eight core capacities, as well as capacities at points of entry, and capacities to respond to four relevant types of hazard (zoonotic, food safety, chemical and radiological). As at 28 February 2013, the 2012 self-assessment questionnaire, sent to States Parties between March and November 2012, had elicited 127 responses, representing 65% of the 195 States Parties. The data showed States Parties making fair progress for a number of core capacities, notably those for surveillance (with a global average score of 81%), response (78%), and zoonotic events (80%). On the other hand, States Parties reported relatively low capacities for human resources (with a global average of 53%), chemical events (51%) and radiological events (53%). The Annex to the present document shows the capacity scores by WHO region of all States Parties that have submitted a completed questionnaire in 2012 prior to the finalization of this report.

31. As discussed below, the initial deadline for establishing national core capacities to ensure public health surveillance and response throughout their territory and public health capacity at designated

[1] See the summary records of the Executive Board at its 130th session, seventh and ninth meetings.

Points of Entry was 15 June 2012 for most States Parties. Since then, 110 States Parties have obtained a two-year extension. In this context, pursuant to the relevant paragraphs of resolution WHA65.23, the Secretariat has developed a document containing proposals for monitoring progress of work to develop core capacities under the Regulations and to satisfy related reporting requirements during the period 2013–2014. This document takes into account the fact that reporting may vary depending on whether or not a State Party has obtained an extension. The document has been shared with States Parties on the Event Information Site for National IHR Focal Points for information and implementation.

EXTENSION REQUESTS FOR 2012–2014

32. States Parties to the International Health Regulations (2005) have undertaken to develop, strengthen and maintain a number of functional capacities described in Annex 1 of the Regulations within five years of the entry into force of the Regulations, which for the majority of countries was on 15 June 2007. States Parties unable to fully complete this work by that time can avail themselves of an extension of the period for a further two years upon submitting a request to WHO accompanied by an implementation plan. In order to support countries requiring an extension, the Secretariat wrote to all States Parties in September 2011, reminding them of the June 2012 deadline and proposing procedures to facilitate decision-making on the submission of any subsequent request. Further reminders were sent in January and May 2012. As at 1 March 2013, a total of 110 States Parties had obtained extensions to the deadline and a further 13 States Parties had submitted requests but had not yet provided the necessary implementation plan. Of the 71 States Parties that had not requested an extension, 42 had positively indicated that they did not need an extension to the time period. The Secretariat is working with the remaining 29 States Parties to ensure that they do not miss the opportunity of obtaining an extension through oversight.

CRITERIA FOR EXTENSIONS IN 2014

33. Under the International Health Regulations (2005), a further period of extension to the capacity establishment timeline may be requested by States Parties, after 15 June 2014, for a period not exceeding two years. It is anticipated that such extensions will be sought by a significant number of States Parties. According to the Regulations, this request is granted by the Director-General in exceptional circumstances and when the request is supported by a new implementation plan. In this connection, resolution WHA65.23 requests the Director-General, inter alia, "to develop and publish the criteria to be used in 2014 by the Director-General (…) when making decisions about the granting of any further extensions".

34. In developing relevant and useful criteria, it is necessary to consider the objectives of the capacity obligations in the International Health Regulations (2005) and the timetable that accompanies them. The purpose of these provisions is to ensure a minimum capacity to prevent, detect and respond to a range of public health events in all countries and territories of the world. The aim is not only to achieve the widest possible population coverage, it is also to ensure that there are no significant gaps at national level, as these have the potential to threaten the health security of all countries in the world. This interdependency of the States Parties highlights the need both to keep all States Parties within the framework of the Regulations and to provide support and incentives for those countries not able to achieve the capacity requirements within the anticipated time frame. With this in mind, the criteria developed should not introduce hurdles that hinder States Parties' ability to obtain extensions; rather, they should justify the continued efforts of all States Parties and international actors to focus support on those countries that face the greatest obstacles in meeting requirements under the Regulations in relation to core capacities.

35. The Secretariat proposed criteria to the Executive Board for its consideration at its 132nd session[1], in order that Member States had adequate foreknowledge of the criteria to be used when considering future extension requests and to provide an opportunity for the Board to provide advice and direction. In proposing these criteria, the Secretariat sought to ensure that obstacles to States' full participation in the Regulations would not be created. At the same time, the aim was to provide a concrete incentive to ensure that the national capacities required by the International Health Regulations (2005) were indeed present throughout the world.

CRITERIA PROPOSED BY THE SECRETARIAT

36. Based on the requirements stated in the Regulations, the first criterion proposed by the Secretariat is that a **State Party makes a formal request in writing to the Director-General at least four months in advance of the target date** (which for most countries is 15 June 2014). This request must include a statement explaining the exceptional circumstances that have prevented the development and maintenance of the national International Health Regulations (2005) capacities.

37. Secondly any such request must be accompanied by a **new implementation plan** that includes the following elements: (1) a clear and specific identification of those capacity elements that are missing or inadequate; (2) a description of the activities and progress made in establishing those capacities up until that date; (3) a set of proposed actions that will be undertaken and a specified time frame to ensure the capacities are present; and (4) an estimation of the technical support and financial resources required to implement these activities; the proportion of these resources that will be invested from national budgets; and the extent of any external support required.

38. The Executive Board at its 132nd session concluded that, while there were no objections to the criteria proposed, they would benefit from the opportunity of further consideration by Member States through the mechanism of the regional committee meetings to be held in 2013, allowing the final criteria to be provided to the Executive Board at its 134th session in January 2014.

CONCLUSION

39. The Review Committee's report and recommendations continue to play an important role in shaping the Secretariat's work, both in terms of the implementation of the International Health Regulations (2005) and the preparations for future influenza pandemics. While the value of the Regulations to countries and to the Secretariat continues to be demonstrated during the management of acute public health events, such as the ongoing illness associated with a novel coronavirus, at the same time the extension procedures have kept international attention on the establishment of the national capacities. At a time of global economic crisis, when rapid progress is challenged by limitations in technical, human and financial resources, the Regulations remain a focus for commitment to maintain and improve global public health security.

ACTION BY THE HEALTH ASSEMBLY

40. The Health Assembly is invited to take note of this report.

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[1] Document EB132/15 Add.1.

ANNEX

International Health Regulations (2005): national capacity monitoring. Capacity scores for all reporting States Parties for 2012

African Region

State Party	Legislation	Coordination	Surveillance	Response	Preparedness	Risk communications	Human resources	Laboratory	Points of entry	Zoonotic	Food safety	Chemical	Radiological
Algeria	0	53	35	35	10	14	0	4	11	56	0	31	31
Angola	Data for 2012 not yet available												
Benin	0	80	45	64	30	57	80	81	60	44	13	0	0
Botswana	Data for 2012 not yet available												
Burkina Faso	100	53	60	58	30	43	20	76	9	56	27	8	8
Burundi	Data for 2012 not yet available												
Cameroon	100	26	75	63	60	86	100	90	29	100	47	15	15
Cape Verde	Data for 2012 not yet available												
Central African Republic	Data for 2012 not yet available												
Chad	Data for 2012 not yet available												
Comoros	Data for 2012 not yet available												
Congo	25	56	100	77	70	71	60	66	67	89	67	54	54
Côte d'Ivoire	Data for 2012 not yet available												
Democratic Republic of the Congo	100	30	85	52	50	100	100	71	31	44	80	8	8
Equatorial Guinea	Data for 2012 not yet available												
Eritrea	Data for 2012 not yet available												
Ethiopia	100	83	85	58	100	86	100	100	36	100	73	69	69

Gabon	Data for 2012 not yet available												
Gambia	Data for 2012 not yet available												
Ghana	50	53	80	65	50	43	40	51	31	78	47	31	31
Guinea	Data for 2012 not yet available												
Guinea-Bissau	Data for 2012 not yet available												
Kenya	50	90	75	77	70	57	40	65	55	89	80	46	46
Lesotho	Data for 2012 not yet available												
Liberia	Data for 2012 not yet available												
Madagascar	Data for 2012 not yet available												
Malawi	Data for 2012 not yet available												
Mali	Data for 2012 not yet available												
Mauritania	0	20	35	6	0	0	0	35	3	100	13	46	46
Mauritius	Data for 2012 not yet available												
Mozambique	0	83	70	94	30	43	100	91	85	33	20	8	8
Namibia	Data for 2012 not yet available												
Niger	Data for 2012 not yet available												
Nigeria	Data for 2012 not yet available												
Rwanda	Data for 2012 not yet available												
Sao Tome and Principe	0	36	55	34	0	14	0	22	12	56	27	0	0
Senegal	0	53	70	35	30	0	0	66	39	22	40	31	31
Seychelles	0	20	95	71	0	0	40	86	40	78	53	46	46
Sierra Leone	Data for 2012 not yet available												
South Africa	75	73	50	94	80	100	40	90	33	100	60	92	92
Swaziland	0	26	95	65	60	57	0	56	24	67	47	15	15

Togo	Data for 2012 not yet available												
Uganda	25	70	75	58	60	71	40	86	0	67	53	8	8
United Republic of Tanzania	50	20	50	59	40	57	100	53	3	67	53	31	31
Zambia	0	83	95	94	100	71	80	96	24	100	93	77	77
Zimbabwe	Data for 2012 not yet available												
Total	**36**	**53**	**70**	**61**	**46**	**51**	**49**	**68**	**31**	**71**	**47**	**32**	**35**

Region of the Americas

State Party	Legislation	Coordination	Surveillance	Response	Preparedness	Risk communications	Human resources	Laboratory	Points of entry	Zoonotic	Food safety	Chemical	Radiological
Antigua and Barbuda	100	66	95	70	60	43	100	66	77	89	80	62	62
Argentina[a]	50	73	80	83	100	86	100	73	See note below[b]	67	60	69	69
Bahamas	Data for 2012 not yet available												
Barbados	50	40	95	66	40	86	80	96	97	100	93	54	54
Belize	25	36	85	76	10	71	40	77	58	78	67	8	8
Bolivia (Plurinational State of)	50	56	75	83	60	43	0	86	51	78	60	31	31
Brazil	Data for 2012 not yet available												
Canada	100	83	100	100	100	100	100	100	94	100	100	100	100
Chile	50	46	85	94	70	57	20	67	87	89	93	23	23
Colombia	100	73	70	65	50	86	80	90	97	33	80	62	62
Costa Rica	100	100	95	94	60	86	100	80	91	100	100	38	38

State Party	Legislation	Coordination	Surveillance	Response	Preparedness	Risk communications	Human resources	Laboratory	Points of entry	Zoonotic	Food safety	Chemical	Radiological
Cuba	100	100	100	100	100	100	100	96	97	100	100	100	100
Dominica	Data for 2012 not yet available												
Dominican Republic	75	90	80	48	70	86	40	39	21	44	27	23	23
Ecuador	0	56	35	47	20	43	20	35	45	56	60	38	38
El Salvador	75	90	100	100	50	71	100	100	97	67	73	46	46
Grenada	50	83	90	52	0	57	0	41	64	100	67	23	23
Guatemala	75	66	85	76	20	86	100	91	38	89	47	62	62
Guyana	100	83	80	94	90	71	80	100	50	100	67	62	62
Haiti	Data for 2012 not yet available												
Honduras	50	26	90	71	20	29	60	91	22	100	67	0	0
Jamaica	50	73	100	100	90	86	0	90	91	100	93	54	54
Mexico	100	53	80	89	60	43	80	96	54	89	87	69	69
Nicaragua	25	100	95	87	80	100	20	81	62	100	80	92	92
Panama	100	73	90	89	50	43	100	96	56	100	93	54	54
Paraguay	Data for 2012 not yet available												
Peru	100	50	100	87	50	57	80	77	27	78	93	8	8
Saint Kitts and Nevis	Data for 2012 not yet available												
Saint Lucia	0	73	80	65	50	29	20	43	12	67	40	15	15
Saint Vincent and the Grenadines	0	46	75	60	10	0	0	81	41	100	40	0	0
Suriname	50	66	35	66	50	43	0	90	51	56	67	54	54

State Party	Legislation	Coordination	Surveillance	Response	Preparedness	Risk communications	Human resources	Laboratory	Points of entry	Zoonotic	Food safety	Chemical	Radiological
Trinidad and Tobago	50	56	80	76	50	71	0	77	74	89	87	46	46
United States of America	100	100	100	100	100	100	100	60	100	100	100	100	100
Uruguay	Data for 2012 not yet available												
Venezuela (Bolivarian Republic of)	25	73	80	94	80	86	80	90	50	100	87	85	85
Total	**62**	**69**	**84**	**80**	**57**	**66**	**57**	**79**	**61**	**85**	**75**	**49**	**43**

[a]Argentina had submitted the report using the MERCOSUR tool, subsequently migrating data from the relevant sections to the format proposed by WHO as per the agreement with the UNASUR Technical Working Group for Surveillance and Response.

[b]Information related to points of entry from Argentina was submitted in a format not allowing its conversion into the WHO format.

South-East Asia Region

State Party	Legislation	Coordination	Surveillance	Response	Preparedness	Risk communications	Human resources	Laboratory	Points of entry	Zoonotic	Food safety	Chemical	Radiological
Bangladesh	75	66	80	81	50	86	80	90	15	89	27	69	69
Bhutan	Data for 2012 not yet available												
Democratic People's Republic of Korea	25	46	70	65	60	71	40	65	21	78	60	15	15
India	100	100	85	88	60	71	100	91	91	100	80	23	23
Indonesia	100	46	85	76	80	100	80	96	77	100	87	85	85
Maldives	75	83	85	71	40	71	40	76	73	67	67	8	8
Myanmar	75	90	100	100	100	100	100	70	91	100	100	38	38

State Party	Legislation	Coordination	Surveillance	Response	Preparedness	Risk communications	Human resources	Laboratory	Points of entry	Zoonotic	Food safety	Chemical	Radiological
Nepal	75	66	35	52	40	29	20	60	65	44	60	0	0
Sri Lanka	100	63	100	83	50	86	80	71	88	100	87	23	23
Thailand	100	90	85	94	90	71	80	100	74	89	93	31	31
Timor-Leste	50	46	50	58	20	57	40	37	58	67	93	0	0
Total	**78**	**70**	**78**	**77**	**59**	**74**	**66**	**76**	**65**	**83**	**75**	**29**	**44**

European Region

State Party	Legislation	Coordination	Surveillance	Response	Preparedness	Risk communications	Human resources	Laboratory	Points of entry	Zoonotic	Food safety	Chemical	Radiological
Albania	Data for 2012 not yet available												
Andorra	75	30	65	37	40	14	0	25	0	44	73	0	0
Armenia	75	90	85	94	100	86	80	75	97	100	87	92	92
Austria	75	90	95	100	100	100	80	91	91	100	100	92	92
Azerbaijan	Data for 2012 not yet available												
Belarus	Data for 2012 not yet available												
Belgium	100	80	65	72	50	100	60	91	70	89	100	92	92
Bosnia and Herzegovina	Data for 2012 not yet available												
Bulgaria	Data for 2012 not yet available												
Croatia	Data for 2012 not yet available												
Cyprus	Data for 2012 not yet available												
Czech Republic	100	83	100	100	90	86	60	100	88	100	100	100	100
Denmark	Data for 2012 not yet available												
Estonia	Data for 2012 not yet available												
Finland	100	100	100	100	80	100	80	96	97	100	100	100	100

State Party	Legislation	Coordination	Surveillance	Response	Preparedness	Risk communications	Human resources	Laboratory	Points of entry	Zoonotic	Food safety	Chemical	Radiological
France	100	63	95	94	80	86	60	96	22	78	93	92	92
Georgia	100	100	100	100	100	100	100	91	66	100	67	62	62
Germany	100	100	100	94	80	100	100	100	27	100	100	100	100
Greece	Data for 2012 not yet available												
Holy See	Data for 2012 not yet available												
Hungary	100	50	80	65	60	71	60	91	92	100	93	92	92
Iceland	100	100	75	83	100	71	20	77	74	100	100	54	54
Ireland	25	80	85	100	80	100	40	77	73	100	100	92	92
Israel	Data for 2012 not yet available												
Italy	Data for 2012 not yet available												
Kazakhstan	100	53	70	76	90	43	100	96	97	89	100	100	100
Kyrgyzstan	Data for 2012 not yet available												
Latvia	100	66	80	94	100	71	20	96	59	100	100	92	92
Liechtenstein	Data for 2012 not yet available												
Lithuania	100	83	85	55	70	100	20	87	94	100	100	100	100
Luxembourg	0	53	50	83	50	100	0	83	88	89	73	46	46
Malta	100	100	100	71	60	57	0	79	28	100	100	54	54
Monaco	75	63	70	83	60	71	20	57	75	0	100	69	69
Montenegro	25	100	75	59	70	57	20	77	9	56	80	31	31
Netherlands	100	100	100	94	70	86	0	86	77	89	100	100	100
Norway	100	100	95	100	100	100	40	100	97	100	100	85	85
Poland	50	100	95	94	90	43	0	100	85	100	73	62	62
Portugal	Data for 2012 not yet available												
Republic of Moldova	100	83	95	88	40	57	20	66	85	89	67	69	69
Romania	Data for 2012 not yet available												
Russian Federation	Data for 2012 not yet available												

State Party	Legislation	Coordination	Surveillance	Response	Preparedness	Risk communications	Human resources	Laboratory	Points of entry	Zoonotic	Food safety	Chemical	Radiological
San Marino	Data for 2012 not yet available												
Serbia	Data for 2012 not yet available												
Slovakia	100	100	100	89	90	100	40	86	9	89	100	77	77
Slovenia	100	30	85	55	40	14	20	43	41	100	87	69	69
Spain	100	83	95	94	100	43	60	81	96	100	93	92	92
Sweden	100	100	95	100	100	100	80	100	88	100	100	100	100
Switzerland	100	100	90	100	100	86	20	100	22	100	93	100	100
Tajikistan	100	90	95	83	90	100	20	34	5	100	80	77	77
The former Yugoslav Republic of Macedonia	Data for 2012 not yet available												
Turkey	75	100	65	94	70	57	100	100	62	89	80	69	69
Turkmenistan	Data for 2012 not yet available												
Ukraine	Data for 2012 not yet available												
United Kingdom of Great Britain and Northern Ireland	Data provided in a format that could not be included in the analysis												
Uzbekistan	Data for 2012 not yet available												
Total	**86**	**82**	**86**	**85**	**78**	**77**	**44**	**83**	**64**	**90**	**91**	**79**	**85**

Eastern Mediterranean Region

State Party	Legislation	Coordination	Surveillance	Response	Preparedness	Risk communications	Human resources	Laboratory	Points of entry	Zoonotic	Food safety	Chemical	Radiological
Afghanistan	0	36	80	47	0	43	20	26	3	56	13	0	0
Bahrain	100	100	100	94	70	86	20	86	100	78	93	85	85
Djibouti	50	36	45	52	0	57	60	29	50	56	67	8	8
Egypt	75	83	90	94	80	86	80	86	100	89	73	77	77
Iran (Islamic Republic of)	100	90	100	94	80	86	100	100	91	100	100	77	77
Iraq	Data for 2012 not yet available												
Jordan	Data for 2012 not yet available												
Kuwait	100	100	65	94	90	100	60	100	89	100	80	0	0
Lebanon	Data for 2012 not yet available												
Libya	75	73	65	54	60	29	40	33	12	33	33	0	0
Morocco	100	100	95	100	100	100	100	86	83	100	100	38	38
Oman	Data for 2012 not yet available												
Pakistan	Data for 2012 not yet available												
Qatar	Data for 2012 not yet available												
Saudi Arabia	100	100	90	100	100	100	100	100	39	100	100	100	100
Somalia	Data for 2012 not yet available												
Sudan	0	56	85	64	60	14	40	49	18	100	7	15	15
Syrian Arab Republic	50	53	70	58	20	29	60	96	42	67	87	46	46
Tunisia	75	100	85	48	40	43	80	49	60	89	73	31	31
United Arab Emirates	50	63	70	71	50	43	0	96	3	67	67	54	54
Yemen	Data for 2012 not yet available												
Total	**67**	**76**	**80**	**75**	**58**	**63**	**58**	**72**	**53**	**80**	**69**	**41**	**60**

Western Pacific Region

State Party	Legislation	Coordination	Surveillance	Response	Preparedness	Risk communications	Human resources	Laboratory	Points of entry	Zoonotic	Food safety	Chemical	Radiological
Australia	100	100	95	94	100	100	100	100	100	100	100	100	100
Brunei Darussalam	50	63	90	94	70	57	60	71	81	100	93	15	15
Cambodia	50	56	95	65	20	43	40	57	72	89	40	15	15
China	100	100	100	94	100	100	100	87	24	44	93	77	77
Cook Islands	100	90	100	100	100	100	60	96	100	100	100	77	77
Fiji	75	36	50	94	40	0	20	86	46	0	60	54	54
Japan	100	100	100	87	100	100	100	100	94	100	100	100	100
Kiribati	100	100	100	100	100	100	0	56	24	89	80	0	0
Lao People's Democratic Republic	50	36	75	40	10	14	60	31	0	44	40	0	0
Malaysia	100	100	100	100	100	100	100	100	97	100	100	100	100
Marshall Islands	75	60	75	94	90	86	40	37	12	0	20	0	0
Micronesia (Federated States of)	100	83	75	83	80	100	20	73	91	56	87	38	38
Mongolia	100	100	55	76	50	71	40	73	97	100	33	46	46
Nauru	Data for 2012 not yet available												
New Zealand	100	90	100	100	100	100	100	86	97	100	100	85	85
Niue	25	20	55	71	40	57	0	67	72	67	53	8	8
Palau	100	70	100	100	90	100	80	96	80	100	100	100	100
Papua New Guinea	0	73	80	76	50	86	40	66	41	44	47	0	0
Philippines	25	100	100	100	100	86	100	57	31	33	47	100	100
Republic of Korea	100	100	100	100	100	100	100	100	100	100	100	100	100

State Party	Legislation	Coordination	Surveillance	Response	Preparedness	Risk communications	Human resources	Laboratory	Points of entry	Zoonotic	Food safety	Chemical	Radiological
Samoa	75	90	70	70	80	86	40	56	60	67	53	0	0
Singapore	100	100	100	100	100	100	100	100	97	100	100	100	100
Solomon Islands	0	63	75	60	10	43	20	57	0	44	27	0	0
Tonga	100	100	65	77	10	71	80	25	18	100	40	8	8
Tuvalu	100	100	100	100	100	100	60	100	100	78	100	85	85
Vanuatu	0	0	30	37	0	0	0	49	0	0	27	0	0
Viet Nam	50	46	60	94	70	14	60	56	84	100	87	46	46
Total	**72**	**76**	**82**	**85**	**70**	**74**	**58**	**72**	**62**	**71**	**70**	**48**	**45**
Global Total	**67**	**71**	**81**	**78**	**63**	**68**	**53**	**75**	**56**	**80**	**73**	**51**	**53**

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