World Health Organization

EXECUTIVE BOARD
128th Session
Provisional agenda item 4.2

EB128/5
16 December 2010

Implementation of the International Health Regulations (2005)

Report by the Director-General

1. In resolution WHA61.2, the Health Assembly decided that, in accordance with Article 54 of the International Health Regulations (2005), States Parties and the Director-General would report annually to the Health Assembly on the implementation of the Regulations.

2. This report summarizes information received by WHO regarding the status of implementation activities carried out by States Parties to the Regulations. It also gives an account of key activities undertaken by WHO under the "areas of work for implementation" established in 2007.[1]

WHO'S ACTIONS IN RESPONSE TO PANDEMIC (H1N1) 2009

3. A detailed evaluation of the international response to pandemic (H1N1) 2009, including actions by WHO under the International Health Regulations (2005), is being carried out by the IHR Review Committee, whose final report will be presented to the Sixty-fourth World Health Assembly. The addendum to the present report summarizes the progress of the Committee to date.[2]

INFORMATION RECEIVED FROM STATES PARTIES TO THE INTERNATIONAL HEALTH REGULATIONS (2005)

4. WHO, relevant partner agencies and selected Member States from all WHO regions have developed a framework that enables States Parties to monitor the development of their core capacities,[3] in accordance with Annex 1 of the Regulations, and to identify gaps to be dealt with. The framework, which has been field tested in all the WHO regions, provides a set of global indicators for reporting to the Health Assembly that are summarized in the following paragraphs. A self-assessment questionnaire sent to States Parties to the Regulations in mid-February 2010 elicited 126 responses, representing 65% of the 194 States Parties. Although the questionnaire had a new format with

[1] See document WHO/CDS/EPR/IHR/2007.1, "International Health Regulations (2005): areas of work for implementation" at http://www.who.int/ihr/area_of_work/en/index.html (accessed 24 November 2010).

[2] See document EB128/5 Add.1.

[3] The framework is available at http://www.who.int/ihr/checklist/en/index.html (accessed 6 December 2010).

additional questions, the overall submission rate was higher compared with 2009. States Parties were encouraged to provide feedback on the use of the questionnaire in order to optimize subsequent data collection.

5. The monitoring framework defined the following eight types of core capacity for tracking implementation: (1) national legislation, policy and financing; (2) coordination at national level and the communication of National IHR Focal Points, both globally and nationally; (3) surveillance; (4) response; (5) preparedness; (6) appropriate communication of risks; (7) human resources; and (8) adequate laboratory services. The framework also defined five relevant hazard types: (1) infectious; (2) zoonotic; (3) food safety-related; (4) chemical; and (5) radionuclear. For each type of capacity, progress is monitored by measuring specific achievements over time in respect of defined attributes. Implementation status for each capacity is assessed on a four-point scale: Level <1 (foundational); Level 1 (inputs and processes in place); Level 2 (outputs and some outcome demonstrated); and Level 3 (capacities beyond the State's borders).

6. The results from the questionnaire show that 68% of reporting States Parties have assessed their core capacities for implementation of the International Health Regulations (2005), and that 58% have developed national plans to meet the core capacity requirements. Among the eight core capacities for tracking implementation, States Parties report making good progress in national legislation, response and risk communication, with more than 30% of reporting States Parties indicating that they have met the requirements for 2012 (Level 2) and or higher (Level 3). More than half the reporting States Parties are still at the foundational level (Level <1) for two types of core capacity, namely, preparedness and human resources; a similar proportion have the inputs and processes in place (Level 1) for coordination, surveillance and risk communication. Seventy-two per cent of reporting States Parties confirm that they have a multisectoral, multidisciplinary body, committee or task force dealing with the Regulations' requirements on surveillance and response to public health emergencies of international concern, and 73% of reporting States Parties indicate that the multisectoral and multidisciplinary coordination and communication mechanisms have been tested and updated regularly through exercises or through the occurrence of an actual event. There has also been an overall increase of 31% in the number of reporting States Parties that have conducted assessments of their relevant legislation, regulations, administrative requirements and other governmental instruments for the International Health Regulations (2005). Eighty-three per cent of reporting States Parties confirm that baseline estimates, trends and thresholds for alert and action have been defined for the response at the local public health level with regard to priority diseases and events, and 87% of reporting States Parties affirm that designated units exist for event-based surveillance. Seventy-one per cent of reporting States Parties have systems in place at national and/or subnational levels for capturing and registering public-health events from a variety of sources, including from the veterinary sector and the media. Globally, 90% of reporting States Parties are using the decision instrument in Annex 2 of the Regulations to notify WHO in respect of events detected by their national surveillance systems. Fifty per cent of reporting States Parties have developed national public health emergency response plans for discharging their obligations under the Regulations with regard to hazards and points of entry. Forty-one per cent of reporting States Parties have conducted national risk assessments to identify the most likely sources of nationally urgent public health events and vulnerable populations and 70% have a national plan in place for the management and distribution of stockpiles. A risk communication plan, including mobilization of communities, has been developed in 59% of reporting States Parties. Thirty-nine per cent of reporting States Parties have carried out assessments of training needs and have developed a plan to meet requirements imposed by the International Health Regulations (2005) and 29% have approved workforce development plans and funding for the implementation of the Regulations. Seventy-seven per cent of reporting States Parties have established a network of national and international laboratories to meet requirements for laboratories to perform

tests for the diagnosis and confirmation of events and to support outbreak investigations for events specified in Annex 2 of the Regulations. Nearly 80% of reporting States Parties affirm that national or international schemes have been established for the external quality assessment of diagnostic laboratories in the country in respect of the relevant disciplines.

7. States Parties report having made progress at different rates for each of the hazard types, with more attributes being achieved for zoonotic and food-safety events, and fewer being achieved for chemical and radionuclear events. Of the reporting States Parties, 31% have reached Level 2 and above regarding capacities for surveillance of and response to zoonotic events; for food-safety events, the proportion is 25%. Sixty-seven per cent of reporting States Parties have established a coordination mechanism for intersectoral collaboration for zoonotic events, while fewer than 50% of reporting States Parties have established such a mechanism for food-safety events. Among reporting States Parties, 72% have regular information exchange between sectors for zoonotic events, while the proportion for food-safety events is 53%. For chemical and radionuclear events, nearly 50% of reporting States Parties are still in the foundational level (Level <1) in terms of overall capacity. For chemical events, 41% of reporting States Parties have inputs and processes in place (Level 1); for radionuclear events, the proportion is 23%. Fewer than 50% of reporting States Parties have established coordination mechanism for intersectoral collaboration for chemical events and radionuclear events. For the same types of hazard, only 37% of reporting States Parties have established information exchange mechanisms between relevant sectors. Globally, more than 80% of reporting States Parties have developed a national policy, strategy or plan for surveillance and response to zoonotic and food-safety events, while fewer than 50% of reporting States Parties have done so for chemical and radionuclear events.

8. With regard to capacities at points of entry, 62% of reporting States Parties have reached Level 1 in fulfilling the general obligations component; for surveillance, 28% of reporting States Parties have achieved Level 2, with 41% at Level 1. Response capacities at the points of entry are weaker; 46% of the reporting States Parties are still at Level <1. Seventy-three per cent of reporting States Parties have designated the ports/airports that will develop capacities as specified in Annex 1 of the International Health Regulations (2005). Globally, over 50% of reporting States Parties indicate that they have established surveillance for the presence of vectors and reservoirs at designated points of entry, with a programme for surveillance and control functioning at designated points of entry.

9. States Parties to the International Health Regulations (2005) are using the monitoring framework and indicators to identify gaps and strengthen capacity in the areas concerned. In addition, States Parties report that they are providing support for implementation of the Regulations beyond their borders. For example, 44% of reporting States Parties are sharing country experiences in the early warning function of surveillance with the global community and 42% indicate that they have assisted other States Parties in developing response capacities or implementing control measures. A web-based tool that will allow States Parties to submit and update their data online has been developed in order to facilitate the data collection process. Once the relevant data have been submitted, the tool can be used to generate various outputs, including charts and tables.

GLOBAL PARTNERSHIP

10. WHO continues to enjoy strong ties with other international and intergovernmental organizations, including the International Civil Aviation Organization, the United Nations World Tourism Organization, and the International Air Transport Association, all of whom provided testimony to the IHR Review Committee. Collaboration continues between WHO, FAO and OIE; this

was reaffirmed in April 2010 in a mutually-agreed Tripartite Concept Note. A particular focus for collaborative activities has been directed at the provision of support to the development of animal and human health laboratory networks and the strengthening of diagnostic capacities in geographical "hot spots" for emerging diseases. Finally, FAO and WHO continue to collaborate through the International Food Safety Authorities Network (INFOSAN) which monitors, assesses and verifies food-safety events that could have international implications.

STRENGTHENING NATIONAL CAPACITY

11. All levels of the Organization continue to support States Parties in fulfilling the core capacity requirements under the International Health Regulations (2005), including for points of entry; this effort is primarily conducted through WHO's regional strategies and through networks of national disease surveillance and response systems. Continuous support is being provided to countries in laboratory capacity building by means of global and regional projects on quality systems, human resources strengthening, and connecting laboratory-based networks in order to facilitate sharing of resources, knowledge and expertise. In the laboratory and transport environments, commitment to biorisk management principles for safety and biosecurity is being ensured by WHO and partners through the organization of awareness workshops, the training of trainers and the strengthening of national capacity for biorisk management. Highlights include the expansion and development of collaborative external quality assessment programmes, the expansion of the laboratory twinning initiative and the completion of a global survey on laboratory quality standards. A key element of the strengthening of laboratory quality and management is the development of partnerships and knowledge sharing between institutions and countries.

12. Raising awareness of the International Health Regulations (2005) and their implementation continues to be a priority. In the area of training, 33 professionals enrolled on WHO's first course on implementing the Regulations. The course, which concluded with a two-week face-to-face session in Véyrier-du-Lac, France, in July 2010, covered the many aspects of implementation. The second such course began on 27 September 2010 and will run until February 2011.

13. Under the International health Regulations (2005), poliomyelitis caused by wild poliovirus is one of four specific diseases that must be notified to WHO following detection. In 2010, cases of poliomyelitis have been notified through the Regulations in the context of outbreaks following importation of wild poliovirus into countries previously free of the disease, and/or the existence of an evolving risk with potential international implications. Poliomyelitis-related events have been posted on the WHO web site under Disease Outbreak News[1] and on the Event Information Site for National IHR Focal Points. The International Health Regulations (2005) mechanism has helped to alert countries to the emerging risk of an international spread of wild poliovirus, including in central Africa (e.g. Angola and the Democratic Republic of the Congo), central Asia (e.g. Tajikistan) and West Africa (e.g. Nigeria). The Global Polio Eradication Initiative has established an active surveillance network at the global, regional and country levels, to enable the reporting of cases of acute flaccid paralysis, with collection and virological examination of stool specimens. In this way, all remaining chains of poliovirus transmission can be detected and tackled in a timely manner. The network also continues to support the detection and reporting of other diseases of potential public health importance, including pandemic (H1N1) 2009, H5N1 avian influenza, yellow fever, cholera and

[1] Available at http://www.who.int/csr/don/en/ (accessed 2 December 2010).

meningitis. The International Health Regulations (2005) will be important for the period following the eradication of poliomyelitis because highly sensitive surveillance for the disease will be required immediately after the interruption of transmission of wild poliovirus globally, in order to detect rapidly, and respond to, any potential reintroduction or re-emergence of poliomyelitis. With this in mind, and to ensure that the long-term surveillance capacity for poliomyelitis is maintained, the surveillance network for acute flaccid paralysis will be increasingly aligned with the International Health Regulations (2005) following the eradication of poliomyelitis.

PREVENTION AND RESPONSE TO INTERNATIONAL PUBLIC HEALTH EMERGENCIES

14. Public health information continues to be channelled through National IHR Focal Points and WHO IHR Contact Points, a communications network that is maintained by regular testing and innovative training initiatives at the regional level. Of the 194 States Parties to the International Health Regulations (2005), 181 have access to the Event Information Site for National IHR Focal Points.

15. WHO continues to work closely with countries to detect and respond to public health risks and emergencies within the framework of the International Health Regulations (2005). Between April and September 2010, 249 events were recorded in the event management system and followed. The events concerned included the following hazard types: African Region: cholera, Lassa fever, measles and yellow fever; Region of the Americas: dengue fever, malaria, measles, rabies, yellow fever, radionuclear and chemical; South-East Asia Region: cholera, floods and radionuclear; European Region: West Nile fever, anthrax, dengue fever, poliomyelitis and chemical; Eastern Mediterranean Region: cholera; Western Pacific Region: dengue fever and cholera. Information-sharing mechanisms under the International Health Regulations (2005) are currently being reviewed by the Secretariat with a view to improving the service provided to States Parties.

16. As indicated in the Director-General's report to the Sixty-third World Health Assembly on implementation of the International Health Regulations (2005),[1] the studies to review and evaluate the functioning of Annex 2 of the Regulations were completed in March 2010 and the results and analysis shared with the IHR Review Committee at its first meeting in April 2010. Results from the studies are expected to be published in peer-review journals shortly.

17. During the period under review, WHO has conducted surveillance and assessment of chemical-related outbreaks. In addition, the Organization has provided technical support to countries facing chemical emergencies; these have included a mass lead poisoning affecting approximately 2000 children, and chemical hazards following an earthquake.

18. The list of countries and/or areas where a risk of transmission of yellow fever exists has been revised and the relevant information provided to Member States. The updated list will be published at the beginning of 2011 in the next edition of *International travel and health*. An informal working group of experts on country-specific mapping of yellow fever risk is continuing its work by means of a review of criteria and methodologies to categorize countries' yellow fever risk status. Another working group is developing the criteria for determining the list of countries or areas for which WHO

[1] Document A63/5.

will recommend disinsection for departing conveyances, as set out in Annex 5 of the International Health Regulations (2005).

LEGAL ISSUES

19. WHO continues to provide legal advice to countries upon request with regard to implementation of the Regulations. The areas covered included the updating of national legislation to meet the requirements of the Regulations. A considerable amount of advice on the requirements of the Regulations has also been given to the IHR Review Committee in the context of its continuing work.

IMPLEMENTATION PROGRESS

20. States Parties have made progress in implementing the International Health Regulations (2005) with the support of the WHO regional offices; the response to pandemic (H1N1) 2009 has demonstrated the value of investment in national capacity strengthening. Moreover, the continuing review of the functioning of the Regulations that is being undertaken by the IHR Review Committee has raised the awareness of governments regarding the importance and uniqueness of the Regulations as a global framework for the management of international public health risks and emergencies. However, the implementation of the Regulations in countries continues to present serious challenges and, based on the information received from States Parties, a number of countries may not meet the core capacity requirements for surveillance and response described in Annex 1A of the Regulations by the deadline of 15 June 2012.

ACTION BY THE EXECUTIVE BOARD

21. The Executive Board is invited to take note of this report.

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