
Implementation of the International Health Regulations (2005)

Report by the Director-General

1. In accordance with paragraph 1 of article 54 of the International Health Regulations (2005) and resolution WHA61.2 (2008), States Parties and the Director-General report annually to the Health Assembly on the implementation of the Regulations. This report gives an account of actions taken by the Secretariat within the framework of the Regulations regarding the international response in 2015 to public health events and emergencies – in particular, Ebola virus disease, Middle East respiratory syndrome (MERS), poliomyelitis and avian influenza. The report also includes information about the convening of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response, and the first amendment to the International Health Regulations (2005) regarding yellow fever vaccination.

KEY PUBLIC HEALTH EVENTS AND EMERGENCIES IN 2015

2. From 1 March to 15 October 2015, 161 “public health events” were recorded. During that period, WHO posted 170 updates on the event information site for National IHR Focal Points, relating to 48 public health events (including updates on meetings of the Emergency Committee and regional updates). Most updates concerned Ebola virus disease in West Africa, MERS and avian influenza in humans.

Ebola virus disease

3. Since the declaration of a public health emergency of international concern in 2014, the IHR Emergency Committee regarding the Ebola outbreak in West Africa has met eight times. In October 2015, the Committee noted that Liberia had been declared free of Ebola virus disease transmission for a second time, the overall case incidence in Guinea and Sierra Leone was fewer than 10 cases per week, and the Sierra Leonean capital city of Freetown had been transmission-free for over 42 days. The Committee noted, however, that a risk of transmission remained, owing (among other things) to the continued identification of cases not previously registered as contacts, the resistance to response operations in some areas, and the ongoing movement of cases and contacts to Ebola-free areas. The Committee also noted the small number of cases in which virus from a convalescent individual could not be ruled out as the origin of infection; while viral persistence was understood to be time-limited, further investigation was needed into its implications. Advising that the outbreak continued to constitute a public health emergency of international concern, the Committee proposed several new

and revised Temporary Recommendations under the International Health Regulations (2005); the Director-General endorsed the Committee's advice and issued the Temporary Recommendations.¹ Details of the evolution of the outbreak, the response and the current situation are provided in the report on WHO response in severe, large-scale emergencies.²

4. In July 2015, the Ebola Interim Assessment Panel report was issued by the independent experts who had reviewed WHO's response to the Ebola outbreak. The recommendations address the review of the International Health Regulations (2005), WHO's health emergency response capacity, and WHO's role and cooperation with the wider health and humanitarian systems. The panel's report and WHO's response to the report are available on the WHO website.³

5. The Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response, established and convened by the Director-General pursuant to decision WHA68(10) (2015), held its first meeting on 24–25 August 2015 and two intersessional meetings on 5–9 October and 9–13 November 2015. Subsequent intersessional meetings are planned for December 2015 and February 2016. The report of the first meeting of the Review Committee, as well as reports of the two intersessional meetings held so far, are available on the WHO website.⁴

Middle East respiratory syndrome

6. The MERS coronavirus is still circulating in the Arabian Peninsula three years after it was identified. By October 2015, 1600 laboratory-confirmed cases of infection had been reported to WHO in 26 countries in the Middle East, North America, Europe and Asia; these included at least 580 deaths. Major hospital outbreaks occurred in the Republic of Korea in May–August 2015 and in Saudi Arabia in August 2015.

7. Since 2013, the IHR Emergency Committee on MERS has met 10 times, most recently in September 2015.⁵ At the latest meeting, the Committee advised that the situation did not constitute a public health emergency of international concern. However, the virus continued to be transmitted from camels to humans, and from humans to humans in health care settings. Ongoing challenges include inadequate reporting of asymptomatic cases that had tested positive for the virus, lack of information-sharing and inadequate implementation of infection control measures. The Committee emphasized that there was no public health justification for restricting trade or travel to prevent the spread of MERS, and screening at points of entry was considered unnecessary. However, raising awareness about MERS and its symptoms among travellers, particularly in light of the Hajj, was strongly advised.

¹ Available at <http://www.who.int/mediacentre/news/statements/2015/ihr-ebola-7th-meeting/en/> (accessed 8 December 2015).

² Document EB138/23.

³ Available at <http://www.who.int/csr/resources/publications/ebola/ebola-panel-report/en/> (accessed 8 December 2015).

⁴ See <http://www.who.int/ihr/review-committee-2016/en/> (accessed 8 December 2015).

⁵ See <http://www.who.int/mediacentre/news/statements/2015/ihr-emergency-committee-mers/en/> (accessed 8 December 2015).

Poliomyelitis

8. After the declaration of a public health emergency of international concern on 5 May 2014, the IHR Emergency Committee regarding the international spread of poliovirus has convened seven times to date. In November 2015, the Committee agreed that the epidemiological situation still constituted a public health emergency of international concern and advised the extension of the revised Temporary Recommendations, focusing on large-scale population movements and increasing vaccination coverage among refugees, travellers and cross-border populations. The Committee noted that no cases of wild poliovirus had been reported in Africa since August 2014; that regional outbreaks had been stopped in Central Africa, the Horn of Africa and the Middle East; and that vaccination coverage had increased in Pakistan. However, the Committee noted the continued spread of poliovirus between Pakistan and Afghanistan, and outbreaks of vaccine-derived poliovirus elsewhere, and urged regular review of the risk of international spread in high-risk areas. The Director-General endorsed the Committee's conclusions and issued Temporary Recommendations under the Regulations.¹

9. By decision WHA68(9) (2015), the Sixty-eighth Health Assembly requested the Director-General to report to the Sixty-ninth Health Assembly on progress towards reduction in the risk of international spread of wild poliovirus.²

Avian influenza A(H5N1) and A(H7N9) viruses

10. The threat of an influenza pandemic is persistent owing to the constantly evolving nature of influenza viruses. The epidemiological pattern of avian influenza A(H7N9) infection in humans so far in 2015 seems similar to that of 2014. Highly pathogenic avian influenza A(H5) viruses in various subtypes, including H5N1, H5N2, H5N6 and H5N8, continue to circulate and spread in birds and cause sporadic human infections. Virological and epidemiological assessment of A(H5) viruses shows that the associated risk has remained unchanged since the 2014 assessment.

11. With the spread of A(H5) virus to North America and Western Africa, the epidemic of A(H7N9) virus in poultry and its continuous reassortment with A(H9N2) virus, and repeated zoonotic infections, the threat posed by avian A(H5) and A(H7N9) viruses is graver than ever.

12. Through the Global Influenza Surveillance and Response System, covering 112 countries, WHO is closely monitoring the evolution and emergence of influenza viruses of potential public health significance.

PROGRESS ON IMPLEMENTATION OF THE INTERNATIONAL HEALTH REGULATIONS (2005)

Capacity-building

13. The IHR core capacity monitoring framework has been used by States Parties over the past five years to report to the Health Assembly on the status and development of the minimum core public

¹ Available at <http://www.who.int/mediacentre/news/statements/2015/ihr-polio-17-august-2015/en/> (accessed 8 December 2015).

² See document EB138/25.

health capacities required by the International Health Regulations (2005). In 2015, States Parties have continued to provide information to the Secretariat. As of 29 October 2015, 118 of 196 States Parties had completed the self-assessment questionnaire sent in April 2015.

14. Analysis of information from countries' self-assessment of IHR core capacity provided to the Secretariat by the States Parties suggests that progress has been made in the following areas: appropriate legislation and policy in place for implementation of the Regulations; coordination and collaboration with other sectors for capacity-building; functional and improved detection capacities with early warning; coordinated preparedness and emergency response capacities; and improved communication to the public and to stakeholders. However efforts to maintain these capacities operational will require continuous strengthening of human resources. In addition, detection and response capacities for chemical and radiological events are often not yet in place.

15. The International Health Regulations (2005) require the development, strengthening and maintenance of core capacities for surveillance and response, and at designated points of entry. The initial deadline for developing core capacities was 2012, with potential extensions until 2016. While progress has been made in this area, establishment of these capacities has not been achieved in many countries. The Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation recommended in 2014 that "the Director-General consider a variety of approaches for the shorter- and longer-term assessment and development of IHR core capacities".¹

16. WHO has developed a concept note describing a new approach to monitoring and assessment of core capacities after 2016, which has been shared with National IHR Focal Points and published on the WHO website;² this will be submitted to the Sixty-ninth World Health Assembly. The framework includes a self-administered assessment tool, after-action review, simulation exercises and independent (external) evaluation. Feedback on the concept note from WHO regional committees has been positive, and States Parties have asked for self-administered annual reporting to be simplified and for the question of how to add a component of external evaluation to be explored. In this regard, the Secretariat has established a draft IHR Joint External Evaluation tool. WHO is working with the Global Health Security Agenda to help ensure that work done in that context can contribute systematically to the objective assessment of key elements of IHR core capacities in concurring Member States. The Secretariat is also exploring how the draft IHR Joint External Evaluation links to other assessment instruments, such as the World Organisation for Animal Health's tool for evaluation of the performance of veterinary services, and how it would relate to the preparedness capacities needed under the Sendai Framework for Disaster Risk Reduction 2015–2030 (such as safe hospitals).

17. A WHO technical consultation on monitoring and evaluation of functional core capacity for implementing the International Health Regulations (2005) was held in Lyon, France from 20 to 22 October 2015. Participants included experts from Member States, representatives of international organizations and global initiatives such as the Global Health Security Agenda, and WHO staff involving the six regional offices. The meeting agreed on the main features of joint external evaluations, which include: voluntary country participation; joint evaluation teams, including external multisectoral technical experts and local specialists; increased operational support, so that WHO can effectively coordinate the monitoring and evaluation process; and transparency and openness of data and information-sharing. A revised tool will be used in the joint external evaluations, to assess all core

¹ See document A68/22 Add.1, paragraph 43.

² Available at http://www.who.int/ihr/publications/concept_note_201507/en/ (accessed 8 December 2015).

capacities under the Regulations and drawing on WHO experience and initiatives such as the Global Health Security Agenda. The Secretariat will continue working on the monitoring and evaluation process to ensure increased quality and reliability of countries' assessment of IHR core capacity.

18. WHO and the Government of South Africa jointly convened a high-level partner and stakeholder meeting on "Building health security beyond Ebola" in Cape Town, South Africa, from 13 to 15 July 2015. The meeting brought together over 200 participants, including representatives of countries affected by Ebola virus disease. Its goal was to agree on priority actions to boost health security, with the aim of strengthening health systems and capacities for implementing the International Health Regulations (2005). Participants agreed on the need for collective action on national and global health security, and set out expectations regarding future steps in synchronizing multistakeholder initiatives. There was broad agreement on WHO's role as a convenor of countries and partners. WHO proposed a collaborative approach between international and national stakeholders to strengthen and sustain the health system capacities needed to implement the Regulations.

19. On 8 and 9 October 2015, the health ministers of the seven leading industrialized nations met in Berlin and discussed health topics, including Ebola virus disease. Their final Declaration¹ addressed a number of key areas, drawing attention to the central mandate and "committed leadership of the WHO" and the fact that the "legally binding International Health Regulations (2005) are the primary international instrument designed to help protect countries from the international spread of disease, including public health risks and public health emergencies". The ministers supported "the [International Health Regulations (2005)] in expressly requiring countries to collaborate with each other in developing and maintaining the core capacities for implementation [of the Regulations]", noting that "full compliance [with the Regulations] is ultimately each country's responsibility".

First amendment to the International Health Regulations (2005): vaccination against yellow fever

20. The International Health Regulations (2005) were amended for the first time in 2014. The amendment was proposed by the Director-General in light of a recommendation from the Strategic Advisory Group of Experts on immunization that a single dose of yellow fever vaccine confers life-long protection. The Sixty-seventh World Health Assembly accordingly adopted resolution WHA67.13 (2014) to update Annex 7 of the Regulations, revising the period of effectiveness of vaccination against yellow fever and the validity of the related certificate from 10 years to the life of the person vaccinated.² This amendment will enter into force in July 2016.

21. In response to a request by the Sixty-eighth World Health Assembly, which noted that vaccination against yellow fever may be required of any traveller leaving an area where WHO has determined that a risk of yellow fever transmission is present, the Director-General has started to publish an updated online list of countries accepting a certificate of vaccination against yellow fever for life, and has established a scientific and technical advisory group to map the risk of yellow fever and provide guidance on vaccination for travellers.³

¹ Available at <http://www.bmg.bund.de/en/ministry/international-co-operation/g7-presidency/g7-health-ministers-meeting-in-berlin.html>, accessed 8 December 2015).

² See WHA67/2014/REC/1, resolution WHA67.13 (2014) and Annex 5.

³ See resolution WHA68.4 (2015).

KEY CHALLENGES IN IMPLEMENTATION OF THE INTERNATIONAL HEALTH REGULATIONS (2005)

Empowerment of National IHR Focal Points

22. By September 2015, all 196 States Parties had established their National IHR Focal Points as called for by the International Health Regulations (2005). All but one of the 196 National IHR Focal Points have reported being available at all times for communication with the WHO IHR Contact Points. However, National IHR Focal Points continue to be hampered in their functions as core liaison points for implementation of the Regulations, owing to insufficient resourcing, their status in the government hierarchy and insufficient engagement and collaboration with other sectors.

Unjustified restrictions on international travel, trade and transport

23. WHO has identified 41 measures concerning Ebola virus disease taken between March 2014 and March 2015 that interfered with travel and transport; most were implemented after the public health emergency of international concern had been declared. The measures were mostly related to the closure of air, land or sea borders, but some also related to visa issuance and compulsory quarantine. Although the International Health Regulations (2005) require States Parties to inform WHO about the implementation of such measures, few did so. These measures exceed the Temporary Recommendations issued by the Director-General, are often without public health justification, and have important consequences for countries' economy, trade and public health response.

CONCLUSION

24. The Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response is currently addressing ways to improve the functioning of the Regulations. Effective implementation of the Regulations is more critical than ever, considering the public health challenges facing a world in which borders are unable to contain disease threats. Global health security remains high on the international agenda; the Regulations are central both to achieving global health security and to avoiding unnecessary interference with travel and trade. The inadequacy of core surveillance and response capacities in many countries continues to hamper the ability of the Regulations to protect the world from public health emergencies such as the outbreak of Ebola virus disease. Ensuring compliance with the Regulations, especially in preventing inappropriate additional measures related to trade and travel, remains a significant challenge. Renewed and sustained commitment to and compliance with the Regulations on the part of their main stakeholders are critical for their successful and effective implementation.

25. WHO has embarked on an accelerated reform process to enhance the international community's ability, through the Organization, to respond swiftly and efficiently to major public health emergencies. This process and other initiatives have created a new momentum and an opportunity to improve implementation of the International Health Regulations (2005) for better public health and global health security.

ACTION BY THE EXECUTIVE BOARD

26. The Board is invited to note the report.

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