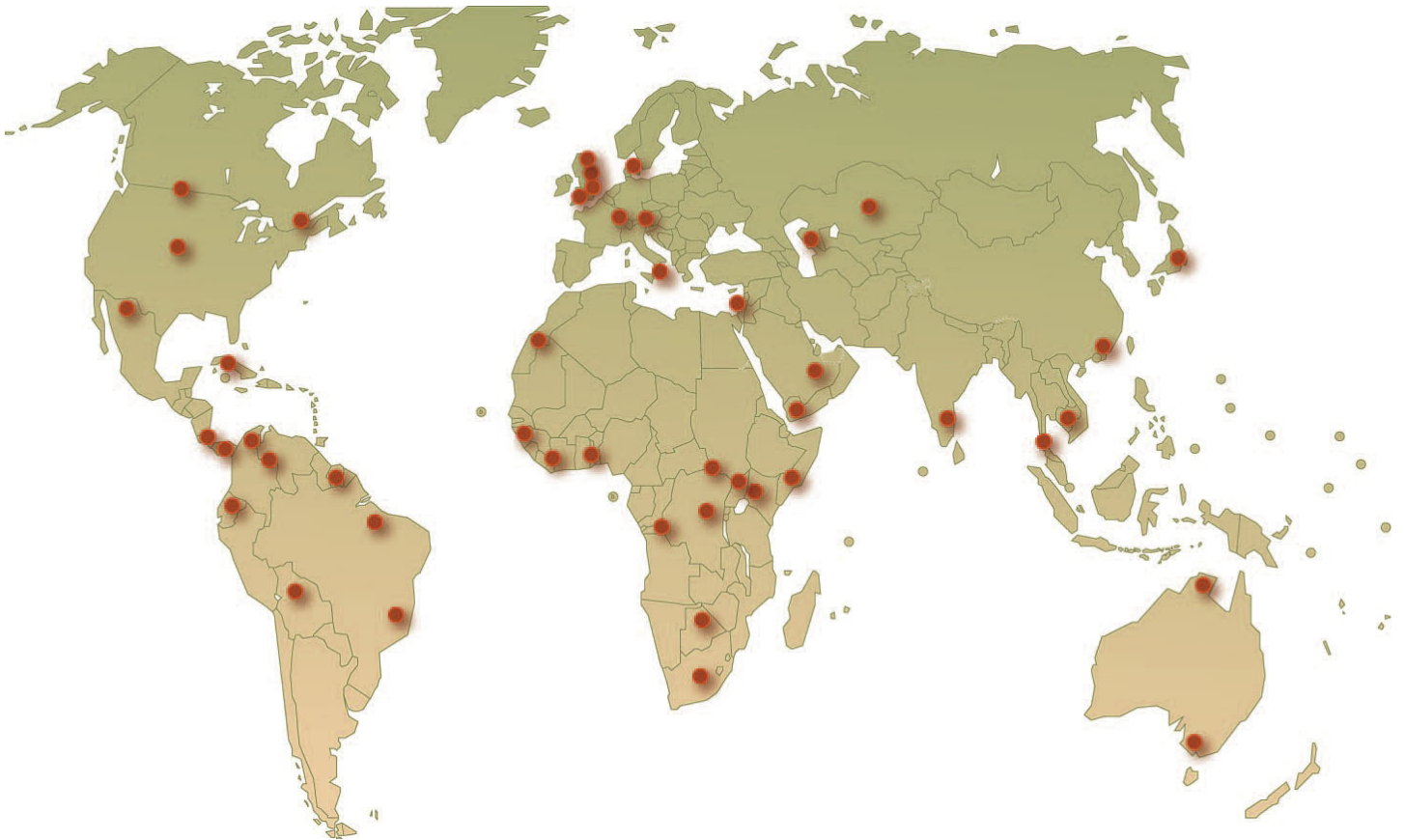


Global Crises – Global Solutions

Managing public health emergencies of international concern through the revised
International Health Regulations



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World Health Organization
Geneva

Cover illustration

Map showing the location of emerging and re-emerging infectious diseases 1996–2001.
Source: WHO, 2002.

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International Health Regulations and diseases in a globalizing world — an overview

The phenomenon of globalization in the twenty-first century has altered the traditional distinction between national and international health. Very few, if any, urgent public health risks are solely within the purview of national authorities.

One of the obvious consequences of globalization is the increased risk of international spread of infectious diseases. People and goods are crossing national borders in massive numbers unparalleled in human history. While some countries may still opt for extreme protectionism, importation of diseases is always difficult to prevent. The cross-border impact of infectious diseases is better addressed through multi-lateral efforts.

In the past, the most concrete measures to stop importation of infectious diseases were thought to be quarantine and trade embargoes. The ultimate way to stop international spread of disease would be to stop all international trade, travel and tourism. Such drastic measures, though no longer viable in today's globalizing world, nonetheless underline the close connection between disease control, trade and travel. The International Health Regulations (IHR) are a multilateral initiative by countries to develop an effective global surveillance tool for cross-border transmission of diseases. The IHR strive to harmonize the protection of public health with the need to avoid unnecessary disruption of trade and travel. They remain the only legally binding set of regulations, for WHO Member States, on global alert and response for infectious diseases.

Background and historical development

The historical evolution of the International Health Regulations dates back to the mid-nineteenth century when epidemics of cholera overran Europe between 1830 and 1847. These cholera epidemics paved the way for intensive infectious disease diplomacy and multilateral cooperation in the field of public health, which started with the first International Sanitary Conference, held in Paris in 1851.

From 1851 to the end of the nineteenth century, 10 conferences were convened and 8 conventions were negotiated about the spread of infectious diseases across national boundaries. Although most of these international sanitary conventions never came into force, it became clear that the transboundary effect of infectious diseases was a problem that required multilateral efforts by countries. The International Sanitary Conference held in Venice in 1892 adopted the International Sanitary Convention, which was restricted to cholera. In 1897, another International Sanitary Convention dealing with preventive measures against plague was adopted.

At the dawn of the twentieth century, the development of international regimes for cross-border surveillance of diseases coincided with the need to establish multilateral institutions to enforce these conventions. In 1902, an international conference of American States meeting in Washington DC established the International Sanitary Bureau – the precursor of the Pan-American Sanitary Bureau and the present Pan American Health Organization (PAHO). The 1892 and 1897 conventions were replaced in 1903 by a new International Sanitary Convention. In 1907, the bulk of the European States that had negotiated the nineteenth century international sanitary conventions met in Rome and adopted an agreement establishing “L’Office International d’Hygiène Publique”, OIHP, (International Bureau of Public Health) with a permanent secretariat in Paris.

Between the wars (1918–1939), international health regimes were not well coordinated. Between 1919 and 1945, the health office of the League of Nations in Geneva, the Pan-American Sanitary Bureau in Washington DC and the OIHP in Paris, existed independently of each other and enforced conventions and agreements within their respective areas.

On 7 April 1948, the Constitution of the World Health Organization came into force, and in 1951 WHO Member States adopted the International Sanitary Regulations – the end product of the intensive infectious disease diplomacy by countries in the mid-nineteenth and early twentieth centuries. WHO renamed these regulations the International Health Regulations in 1969, and the Regulations were slightly modified in 1973 and 1981. Since then the Regulations have been in force, representing the first legally binding international set of regulations adopted by WHO Member States.

The present International Health Regulations: vision and shortcomings

The IHR are a mechanism for the sharing of epidemiological information on the transboundary spread of infectious diseases. Their purpose is to ensure maximum security against the international spread of diseases with a minimum interference with world trade and travel. The IHR contain provisions for the application of non-urgent public health measures to international travellers, conveyances and goods, and require countries to report three infectious diseases when they occur in humans: cholera, plague and yellow fever.

To achieve this purpose, the present IHR oblige WHO Member States to notify WHO of cholera, plague and yellow fever outbreaks in their territories, list the maximum measures applicable during such outbreaks, and set out health-related rules for international trade and travel. Requirements are included for health and vaccination certificates for travellers from infected to non-infected areas, deratting, disinfecting and disinsecting of ships and aircraft as well as detailed health measures at airports and seaports in the territories of WHO Member States.

The rationale for listing the maximum measures permissible is simple: if a template is not given for protective measures to be taken by other countries in an outbreak situation, then there is great risk of overreaction, which could be damaging to the affected country. Trade, travel and tourism might well suffer, with economic consequences that extend far beyond the measures necessary from a public health point of view.

Because of extensive globalization in travel and trade, countries are concerned that diseases from other parts of the world could be imported. Potentially damaging travel and trade embargoes, not within the purview of the IHR, are thus often imposed, sometimes based solely on a perceived risk of disease importation. This overreaction on the part of contiguous neighbours, trading partners and other countries can sometimes take on global proportions, as happened during the plague outbreak in India in 1994. An estimated US\$ 1.7 billion was lost by India, and other countries spent millions of dollars in unnecessary “countermeasures” before the event could be put into proper public health focus.

Public health emergencies require a measured and evidence-based response from a credible third party, and under its United Nations constitution WHO is well placed to perform this function. The Regulations are the only legally binding global tool for public health, and enable WHO, in direct collaboration with its Member States, to address public health emergencies of international concern.

Constraints

The present Regulations, as a global tool for disease surveillance and public health protection, have the following major constraints:

- **Limited coverage.** The IHR require reporting of cholera, plague and yellow fever only.
- **Dependence on country notification.** The IHR wholly depend on the affected country to make an official notification to WHO once cases are diagnosed.
- **Lack of mechanisms for collaboration.** At present, little exists in the IHR to foster collaboration between WHO and a country in which infectious diseases with a potential for international spread are occurring.
- **Lack of incentives.** The present IHR lack effective incentives to encourage compliance by Member States.
- **Lack of risk-specific measures.** WHO lacks the capacity to proscribe specific measures, tailored to the actual threat posed by an outbreak, that will prevent international spread of disease.

With these major constraints in mind, key changes have been proposed to develop revised IHR that would adapt to trends, emerging in the twenty-first century, shaped by changes in the epidemiology of infectious diseases and by the growth of international travel and trade.

Summary of vision behind the proposed changes

The need for WHO to issue recommendations for public health emergencies of international concern is founded on a chain of reasoning that underscores the cross-border impact of globalization on public health.

This chain of reasoning follows a logical sequence:

1. The best way to prevent international spread of diseases is to detect disease pathogens or other public health threats early, and contain them while they are still a national emergency.
2. Early detection of unusual disease events requires good national or sub-regional surveillance capacity.
3. International coordination is necessary since many countries may need assistance from multilateral institutions during serious disease events, and international trade, travel and tourism may be quickly affected, to the detriment of many States.
4. The need for international coordination presupposes the existence of an international coordinator (WHO) to help harmonize and standardize notifications, responses from other countries and the global sharing of epidemiological information.
5. Effective notification of disease risks to an international coordinator (WHO) would be facilitated by an assurance of how this information would affect the Member State's economic interests in trade, travel and tourism.

Building on the five-pronged dimensions of this chain of reasoning, the IHR as a legally binding mechanism for global surveillance of international disease events seek to strike a critical balance between protecting public health and minimizing interference with international trade and travel. It is not an easy task to maintain this delicate balance, and negotiations with trade bodies such as the World Trade Organization have, at times, been complex and time consuming. It is in this context that the difficulties of the IHR revision should be understood.

Proposed changes to the International Health Regulations

The IHR revision is a collaborative process. Its essence is to identify the gaps in the present IHR, and transform the Regulations into an effective tool that will allow WHO Member States to strengthen global disease surveillance and to respond pro-actively to a public health emergency of international concern. Although many of the core concepts proposed for the revision of the IHR are new, some of their elements already exist in the present IHR.

The IHR are being developed and fine-tuned to adapt to contemporary needs for surveillance for the control of public health emergencies of international concern. All of the core concepts listed below are proposals, and as such require extensive consultation before presentation to the World Health Assembly and ultimate decisions by Member States.

Definitions

Some of the terms used below are still incompletely defined and must be finalized before inclusion in the text of the Regulations. As in the existing Regulations, part of the revised text will include all relevant definitions.

For the central term, “public health emergency of international concern”, see item 1 below for the criteria defining this term.

Core concepts

The proposed core concepts in the revised IHR will cover ten main areas.

1. The reporting of all public health emergencies of international concern.

This concept would ensure that all public health events that could have international consequences are identified. The outbreaks or hazards notified to WHO will be assessed by WHO, in confidential collaboration with the affected Member State, to determine the actual risk of international spread. The Organization will offer assistance to help control the outbreak.

Rationale. In a world of emerging and re-emerging diseases, any disease list could become obsolete the day after it was printed. Also, an occurrence of a disease in itself does not always pose a danger of international spread. The disease must be coupled with circumstances, such as place, time, size of outbreak, closeness to an international border (or an airport), speed of spread and mode of transmission. There will still be specific diseases of concern, however, and the WHO headquarters and regional offices will at times list diseases of direct interest to Member States.

A key concept of the revised IHR – and one which would require a change in the way countries interact with WHO – is that *public health emergencies of international concern* would be notified to WHO. The revised IHR would contain an algorithm, or decision tree, as a tool to help determine when an event would be both a *public health emergency* and *of international concern*. Obtaining agreement on such an algorithm will be one of the main tasks of the IHR revision project team. The latest draft of the algorithm contains the following decision-points:

- Seriousness
- Unexpectedness
- Capacity for international spread
- International restrictions

Impact. The concept of the revised IHR would mean that countries need to assess public health emergencies in terms of their potential international consequences. The national administration would need to decide quickly, often in consultation with WHO, whether the emergency fulfils the WHO criteria, and if so, promptly notify WHO. Tools such as the algorithm will facilitate these decisions.

2. Each country would need a focal point for the IHR renewal process.

Rationale. Since the revised IHR will cover a much wider span of public health risks, and since these risks may appear very quickly, communication with WHO needs to be available “around the clock”. This will be required both for information sent by a country affected by a public health emergency, and for information sent by WHO about risks in other countries. Information from WHO may then have to be disseminated nationally to hospitals, health officials, ports, and airports very quickly.

Impact. Such communication, within the country and to WHO, would need to be electronic, and would require a back-up system within each Member State, so that one single e-mail address would always lead to someone who is available. In an emergency situation, a single contact point is vital to ensuring that a Member State can protect itself from or respond to the emergency. Emergency measures may need to be put in place within hours, which requires that national public health administrations, clinics, hospitals and ports of entry have the capacity to implement measures quickly in a coordinated manner.

3. Each country would need to have the capacity to quickly report and analyse national disease risks and to determine their potential to spread internationally and to affect other Member States.

Rationale. Rapid identification of urgent national risks that may be public health emergencies of international concern would require that each country have a national surveillance system that feeds data from the periphery to the central administration in a very short time. The system should be able to manage data about unusual or unexpected events as well as designated diseases. Further, the system should be able to analyse such data rapidly and facilitate quick decisions. The revised IHR will therefore define minimum core requirements for a national surveillance system.

Impact. Some countries already have satisfactory capacity for surveillance and analysis. In other countries, there may be a need for a grace period to fulfil the IHR requirements, and external assistance and funding may become necessary. One advantage of having an IHR template for core requirements would be that Member States could use this in defining their core surveillance needs when approaching external donors. Draft descriptions of appropriate capacity have been prepared by WHO and are being circulated for review to those Member States collaborating with the Secretariat on the IHR revision.

4. Member States would then have the option of making confidential, provisional notifications to WHO. This option is not available within the existing IHR, which automatically list notified cases of cholera, plague or yellow fever in the *Weekly epidemiological record* (WER).

Rationale. In the early days of an outbreak, it is often not clear if the criteria for a public health emergency of international concern are fulfilled. With this proposed

change, Member States would have the option to contact WHO on a provisional and confidential basis, with no information made public. The affected State would then work together with WHO to assess the extent and potential impact of the risk. This process could lead to a joint statement from the country and WHO, for example, either to inform other Member States that the threat was only national in scope, or to state that there is a possibility of international spread, but that only certain control measures need to be taken. In many instances, the threat will remain national, and no further international action would be required.

Provisional notification would end when there is an increased risk or evidence of international disease spread. At this time, and after continued direct consultation with the affected State, WHO would release the information necessary for the protection of other Member States. The present procedure for informing other States, which relies on publication of notified cases of cholera, plague and yellow fever in the *Weekly epidemiological record*, would therefore be superseded.

Impact. The affected Member State(s) would have the opportunity to reduce potential economic damage by gaining credibility through collaboration with WHO, and through application of the template (norms) of core measures for the protection of other States. Other countries can reduce the costs associated with overreaction. Any State which has not involved WHO in the assessment of a problem would not have the protection of recommendations (and credibility) from the Organization when news of the event becomes public, and would be open to possibly unwarranted restrictions from other countries.

5. Information other than official notifications would be used by WHO to help identify and control public health emergencies of international concern. There would be an obligation on Member States to respond to requests from the Organization to verify the reliability of such information.

Rationale. In the present era of rapid electronic communications, news about many emergencies of international concern becomes public before even the most efficient administration has had time to react and notify. Such news, even if unverified, may quickly lead to unwarranted restrictions on travel and trade from other countries that perceive the outbreak as a threat to their health security. WHO is an important collaborator in the early assessment of such public information through the Global Outbreak Alert and Response Network (GOARN). In situations where this information is apparently reliable, the Organization would contact the State(s) concerned and ask for verification of the risk status within a very short time.

Faced with non-notification of what appears to be an emergency of international concern, the Organization would need to inform other Member States for their protection, and if necessary, issue recommendations on appropriate measures to be taken.

Impact. The present IHR obligation on Member States to notify for three diseases would thus be extended to an obligation to notify and to respond to inquiries from WHO about any public health emergency of international concern, within a limited time frame. It can be foreseen that, in most instances, the affected country would work closely with WHO to protect itself from unnecessary trade and travel restrictions. When, under the revised IHR, a decision is made not to notify an event, the process used to arrive at this decision would be consistent and clear.

6. The revised IHR would attempt to offset the economic losses associated with public health emergencies of international concern by issuing recommendations that in effect establish a template (norms) for the measures required for the protection of other Member States.

These measures would be based on the actual public health threat or impact of the risk, as determined by assessing all of the evidence available at the time, in collaboration with the affected State. The measures would be tailored to the potential impact of the emergency of international concern, and would be applicable to the Member State suffering the emergency. When necessary, appropriate response measures for other Member States would be recommended.

Rationale. Any functioning global surveillance system must take into account the economic consequences of reporting public health emergencies. If the WHO notification and response system cannot help to reduce tourism and trade losses to those necessary from a public health perspective, Member States are likely to ignore the obligation to notify and report. This role is consistent with the clearly stated purpose of the IHR: “to ensure the maximum security against the international spread of diseases with a minimum interference with world traffic”.

Impact. WHO is seeking to maintain a dual-purpose regulation, protecting both health security and international trade and travel, and the revised IHR should likewise address both concerns. Besides working with Member States and regional offices, the revision consultation must include all WHO departments involved in goods, including those pertaining to food safety and the environment, as well as a wide range of external stakeholders which could be affected by public health emergencies of international concern.

7. There would be an obligation on WHO to rapidly assist Member States in assessing and controlling outbreaks.

Rationale. Both after a provisional notification (item 4) and after a request from WHO for further information (item 5), Member States may need external assistance. If the extent and potential threat of the outbreak are unclear, the Organization would offer support through the WHO operational response team, which would collaborate closely with the affected State to investigate the outbreak, control its spread and minimize related economic damage.

A key benefit of working with the WHO operational response team would be to assist affected countries to achieve international acceptance of their capacity to prevent international spread, through an independent and credible third-party evaluation. This verification process should help reduce unnecessary economic hardship for the affected country.

Impact. The capacity of WHO to react to and assist in outbreaks, especially when multiple outbreaks occur simultaneously, should be strengthened. The Global Outbreak Alert and Response Network, strengthened in December 2001, is helping in a key way to increase this capacity.

8. There would be a transparent process within WHO to issue recommendations.

Rationale. When there is imminent risk of international spread of disease or disruption of international travel and trade, WHO would issue recommendations for action by Member States. These recommendations could be directed at the affected country (containment and control measures), at other Member States, or at both.

Impact. This decision process would require efficiency, while at the same time building on a broad base of consensus. It would be important that these recommendations come from a single point within WHO.

9. The revised IHR would contain a non-exhaustive list of key measures that could be used in a WHO recommendation.

Rationale. Each emergency of international concern is unique, and there is no way to list or describe the measures appropriate for each emergency in advance. The proposed model is a compromise. The list of key measures that could be drawn upon to prevent international spread of disease – at embarkation, during travel, and at point of entry – is brief, and could be contained in the revised IHR.

Some examples of the draft measures currently under assessment for the ongoing revision process are shown below.

<p>Draft measures potentially applicable at point of entry into non-affected Member States from an affected Member State</p> <p>1. To travellers</p> <ul style="list-style-type: none"> – no measures required – require travel history in affected country – require proof of medical examination – require medical examination on entry – require proof of vaccination or other prophylaxis for entry – require vaccination or other prophylaxis for entry – require protective measures for suspected cases
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- require active or passive medical surveillance from travellers from affected area
- require isolation of traveller for incubation period of disease
- refuse entry of persons from affected area

2. To goods and conveyances

- no measures required
- require inspection of conveyance, cargo or goods
- require treatment of conveyance, cargo or goods
- require isolation of conveyance, cargo or goods
- require destruction of cargo or goods
- refuse entry of conveyance, cargo or goods

During an actual public health emergency of international concern, WHO and the concerned State(s) would choose the appropriate measures to be taken from the complete list, and use this as a basis for recommendations for use by Member States. These recommendations would be time-limited, and may need to be changed during the risk period. A clear protocol for ending recommended measures would be included in the IHR text.

Impact. The measures for disease response currently listed in the IHR are the maximum permitted, and they are binding on Member States. To create the flexibility required to adapt to each major international threat, “real-time” recommendations would provide the required template for action by Member States in the revised IHR.

10. A permanent IHR review body would need to be established to build continuity within the IHR process

Rationale. The existing IHR became out of date in part due to the lack of a mandatory review process. The revised IHR would have broad-based provisions, and would require on-going interpretation and precedent setting. For example, the similar network for reporting of urgent events between European Union Member States is backed by a committee that meets several times per year to clarify the application and scope of this obligation.

Impact. The Organization would need to ensure that work of the permanent review body is fully supported.

Benefits of the revised IHR to WHO Member States

The revised IHR recognize health as a global public good. As already stated, the traditional distinction often drawn between national and international public health has been eroded by the phenomenon of globalization.

Pathogens know no borders and national boundaries have become particularly vulnerable to diseases in a highly mobile, globalizing world. The only realistic way to reduce the international spread of infectious diseases is to develop an effective global surveillance system, which builds on sensitive national or sub-regional surveillance systems. The proposals for the revised IHR seek to do this within a multilateral framework, which emphasizes partnership and collaboration, at national and regional levels, to achieve surveillance and response capacity at the global level.

Within this multilateral framework, the revised IHR stand to benefit Member States by:

- improving national or sub-regional surveillance in many countries
- building on the current WHO system to detect and quickly respond to public health emergencies of international concern
- encouraging the use of modern communication tools
- recognizing that disturbances to international traffic constitute an obstacle to reporting and that mechanisms to counter this interference need to be developed
- developing a set of generic rules to evaluate and resolve different kinds of urgent events
- developing a rapid mechanism to agree on appropriate levels of national or sub-regional protection within this set of rules.

No isolated control strategy will work in the long run. The only certain way for countries to protect their populations from public health emergencies of international concern is to agree on global solutions that address a shared threat. These solutions can be made available to Member States by including them in the revised IHR.

Building consensus for the IHR

The IHR revision process strives to build broad consensus with WHO Member States. The current collaboration between the WHO Secretariat and interested Member States is designed to test the proposed changes and to seek suggestions on how Member States would like the revised IHR to operate.

The consensus-building process includes WHO country representatives in various Member States, and WHO regional offices as well as collaboration with international agencies and institutions whose work is related to the IHR. Examples of these organizations include the Food and Agriculture Organization of the United Nations (FAO), the International Air Transport Association (IATA), the International Civil Aviation Organization (ICAO), the World Trade Organization (WTO) and the International Maritime Organization (IMO). The requirements of the IHR will have an impact on many stakeholders, and these stakeholders need to be consulted during the revision process.

APPENDIX 1

Summary of proposed core obligations, capacities and operational requirements in the revised IHR

This summary is provided to illustrate what will be the global elements of the revised IHR. These elements will be captured in either the core (essentially unchanging) text, or in the technical annexes (operational requirements).

Core obligations

Definition. Those unchanging and essential public health needs that establish the framework for the Regulations.

Core obligations for Member States

- Notify WHO of public health emergencies of international concern.
- Respond to requests for verification of information regarding urgent national risks.
- Control urgent national public health risks that threaten to transmit disease to other Member States.
- Provide routine and emergent port of entry/embarkation inspection and control activities to prevent international disease transmission.
- Apply the measures recommended by WHO during public health emergencies.

Core obligations for international conveyance operators

- Maintain the conveyance in a manner that does not contribute to international disease transmission.
- Comply with the requirements of the Regulations, as directed and verified by Member States.

Core obligations for WHO

- Respond to the needs of Member States regarding the interpretation and implementation of the Regulations.
- Update the Regulations and supporting guides as required to maintain scientific and regulatory validity.
- Provide recommended measures for use by Member States during public health emergencies of international concern, based on a consistent process of risk verification and assessment.

Core capacities

Definition. The elemental level of activity needed to fulfil the core obligations.

Core capacities for Member States

- Provide a surveillance system to quickly identify and analyse public health emergencies and, if indicated, notify WHO.

- Provide control mechanisms that prevent the spread of disease to other Member States.
- Provide port of entry and related inspection and control activities for international travellers, conveyances, goods and cargoes.

Core capacities for international conveyance operators

- Provide on-board inspection and control measures to ensure that diseases are not carried by passengers, crews, goods, insect vectors or rodents, or by the conveyance itself.

Core capacities for WHO

- Provide a 24-hour service to coordinate international response to urgent public health emergencies that threaten Member States.
- In conjunction with the affected Member State(s), provide a consistent and transparent process to assess urgent international risks.
- Based on this assessment, issue recommendations regarding the application of selected health measures.
- Provide a collaborative notification and response process involving WHO country representatives, WHO regional offices and headquarters and health administrations of Member States, to assist Member States to deal with urgent international risks.
- Provide an assisted bilateral process and a Committee of Arbitration for disputes between Member States involving the interpretation of the IHR.

Operational requirements of the revised IHR

Definition. The detailed instructional models for carrying out activities.

It is the practice within WHO for departments to publish operational guidelines. These guides could be adopted for reference in the revised IHR after meeting an established review process. To be referenced in the IHR, a guideline would have to answer the following questions:

- Is it directly relevant to the application of the IHR as a global reference?
- Is it based on core requirements only?
- Has it completed a scientific review?
- Has it completed an operational review by Member States, operators, and other stakeholders?
- How will it maintain scientific validity?
- Will it be regularly reviewed and updated as required?

APPENDIX 2

The International Health Regulations revision process

Retrospective summary

May 1995	World Health Assembly passes Resolution 48.7 calling for the revision of the IHR.
December 1995	Meeting of international experts decides to pursue syndrome notification, to try and capture all important disease events.
1996-1997	Informal Working Group of internal and external experts established. The group recommends the use of disease syndromes and continuation of existing public health requirements in the 1969 version of IHR.
October 1997	Initiation of Syndrome Notification Pilot Study in 21 countries selected by WHO Regional Offices.
January 1998	Preliminary IHR draft distributed to Member States for review and comment.
May 1998	Progress report to the World Health Assembly.
November 1998	Meeting of the Committee on International Surveillance of Communicable Diseases (CISCD).
January 1999	Meeting of a small working group to analyse CISCD meeting and propose future changes.
March 1999	Syndrome Notification Pilot Study terminated.
August 1999	<ul style="list-style-type: none">– IHR revision project team strengthened.– New concepts elaborated and developed.– 21 meetings held with collaborating Member States.– Electronic virtual discussion forum initiated with participants from some 70 Member States.– Collaboration pursued with relevant international agencies: European Union (EU), International Atomic Energy Agency (IAEA), IATA, ICAO, IMO and WTO .– IHR policy paper discussed by WHO cabinet.– Synergy explored between IHR and WTO’s Sanitary and Phytosanitary Measures (SPS) agreement.
November 2000	Report by the Secretariat to the 107 th Session of the WHO Executive Board (EB) on “Global Health Security – epidemic alert and response” requesting the EB to support the continuing work on the revision of the International Health Regulations.
April 2001	Report by the Secretariat to the 54 th World Health Assembly (WHA) on “Global Health Security – epidemic alert and response” inviting the WHA to adopt resolution EB107.R13.

21 May 2001 Resolution 54.14 on “Global Health Security – epidemic alert and response” adopted by the 54th WHA, expressing its support for the ongoing IHR revision process and urging Member States to designate IHR focal points.

Update on progress and activities since WHA Resolution 54.14

Criteria to define *Public Health Emergencies of International Concern*. An Agreement for Performance of Work was established in May 2001 between WHO and the Swedish Institute for Infectious Disease Control (SMI) to undertake the technical work needed to define these criteria. An “expert meeting” was held at the end of January 2002 at which a long list of potential criteria was organized into the basis for a tool to use at national and international level.

This tool was presented to WHO at the end of March and will require testing in both international and national settings before being incorporated into the first, non-regulatory draft of the revised IHR. The principles and preliminary version of the tool were discussed with representatives of the G7 countries at a meeting in London on 13–14 March 2002 reviewing global preparedness for intentional use of biological agents.

Identification of Member State IHR focal points. An official communication was sent from the WHO Director-General’s Office, 28 January 2002, requesting all Member States to designate a national centre to act in the capacity of focal point for IHR activities. To date, 57 countries have responded from all 6 WHO regions.

The IHR team will:

- Contact countries that have not responded, requesting them to take action (where possible the WHO country office will also be requested to follow this up with the national authorities).
- Communicate with designated focal points to further clarify the process of the IHR revision project and the role of national centres and individual contact points.

Defining *Core Capacities in National Surveillance*. The IHR revision project held workshops during November and December 2001 to define what would be required of a national surveillance system in order to ensure a Member State’s ability to fully participate in the identification, notification and response to *public health emergencies of international concern*. The outputs from these meetings included:

- A short document entitled *Core Requirements in Public Health Surveillance for the Operation of the Revised International Health Regulations by WHO Member States*.
- A decision to engage a short-term professional to develop Guidelines on Early Warning Systems in Surveillance. (This document to be included in those referenced by the revised IHR along with the updated guidelines on ship and aviation hygiene and sanitation).

Early warning systems. Following the decision described above, a senior epidemiologist has joined the team to oversee the development of the guidelines.

Updating routine permanent measures. The IHR revision project is concerned with the updating of the existing measures relating to the carrying out of routine environmental provisions that reduce the spread of disease. These measures essentially apply at airports and ports. The first phase of the work with the 35 Member States collaborating with the WHO Secretariat is the review and validation of the existing IHR articles and provisions. Relevant teams in the WHO department for Protection of the Human Environment (PHE) are undertaking the revision of the WHO guidelines on ship and aviation sanitation, in close collaboration with the IHR team.

Ship sanitation. Following a meeting in Miami, Florida (USA) in October 2001, a draft revision of the WHO *Guide to ship sanitation* has been developed. A further meeting to discuss the final draft with stakeholders, supported by Health Canada, is scheduled for the 8–10 October 2002, in Vancouver.

Aviation hygiene and sanitation. A first meeting of key partners and stakeholders was held in Geneva in January 2002. The meeting considered a number of issues relevant to the revision of the IHR as well as initiating the revision of the WHO *Guide to hygiene and sanitation in aviation*. Follow-up meetings with ICAO and IATA were held in Montreal in March 2002. Working groups composed of Member State representatives, the aviation stakeholders and the WHO Secretariat will address the outstanding issues raised at the January meeting.

International travel medicine meetings. The IHR revision project has been invited to present its work at the following meetings which provide an opportunity for raising awareness of the purpose and vision for the revised Regulations amongst experts in travel medicine as well as being useful fora for furthering discussion of the travel related aspects of the Regulations.

- Saudi Arabia: International Conference on Travel Medicine, 13–15 April 2002.
- Italy: 3rd European Conference on Travel Medicine, 15–18 May 2002.
- China: 4th Asia Pacific Travel Health Conference, 21–23 October 2002.

WebBoard. A WebBoard (IHR/WB – an electronic conferencing system) has been developed to facilitate the revision process. The IHR/WB contains 22 conference headings covering key IHR revision topics, several of which have topic-specific documents attached to them. The IHR/WB will enable electronic access and feedback on IHR revision documents posted on the WB to Member States and other key stakeholders. It will be particularly useful during the revision rounds to post and obtain feedback on composite drafts as well as regulatory texts as they evolve.

International consensus building. It is crucial to the success of the IHR revision that, at the same time as technical experts are being consulted on the appropriate technical content, Member States are engaged in the revision process.

- **Andean States.** A two-day workshop involving 6 Andean Member States was held on 5–6 March 2002 to examine the feasibility of applying the revised IHR in the Andean sub-region and to develop a plan for the implementation of the revised IHR. Each of the Member States agreed to work on specific aspects of the IHR and report back in two months.
- **MERCOSUR (Southern Cone Common Market) Meeting.** IHR project revision staff from headquarters and staff from the Regional Office for the Americas (AMRO) attended a three-day workshop held in Montevideo in October 2001 on the subject of the IHR revision. The meeting was jointly organized by AMRO and MERCOSUR. The participating countries provided enthusiastic input to the IHR revision process, and will be an excellent sounding board for the proposed IHR changes, given the health/trade mandate of MERCOSUR.
- **Pacific public health surveillance network.** A five-day workshop to develop collaboration in outbreak surveillance and response in the Pacific sub-region was held on 4–8 March 2002 in Noumea, New Caledonia with the participation of IHR project revision staff. Considerable interest was shown in the IHR objective to minimize travel disruption associated with disease outbreaks and useful discussions took place on the issue of sub-regional, regional and global roles in responding to outbreak events.
- **Burkina Faso.** A consultant for the IHR revision project visited Burkina Faso on 24–30 November 2001. A programme of work to facilitate active participation of key national officials was developed, including a workshop with IHR revision project staff scheduled for the summer of 2002.
- **India.** Meetings were held on 14–15 June 2001 with several Indian health agencies regarding India's participation in the revision of the IHR. Further IHR revision project team input is planned to maintain the active engagement of this important regional leader.
- **Thailand.** IHR revision project team representatives briefed the new Thai team on the revision of the IHR on 10–12 June 2001. Thailand is expected to be a key collaborator in the revision process.
- **United Kingdom.** A meeting with Department of Health and other key stakeholders was held on 19 April 2002, preceded by discussions with IMO, International Shipping Federation and the UK Association of Port Health Authorities.

Continued engagement. Plans for continued engagement of WHO Member States and expert groups in the IHR revision project include:

- **Burkina Faso.** National IHR workshop planned for July 2002.
- **Morocco.** IHR revision project staff to visit at request of Member State in May 2002.

- **Senegal.** IHR revision project staff to visit at request of Member State to discuss country role in revision process in April/May 2002.
- **Slovenia.** One day of a meeting, from 19–23 June 2002, of 17 countries of central and eastern Europe and the Baltics will be devoted to IHR issues presented by IHR revision project staff.
- **South Africa.** IHR revision project staff to visit at request of Member State to discuss country role in revision process. South Africa has arranged a multi-department stakeholder group for this meeting.
- **Spain.** A combined Spanish government/World Tourism Organization mission is planned for May 2002.
- **South-East Asia countries.** Follow up visits to India and Thailand or an inter-country meeting are being explored with the WHO Regional Office for South-East Asia (SEARO).
- **WHO regional office meetings.** Consensus meetings in the 6 WHO regional offices are proposed for the end of 2002, at the time when the first, non-legally binding draft of the revised regulations will be sent to Member States for comment. As well as providing an opportunity clearly to explain the new strategy shaping the revised regulations, these meetings will allow Member States to interact among themselves on the IHR issues as well as with WHO.

APPENDIX 3
Contact addresses

Since the IHR revision process is still in the development stage, no revised draft IHR version currently exists. Information on the IHR revision can be obtained from the Secretariat at WHO headquarters in Geneva.

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