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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 in support of implementation. This year's report focuses on the establishment and strengthening of national core capacities, the management of acute public health risks and procedures relating to the approaching target date for establishing national core capacities.

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

3. A monitoring framework and corresponding tools have been made available to allow States Parties to monitor the status of their national core capacities,[1] in accordance with the requirements set out in Annex 1 of the Regulations, and to identify areas that require action. In addition, this framework provides the Secretariat with country data that can be summarized for the purposes of reporting to the Health Assembly. The Secretariat continues to consult with Member States and draw from their experience in order to further enhance the monitoring tools.

4. The monitoring process involves assessing the development of eight core capacities, as well as capacities at points of entry, and four relevant hazards (zoonotic, food safety, chemical and radiological and nuclear). A self-assessment questionnaire sent to States Parties to the Regulations in mid-February 2011 elicited 117 responses, representing 60% of the 194 States Parties. The overall submission rate is lower than that in 2010 (128 responses, representing 65% of States Parties); however, it is anticipated that by the time the report for the Sixty-fifth World Health Assembly is being finalized, the number of responses received from States Parties will have increased significantly.

[1] *International Health Regulations (2005): IHR core capacity monitoring framework: checklist and indicators for monitoring progress in the development of IHR core capacities in States Parties.* Geneva, World Health Organization, 2011 (http://whqlibdoc.who.int/hq/2011/WHO_HSE_IHR_2011.6_eng.pdf, accessed 2 November 2011).

5. The table below shows the average capacity score of all countries that submitted a completed questionnaire in 2011. The scores, which are presented both globally and broken down by WHO region, are derived by expressing the number of attributes achieved for a particular core capacity as a percentage of the total number of attributes for that capacity. The table also shows the percentage of countries attaining a capacity score of greater than 75, indicating good progress in achieving core capacities.

6. The data for 2011 showed States Parties making fair progress for a number of core capacities, notably those for surveillance (with a global average score of 75%), response (with a global average of 72%), laboratory (with a global average of 71%), and zoonotic events (with a global average of 78%). On the other hand, most regions reported relatively low capacities in human resources (with a global average of 45%), at points of entry (with a global average of 45%) and for chemical events (with a global average of 45%).

Table. Capacity scores by WHO region in 2011, based on responses to the national capacity monitoring framework

Capacity/number of responses	Average capacity score and percentage of countries with a score greater than 75%[a]						
	Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific	Global
Number of responses	28	26	6	34	11	12	117[b]
Legislation, policy and financing	28 (14)	64 (50)	62 (50)	75 (73)	70 (64)	75 (75)	60 (51)
Coordination and National Focal Point communications	46 (14)	72 (45)	47 (17)	68 (48)	74 (55)	91 (92)	66 (42)
Surveillance	64 (54)	75 (59)	67 (50)	80 (73)	78 (64)	90 (92)	75 (65)
Response	52 (21)	77 (64)	69 (33)	77 (61)	78 (64)	91 (92)	72 (53)
Preparedness	35 (11)	55 (36)	56 (17)	70 (55)	60 (55)	73 (67)	57 (39)
Risk communication	43 (11)	68 (41)	64 (33)	69 (33)	67 (36)	86 (75)	64 (34)
Human resources	27 (18)	57 (50)	50 (33)	39 (27)	56 (45)	62 (58)	45 (35)
Laboratory	63 (36)	73 (55)	65 (33)	73 (70)	70 (55)	80 (67)	71 (54)
Points of entry	32 (4)	44 (14)	40 (17)	51 (15)	46 (27)	64 (50)	45 (17)
Zoonotic events	60 (43)	84 (86)	81 (67)	87 (82)	74 (55)	89 (75)	78 (68)
Food safety events	42 (11)	68 (50)	61 (33)	89 (94)	62 (55)	79 (67)	68 (54)
Chemical events	18 (0)	41 (23)	34 (33)	67 (58)	45 (9)	59 (58)	45 (30)
Radiation emergencies	25 (11)	36 (27)	36 (17)	79 (73)	49 (27)	63 (58)	51 (39)

[a] Shown in brackets.

[b] 117 responses received as at 2 November 2011: Afghanistan, Algeria, Andorra, Angola, Antigua and Barbuda, Argentina, Armenia, Australia, Austria, Azerbaijan, Bahrain, Bangladesh, Barbados, Belgium, Belize, Benin, Bosnia and Herzegovina, Brazil, Brunei Darussalam, Burundi, Cambodia, Cameroon, Canada, Chad, Chile, China, Colombia, Congo, Costa Rica, Croatia, Cyprus, Czech Republic, Democratic People's Republic of Korea, Democratic Republic of the Congo, Denmark, Dominica, Ecuador, Egypt, El Salvador, Equatorial Guinea, Eritrea, Ethiopia, Finland, France, Gabon, Gambia, Georgia, Germany, Ghana, Grenada, Guinea, Guyana, Haiti, Honduras, Hungary, Iceland, Iran (Islamic Republic of), Iraq, Ireland, Italy, Jamaica, Japan, Jordan, Kazakhstan, Kenya, Lao People's Democratic Republic, Latvia, Lesotho, Lithuania, Madagascar, Malawi, Malaysia, Malta, Mauritania, Mexico, Mongolia, Morocco, Myanmar, Nepal, New Zealand, Oman, Panama, Paraguay, Philippines, Poland, Portugal, Republic of Moldova, Romania, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Sao Tome and Principe, Senegal, Serbia, Seychelles, Sierra Leone, Singapore, Slovakia, Slovenia, Spain, Sri Lanka, Sudan, Suriname, Sweden, Switzerland, Syrian Arab Republic, the Former Yugoslav Republic of Macedonia, Togo, Tonga, Trinidad and Tobago, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, United States of America, Uzbekistan, Zambia and Zimbabwe. (Data from Argentina, Brazil, Chile, Colombia and Paraguay were submitted using the reporting tool of MERCOSUR (the Common Market of the South)).

GLOBAL PARTNERSHIP

7. WHO continues to strengthen its cooperation with other international and intergovernmental organizations. This was particularly important during the recent nuclear emergency in Japan, during which the Organization collaborated directly with the IAEA, while also participating as a member of the Inter-Agency Committee on Radiological and Nuclear Emergencies, a coordinating body for the existing international arrangements for preparedness and response to radiological and nuclear emergencies. The nuclear event also stimulated extensive collaboration with international partners in the transport sector, particularly information sharing about the impact on international transport. Progress is also being made on WHO's collaboration with other organizations and partners to tackle health risks at the human–animal–environmental interface. These efforts include the tripartite arrangements with FAO and OIE.

STRENGTHENING NATIONAL CAPACITY

8. In the final report of the Review Committee on the Functioning of the International Health Regulations (2005) and on Pandemic Influenza A (H1N1) 2009,[1] the first recommendation to WHO and to States Parties was to accelerate implementation of core capacities required by the Regulations. With this goal in mind, all levels of the Organization are intensifying activities to support States Parties in fulfilling these core capacity requirements. These efforts continue to be conducted primarily through WHO's regional strategies and the networks of national systems for disease surveillance and response.

9. Laboratory capacity continues to be enhanced through the development of guidance, the establishment of national frameworks for laboratory services, the implementation of quality systems and the strengthening of human resources. Laboratory-based networks are encouraged to facilitate the sharing of resources, knowledge and expertise. Highlights include the continuing development of a tool for the assessment of laboratories supporting implementation of the International Health Regulations (2005), the expansion both of regional and national programmes for external quality assurance and of the laboratory twinning initiative. The laboratory quality management system handbook has also been disseminated in various languages.[2] Laboratory biorisk management has been strengthened through a series of workshops and guidance provided in collaboration with OIE.

10. New tools have been developed in the area of capacity strengthening at points of entry, including a handbook for inspection of ships and issuance of ship sanitation certificates.[3] The third edition of the *WHO guide to ship sanitation* was released by WHO in 2011.[4] Country visits have been undertaken to support States Parties in their assessment of capacity at points of entry. An exercise on public health emergency planning in air travel was organized in close collaboration with the Spanish authorities and involved participants from all six WHO regions.

[1] See document A64/10.

[2] *Laboratory quality management system: handbook.* Geneva, World Health Organization, 2011.

[3] *International Health Regulations (2005): handbook for inspection of ships and issuance of ship sanitation certificates.* Geneva, World Health Organization, 2011.

[4] *WHO guide to ship sanitation,* 3rd ed. Geneva, World Health Organization, 2011.

11. Since 2009, the IHR Implementation Course, covering many aspects of the implementation of the Regulations, has trained public health professionals from all six WHO regions. The current course has 38 participants enrolled on it. Support is also provided for the design and implementation of related courses at the national and subregional levels. In Cameroon, the Central African Republic and Democratic Republic of the Congo, the capacity and quality of surveillance and response are being strengthened for vaccine-preventable and epidemic-prone diseases, through training and infrastructure improvements as well as the provision of support to networks and data management systems. In 27 Mediterranean and south-eastern European countries, there is a continuing effort to establish a network of laboratories, promote common procedures in preparedness and risk management, enhance early warning systems and coordinate surveillance and response for public health emergencies at points of entry.

12. 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 2011, cases of poliomyelitis were notified in the context of (i) outbreaks following importation of wild poliovirus into countries previously free of the disease, and/or (ii) the existence of an evolving risk with potential international implications. Poliomyelitis-related events continue to be posted on the WHO web site under "Disease Outbreak News"[1] and on the Event Information Site for National IHR Focal Points. These mechanisms continue to alert countries to the emerging risk of an international spread of wild poliovirus, including in West Africa (e.g. Côte d'Ivoire), central Africa (e.g. Angola, Chad, Congo and Democratic Republic of the Congo), the Horn of Africa (border areas of Kenya and Uganda) and Pakistan. The Global Polio Eradication Initiative's active surveillance network at the global, regional and country levels continues to enable the reporting of cases of acute flaccid paralysis, with collection and virological examination of stool specimens, thus allowing all remaining chains of poliovirus transmission to be detected and tackled in a timely manner. The International Health Regulations (2005) will be important in the period following the eradication of poliomyelitis: highly sensitive surveillance for the disease is required immediately after the interruption of transmission of wild poliovirus globally so that any potential reintroduction or re-emergence of poliomyelitis can be detected, and responded to, rapidly.

13. Work with countries to strengthen national preparedness for radiation emergencies has involved the members of two global networks: the Radiation Emergency Medical Preparedness and Assistance Network (REMPAN) and the global biodosimetry network, WHO BioDoseNet. The activities concerned included sharing information, holding coordination meetings, conducting exercises, mapping the networks' capacities and running regional and national training programmes.

PREVENTION OF AND RESPONSE TO INTERNATIONAL PUBLIC HEALTH EMERGENCIES

14. Information on public health events continues to be channelled through National IHR Focal Points and WHO IHR Contact Points, a communications network that is maintained by regular testing at the regional level. Of the 194 States Parties to the International Health Regulations (2005), 182 now have access to the Event Information Site for National IHR Focal Points. There are 14 States Parties with access to the Site that have as yet not logged on. In response to the results of an online user satisfaction survey, the Secretariat is currently engaged in carrying out the following improvements:

[1] See http://www.who.int/csr/don/en/index.html (accessed 26 October 2011).

(i) identifying a cohort of users to work with the Secretariat in order to make enhancements to the Site; (ii) increasing the added value of the information provided; and (iii) redesigning the Site to improve the retrieval and utility of the information shared.

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). Over a seven-month period from 1 February 2011 to 31 August 2011, 242 events were recorded in the Event Management System. Of these, 127 (52.5% of the total) were substantiated as real events needing to be monitored, 19 (7.9%) were discarded as false rumours after verification, 41 (16.9%) were real events that did not, however, meet the definition of an outbreak and 2 (0.8%) were unverifiable. The final designation is pending for the remaining 53 events (21.9%). In summary, 77.3% of the events recorded have completed a verification process in the observation period.

16. Following the emergency at the Fukushima nuclear plant in Japan, WHO worked closely with IAEA and other international partners, supported by the REMPAN network. The Regional Office for the Western Pacific and the WHO Centre for Health Development in Kobe, Japan were particularly involved. A WHO field mission from the Regional Office for the Western Pacific was deployed to Japan to collect more information from the areas affected by the earthquake and tsunami in order to understand better the health situation and needs locally. Countries' requests in the early phase of the response focused on two areas: travel advice (including the safety of travel to Japan; border control measures; and the screening of passengers, aircraft, cargo and ships) and technical advice on interventions. Telephone and video conferences with REMPAN technical experts were held on a regular basis.

17. The International Food Safety Authorities Network (INFOSAN) continues to play a critical role in monitoring, assessment and response activities in respect of a substantial number of food safety-related events with potential international implications. The outbreak of enteroaggregative, verotoxin-producing *Escherichia coli* that was identified in Germany in May 2011 was both unusually large and serious. There were more than 4000 reported cases and 51 deaths were recorded. More than 900 patients suffered haemolytic uraemic syndrome; many of these will demonstrate long-term renal sequelae and some will require life-long dialysis. WHO worked closely with European partners to provide consistent information to both health and food-safety authorities globally, utilizing the communication channels of both INFOSAN and the National IHR Focal Points.

18. Updated information is provided on the list of countries and areas where a risk of transmission of yellow fever exists and on yellow fever vaccination requirements and recommendations. Information is published in the WHO's *Weekly epidemiological record* and on WHO's International travel and health web site.[1] Work continues on reviewing criteria and methodologies to categorize countries' yellow fever risk status and on developing a database for electronic archiving of unpublished reports on the geographical distribution of yellow fever.

LEGAL ISSUES

19. WHO continues, upon request, to provide legal advice to countries with regard to implementation of the Regulations. The areas covered have included the updating of national

[1] See http://www.who.int/ihr.

legislation in order to meet the requirements of the Regulations, with direct support given by the Secretariat through country visits. A considerable amount of advice on the requirements of the Regulations has also been provided, both within the Organization and to external bodies and stakeholders.

CONCLUSION

20. States Parties continue to make progress in implementing the International Health Regulations (2005) with the support of the WHO regional offices. In the approach to the mid-2012 deadline for establishing core capacities under the Regulations, governments are intensifying their implementation activities. In this connection, the Secretariat has written to all States Parties to explain the extension procedures set out in Articles 5 and 13 of the Regulations, according to which States Parties will, upon request, be granted an additional two years to meet the requirements set out in Annex 1 of the Regulations. A number of States Parties have already informed WHO of their intention to request such an extension based on a justified need. It is anticipated that the number of such requests will increase significantly as the deadline for most countries grows near.[1]

ACTION BY THE EXECUTIVE BOARD

21. The Board is invited to note the report.

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[1] For most States Parties, the deadline falls on 15 June 2012.