World Health Organization

SEVENTY-FIRST WORLD HEALTH ASSEMBLY **A71/7**
Provisional agenda item 11.2 **5 April 2018**

Implementation of the International Health Regulations (2005)

Annual report on the implementation of the International Health Regulations (2005)

Report by the Director-General

1. This document has been drafted in response to resolution WHA61.2 (2008), which requests the Director-General "to submit every year a single report, including information provided by States Parties and about the Secretariat's activities, to the Health Assembly for its consideration, pursuant to paragraph 1 of Article 54 of the International Health Regulations (2005)".

EVENT MANAGEMENT

Event-related information

2. From January to December 2017, a total of 418 public health events were recorded in WHO's event management system, of which 299 (72%) were attributed to infectious diseases, 39 (9%) to disasters and 28 (7%) to food safety. The initial source of information in reporting 136 (33%) of these events was national government agencies, including National IHR Focal Points. Other sources of information included WHO offices, news media and other organizations. As in previous years, there were substantial delays in the notification by States Parties of events to WHO and in their response to requests for verification of information under Articles 6 to 10 of the Regulations. The Secretariat has embarked on a pilot study on the prospective further documentation of the compliance of States Parties with requirements for information verification and notification.

3. During the same period, WHO posted 183 updates[1] on the event information site for National IHR Focal Points, relating to 82 public health events reported from the African Region (46%), the Region of the Americas (16%), the Eastern Mediterranean Region (15%), the European Region (13%), the South-East Asia Region (5%) and the Western Pacific Region (5%). Most event updates concerned

[1] Including updates on acute public health events, regional summaries and meetings of the Emergency Committee.

cholera, influenza, dengue fever and pneumonic plague. In addition, WHO published 98 updates as disease outbreak news on its official website in 2017.[1]

4. In 2017, the WHO Health Emergencies Programme actively supported outbreak responses at all three levels of the Organization. Technical support and operational logistics support were provided for outbreaks of acute watery diarrhoea/cholera, dengue, diphtheria, Ebola virus disease, hepatitis E, influenza A(H1N1), Lassa fever, malaria, legionellosis, listeriosis, Marburg virus disease, measles, meningitis, Middle East respiratory syndrome coronavirus (MERS-CoV), monkeypox, multidrug resistant Acinetobacter baumannii, necrotizing cellulitis, plague and yellow fever. Significant support from the Secretariat was provided for the response to the outbreak of Ebola virus disease in the Democratic Republic of the Congo, from May to June 2017 and the plague epidemic in Madagascar, from August to November 2017. Both responses involved the rapid deployment of field teams including WHO staff from all three levels of the Organization and from the Global Outbreak Alert and Response Network (GOARN) partners.

5. WHO worked closely with GOARN partners and networks, including in particular the Emerging and Dangerous Pathogens Laboratory Network as well as the Global Health Cluster, Emergency Medical Teams, standby partners and the United Nations Inter-Agency Standing Committee, to coordinate international technical assistance to States Parties relating to all hazards in order to improve surveillance and mobile laboratory capacity, support alert and response systems and implement comprehensive outbreak response interventions, including vaccination campaigns, distribution of medicines and supplies and provision of training and protection to health workers.

Emergency committees

6. The Emergency Committee under the International Health Regulations (2005) concerning ongoing events and context involving transmission and international spread of poliovirus was the only such committee active during the reporting period. It has been meeting every three months since May 2014, when the international spread of poliovirus was declared a public health emergency of international concern. The situation continues to be managed through temporary recommendations under the Regulations, in accordance with Health Assembly decision WHA68(9) (2015). At the Emergency Committee meeting on 7 February 2018, five countries affected by poliovirus were invited to provide updates on measures taken to implement the temporary recommendations. Following this meeting, the Director-General maintained the public health emergency of international concern and issued corresponding temporary recommendations.[2]

Monitoring compliance in relation to additional health measures

7. During the 2017 Ebola outbreak in the Democratic Republic of the Congo and the plague outbreak in Madagascar, the Secretariat piloted a structured approach for a constructive dialogue with States Parties regarding additional health measures. In two instances the additional measures implemented by States Parties in relation to these public health events were classified as significantly interfering with international traffic as specified in Article 43.3 of the Regulations, in that they

[1] See the WHO Disease Outbreak News (DONs) webpage at http://www.who.int/csr/don/en/ (accessed 1 March 2018).

[2] Statement of the Sixteenth IHR Emergency Committee Regarding the International Spread of Poliovirus (http://www.who.int/mediacentre/news/statements/2018/16th-ihr-polio/en/, accessed 5 March 2018).

entailed "refusal of entry or departure of international travellers, baggage, cargo, containers, conveyances, goods, and the like, or their delay, for more than 24 hours".[1] In one of these instances, the State Party did not provide WHO with the public health rationale for the measures implemented. In the other instance, the information was made available to WHO only 25 days after the additional health measure had been implemented by the State Party. The Secretariat will continue to systematically monitor additional health measures in relation to public health events, with the objective of providing regular updates to the governing bodies in future reports.

STRENGTHENING NATIONAL CORE CAPACITIES

8. Since 2010, 195 of the 196 States Parties have reported at least once to the Secretariat using the annual reporting questionnaire.[2] As at 6 March 2018, 158 (81%) of 196 States Parties had submitted the questionnaire sent in June 2017; by region, 47 (100%) of States Parties from the African Region, 30 (86%) from the Americas Region, 11 (100%) from the South-East Asia Region, 35 (64%) from the European Region, 19 (90%) from the Eastern Mediterranean Region and 17 (63%) from the Western Pacific Region have done so. Detailed information on the 2017 annual reporting by States Parties is published on the WHO Global Health Observatory website,[3] together with analysis of scores for core capacities required to implement the Regulations by country by year since 2010.[4] Globally, progress has been reported since 2010 across the 13 core capacities, particularly in respect of zoonoses, surveillance and laboratory, but the overall average scores suggest further and sustained efforts are urgently needed in the areas of chemical events, capacities at points of entry, human resources and radiation emergencies.[5] In some regions, additional capacity is required in the areas of food safety and preparedness.

9. The Secretariat has actively supported the development of national action plans for health emergency preparedness, based on the outcome of the different monitoring and voluntary evaluation processes. National planning was completed in 18 countries[6] and is currently under development in a further 12 countries.[7] The Secretariat has developed and is further refining guidance documents and tools for the development of national action plans. Orientation training to expedite the development of such plans was conducted for 25 staff members at WHO country offices in the African Region and for the representatives of 10 countries in the European Region and further such training is planned for the South-East Asia and Eastern Mediterranean regions during the first quarter of 2018. WHO regional and country offices have actively supported States Parties in the development and costing of national action plans.

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[1] International Health Regulations (2005), 3rd edition. Geneva: World Health Organization; 2016 (http://www.who.int/ihr/publications/9789241580496/en/, accessed 27 February 2018).

[2] IHR core capacity monitoring framework: questionnaire for monitoring progress in the implementation of IHR core capacities in States Parties. Geneva: World Health Organization; 2017 (http://www.who.int/ihr/publications/WHO-HSE-GCR-2016.16/en/, accessed 27 February 2018).

[3] http://apps.who.int/gho/data/node.main.IHR00ALLN?lang=en (to be updated when 2017 data become available).

[4] See the International Health Regulations (2005) monitoring framework – country profiles website (http://apps.who.int/gho/tableau-public/tpc-frame.jsp?id=1100, accessed 27 February 2018).

[5] Based on the analysis of information received from 144 States Parties as at 16 February 2018.

[6] Cambodia, Eritrea, Finland, Jordan, Kyrgyzstan, Lao People's Democratic Republic, Liberia, Mongolia, Morocco, Mozambique, Myanmar, Namibia, Pakistan, Saudi Arabia, Senegal, Sierra Leone, Uganda, United Republic of Tanzania.

[7] Afghanistan, Benin, Chad, Comoros, Côte d'Ivoire, Ethiopia, Ghana, Mauritania, Papua New Guinea, Sudan, United States of America and Viet Nam.

10. As at 2 February 2018, a total of 67 countries had conducted a voluntary joint external evaluation, of which 39 were conducted in 2017. All those that conducted such an evaluation have acknowledged the unique intersectoral momentum created by the process at the country level and the value of the external experts. In 2017, the Secretariat supported 22 simulation exercises, in 19 countries, designed to test various functional capacities in preparedness and response. These exercises included testing rapid response teams, risk communication, coordination mechanisms and emergency preparedness and response procedures for different events, such as Ebola, meningitis, cholera, mass gathering events and deliberate events. The Secretariat, in particular the regional and country offices, also supported the conduct of after-action reviews in 21 countries, covering a total of 15 technical response areas. The reviews involved national health stakeholders at the national, regional and local levels, community representatives, non-State actors and international partners. Detailed information about the joint external evaluations, simulation exercises and after-action reviews conducted can be found at the WHO Strategic Partnership Portal.[1]

11. In May 2017, G20 health ministers participated for the first time with representatives from the WHO Secretariat and the World Bank in a simulation exercise to rehearse the response to a severe and rapidly spreading international outbreak.

12. The Regional Office for Africa supported the conduct of after-action reviews in 13 countries between 2016 and 2017. These reviews consistently provided unique information on the active functionality and interoperability of the different capacities identified through self-assessment or joint external evaluation. States Parties appreciate the value of the reviews in testing the functionality of the emergency response system, as they complement the static assessment of the core capacities required by the Regulations.

PROCEDURES UNDER THE REGULATIONS

National IHR Focal Points

13. The Secretariat has continued to maintain the accessibility around the clock of the six WHO Regional IHR Contact Points and assessed the availability around the clock of National IHR Focal Points through a global pilot test conducted in October 2017. Of the 161 National IHR Focal Points contacted by email and telephone during Geneva working hours, 90 (56%) responded to email within 72 hours and 103 (63%) were reachable by telephone. The Regulations require that all National IHR Focal Points and WHO IHR Contact Points be accessible to receive and respond to urgent communications at all times; the performance of the National IHR Focal Point network as indicated in the test is not optimal and needs to be improved urgently. The Regional Office for the Americas did not participate in the pilot test, as it conducts its own routine connectivity tests between the Regional IHR Contact Point and the National IHR Focal Points in the Region and reports the results to the Directing Council of the Pan American Health Organization. In 2016, the tests performed were successful for 32 of the 35 States Parties (91%) by email and for 33 (94%) by telephone.[2]

14. With regard to the use of the event information site by National IHR Focal Points, 169 out of 196 (86%) National IHR Focal Points accessed the site at least once in 2017 in order to obtain up to date information in relation to ongoing public health events and emergencies.

[1] WHO Strategic Partnership Portal. Available online at https://extranet.who.int/spp/ (accessed 27 February 2018).

[2] See document CSP29/INF/6, para. 4.

15. Four of the six WHO regional offices held meetings with the National IHR Focal Points during 2017 with the aim of providing training, sharing lessons and experiences and building communities of practice at the regional level. For example, the annual simulation exercise IHR Exercise Crystal, which tests event communication among National IHR Focal Points and Regional IHR Contact Points, was held in the Western Pacific Region in 2017, involving 30 States Parties, areas and territories. National IHR Focal Points from selected States Parties in the European Region received training in October 2017 to better understand their functions under the Regulations, discuss commonly encountered challenges and share experiences of their daily work. The WHO Secretariat will maintain the Health Security Learning Platform,[1] which includes e-learning and real-time exercises targeting National IHR Focal Points.

Points of entry

16. Since 2007, 103 out of a total of 152 non-landlocked countries and four landlocked countries with inland ports have sent WHO the list of ports authorized to issue ship sanitation certificates as required by Article 39 of the Regulations. Some States Parties have reported that some ship sanitation certificates are being issued at unauthorized ports; some are being issued by unauthorized authorities and are possibly fraudulent; some do not conform to the model in Annex 3 of the Regulations; and some are being filled out poorly or incorrectly. In order to support States Parties in addressing these difficulties, in 2017 the Secretariat provided training to 970 staff in 105 countries on the issuance of ship sanitation certificates.

17. In the same year, the Secretariat, in collaboration with the International Civil Aviation Organization, supported a regional training of trainers programme on the Management of Public Health Events in Air Transport, attended by more than 40 participants from 17 African countries. Furthermore, the Secretariat developed a vector identification platform for vectors detected at points of entry in order to support National IHR Focal Points and public health authorities at points of entry.

IHR Roster of Experts

18. The IHR Expert Roster established by the Director-General under the Regulations currently includes a total of 460 experts, of whom only 88 were appointed by the Director-General at the request of States Parties. These figures indicate that less than half of States Parties make full use of their rights under Article 47 of the Regulations. Less than one third of experts on the roster are female. The European Region has the highest representation (34% of experts on the roster, with three countries providing almost half of these), followed by the Region of the Americas (24%, with one country providing almost half of these experts), the Western Pacific Region (15%, with three countries providing almost two thirds of these experts). The regions with the lowest representation are the South-East Asia Region and the Eastern Mediterranean Region (8% each) followed by the African Region (10%). The roster includes experts in 81 areas of expertise including epidemiology, vector control, infection control, travel medicine, risk communications, viral haemorrhagic fevers, mass gatherings and points of entry. The Secretariat is actively undertaking to improve the gender balance of the roster and to identify additional experts from the less represented regions and in areas of expertise with few experts, such as logistics and field support, mathematical modelling, medical anthropology and social sciences.

[1] Health Security Learning Platform. Available at https://extranet.who.int/hslp/training/ (accessed 8 February 2018).

Yellow fever

19. As at 6 February 2018, 89 countries and eight overseas territories had responded to the annual questionnaire on international travel and health, sent through a circular letter in order to collect States Parties' requirements for yellow fever vaccination for international travellers. Currently, 114 countries and 17 territories request a vaccination certificate against yellow fever for incoming travellers. Of these, only 42 countries and seven overseas territories confirmed that the international certificates of vaccination against yellow fever, using approved WHO vaccines, are now accepted as valid for the life of the person vaccinated, as they should be in accordance with Annex 7 of the Regulations, as amended by resolution WHA67.13 (2014).

20. The scientific and technical advisory group on geographical yellow fever risk mapping[1] met by teleconference in June 2017 in order to discuss the request made by countries to review the areas at risk for yellow fever transmission and recommendations for vaccination of international travellers. The group was also briefed on the situation of yellow fever in Brazil. The Secretariat organized a technical consultation in December 2017 to review the methodologies for yellow fever risk assessment and risk mapping. As a result, a small working group, including members of the advisory group, is developing a map for yellow fever transmission which will serve as a basis for both the advisory group and the Eliminate Yellow fever Epidemics strategy to guide their respective recommendations to international travellers and countries at risk of yellow fever transmission.

ACTIVITIES BY THE SECRETARIAT IN SUPPORT OF STATES PARTIES TO IMPLEMENT THE REGULATIONS

21. As requested by the Health Assembly in decision WHA70(11) (2017), the Secretariat developed a draft five-year global strategic plan to improve public health preparedness and response. This was presented for consideration by the Executive Board at its 142nd session. The Board then adopted decision EB142(1), in which it recommended to the Seventy-first World Health Assembly the adoption of a decision that would, inter alia, endorse the strategic plan.[2]

22. In 2017, WHO and the World Organization for Animal Health (OIE) held a national bridging workshop to support six countries in strengthening collaboration between animal and human health services. In these workshops, national stakeholders from central, regional and local levels from both sectors come together to develop a joint road map for the prevention and detection of and response to zoonotic disease outbreaks and food safety emergencies. The results of these workshops are used to identify priorities for inclusion in national action plans for health emergency preparedness.

23. As recommended by the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response,[3] the Secretariat is establishing a scientific advisory group for infectious hazards to provide further support in the analysis and risk assessment of emerging pathogens.

[1] See http://www.who.int/ith/yellow-fever-risk-mapping/en/ (accessed 28 February 2018).

[2] See document A71/8.

[3] Document A69/21, recommendation 6.

24. The Secretariat revised and published the Guidance on regulations for the transport of infectious substances.[1] A global laboratory-proficiency testing scheme was offered to more than 100 national reference laboratories across the six WHO regions, to test capacity for the identification of arboviruses. The Secretariat further supported the implementation of national laboratory policies and strategic plans to enhance national public health systems. In addition, an electronic tool to enhance indicator-based surveillance was developed and piloted before further dissemination in 2018.

25. The Secretariat continued to strengthen its partnerships to promote implementation of the Regulations. Two important meetings convened in 2017 brought together countries and partners across various sectors, including animal health and civilian and military health services, to share lessons and identify areas for future collaboration.[2]

26. In 2017, WHO regional offices and country offices actively supported States Parties in accelerating implementation of the Regulations and strengthening capacities in public health emergency preparedness. Efforts to support States Parties in the monitoring and evaluation of capacities required under the Regulations have continued, through both a multisectoral approach and integration with health systems. The Asia Pacific Strategy for Emerging Diseases and Public Health Emergencies continued to serve as a framework for action to advance implementation of the Regulations and provide guidance for States Parties in updating their national action plans.

27. The Universal Health Coverage Forum, held in Tokyo from 12 to 15 December 2017 and co-hosted by the Government of Japan, the World Bank, WHO, UNICEF, UHC2030 and the Japan International Cooperation Agency, committed to "targeted investments to prevent, detect and respond to disease outbreaks and other emergencies including surveillance systems in order to safeguard health security and international collaboration under the International Health Regulations (2005)".[3] The Secretariat will develop a common framework for harmonizing the core capacities required by the Regulations with the essential public health functions of health systems.

CONCLUSION

28. There is consensus that since their adoption in 2005, the Regulations have helped the international community to prepare for and respond to public health emergencies more efficiently. Many States Parties have made good progress in developing and strengthening the core capacities required by the Regulations. However, significant gaps in the core capacities persist in several countries and emerging and re-emerging threats with pandemic potential continue to challenge fragile health systems. Taking advantage of the existing momentum and initiatives in support of the implementation of the Regulations, States Parties must accelerate their efforts to build and maintain the core capacities and ensure that they are fully embedded in their health systems, including the capacities related to points of entry. Efforts should continue to involve other relevant sectors such as animal health, travel and transport. The global network of National IHR Focal Points continues to play

[1] Guidance on regulations for the transport of infectious substances 2017–2018. Geneva: World Health Organization; 2017 (http://www.who.int/ihr/publications/WHO-WHE-CPI-2017.8/en/, accessed on 28 February 2018).

[2] Delivering Global Health Security through Sustainable Financing (Seoul, Republic of Korea, 26–27 July 2017); and Managing Future Global Health Risk by Strengthening Civilian and Military Health Services, held jointly with the International Committee of Military Medicine (ICMM) (Jakarta, 24–26 October 2017).

[3] See the Tokyo Declaration on Universal Health Coverage (http://www.worldbank.org/en/news/statement/2017/12/14/uhc-forum-tokyo-declaration accessed on 28 February 2018).

a central role in the implementation of the Regulations and in the global health security architecture, although in some countries, significant challenges persist regarding the actual functionality and responsiveness of National IHR Focal Points.

29. The draft five-year global strategic plan to improve public health preparedness and response, 2018–2023, which is being submitted for consideration by the Seventy-first World Health Assembly,[1] should allow the Secretariat and States Parties to address the challenges referred to above and expedite the implementation of the Regulations.

ACTION BY THE HEALTH ASSEMBLY

30. The Health Assembly is invited to note this report.

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[1] Document A71/8.