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IMPLEMENTATION OF THE INTERNATIONAL HEALTH REGULATIONS (IHR)

Introduction

1. This document reports on the status of the application and implementation of and compliance with the International Health Regulations (hereafter referred to as IHR or the Regulations). The document also informs the Pan American Sanitary Conference about the recommendations made by States Parties' delegated officials during the Formal Regional Consultation on the International Health Regulations, held in São Paolo, Brazil, pursuant to Decision WHA70(11) of the World Health Assembly *(1)*, and based on the document *Development of a draft five-year global strategic plan to improve public health preparedness and response: Consultation with Member States* (Annex B).

2. This report *a)* updates the information presented to the 55th Directing Council in 2016 *(2)*; *b)* reviews activities undertaken by States Parties and the Pan American Sanitary Bureau (PASB), both in response to acute public health events, including Public Health Emergencies of International Concern (PHEIC), and for the purpose of capacity building; and *c)* highlights issues requiring concerted action by States Parties in the Region of the Americas for the future application and implementation of and compliance with the Regulations.

Background

3. The International Health Regulations, adopted by the Fifty-eighth World Health Assembly in 2005 through Resolution WHA58.3,[1] constitute the legal framework that, among others, defines national core capacities, including at points of entry, for the management of public health events of potential or actual national and international concern and related procedures.

[1] The text of the International Health Regulations (Resolution WHA58.3) is available at: http://whqlibdoc.who.int/publications/2008/9789241580410_eng.pdf.

Situation Analysis

Acute public health events

4. The Pan American Health Organization (PAHO) serves as the World Health Organization (WHO) IHR Contact Point for the Region of the Americas and facilitates the management of public health events through established communication channels with the National IHR Focal Points (NFPs). In 2016, of the 35 States Parties in the Region, all but two, Saint Lucia and Trinidad and Tobago, submitted the annual confirmation or update of contact details for their NFPs. In 2016, routine connectivity tests performed between the WHO IHR Contact Point and the NFPs in the Region were successful for 32 of the 35 States Parties (91%) by e-mail and for 33 of the 35 States Parties (94%) by telephone.

5. In the period from 1 January 2016 to 30 June 2017, a total of 315 public health events of potential international concern were identified and assessed in the Region: 238 events in 2016, and 77 during the first six months of 2017. For 184 of the 315 events (58%), national authorities, including through the NFP on 145 occasions, were the initial source of information. Verification was requested and obtained for 35 events identified through informal or unofficial sources. It is worth noting that, for 53 events detected in 2017, the final designation status had yet to be assigned. Therefore, of the 262 events for which the designation status was known, 161 (61%), affecting 49 countries and territories in the Region, were of substantiated international public health concern. The great majority of these 161 events were attributed to infectious hazards (140 events, or 87%), and the etiology most frequently recorded was Zika virus (81 events). Of the remaining 21 events of substantiated international public health concern, 10 were zoonosis-related and 5 were food safety-related; for 6 events the etiology remained undetermined.

6. Significant acute public health events that affected, or had public health implications for, States Parties in the Americas and PASB, from 1 January 2016 to 30 June 2017, include *a)* the current PHEIC determined in association with the spread of wild poliovirus, together with the circulating vaccine-derived poliovirus (cVDPV);[2] *b)* the PHEIC, terminated in November 2016, associated with the spread of Zika virus and the observed increase in neurological disorders and neonatal malformations;[3] *c)* the increase of cholera activity in Haiti following the landfall of category 5 Hurricane Matthew in October 2016;[4] and *d)* the increase in yellow fever virus activity in South

[2] The web page of the IHR Emergency Committee concerning ongoing events and context involving transmission and international spread of poliovirus is available on the WHO website at: http://www.who.int/ihr/ihr_ec_2014/en/.

[3] The Zika virus infection web page on the PAHO website is available at: http://www.paho.org/hq/index.php?option=com_content&view=article&id=11585&Itemid=41688&lang=en.

[4] The Hurricane Matthew Response web page on the PAHO website is available at: http://www.paho.org/hq/index.php?option=com_content&view=article&id=12574%3Apahos-response-to-hurricane-matthew&catid=8897%3Ahurricane-matthew&Itemid=42136&lang=en.

America that started in 2015 and resulted in an exceptional upsurge of cases in the animal and human populations in Brazil in 2017.

Core capacities of States Parties

7. In 2016, all 35 States Parties in the Region of the Americas submitted their State Party Annual Report to the Sixty-ninth World Health Assembly. In 2017, 33 (94%) of the 35 States Parties submitted their report to the Seventieth World Health Assembly; Belize and Saint Kitts and Nevis did not comply with this obligation. Since 2011, when the State Party Annual Report in its current format was instituted for reporting to the Sixty-fourth World Health Assembly, 12 States Parties have systematically complied by submitting their report every year: Antigua and Barbuda, Barbados, Canada, Colombia, Costa Rica, Dominica, Ecuador, Guyana, Honduras, Jamaica, Mexico, and the United States. Information on the degree of compliance with this commitment on the part of the remaining States Parties is presented in Annex A.

8. States Parties Annual Reports submitted to the World Health Assemblies between 2011 and 2017 showed steady improvements at the regional level in all core capacities. However, the status of the core capacities across the subregions continues to be heterogeneous, with the lowest scores generally registered in the Caribbean subregion. When the 2017 Annual Reports are compared with those submitted in 2016, variations in regional average scores are in the range of 10 percentage points in the case of all capacities. The highest regional average score registered, 95%, relates to the zoonotic hazard. The capacities to respond to events associated with chemical and radiation-related hazards continue to register the lowest scores, 61% and 66% respectively, while the regional average score for all remaining capacities is close to or above 75%. Nonetheless, it is noteworthy that the regional average scores for chemical and radiation-related hazards have reached and exceeded 60% for the first time since this reporting format was introduced. Moreover, the average scores for these two capacities in the Caribbean subregion represent some of the most significant annual improvements recorded for any given capacity at the regional or subregional level. From 2016 to 2017, in the Caribbean subregion, the average score for the capacities to respond to chemical and radiation-related events increased from 49% to 59% and from 27% to 40%, respectively. Annex A also presents a summary of the States Parties Annual Reports to the Seventieth World Health Assembly.[5]

9. To support institutional and intersectoral strengthening efforts in States Parties in the Region, PASB has continued its joint activities with other international specialized United Nations agencies, international organizations, and partners. Experts from the Region and PASB staff have continued to contribute to *a)* global initiatives, with the World Organisation for Animal Health (OIE), the Global Outbreak Alert and Response Network (GOARN), and the WHO Secretariat, *b)* regional initiatives, with the

[5] Historical and additional information regarding the States Parties Annual Reports submitted to the World Health Assembly is available in the WHO Global Health Observatory data repository on the WHO website at: http://apps.who.int/gho/data/node.main.IHR?lang=en.

International Civil Aviation Organization (ICAO), the International Air Transport Association (IATA), and the Food and Agriculture Organization (FAO) of the United Nations; and *c)* subregional initiatives, with the International Atomic Energy Agency (IAEA) and the Global Health Security Agenda (GHSA).

10. To support national authorities in their efforts to advance in the continuous public health preparedness process, PASB has implemented subregional, multi-country, and country missions and workshops focusing on, among other topics, the early warning function of the surveillance system; NFP functions; laboratory diagnostics and public health laboratories; infection prevention and control; risk communication; points of entry; simulation exercises; and mass gatherings.

Administrative requirements and governance

11. As of 11 July 2017, 489 ports in 27 States Parties in the Region of the Americas were authorized to issue Ship Sanitation Certificates *(3)*. Eleven (11) additional ports were authorized in nine overseas territories of France, the Netherlands, and the United Kingdom. As of the same date, no information had been provided to the WHO Regional Offices regarding the status of the WHO Procedures for the voluntary certification of designated airports and ports already submitted for comments to the States Parties on two occasions, in 2014 and 2015.

12. As of 13 July 2017, the IHR Roster of Experts included 449 experts, 115 of whom are from the Region of the Americas. They include experts designated by nine of the 35 States Parties in the Region: Argentina, Barbados, Brazil, Cuba, Mexico, Nicaragua, Paraguay, United States of America, and Venezuela.

13. In the context of the exceptional upsurge of yellow fever activity in Brazil at the beginning of 2017, and considering the challenges related to the application of IHR Article 43, "Additional health measures," and of the revised Annex 7, "Requirements concerning vaccination or prophylaxis for specific diseases," which entered into force in July 2017 pursuant to Resolution WHA67.13 *(4)*, and taking into account as well the ambiguous global process utilized by the WHO Secretariat to update and publish States Parties' requirements related to the International Certificate of Vaccination or Prophylaxis (ICVP) as part of the WHO publication *International Travel and Health (5)*, PASB launched a survey in the Region to gather information on ICVP requirements related to the proof of vaccination against yellow fever as a condition for international travelers to enter and/or exit any specific country in the Region. Twenty-nine (83%) of the 35 States Parties in the Region responded to the survey and subsequently used the process to update their ICVP requirements *(6)*.

14. Under Resolution WHA68.4 *(7)*, aimed at guaranteeing a participatory process in mapping areas at risk for yellow fever transmission, the Scientific and Technical Advisory Group on Geographical Yellow Fever Risk Mapping (GRYF) was established in December 2015. It includes experts from five countries in the Region: Argentina,

Brazil, Panama, Trinidad and Tobago, and the United States.[6] Since it was established, the GRYF has held six virtual meetings and has considered the mapping of risk for yellow fever virus transmission in Argentina and Peru.

15. One of the critical issues for governance of the IHR is the monitoring of their application, implementation, and compliance. Pursuant to Resolution WHA68.5 *(8),* adopted by the Sixty-eighth World Health Assembly in 2015, and endorsing the recommendations of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation, the WHO Secretariat initiated the process for collegial revision of the IHR Monitoring and Evaluation Framework (hereafter referred to as IHR MEF or Framework) through the WHO Governing Bodies and the Regional Committees. As mandated by Article 54 of the IHR, the Framework is due to be considered and adopted by the World Health Assembly. However, lack of consensus among countries has elicited debates at that level and triggered three rounds of Formal Regional Consultations in three consecutive years. It has also highlighted the challenges for the WHO Secretariat to incorporate the very detailed and extensive suggestions of States Parties in the Americas on this matter *(1)*, supported by Decision CD55(D5) *(9)*, and to take into consideration their call not to undermine the Governing Bodies process set by the IHR. The chronological iterations of the IHR MEF, as well as the consolidated concerns, comments, and suggestions of States Parties in the Americas offered in 2015, 2016, and 2017, are presented in the Report of the Formal Regional Consultation on the International Health Regulations held in São Paulo, Brazil, on 17 to 19 July 2017 (hereafter referred to as the 2017 Consultation).[7]

16. The proposed IHR MEF has four components: one compulsory (State Party Annual Reporting) and three voluntary (After-Action Review of public health events, Simulation Exercises, and Joint External Evaluations) *(10)*. PASB staff has participated in WHO internal meetings for the development of the State Party Annual Reporting and After-Action Review components (November 2016 and March 2017), and together with experts from the Region, in the WHO meeting for the revision of the tool for conducting Joint External Evaluations (April 2017). At the time of writing of this report, outcomes of these exercises were not available for sharing with States Parties.

17. In the wake of the Ebola outbreak in West Africa, the WHO Secretariat, through Decisions WHA69(14) *(11)* and WHA70(11) *(1)* of the World Health Assembly, was tasked to lead the collaborative development of a draft five-year global strategic plan to improve public health preparedness and response (hereafter referred to as Draft GSP). Like the IHR MEF, the Draft GSP was the subject of two rounds of Formal Regional Consultations, in 2016 and 2017. The very substantial concerns, comments, and

[6] The web page of the Scientific and Technical Advisory Group on Geographical Yellow Fever Risk Mapping (GRYF) is available on the WHO website at: http://www.who.int/ith/yellow-fever-risk-mapping/en/.

[7] The Report of the Formal Regional Consultation on the International Health Regulations, São Paulo, Brazil, 17-19 July 2017, is available in English at: http://www.paho.org/disasters/index.php?option=com_docman&task=doc_view&gid=2523&Itemid=270

suggestions offered by States Parties in 2016 and 2017 are presented in the Report of the 2017 Consultation.

Action Necessary to Improve the Situation

18. Both the Formal IHR Regional Consultations held in Miami, United States, in August 2016 (hereafter referred to as the 2016 Consultation) *(2)* and the 2017 Consultation were affected by different understandings and aspirations of the States Parties which have hampered the implementation of and compliance with the IHR. The efforts of States Parties in the Region to solve this issue and achieve a harmonized national vision for each State points to an ongoing cultural shift, as well as to increased national ownership and awareness that is arguably more deeply rooted than that observed among States Parties in other WHO Regions.

19. On one hand, the IHR are increasingly understood as a tool to strengthen and increase the sustainability of *a)* national essential public health functions, including planning and financing, that are largely already existing and operational, to different degrees, within national health systems, and *b)* national intersectoral mechanisms. On the other hand, especially at the political level, the IHR often continue to be perceived as a new technical discipline, one whose requirements and implications are confined to the health sector, pertaining mainly to public health "crises" and obligations – with somewhat punitive connotations. In alignment with the scope and purpose of the Regulations, the current situation warrants interventions at national level to demonstrate the cost-effectiveness of sustained resource allocation for strengthening essential public health functions as opposed to merely responding to acute public health events as they happen, a strategy with high costs and economic consequences.

20. PASB faces continuing challenges with respect to its ability to clearly frame core capacities detailed in Annex 1 of the IHR as essential public heath functions, including planning and financing; to effectively convey this message to PAHO Member States in the context of the strategy for universal access to health and universal health coverage; and to advocate accordingly in the appropriate high-level forums at regional and subregional levels.

21. To maintain States Parties' commitments toward the international community as high priorities on national political agendas, the IHR provide for mechanisms to ensure mutual accountability, along with requirements for monitoring implementation and compliance by States Parties. Therefore, as signaled by debates within the PAHO and WHO Governing Bodies, resulting in three rounds of Formal Regional Consultations in three consecutive years, the relevance of the IHR can only be guaranteed if their governance is *a)* collegially enabled by States Parties and by the WHO Secretariat through the WHO Governing Bodies, and *b)* exerted through the transparent facilitation and farsighted leadership of the WHO Secretariat, as custodian of the Regulations.

22. Summarized below are the key concerns, comments, and suggestions formulated by States Parties in the Americas during the 2015, 2016 *(2)*, and 2017 Consultations to expedite the revision and finalization of both the Draft GSP and the IHR MEF through the PAHO and WHO Governing Bodies.

a) In compliance with Article 54, "Reporting and review," the vast majority of countries recommended that the IHR MEF should be presented as a stand-alone document, separate from the Draft GSP, for consideration and adoption by the Seventy-first World Health Assembly in May 2018, through the WHO Executive Board at its 142nd session, January 2018.

b) The WHO Secretariat should take into account the following considerations as it works to shape future iterations of the Draft GSP in the context of the ongoing consultative process:

- In its current form, the Draft GSP is more operational than strategic in nature. Therefore, it needs to be revised in order to acquire the desired strategic breadth, especially with respect to strategic pillars 2 and 3.
- *Strategic pillar 1 - Building and maintaining State Parties Core Capacities:* This pillar should *i)* present a conceptual framework that bridges core capacities detailed in Annex 1 of the IHR and essential public health functions, and *ii)* reflect the wide variation across States Parties with respect to both the maturity of their health systems and the status of their application and implementation of the IHR, in order to explicitly overcome the one-size-fits-all concept of a "dedicated national IHR plan."
- *Strategic pillar 2 - Event management and compliance* and *Strategic pillar 3 - Measuring progress and accountability:* These pillars need to be reshaped because *i)* the responsibility to demonstrate accountability falls exclusively upon States Parties; *ii)* the IHR MEF Framework only covers a subset of provisions related to core capacities; and *iii)* the proposed monitoring of compliance with IHR provisions is restricted to States Parties' obligations under Article 43.

c) The development of a stand-alone five-year regional operational plan, separate from the PAHO Biennial Work Plans (2018-2019 and beyond), is not considered necessary. Additionally, the Sustainable Health Agenda for the Americas 2018-2030 *(12)* comprehensively encompasses IHR-related issues.

d) To bring closure to years of debates within the PAHO and WHO Governing Bodies, the IHR MEF should be revised as part of the ongoing consultative process. The proposal developed during the 2017 Consultation seeks to find an acceptable common ground that can bridge increasingly polarized positions among States Parties. Therefore, taking into account comments expressed during the 2015 and 2016 Consultations, the IHR MEF, for each of its four components, should present *i)* the public health rationale and objectives; *ii)* roles and responsibilities of States Parties and the WHO Secretariat; *iii)* the extent to which

the component complements the other components, with related considerations of cost-effectiveness; *iv)* explicit references to the tool or tools supporting the roll-out of the component, and the process underlying the tools' development adopted by the WHO Secretariat; *v)* the frequency of the component's implementation; *vi)* a description of the type of information that will be presented to the World Health Assembly resulting from the application of the component; *vii)* how the information produced by the application of the component will be used by the WHO Secretariat to inform its country cooperation activities.

e) The outline of the process for conducting voluntary joint external evaluations in the Americas proposed by PASB was generally accepted.

f) Extensive comments and suggestions provided by States Parties in the Region during the 2015 and 2016 Consultations, related to both the Draft GSP and the IHR MEF, are still valid and should be considered by the WHO Secretariat as part of the ongoing consultative process.

g) For the ongoing consultative process, the WHO Secretariat should adopt a more transparent approach than was used in 2015 and 2016 for consolidating the inputs received from States Parties.

Action by the Pan American Sanitary Conference

23. The Pan American Sanitary Conference is invited to *a)* review the information provided in this report on the implementation of IHR in the Region, and *b)* in compliance with Decision WHA70(11) *(1)*, and following careful consideration of the information presented in the Report of the 2017 Consultation, review the guiding principles and pillars of the WHO Secretariat document: *Development of a draft five-year global strategic plan to improve public health preparedness and response: Consultation with Member States* (Annex B) and provide its views on the IHR Monitoring and Evaluation Framework. These will inform the deliberations of the WHO Executive Board at its 142nd session in January 2018.

Annexes

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Annex A

Summary Table: States Parties Annual Reports to the 70th World Health Assembly (Core Capacities Scores in Percentages)

State Party	Requested and Obtained 2012-2014 Extension	Requested and Obtained 2014-2016 Extension	Number of Annual Reports Submitted from 2011 to 2017 (7-year period)	Legislation Policy Financing	Coordination and NFP Communication	Surveillance	Response	Preparedness	Risk Communication	Human Resources	Laboratory	Points of Entry	Zoonotic Events	Food Safety Events	Chemical Events	Radiation Emergencies
Antigua and Barbuda	yes	yes	7	100	73	85	83	73	86	100	68	100	89	100	69	23
Argentina	yes	no	6	50	67	80	78	82	86	40	86	89	89	93	69	77
Bahamas	yes	yes	5	75	83	100	76	62	100	40	96	78	56	87	69	54
Barbados	yes	yes	7	75	63	100	76	70	100	80	96	100	100	80	77	69
Belize	yes	yes	5	-	-	-	-	-	-	-	-	-	-	-	-	-
Bolivia (Plurinational State of)	yes	yes	6	100	90	90	82	73	57	80	96	24	100	87	23	100
Brazil	no	no	6	100	100	100	100	100	100	100	96	67	100	100	100	100
Canada	no	no	7	100	100	100	100	100	100	100	100	100	100	100	100	100
Chile	no	no	6	100	100	90	89	42	71	60	66	91	100	100	46	77
Colombia	no	no	7	100	100	95	88	100	100	60	80	97	89	87	85	77
Costa Rica	no	no	7	100	100	100	100	72	100	80	90	97	100	100	38	46
Cuba	yes	no	6	100	100	100	100	100	100	100	90	100	100	100	100	92
Dominica	yes	yes	7	50	100	80	78	60	100	40	43	30	100	100	15	15
Dominican Republic	yes	yes	6	75	90	75	58	82	71	40	80	89	100	47	38	77
Ecuador	yes	yes	7	100	90	90	94	90	86	20	83	86	100	80	31	100
El Salvador	yes	no	6	100	100	95	94	90	71	100	100	97	100	100	92	85
Grenada	yes	yes	5	100	83	95	69	33	86	60	49	52	100	67	46	15
Guatemala	yes	no	6	50	53	55	77	35	43	80	29	29	100	60	54	54
Guyana	yes	yes	7	100	100	90	100	100	100	100	100	46	100	73	85	31

Summary Table: States Parties Annual Reports to the 70th World Health Assembly (Core Capacities Scores in Percentages) *(cont.)*

State Party	Requested and Obtained 2012-2014 Extension	Requested and Obtained 2014-2016 Extension	Number of Annual Reports Submitted from 2011 to 2017 (7-year period)	Legislation Policy Financing	Coordination and NFP Communication	Surveillance	Response	Preparedness	Risk Communication	Human Resources	Laboratory	Points of Entry	Zoonotic Events	Food Safety Events	Chemical Events	Radiation Emergencies
Haiti	yes	yes	5	0	47	85	64	73	71	40	80	9	100	40	69	54
Honduras	yes	yes	7	100	100	95	100	70	71	60	80	94	89	93	46	77
Jamaica	yes	yes	7	50	100	90	100	92	71	60	96	88	78	87	77	85
Mexico	yes	no	7	100	70	95	94	100	100	100	100	100	100	100	100	100
Nicaragua	yes	no	6	75	83	100	88	100	100	100	86	44	100	80	92	100
Panama	yes	yes	6	75	100	100	88	60	71	40	86	61	100	60	15	62
Paraguay	yes	yes	5	100	100	85	89	43	100	60	76	100	89	67	38	77
Peru	yes	yes	5	25	80	90	78	62	57	100	90	27	100	67	31	100
Saint Kitts and Nevis	yes	yes	4	-	-	-	-	-	-	-	-	-	-	-	-	-
Saint Lucia	yes	yes	6	75	100	80	100	60	100	100	96	97	89	73	23	8
Saint Vincent and the Grenadines	yes	yes	6	100	67	70	94	28	71	80	76	72	100	73	8	0
Suriname	yes	yes	6	50	83	90	100	100	71	40	86	78	78	93	62	0
Trinidad and Tobago	yes	yes	6	50	57	95	83	80	86	20	82	88	78	87	62	77
United States of America	no	no	7	100	100	100	100	100	100	100	60	100	100	93	100	100
Uruguay	yes	no	3	100	100	95	89	90	71	40	60	91	100	100	69	62
Venezuela (Bolivarian Republic of)	yes	yes	5	100	90	95	100	100	86	100	90	94	100	87	100	85

Summary Table: States Parties Annual Reports to the 70th World Health Assembly (Core Capacities Scores in Percentages) *(cont.)*

State Party by Subregion	Legislation Policy Financing	Coordination and NFP Communication	Surveillance	Response	Preparedness	Risk Communication	Human Resources	Laboratory	Points of Entry	Zoonotic Events	Food Safety Events	Chemical Events	Radiation Emergencies
Caribbean* (*n*=13)	71	81	89	86	72	88	66	81	72	90	82	59	40
Central America (*n*=7)**	82	89	89	86	73	75	71	79	73	98	77	54	72
South America* (*n*=10)**	88	92	91	89	78	81	66	82	77	97	87	59	86
North America** (*n*=3)**	100	90	98	98	100	100	100	87	100	100	98	100	100
Region of the Americas (*n*=33)	81	87	90	88	76	84	70	82	76	95	84	61	66

* Caribbean subregion includes: Antigua and Barbuda, Bahamas, Barbados, Belize, Cuba, Dominica, Grenada, Guyana, Haiti, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, and Trinidad and Tobago.

** Central America subregion includes: Costa Rica, Dominican Republic, El Salvador, Guatemala, Honduras, Nicaragua, and Panama.

*** South America subregion includes: Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay, and Venezuela.

**** North America subregion includes: Canada, Mexico, and United States.

ANNEX B

Information document

WHE/CPI/IHR
1 August 2017

Development of a draft five-year global strategic plan to improve public health preparedness and response

Consultation with Member States

SUMMARY

1. This document has been prepared for consultation with Member States at the sessions of the regional committees in 2017, in order to develop a draft five-year global strategic plan to improve public health preparedness and response, as requested in decision WHA70(11) (2017). It includes: issues raised by Member States on implementation of the International Health Regulations (2005) during the Seventieth World Health Assembly; the mandates and technical work carried out by the Secretariat on monitoring and evaluation of the core capacities required by the Regulations; and a proposed way forward for the consultative process for the development of the draft five-year global strategic plan. The Annex to this document contains the guiding principles and pillars proposed by the Secretariat for the five-year global strategic plan.

BACKGROUND

2. In response to decision WHA69(14) (2016), the Secretariat developed a draft global implementation plan for the recommendations of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response. The final version of the global implementation plan was submitted to the Seventieth World Health Assembly in May 2017,[1] through the Executive Board at its 140th session in January 2017. The finalized global implementation plan incorporated proposals from extensive consultations with all six regional committees, and included six areas of action for taking forward the recommendations of the Review Committee, and 12 guiding principles for the five-year global strategic plan to improve public health preparedness and response.

[1] Document A70/16.

3. The Seventieth World Health Assembly took note of the report containing the global implementation plan and through decision WHA70(11) requested the Director-General, "to develop, in full consultation with Member States, including through the regional committees, a draft five-year global strategic plan to improve public health preparedness and response, based on the guiding principles contained in Annex 2 to document A70/16, to be submitted for consideration and adoption by the Seventy-first World Health Assembly, through the Executive Board at its 142nd session".

ISSUES RAISED BY MEMBER STATES ON IMPLEMENTATION OF THE INTERNATIONAL HEALTH REGULATIONS (2005) DURING THE SEVENTIETH WORLD HEALTH ASSEMBLY

IHR Monitoring and Evaluation Framework

4. The main issue for which divergent views were raised by Member States during the Seventieth World Health Assembly was the proposed IHR Monitoring and Evaluation framework.[2]

5. The majority of Member States appreciated the Secretariat's leadership in implementing the new and voluntary components of the IHR Monitoring and Evaluation Framework, including the joint external evaluation. This was considered by some Member States as a powerful tool for effectively acquiring the core capacities required by the International Health Regulations (2005). These Member States also appreciated the fact that the process of external evaluation is implemented as a package, whereby the evaluation is planned together with the development of national action plans for public health preparedness and response. Some Member States considered that the technical guidance developed by the Secretariat for monitoring and reporting on implementation of the Regulations should be evidence-based, neutral and never subject to political influence. Some Member States stressed the need to take into account regional resources to achieve the core capacities required by the Regulations, particularly in the context of small countries, such as small island States.

6. A few Member States expressed substantial reservations and concerns with regard to the joint external evaluation and the IHR Monitoring and Evaluation Framework. They requested that new instruments for monitoring, evaluation and reporting should be submitted to and adopted by the WHO governing bodies. Other Member States considered that the introduction of external evaluations and other new mechanisms not provided by the Regulations may require amendments to the Regulations. Another concern was in relation to national sovereignty: it was considered that the external evaluation should not become a precondition for receiving financial and technical assistance.

[2] See the provisional summary records of the Seventieth World Health Assembly, Committee A, first, second, fourth and seventh meetings.

Integrating core capacities required by the International Health Regulations (2005) and resilient health systems

7. There was an overwhelming realisation by Member States following the Ebola virus disease outbreak in West Africa in 2014 and 2015 that strong and resilient health systems are an underlying factor for well functioning core capacities required by the Regulations. Member States were unanimous in acknowledging the critical importance of strong resilient health systems for the implementation of the Regulations, and the need to integrate the core capacities required by the Regulations with essential public health functions, within the framework of universal health coverage. They requested the Secretariat to develop specific guidance on how countries, in particular those that face resource constraints, could be supported in building their core capacities required by the Regulations. A forum on universal health coverage in December 2017 – co-organized by the World Bank, WHO, UNICEF, UHC2030, the Government of Japan and the Japan International Cooperation Agency[3] – is expected to provide a framework and a road map for building resilient health systems through the framing of core capacities required by the International Health Regulations (2005) as essential public health functions of health systems.

Other issues

8. Additional comments were related to developing the national action plans for public health preparedness and response, supporting the National IHR Focal Points, developing tools for an international early warning system, and risk assessment.

9. The issues of research and development in emergency situations, data and sample sharing, and overall administration and functioning of the WHO Health Emergencies Programme were also raised by many Member States, but they are not included in this document, as these will be addressed in separate reports on the WHO Health Emergencies Programme to the Seventy-first World Health Assembly in 2018.

MONITORING AND EVALUATION OF CORE CAPACITIES REQUIRED BY THE INTERNATIONAL HEALTH REGULATIONS (2005): MANDATES AND TECHNICAL WORK OF THE SECRETARIAT TO DATE

10. The International Health Regulations (2005) are legally binding on 196 States Parties, including all 194 WHO Member States. They were adopted by the Health Assembly in May 2005[4] and entered into force on 15 June 2007. Following the entry into force, States Parties had five years to "develop, strengthen and maintain … the capacity to respond promptly and effectively to public health risks and public health emergencies

[3] See https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/Upcoming_events/UHC_Forum_2017/Flyer_for_UHC_Forum_2017.pdf (accessed 20 July 2017).

[4] See resolution WHA58.3 (2005).

of international concern”,[5] including the core capacity requirements for designated airports, ports and ground crossings, as described in Annex 1 to the Regulations. For States Parties that were not able to meet these minimum requirements in the first five years, the Regulations provided for two two-year extensions (2012–2014 and 2014–2016) to allow States Parties time to comply.

11. Article 54.1 of the Regulations requires that “States Parties and the Director-General shall report to the Health Assembly on the implementation of these Regulations as decided by the Health Assembly”, which also comprises monitoring the status of core capacities. In 2008, the Health Assembly, through resolution WHA61.2, decided that “States Parties and the Director-General shall report to the Health Assembly on the implementation of the Regulations annually”. That resolution also requested 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” In 2008 and 2009, a questionnaire was sent by the Secretariat to States Parties, focused mainly on self-reported processes related to the establishment and functioning of the National IHR Focal Points.[6]

12. In 2010, the Secretariat developed and shared with States Parties a core capacity monitoring framework,[7] with a questionnaire for States Parties to complete on a voluntary basis on the status of implementation of the Regulations. This framework included a checklist and 20 indicators on the status of eight core capacities and capacities at points of entry and four specific hazards covered by the Regulations, notably biological (zoonotic diseases, food safety events and other infectious hazards), chemical, radiological and nuclear events. The self-assessment tool, completed and submitted by States Parties to the Secretariat on an annual basis (from 2010 to 2017), constituted the basis for compiling the report on the implementation of the Regulations by the Secretariat to the Health Assembly. States Parties’ specific scores related to the status of each core capacity were included in the Secretariat’s annual implementation report to the Health Assembly from 2013 to 2015.[8] From 2015, these scores were made available online through the Global Health Observatory.[9]

13. In 2015, the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation recommended that the Secretariat should develop options to move “from exclusive self-evaluation to approaches that combine self-evaluation, peer review and voluntary external evaluations involving a

[5] International health regulations (2005) – 3rd edition. Geneva: World Health Organization; 2016. Article 13.1.
[6] See documents A62/6 and A63/5.
[7] IHR core capacity monitoring framework: checklist and indicators for monitoring progress in the development of IHR core capacities in States Parties. Available at: http://apps.who.int/iris/bitstream/10665/84933/1/WHO_HSE_GCR_2013.2_eng.pdf?ua=1 (accessed 17 July 2017).
[8] Documents A64/9, A65/17, A66/16 and A66/16 Add.1, A67/35 and A67/35 Add.1 and A68/22.
[9] See http://www.who.int/gho/ihr (accessed 17 July 2017).

combination of domestic and independent experts".[10] Resolution WHA68.5 (2015) urged Member States to support the implementation of the recommendations of the Review Committee and requested the Director-General to present an update to the Sixty-ninth World Health Assembly on progress made in taking forward the recommendations of the Review Committee. The Secretariat then developed a concept note outlining a new approach for monitoring and evaluation of the core capacities required by the Regulations.[11] The concept note was discussed by the regional committees in 2015, and a revised monitoring and evaluation framework was submitted to, and noted by, the Sixty-ninth World Health Assembly in 2016.[12]

14. The revised IHR Monitoring and Evaluation Framework submitted to the Health Assembly in 2016 comprises four complementary components: the mandatory annual self-reporting by States parties in accordance with resolution WHA61.2 (2008) on implementation of the Regulations, and three voluntary components: joint external evaluation, after-action review and/or simulation exercise(s). As part of its function and mandate under the Regulations,[13] the Secretariat is developing technical tools for each of the three voluntary components. The IHR Monitoring and Evaluation Framework is an important part of pillar 3 of the draft five-year global strategic plan to improve public health preparedness and response (see the Annex to this document).

PROPOSED WAY FORWARD FOR THE CONSULTATIVE PROCESS FOR THE DEVELOPMENT OF THE DRAFT FIVE-YEAR GLOBAL STRATEGIC PLAN

15. The current document highlights the area of monitoring and evaluation of implementation of the Regulations as the main issue to be brought for further consultation in preparing for the development of the draft five-year global strategic plan.

16. In addition to consulting Member States at the sessions of the regional committees between August and October 2017, the Secretariat is also planning a web-based consultation on the document between mid-August and mid-October 2017.

17. The input received from Member States at the sessions of the regional committees will be used by the Secretariat to further refine the draft plan. The Secretariat will also organize a face-to-face consultation of Member States through the Geneva-based mission focal points. The consultation is planned to take place in Geneva in November 2017. The updated version of the draft five-year global strategic plan will be submitted to the Executive Board at its 142nd session in 2018.

[10] See WHA68/2015/REC/1, Annex 2.

[11] Development, monitoring and evaluation of functional core capacity for implementing the International Health Regulations (2005). Concept note. Available at: http://www.who.int/ihr/publications/concept_note_201507/en/ (accessed 17 July 2017).

[12] See document A69/20.

[13] Resolution WHA58.3 (2005), Article 44.2 and Annex 1.

ACTION BY THE REGIONAL COMMITTEES

18. The regional committees are invited to review the guiding principles and pillars of the five-year global strategic plan, and to provide their views on the IHR Monitoring and Evaluation Framework.

Annex

FIVE-YEAR GLOBAL STRATEGIC PLAN TO IMPROVE PUBLIC HEALTH PREPAREDNESS AND RESPONSE: GUIDING PRINCIPLES AND PILLARS

This Annex recalls the guiding principles contained in document A70/16 and proposes three pillars for public health preparedness and response. The goal of the plan is to strengthen capacities at the global, regional and country levels to prepare for, detect, assess and respond to public health risks and emergencies with the potential for international spread. The guiding principles are outlined in the table.

Table. Guiding principles for the five-year global strategic plan to improve public health preparedness and response[1]

Guiding principle	Details
1. Consultation	Consultative process from May to November 2017 through the regional committees and a web-based consultation. One formal consultation of Member States, through the Geneva-based mission focal points, is planned to be held in Geneva, in November 2017.
2. Country ownership	Building and sustaining core capacities as required by the International Health Regulations (2015) as essential public health functions of their health systems, at the national and subnational levels, is the primary responsibility of national governments, taking into account their national health, social, economic, security and political contexts.
3. WHO leadership and governance	The WHO Health Emergencies Programme will lead the development and implementation of the five-year global strategic plan. The WHO Secretariat will report on progress to the meetings of the governing bodies, as part of the regular reporting on the application and implementation of the International Health Regulations (2005).
4. Broad partnerships	Many countries require technical support to assess, build and maintain their core capacities as required by the Regulations as essential public health functions of their health systems. Many global partners support countries in the field of health systems strengthening and public health preparedness and response. As decided by the Fifty-eighth World Health Assembly, WHO will cooperate and coordinate its activities, as appropriate, with the following: the United Nations, ILO, FAO, IAEA,

[1] Based on document A70/16, Annex 2.

Guiding principle	Details
	ICAO, IMO, International Committee of the Red Cross, International Federation of Red Cross and Red Crescent Societies, IATA, International Shipping Federation and OIE. Cooperation with other relevant non-State actors and industry associations will also be considered, within the Framework of Engagement with Non-State Actors.
5. Intersectoral approach	Responding to public health risks, events and emergencies requires a multisectoral, coordinated approach (for example, with agriculture, transport, tourism and finance sectors). Many countries already have health coordination platforms or mechanisms in place, such as the One-Health approach. The five-year global strategic plan will provide strategic orientation for planning for public health preparedness and response across multiple sectors.
6. Integration with the health system	The Ebola virus disease outbreak in West Africa in 2014 and 2015 put both health security and health systems resilience high on the development agenda. Framing the core capacities detailed in Annex 1 to the Regulations as essential public health functions will mutually reinforce health security and health systems, leading to resilient health systems.
7. Community involvement	Effective public health preparedness can only be achieved with the active participation of local governments, civil society organizations, local leaders, and individual citizens. Communities must take ownership of their preparedness and strengthen it for emergencies that range in scale from local or national events to pandemics and disasters.
8. Focus on fragile contexts	While the WHO Health Emergencies Programme is supporting all countries in their preparedness and response efforts in relation to public health risks, events and emergencies, the initial focus will be on a set of priority countries in fragile situations. The identification of priority countries will take into account an assessment of national core capacities and other risk assessments, for example using the INFORM methodology.[2]
9. Regional integration	Building on the five-year global strategic plan, the regional offices will develop regional operational plans, taking into account existing regional frameworks and mechanisms, such as: the regional strategy for health security and emergencies 2016–2020 – a strategy of the Regional Office for Africa;[3] the Asia Pacific Strategy for Emerging Diseases and Public Health Emergencies (APSED III) – a common strategic framework for the regions of South-East Asia and the Western Pacific;[4] Health 2020 – a policy framework and strategy for the European Region;[5] the Regional

[2] INFORM Index for Risk Management is a tool for understanding the risk of humanitarian crises and disasters. Available at: http://www.inform-index.org/Portals/0/InfoRM/INFORM%20Global%20Results%20Report%202017%20FINAL%20WEB.pdf?ver=2016-11-21-164053-717 (accessed 17 July 2017).

[3] See http://www.afro.who.int/sites/default/files/2017-07/afr-rc66-6-en-2107.pdf (accessed 20 July 2017).

[4] See http://www.wpro.who.int/about/regional_committee/67/documents/wpr_rc67_9_apsed.pdf (accessed 1 August 2017)

[5] See http://www.euro.who.int/__data/assets/pdf_file/0011/199532/Health2020-Long.pdf?ua=1 (accessed20 July 2017).

Guiding principle	Details
	Assessment Commission for the International Health Regulations (2005) established by the Regional Committee for the Eastern Mediterranean,[6] and other regional approaches.
10. Domestic financing	For long-term sustainability, the budgeting and financing of core capacities required by the Regulations as essential public health functions should be supported to the extent possible from domestic resources. The Secretariat will work with countries to encourage the allocation of domestic financial resources to build and sustain essential public health functions within the context of existing national planning and financing mechanisms. In countries that require substantial external resources, the Secretariat will provide support for strengthening the institutional mechanisms for coordinating international cooperation, based on the principles of effective development cooperation (country ownership, focus on results, inclusive partnerships, transparency and accountability).[7]
11. Linking the five-year global strategic plan with requirements under the International Health Regulations (2005)	The five-year global strategic plan will propose strategic directions in relation to the relevant Regulations requirements for States Parties and for WHO, as well as voluntary operational and technical aspects that are not a requirement under the Regulations.
12. Focus on results, including monitoring and accountability	The five-year global strategic plan will have its own monitoring framework, including indicators and timelines, which will be developed through the consultative process, and used for annual reporting on progress to the Health Assembly.

Pillars

1. Building and maintaining State Parties core capacities required by the International Health Regulations (2005)

(a) In view of lessons learned from the Ebola virus disease outbreak in West Africa in 2014 and 2015 and other recent public health events, States Parties should focus on building and maintaining resilient health systems, and on framing core capacities as essential public health functions of their health systems. While complying with requirements to ensure mutual accountability at international level with respect to the application and implementation of the IHR, countries need to establish domestic monitoring and evaluation mechanisms as part of their health systems, which would also facilitate the monitoring of the status of core capacities, as essential public health functions.

(b) The implications and potential gains, in terms of continuity of certain country capacities that will be triggered by the transition of the Global Polio Eradication initiative towards a post-certification strategy, will have to be considered. The Seventieth Health

[6] See http://applications.emro.who.int/docs/RC62_Resolutions_2015_R3_16576_EN.pdf?ua=1 (accessed 20 July 2017).

[7] Global Partnership for Effective Development Co-operation – principles. Available at: http://effectivecooperation.org/about/principles/ (accessed 17 July 2017).

Assembly requested the Director-General, inter alia, "to develop a strategic action plan on polio transition by the end of 2017, to be submitted for consideration by the Seventy-first World Health Assembly, through the Executive Board at its 142nd session, that: (i) clearly identifies the capacities and assets, especially at country and, where appropriate, community levels, that are required to: sustain progress in other programmatic areas, such as: disease surveillance; immunization and health systems strengthening; early warning, emergency and outbreak response, including the strengthening and maintenance of core capacities of core capacities under the International Health Regulations (2005)".[8]

(c) State Parties have had slightly more than 10 years to put in place core capacities to prevent, detect, assess, report and respond to public health risks, events and emergencies with potential to spread internationally, in accordance with the requirements of the Regulations. States Parties should continue to build and maintain these core capacities as essential public health functions of their health systems, for the effective application of the implementation of the Regulations, including those capacities related to points of entry.

(d) For those States Parties where the existing national planning, financing, and monitoring and evaluation mechanisms of their health systems are suboptimal, the Secretariat will develop guidance to facilitate the building and maintenance of core capacities, as essential public health functions, as part of the continuum of the assessment and planning process, and in alignment with the national health strategy. Similarly, the Secretariat will develop guidance to facilitate the national approach to intersectoral planning and financing. The Secretariat will develop guidance and provide technical support to countries to develop these plans. The development of the national action plans should be aligned with the national health sector's strategies and plans, and, in their development and implementation, they should emphasize coordination of multiple sectors and partners, such as OIE and FAO, under the One Health approach. Because the core capacities required under the Regulations cut across several sectors, financial and other sectors should be part of the planning process to ensure cross-sector coordination and appropriate financial allocations.

2. Event management and compliance

(a) The Secretariat and States Parties should continue to fulfil their obligations under the Regulations in relation to detection, assessment, notification and reporting of and response to public health risks and events with the potential for international spread. The role of the National IHR Focal Points will have to be strengthened, including through the provision of technical guidance, standard operating procedures, training, information sharing and lessons-learned activities.

[8] See decision WHA70(9).

(b) The Secretariat will strengthen its functions for event-based surveillance through the newly developed Epidemic Intelligence from Open Sources platform for early detection and risk assessment of public health events.

(c) The Secretariat will strengthen its role in administering the expert advisory groups established to support the application and implementation of and compliance with the Regulations, that is, the roster of experts for the emergency and review committees, the scientific and technical advisory group on geographical yellow fever risk mapping, and the ad hoc advisory group on aircraft disinsection for controlling the international spread of vector-borne diseases. It will also pursue the establishment of the Technical Advisory Group of Experts on Infectious Hazards, based on the draft terms of reference in Annex 3 to document A70/16.

(d) A critical element for the optimal functioning of the global alert and response system is compliance by States Parties with the requirements of the Regulations in relation to health measures taken in response to public health risks and events, including during public health emergencies of international concern. The Secretariat, in compliance with Article 43 of the Regulations, will share with States Parties information related to additional health measures implemented by States Parties. It will systematically collect information on additional measures, and, for measures that significantly interfere with international traffic under Article 43, it will share with other States Parties the public health rationale and the scientific evidence provided by the States Parties implementing those measures.

3. Measuring progress and accountability

(a) An important element for global health preparedness and response is the continuous monitoring of progress, both in establishing and maintaining by States Parties of the core capacities detailed in Annex 1 to the Regulations, and in the ability of the global system to respond to public health events with the potential for international spread.

(b) Article 54.1 of the Regulations requires that “States Parties and the Director-General shall report to the Health Assembly on the implementation of these Regulations as decided by the Health Assembly”. This also comprises monitoring the status of core capacities detailed in Annex 1 to the Regulations. The annual frequency of reporting to the Health Assembly was determined by the Sixty-first World Health Assembly in 2008.9 Since 2010, the Secretariat has proposed a self-assessment tool, exclusively focusing on core capacities, for States Parties to fulfil their annual reporting obligation to the Health Assembly. In compliance with Article 54 of the Regulations on reporting and review, and with resolution WHA68.5 (2015) on the recommendations of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation, and as a result of the consultations during the regional committees in

[9] See resolution WHA61.2 (2008).

2017, the five-year global strategic plan will propose a revised IHR Monitoring and Evaluation Framework for reporting to the Health Assembly on the status of the application and implementation of the Regulations.

(c) In the interim, the Secretariat will continue to propose the self-assessment annual reporting tool, introduced in 2010, while at the same time responding to requests from Member States that would like to implement additional monitoring and evaluation instruments as part of the IHR Monitoring and Evaluation Framework. As mentioned in document A70/16, which was noted by the Seventieth World Health Assembly in 2017, in order to ensure coherence and consistency between the various instruments, the Secretariat will review the annual self-reporting tool, and this revised instrument will be proposed to States Parties for future annual reporting.

(d) The five-year global strategic plan will include indicators and timelines for measuring progress at the global and regional levels. Most regions already have specific strategies and frameworks that will be taken into account in developing the monitoring approach for the five-year global strategic plan.

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