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INTERNATIONAL HEALTH SECURITY ROUNDTABLE

Implementing the International Health Regulations (IHR (2005))

Concepts and Approaches

1. The IHR (2005) is mainly based on the introduction of the concept of “public health emergency of international concern” (PHEIC) which is defined as “an extraordinary event which is determined to constitute a public health risk to other States through the international spread of disease and to potentially require a coordinated international response.” Consequently, events of potential international concern, which require States Parties to notify PAHO/WHO, can extend beyond communicable diseases and arise from any origin or source.

2. The IHR (2005) explicitly allow PAHO/WHO to take into account information from sources other than official notifications and consultations and, after assessment, to seek verification of specific events from the concerned States Parties. Notification to PAHO/WHO marks the beginning of a dialogue between the notifying State Party and PAHO/WHO on further event assessment, potential investigation and any appropriate local or global public health response.

Notification and other Reporting Requirements

3. The IHR (2005) describe key elements of the procedures to be followed by States Parties and PAHO/WHO in terms of information sharing with regard to notified events. Official event-related communications under the IHR (2005) are carried out between the National IHR Focal Point and the WHO IHR Contact Point at the Regional Office in Washington DC, both of whom are officially designated and required to be available on a 24 hour basis, 7 days a week. Guidance for the designation or establishment of National

IHR Focal Points, including terms of reference and an explanation of principal functions, is provided in the National IHR Focal Point Guide.

(<http://www.who.int/csr/ihr/nfp/en/index.html>)

4. The IHR (2005) specify three ways in which States Parties can initiate event-related communications with PAHO/WHO:

- **Notification** - The IHR (2005) move away from the automatic notification and publication by PAHO/WHO of cases of specific diseases to the notification to PAHO/WHO of all events that are assessed as possibly constituting a PHEIC, taking into account the context in which an event occurs. These notifications must occur within 24 hours of assessment by the country using the decision instrument provided in Annex 2 of the IHR (2005). This decision instrument identifies four criteria that States Parties must follow in their assessment of events within their territories and their decision as to whether an event is notifiable to WHO:
 - Is the public health impact of the event serious?
 - Is the event unusual or unexpected?
 - Is there a significant risk of international spread?
 - Is there a significant risk of international restriction(s) to travel and trade?
- **Consultation** - In cases where the State Party is unable to complete a definitive assessment with the decision instrument in Annex 2, States Parties have an explicit option of initiating confidential consultations with PAHO/WHO and seeking advice on evaluation, assessment and appropriate health measures to be taken.
- **Other Reports** - States Parties must inform PAHO/WHO through the National IHR Focal Point within 24 hours of receipt of evidence of a public health risk identified outside their territory that may cause international disease spread, as manifested by imported or exported human cases, vectors which carry infection or contamination, or by contaminated goods.

5. In addition to these three types of communications, States Parties are required under the IHR (2005) to respond to PAHO/WHO requests for verification concerning unofficial reports or communications, received from various sources. States Parties must acknowledge verification requests by PAHO/WHO within 24 hours and provide public health information on the status of the event, followed, in a timely manner, by continued communication of accurate and sufficiently detailed public health information available to the notifying State Party.

International Event Detection, Joint Assessment and Response

6. The IHR (2005) underpin PAHO/WHO's mandate to manage the international response to acute public health events and risks, including public health emergencies of international concern. They also recognize PAHO/WHO's general surveillance obligations, and set out specific procedures for concerned States Parties and PAHO/WHO to collaborate in the assessment and control of public health events and risks, even before such events have been officially notified to PAHO/WHO.

7. Information relating to public health risks notified or reported under the IHR (2005) to PAHO/WHO is jointly assessed with the affected State Party to ascertain the nature and extent of the risk, the potential for international disease spread and interference with travel and trade, and appropriate response and containment strategies.

PHEIC Determination and Temporary Recommendations

8. If immediate global action is needed to provide a public health response to prevent or control the international spread of disease, the IHR (2005) give the Director-General of WHO the authority to determine that the event constitutes a PHEIC. On such occasions, an IHR Emergency Committee will provide its views to the Director-General on temporary recommendations on the most appropriate and necessary public health measures to respond to the emergency.

9. In cases where the State Party concerned may not agree that a PHEIC is occurring, the Emergency Committee will also provide advice. The temporary recommendations issued by the Director-General are for affected and non-affected States Parties in order to prevent or reduce the international spread of disease and avoid unnecessary interference with international traffic.

National Surveillance and Response Capacities

10. Another fundamental innovation in the IHR (2005) is the obligation for all States Parties to develop, strengthen and maintain core public health capacities for surveillance and response. In order to be able to detect, assess, notify and report events and respond to public health risks and emergencies of international concern, States Parties must meet the requirements described in Annex 1A of the IHR (2005) which outlines these core capacities at the local (community), intermediate and national levels

11. The IHR (2005) require each State Party, with the support of PAHO/WHO, to meet the core surveillance and response capacity requirements "as soon as possible," but not later than five years after the date of entry into force for that country. First, up to 15 June 2009, States Parties must assess the ability of their existing national structures

and resources to meet the core surveillance and response capacity requirements. This assessment must lead to the development and implementation of national plans of action. As specified in the IHR (2005), PAHO/WHO will support these assessments and provide guidance on the national planning and implementation of these capacity strengthening plans.

12. States Parties have until 15 June 2012 for the national action plans to be implemented to ensure that core capacities are present and functioning throughout the country and/or its relevant territories. In exceptional circumstances, the Director-General of WHO may grant an individual State Party an extension to meet its obligations.

13. States Parties are required to collaborate actively with each other, together with PAHO/WHO, to mobilize the financial resources to facilitate the implementation of their obligations under the IHR (2005). Upon request, PAHO/WHO will assist developing countries in mobilizing financial resources and providing technical support needed to build, strengthen and maintain the required capacities provided for in the IHR (2005).

Public Health Security in International Travel and Transport

14. International points of entry, whether by land, sea or air, provide an opportunity to apply health measures to prevent international spread of disease. For this reason, many of the provisions addressing this aspect in the IHR (1969) have been updated in the IHR (2005). States Parties are required to designate the international airports and ports and any ground crossings which will develop specific capacities as access to appropriate medical services (with diagnostic facilities), services for the transport of ill persons, trained personnel to inspect ships, aircraft and other conveyances, maintenance of a healthy environment as well as ensuring plans and facilities to apply emergency measures such as quarantine.

New and Updated Health Documents

15. The IHR (2005) require immediate implementation of a range of new or revised health documents at points of entry. Countries need to move quickly to introduce these new health documents into their daily operations.

16. The Ship Sanitation Control Exemption Certificate/Ship Sanitation Control Certificate replaces the narrower in scope Deratting/Deratting Exemption Certificate as from 15 June 2007. A Deratting/Deratting Exemption Certificate issued before 15 June 2007 is valid for six months only, and, in any case will no longer be valid after 14 December 2007. (<http://www.who.int/csr/ihr/ssc/en/index.html>)

17. The Maritime Declaration of Health has been updated to reflect the broader scope of the IHR (2005) and currently accepted technical standards and terminology. (<http://www.who.int/csr/ihr/ssc/en/index.html><http://www.who.int/csr/ihr/travel/en/index.html>)

18. Yellow fever remains the only disease specifically designated under the IHR (2005) for which proof of vaccination or prophylaxis may be required for travelers as a condition of entry to a State. The international certificate has been revised as follows: as from 15 June 2007, the current “International certificate of vaccination or revaccination against yellow fever” is replaced by the “International certificate of vaccination or prophylaxis.” (<http://www.who.int/csr/ihr/icvp/en/index.html>)

19. The Health Part of the Aircraft General Declaration is a document of the International Civil Aviation Organization (ICAO), a United Nations agency. The document is periodically reviewed by ICAO Member States, and has historically, for practical purposes, been reproduced in the annexes of the IHR. Consequently, the recent amendments to this Declaration adopted by ICAO will be reproduced in future editions of the IHR (2005). (<http://www.who.int/csr/ihr/travel/en/index.html>).

Next Priorities for Member States to Implement IHR (2005)

Establish a National IHR Focal Point

20. The NFP is a national center accessible at all times (7/24/365) for IHR-related communications and collaborative risk assessment with WHO IHR Contact Points. Mandatory functions of the NFPs include: (1) sending to WHO IHR Contact Points urgent communications concerning IHR (2005) implementation; and (2) disseminating information to, and consolidating input from, relevant sectors of the administration within the country, including those responsible for surveillance and reporting, points of entry, public health services, clinics and hospitals.

21. All PAHO/WHO Member States have provided PAHO/WHO with NFP contact details. These contact details must be continuously updated and annually confirmed. While the vast majority of NFP communications will relate to communicable disease outbreaks, it is important to note that the broad scope of the IHR (2005) may require the NFP to carry out activities in respect of events arising from noncommunicable (or unknown) etiologies, such as chemical or radiological.

Ensure Adherence to Reporting Requirements and Verification of Public Health Events

Assessment and notification of public health events

22. Each State Party is required to assess public health events according to the multi-factor decision instrument provided in Annex 2 of the IHR (2005). States Parties must notify WHO of any event that meets at least two of the four decision criteria within 24 hours after having carried out the assessment. Notifications must always include or be followed by detailed public health information on the event, including where possible case definitions, laboratory results, source and type of the risk, number of cases and deaths, conditions affecting the spread of the disease and the health measures employed.

Assess and Strengthen National Capacities

Surveillance and response capacities

23. A fundamental innovation in the new legal public health framework is the mandatory obligation for all States Parties to develop, strengthen and maintain core public health capacities for surveillance and response, as soon as possible. It is urgent that States Parties initiate immediately an assessment of the ability of their existing national public health structures and resources to meet the core surveillance and response capacity requirements described in Annex 1A of the IHR (2005), following this assessment, develop national action plans (that can build on both national and relevant regional strategies) to ensure that these core capacities are present and functioning throughout the country.

Routine and emergency public health capacities at designated points of entry

24. A point of entry is a "passage for international entry or exit of travelers, baggage, cargo, containers, conveyances, goods and postal parcels, as well as agencies and areas providing services to them on entry or exit." Points of entry include international airports, ports and ground crossings. To minimize the risk of international spread of disease through transportation, travel and trade, States Parties must designate the international ports or airports which are required to strengthen their capacity to provide routine public health services at all times and supplementary emergency services to respond to public health emergencies of international concern. Additionally, where justified for public health reasons, States Parties may designate certain ground crossings that shall also develop these capacities.

25. It is important that such designation takes place promptly, so that the assessment of existing structures and the planning and implementation of capacity strengthening activities can be completed by 15 June 2012.

Legislative and administrative capacities

26. States may need to review and adjust their domestic legislation and administrative regulations in order to facilitate compliance with the provisions of the IHR (2005). In this context, States Parties to the IHR (2005) undertake to collaborate with each other in the formulation of proposed laws and other administrative and legal provisions for implementation purposes.

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