

Implementation of the International Health Regulations (2005)

Report by the Director-General

1. Except where otherwise noted, this document is submitted in accordance with resolution WHA61.2 (2008), decision WHA71(15) (2018) and Article 54(1) of the International Health Regulations (2005) (IHR).¹ It covers the reporting period 1 January–31 December 2025.²

National IHR Focal Points

2. In 2025, WHO regional offices continued to support the work of National IHR Focal Points (NFPs). The Western Pacific Region conducted its seventeenth IHR “Crystal” exercise to test real-time IHR communications and multisectoral operational readiness. To strengthen IHR event communication and cross-sectoral information sharing, the third annual South-East Asia Regional Practice of All-Hazard IHR Event Communication (SAPHIRE) simulation exercise tested the response to a food safety incident. The European Region held the sixth annual Joint Assessment and Detection of Events exercise, with 41 participating States Parties, to test and strengthen communication functions of NFPs and the regional WHO IHR Contact Point. In the Eastern Mediterranean Region, training was conducted on all NFP-relevant IHR Articles and the 2024 amendments to the IHR. This training was reinforced through 13 technical sessions attended by the NFP community of practice and targeted support to institutionalize NFP functions.

Event communication

3. In 2025, the Secretariat, pursuant to IHR Article 5, continued to support the global early warning function through detection, verification, risk assessment and information dissemination related to public health risks and events. It assessed and triaged over four million raw signals on potential public health events. Some 255 verification requests were sent to States Parties, of which 155 (61%) were responded to within 24 hours. Additionally, 140 signals and/or events were shared through the joint FAO–WOAH–WHO Global Early Warning System for health threats and

¹ See [International Health Regulations \(2005\)](#): as amended in 2014, 2022 and 2024 (accessed 18 March 2026).

² In accordance with Article 64 of the IHR, on 22 September 2025 the Director-General notified the Observer State of Palestine of the adoption of the Regulations, as amended. On 29 September 2025, the Director-General received notification of acceptance by the Observer State of Palestine. The Regulations entered into force for the Observer State of Palestine on 29 December 2025.

emerging risks at the human–animal–ecosystems interface (GLEWS+) for assessment and action by tripartite partners.

4. Globally, in 2025, the Secretariat assessed 472 events with potential international public health implications, of which 396 were substantiated. Nineteen detailed rapid risk assessments were developed by the Secretariat, including six for global public health events, three for events in a single WHO region, two for separate events occurring in two neighbouring States Parties and eight for an event in a single State Party. For 88 new and ongoing events involving 33 States Parties, updates were posted on the secure Event Information Site for NFPs, as well as six announcements for multicountry events. Event updates mostly concerned influenza due to identified avian or animal influenza virus (43), mpox (18) and poliovirus (6). Additionally, 36 announcements were posted with relevant information for NFPs. Forty Disease Outbreak News³ bulletins were published on new and ongoing events. Further epidemiological updates were provided through situation reports for the mpox upsurge (17), the multicountry outbreak of cholera (7) and the conflict in Sudan (3).

Emergency committees

5. The IHR Emergency Committee concerning ongoing events and context involving transmission and international spread of poliovirus continued to meet quarterly and held its 43rd and 44th meetings on 1 October 2025 and 14 January 2026, respectively.⁴ The event continues to constitute a public health emergency of international concern (PHEIC), with updated temporary recommendations to States Parties issued by the Director-General. The Committee's 43rd meeting was the first since the entry into force of the 2024 IHR amendments, which include broader poliovirus notification requirements; the introduction of the determination of pandemic emergency; measures to strengthen equitable access to relevant health products; and recognition of health documents in non-digital and digital format. At both its 43rd and 44th meetings, the Committee advised the Director-General that, in its view, the event continued to constitute a PHEIC but did not reach the threshold of a pandemic emergency, and the Director-General accepted that advice.

6. The IHR Emergency Committee regarding the upsurge of mpox 2024 held its last three meetings on 25 February, 5 June and 4 September 2025.⁵ On 5 September 2025, the Director-General determined that the event no longer constituted a PHEIC.

Standing recommendations

7. On 21 August 2025, the Director-General communicated to States Parties the issuance of a 12-month extension of the standing recommendations for mpox, hereby submitted to the Health Assembly for information.⁶

³ See [Disease Outbreak News \(DONs\)](#) (accessed 18 March 2026).

⁴ See [Poliovirus IHR Emergency Committee](#) (accessed 18 March 2026).

⁵ See [Mpox IHR Emergency Committee 2024](#) (accessed 18 March 2026).

⁶ See document A79/INF./2.

8. On 30 April 2026, the Director-General communicated to States Parties the issuance of a 12-month extension of the standing recommendations for coronavirus disease (COVID-19), hereby submitted to the Health Assembly for information.⁷

Core capacities for IHR implementation

9. The Secretariat continued to provide the States Parties Self-Assessment Annual Reporting tool (SPAR) electronically. For 2025, 97% of States Parties (191 out of 197) submitted their report. Full up-to-date data for the 2025 cycle are available from the electronic tool.⁸

10. The Secretariat further advanced civil–military collaboration to strengthen health emergency preparedness by supporting three national workshops. In Maldives and Sri Lanka, workshops were conducted using the WHO national civil–military health collaboration framework and the civil–military health security mapping tool. In Papua New Guinea, the workshop identified joint priority actions to improve laboratory and surveillance interoperability, coordinate procurement and enhance governance arrangements.

11. In the African Region, States Parties were supported in submitting their SPAR electronically and in building and monitoring the 15 IHR core capacities, with an emphasis on surveillance, laboratories, risk communication, points of entry and other key preparedness activities. Use of the IHR Monitoring and Evaluation Framework was further promoted to identify gaps and guide investments to strengthen health security. Regional training was organized and guidance disseminated to facilitate alignment with national frameworks.

12. In the Region of the Americas, progress was made in advancing implementation of early action reviews using the 7-1-7 methodology and in institutionalizing performance indicators within early warning systems. With support from “deep dive” training sessions and early action review exercises, eight States Parties began applying timeliness metrics to assess detection, notification and response functions under the IHR Monitoring and Evaluation Framework. Honduras conducted its first voluntary external evaluation, using SPAR indicators, jointly with the regional Performance Monitoring Tool for the National Expanded Programme on Immunization. Under the International Civil Aviation Organization/PAHO/AMRO regional workplan, the two organizations collaborated in the integration of their public health assessment tools for designated airports. The Dominican Republic evaluated its designated airport, while Saint Lucia and the Turks and Caicos Islands (United Kingdom of Great Britain and Northern Ireland) conducted missions for port health strengthening. The Region also organized a two-part in-person training of trainers course on ship inspection and the issuance of ship sanitation certificates for Caribbean States Parties and the Caribbean Public Health Agency.

13. In the South-East Asia Region, Bangladesh conducted a multi-hazard STAR workshop, including high-threat pathogen prioritization, and updated its infectious disease risk profiles through successive STAR processes. Maldives was supported in initiating a review and revision of its national health emergency response operation plan. To enable State Party alignment with the 2024 amendments to the IHR, a webinar was held on establishing or designating National IHR Authorities (NIAs). Progress in external evaluations was reinforced, with Bhutan completing its second round of the JEE and becoming the sixth State Party to undertake a second round. Two additional States Parties completed their first-round JEEs. Recommendations from JEEs and other

⁷ See document A79/INF./3.

⁸ See the [e-SPAR platform](#) (accessed 18 March 2026).

complementary assessments were translated into action, with Bangladesh and Nepal developing multisectoral national action plans for health security.

14. In the European Region, all 55 IHR States Parties were supported in their annual SPAR submission process through two dedicated SPAR online information sessions and three on conducting joint external evaluations (JEEs). Forty-one States Parties participated in the annual Joint Assessment and Detection of Events (JADE) exercise to test IHR communications, and six were supported in implementing simulation exercises. Four States Parties completed a national all-hazard strategic risk assessment using the WHO strategic tool for assessing risks (STAR) and 111 officials from those States Parties were trained to sustain national capacity to conduct additional subnational risk assessments. Two subregional workshops and two bilateral exchange programmes were conducted for members of the Global Knowledge Network of NFPs, attended by over 50 national representatives. Governmental officials from 22 States Parties enhanced their knowledge and skills in risk communication, community engagement and infodemic management, and 41 States Parties were supported through missions, advice and guidance. Ten States Parties strengthened their public health intelligence and event-based surveillance capacities through the Epidemic Intelligence from Open Sources Initiative, with seven States Parties joining the initiative in 2025.

15. The Eastern Mediterranean Region continued to strengthen health security. States Parties were supported through the JEE cycle, and reports for Iraq, Pakistan and Qatar were published. After-action reviews (AARs) were facilitated, including for the first Arbaeen mass gathering in Iraq, and the AAR report following the floods in Pakistan was published. Fifteen simulation exercises were conducted across 20 States Parties (90%), covering 10 technical areas.

16. In the Western Pacific Region, continued targeted technical support was provided to strengthen core capacities and support States Parties in implementing the 2024 amendments to the IHR. At its seventy-sixth session, the Regional Committee adopted a resolution endorsing the first regional plan for implementing the amendments, outlining targets and practical actions to align national legal, institutional and operational systems. The Region's multi-hazard multisectoral approach supported preparedness across sectors, including through national bridging workshops held in Brunei Darussalam and Tonga; the development of One Health-aligned emergency risk profiles in eight States Parties; the development of a zoonotic disease preparedness framework in the Marshall Islands; and a joint risk assessment in Malaysia. By 31 December 2025, 15 of 28 States Parties had multisectoral coordination mechanisms in place, including for One Health.

Points of entry and international travel

17. The Secretariat continued providing policy and technical support to develop, strengthen and maintain the required core capacities for border health preparedness and response, including through public health assessments and trainings at points of entry. Two workshops on conducting ship sanitation inspections, organized by the WHO collaborating centres for the International Health Regulations: points of entry in China and Greece, were attended by 225 port health officers from 20 States Parties in the South-East Asia, European, Eastern Mediterranean and Western Pacific Regions.

18. Since 2007, 115 out of 152 coastal States Parties and four landlocked States Parties with inland ports have sent WHO the list of ports authorized to issue ship sanitation certificates. The total number of authorized ports is now 1967. As per the SPAR data submitted by States Parties in

2024, there are 2427 designated points of entry globally, of which 1889 (78%) have public health emergency contingency plans.

19. The Secretariat continued to gather the latest available evidence and expert guidance on the effectiveness and impact of travel measures, with a focus on vector control at points of entry and disinsection of conveyances.

20. The Secretariat continued to work closely with key partners in the travel and transport sector, such as the International Maritime Organization and the International Civil Aviation Organization, to promote alignment of their legal frameworks with the 2024 amendments to the IHR.

21. The Secretariat disseminated the international travel and health questionnaire to collect information about States Parties' requirements for international travellers and update the information on the risk for malaria.⁹

IHR Roster of Experts

22. Through WHO regional offices, the Secretariat provided information on the composition of the IHR Roster of Experts and guidance on the appointment by the Director-General of an expert at the request of each State Party.

Amendments to the Regulations

23. On 19 September 2024, the Director-General notified States Parties of the amendments to the IHR adopted through resolution WHA77.17. The amendments entered into force on 19 September 2025 for the 182 States Parties that did not reject them. Pursuant to resolution WHA77.17, the Secretariat published the consolidated Regulations¹⁰ and supported States Parties in implementing the 2024 amendments through two Member State information sessions, including on new and updated case definitions for the four diseases requiring notification pursuant to Annex 2 to the IHR. Virtual sessions on the national implications of the 2024 amendments and the establishment or designation of NIAs were held for all regions.

Action by the Health Assembly

24. The Health Assembly is invited to note the report and provide guidance on the following question.

- How can Member States sustainably implement the IHR, taking into consideration the entry into force of the 2024 amendments, as well as the changing global health landscape?

⁹ For the most recently published information, see [Countries with risk of yellow fever transmission and countries requiring proof of vaccination against yellow fever](#); and [Country list: country vaccination requirements and WHO recommendations for vaccination against yellow fever, poliomyelitis, and malaria prophylaxis in international travellers](#) (accessed 18 March 2026).

¹⁰ See [International Health Regulations \(2005\): as amended in 2014, 2022 and 2024](#) (accessed 18 March 2026).