

3 Top priorities for States Parties to implement the IHR (2005)

1. Establish a functioning National IHR Focal Point

A functioning National IHR Focal Point (NFP) network is key to the successful implementation of the International Health Regulations (2005) or "IHR (2005)" by WHO and Member and non-Member States that have agreed to be bound by them ("States Parties"). The NFP is a national centre, established or designated by each State Party, 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 on entry, public health services, clinics and hospitals.

States Parties must provide WHO with NFP contact details. These contact details must be continuously updated and annually confirmed. In 2006, World Health Assembly resolution WHA59.2 urged Member States to immediately designate or establish such Focal Points prior to entry into force of the IHR (2005). To date, 179 States Parties (*number of countries on 15 August 2007*) have designated a NFP. WHO, in turn, has identified IHR Contact Points in each of its six Regional Offices.

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 non-communicable [or unknown] etiologies, such as chemical or radiological. Further information on the designation or establishment of NFPs, their functions and how they can meet their relevant obligations under the IHR (2005) is available in the [National IHR Focal Point Guide](#).

2. Ensure adherence to reporting requirements and verification of public health events.

Assessment and notification of public health events

Under the IHR (2005), notification is based upon the identification and assessment by the State Party of "events" within its territory "which may constitute a public health emergency of international concern" ("PHEIC"). 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 2 of the 4 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. WHO guidance on how and when to use the decision instrument in Annex 2 for the assessment and notification of events that may constitute a PHEIC will be made to States Parties shortly.

Other reporting requirements

Notification is one component of a collaborative process between States Parties and WHO that includes the detection and assessment of public health events and the response to public health risks and emergencies. Other components provided for in the IHR (2005) are:

- **Consultation:** For events not (yet) requiring formal notification to WHO, particularly when information is insufficient to complete the decision instrument at the time of initial assessment, States Parties may nevertheless consult WHO and seek advice on evaluation, assessment and appropriate health measures to be taken.
- **Other reports:** Through the National IHR Focal Point, States Parties must inform WHO 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, infected or contaminated vectors or contaminated goods.
- **Verification:** WHO has an express mandate to obtain verification from States Parties concerning unofficial reports or communications (e.g. the media) about events arising within their territories which may constitute a PHEIC; these reports are initially reviewed by WHO prior to the determination whether to seek verification. States Parties must acknowledge verification requests by WHO within 24 hours and provide public health information on the status of the event

3. Assess and strengthen national capacities

The IHR (2005) require each State Party to develop, strengthen and maintain core national public health capacities at the primary, intermediate and national levels in order to detect, assess, notify and report events and to respond promptly and effectively to public health risks and emergencies. Specific capacities are required for the implementation of health measures at international ports, airports and certain ground crossings designated by States Parties for this purpose. States Parties must also make legal and administrative adjustments to facilitate compliance with the IHR (2005).

Surveillance and response capacities

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. The IHR (2005) set out a two-phase process to assist States Parties to plan for the implementation of their capacity strengthening obligations:

Phase 1: 15 June 2007 - 15 June 2009

By 15 June 2009, States Parties must assess 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, States Parties are required to 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. WHO will support these assessments and provide guidance on the content and structure of national plans.

Phase 2: 15 June 2007 - 15 June 2012

By 15 June 2012, the surveillance and response capacities set out in Annex 1A are expected to be implemented by each State Party. States Parties that experience difficulties in implementing their national plans may request an additional 2-year period until 15 June 2014 to meet their Annex 1A obligations. In exceptional circumstances, the Director-General may grant an individual State Party a further two years until 15 June 2016 to meet their obligations.

WHO will provide guidance to support States Parties in their efforts to develop and implement these national capacity strengthening plans. Upon request, WHO will assist developing countries in mobilizing financial resources needed to build, strengthen and maintain the capacities provided for in Annex 1A.

Routine and emergency public health capacities at designated points of entry

A point of entry is a "passage for international entry or exit of travellers, 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.

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.

In collaboration with States Parties, WHO will regularly assesses and report to the World Health Assembly the progress with implementation of IHR (2005) Capacity requirements

Legislative and administrative capacities

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.