World Health Organization

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Information regarding the amendments to the International Health Regulations (2005), adopted through resolution WHA77.17 (2024), entered into force on 19 September 2025

The Director-General of the World Health Organization (WHO) presents his compliments to States Parties to the International Health Regulations (2005) ("IHR" or "Regulations") and has the honour to refer to resolution WHA77.17 (2024), adopting amendments to the IHR (hereinafter referred to as "2024 amendments").

Following Circular Letter 26.2025 regarding the entry into force of the 2024 amendments, this Circular Letter provides information regarding the implementation of certain of those amendments.

A. Consolidated text of the IHR

In accordance with operative paragraph 3.(3) of resolution WHA77.17 (2024), the WHO Director-General is pleased to inform States Parties that the consolidated text of the Regulations, as amended through resolutions WHA67.13 (2014), WHA75.12 (2022), and WHA77.17 (2024), is available, in the six official languages, on the WHO Governing Bodies web page, under "Other core documents of the Organization", at https://apps.who.int/gb/bd/.

Following completion of the correction procedure of errors identified in the IHR, undertaken in accordance with decision WHA78(24) (2025), updated versions of the consolidated text of the IHR in the Arabic, Chinese, French, Russian and Spanish languages will also be published on the above-mentioned webpage.

Consistent with WHO practice regarding minimization of printed documentation, the WHO Secretariat does not plan to publish the consolidated text of the IHR in printed form. However, digital versions of the consolidated text of the Regulations, in all six official languages, will be available on the WHO website for download.

B. Amended *Article 4 – Responsible authorities*

Pursuant to amended *Article 4 – Responsible authorities*, States Parties shall designate or establish the National IHR Authority (NIA), defined in amended *Article 1 – Definitions* as *"the entity designated or established by the State Party at the national level to coordinate the implementation of these Regulations within the jurisdiction of the State Party"*.

... ENCLS.: (4)

... In this regard, the WHO Director-General offers, in **Appendix 1**, some considerations – developed by the WHO Secretariat in accordance with resolution WHA77.17 (2024)[1] – to support States Parties in designating or establishing the NIA. A more elaborated WHO document – "Considerations regarding the designation or establishment of the National Authority for the International Health Regulations (2005)" (7 May 2025) – can be obtained by emailing the WHO Secretariat at ihradmin@who.int.

To support the NIA's function of coordinating the implementation of the Regulations, States Parties are invited to communicate the respective functions and working arrangements of the NIA and the National IHR Focal Point (NFP) to all relevant domestic entities with responsibilities vis-à-vis the implementation of the Regulations. The updated version of the WHO document "National IHR Focal Point Guide" (4 July 2006), will be shared with States Parties, including through a separate circular letter, in due course.

With reference to amended paragraph 4 of *Article 4 – Responsible authorities*, the WHO Director-General invites States Parties to submit, through an official written communication, the contact details of their NIA and their NFP to the WHO Secretariat (email: ihradmin@who.int),
... as outlined in **Appendix 2**, at their earliest convenience.

Upon receipt of the communication from a State Party providing the contact details for their NIA and NFP, the WHO Secretariat will provide the NIA with relevant guidance for updating the information in the secure WHO IHR Contacts online platform, currently being upgraded. In accordance with Article 4, the contact details of the NIA and the NFP will be made available to all States Parties through the secure online Event Information Site (EIS).

C. Amended provisions under *Part VI – Health documents* (Articles 35–39), and related Annexes

Part VI of the IHR sets out the health documents that States Parties may require for international traffic, save where modifications thereof, or additional health documents are introduced through temporary or standing recommendations issued by the WHO Director-General. Health documents encompass both **individual traveller-related** (Certificate of vaccination or other prophylaxis, in accordance with Article 36, Annex 6, and Annex 7), noting that, at present, States Parties may require proof only of vaccination against yellow fever and/or poliomyelitis; and **conveyance-related** (Ship Declaration of Health (Article 37 and Annex 8), Ship sanitation certificates (Article 39 and Annex 3), and the Health Part of the Aircraft General Declaration (Article 38 and Annex 9).

While new paragraphs 2 and 3 of amended *Article 35 – General rule* provide that health documents may be issued in non-digital format or digital format, and that, regardless of the format, their authenticity shall be ascertainable, its new paragraph 4 stipulates that *"WHO, in*

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[1] Operative paragraph 3.(3) of resolution WHA77.17 (2024) reads *"The Seventy-seventh World Health Assembly, […] 3. REQUESTS the Director-General: […] (3) to commence work, in advance of the entry into force of the amendments adopted through this resolution, on matters addressed in all amended Articles, […]".*

consultation with States Parties, shall develop and update, as necessary, technical guidance, including specifications or standards related to the issuance and ascertainment of authenticity of health documents, both in digital format and non-digital format." In accordance with the afore-mentioned paragraph, the WHO Secretariat plans to initiate the consultative process with States Parties during the first quarter of 2026 at the latest. It is anticipated that the consultation will focus on Certificates of vaccination or other prophylaxis, since the conveyance-related health documents mentioned above fall under international legal instruments governed by the International Civil Aviation Organization (ICAO) and the International Maritime Organization (IMO).

To avoid negatively impacting individuals' freedom of movement due to the format of the International Certificate of Vaccination or Prophylaxis (ICVP) they carry; recalling operative paragraph 2.(2) of resolution WHA77.17 (2024) – whereby amendments to the Model ICVP contained in Annex 6 of the IHR will only apply to certificates issued after 19 September 2025 –; mindful of the rejections of the 2024 amendments by some States Parties, as well as of others requiring until 19 September 2026 to complete relevant domestic arrangements; underscoring that the amendments to Annex 6, including the Model ICVP, primarily pertain to the issuance of the ICVP in digital format; and recognizing that the aforementioned consultative process will take several months to conclude, **the Director-General of WHO**, until the above-referenced consultative process is concluded, **invites States Parties** to consider: (i) **continuing issuing ICVPs** in non-digital format (i.e., **on paper**); and (ii) **accepting ICVPs** issued according to **either** the **amended or non-amended Model ICVP in Annex 6**, provided that the validity criteria in Annex 6 (and, where applicable, Annex 7), are met.

The WHO Secretariat does not plan to update and publish the WHO publication commonly known as "Yellow booklet", containing the Model ICVP. However, print-friendly and Microsoft Word versions of the amended Model ICVP, in English and French, are available upon request by emailing the WHO Secretariat at ihradmin@who.int.

To avoid negatively impacting vessels on an international voyage, as well as operations at ports, considering the rejection of the 2024 amendments by some States Parties, as well as the additional time (i.e., until 19 September 2026) needed by others to finalize relevant domestic legislative and administrative arrangements; and the fact that the amendments to the Model of Ship Declaration of Health (Annex 8) and Model Ship Sanitation Control Exemption Certificate/Ship Sanitation Control Certificate (Annex 3) did not concern their technical content or layout, **the Director-General of WHO**, after having consulted with IMO, **invites States Parties** to consider: (i) **informing** conveyances and their operators about the denomination of Annex 8 applying in its jurisdiction – Ship Declaration of Health or Maritime Declaration of Health; (ii) **issuing** Ship Sanitation Control Exemption/Control Certificates with footnote 1(b) as applicable to the State Party; and (iii) provided the validity criteria in Articles 36 and 39 and Annexes 3 and 8 are met, **accepting**, from the master, ship's surgeon, or conveyance operator, either the Ship Declaration of Health or the Maritime Declaration of Health; and either the Ship Sanitation Control Exemption Certificate or the Ship Sanitation Control Certificate, regardless of footnote 1(b) borne.

D. Amendments to *Annex 2 – Decision instrument for the assessment and notification of events that may constitute a public health emergency of international concern* (Annex 2)

Regarding the amendment to the top left box of Annex 2 – enumerating the diseases that, because they are unusual or unexpected and may have serious public health impact, States Parties shall notify to WHO –, the WHO Director-General hereby informs States Parties that, in accordance with footnote 1 of Annex 2, the case definition for "Poliomyelitis due to
... polioviruses" was developed and is presented in **Appendix 3**, together with the revised case definitions for "Smallpox", "Human influenza caused by a new subtype", and "Severe acute respiratory syndrome (SARS)". These case definitions supersede those contained in the WHO document "Case definitions for the four diseases requiring notification to WHO in all circumstances under the IHR (2005)" (17 November 2009), that will be updated and published on the secure online EIS and WHO website accordingly.

E. IHR Roster of Experts and composition of Emergency Committees

Pursuant to *Article 47 – Composition [of the IHR Roster of Experts]*, each State Party may request the WHO Director-General to appoint to the IHR Roster of Experts one expert designated by the State Party (a "State Party-designated expert").

In light of the clarification introduced by amended paragraph 2 of *Article 48 – Terms of reference and composition [of the Emergency Committee]* – which specifies that *"Members of the Emergency Committee should include at least one expert nominated by State(s) Party(ies) within whose territory the event is occurring"* –, the WHO Director-General invites all States Parties to confirm or designate, at their earliest convenience, their respective expert. Such communication should include the expert's full name, current affiliation, qualifications, fields of expertise, and contact details, and be sent by email to: ihradmin@who.int.

In accordance with Article 47, the WHO Director-General hereby informs
States Parties of the composition of the IHR Roster of Experts, as of 10 September 2025, as set
... out in **Appendix 4**.

F. Risk assessment related to "public health emergency of international concern" and "pandemic emergency"

Under the new definition in *Article 1 – Definitions*, a pandemic emergency is a PHEIC meeting the additional criteria set out therein. While the determination of a pandemic emergency constitutes the highest level of global public health alert that the WHO Director-General may convey to States Parties, under Article 1, the definition of pandemic emergency is provided *"for the purposes of the International Health Regulations…"*. As such, it presupposes that finely technical considerations – whether microbiological (e.g., the emergence of a novel or unknown pathogen, or a known pathogen with novel characteristics), epidemiological (e.g., new or modified modes of transmission, or the degree of susceptibility of the global population), or clinical (e.g., morbidity and mortality) – are provided for in the dynamic, iterative, and

event-specific risk assessments undertaken by the WHO Secretariat in accordance with Articles 5, 12, 13, and 17.

With reference to the above-mentioned risk assessments and operative paragraph 3.(7) of resolution WHA77.17 (2024), the WHO Director-General hereby informs States Parties that, by the end of 2025, the WHO Secretariat plans to initiate the consultative process *"to develop, and regularly review in consultation with Member States, the risk assessment approach to inform the determination of public health emergencies of international concern, including pandemic emergencies."*

G. Reporting by States Parties to the Health Assembly on the implementation of the IHR and amended *Annex 1 – Core capacities*

Pursuant to *Article 54 – Reporting and review*, and in accordance with resolution WHA61.2 (2008) and decision WHA71(15) (2018), States Parties have been using the "States Parties Self-assessment annual reporting tool" (SPAR tool, available at https://www.who.int/publications/i/item/9789240040120) to submit their report to the Health Assembly. The current SPAR tool primarily focuses on core capacities, detailed in amended Annex 1.

The WHO Director-General hereby informs States Parties that the WHO Secretariat will be inviting States Parties to use the current SPAR tool to submit their annual report to the Seventy-ninth World Health Assembly (2026).

The reasons underpinning the above include the rejection of the 2024 amendments by some States Parties, as well as the additional time (i.e., until 19 September 2026) needed by others to finalize legal and administrative arrangements to be able to implement those amendments; the fact that the amendments to Annex 1 reflect an attempt to close the gap between the text of the Regulations and the current SPAR tool; and the need to thoroughly and exhaustively revise the SPAR tool, drawing from the initial phases of the implementation of the 2024 amendments and with a view to expand its scope beyond Annex 1. The WHO Secretariat will make available to States Parties a revised version of the SPAR tool for the submission of their annual report to the Eightieth World Health Assembly (2027).

The Director-General of the World Health Organization takes this opportunity to renew to States Parties to the International Health Regulations (2005) the assurance of his highest consideration.

GENEVA, 17 November 2025

Appendix 1

Considerations for the designation or establishment of the National Authority for the International Health Regulations (2005) (NIA)

Amended *Article 4 – Responsible authorities*

The amendments to the International Health Regulations (2005) (IHR or Regulations) adopted through resolution WHA77.17 (2024) ("2024 amendments") comprise those to *Article 4 – Responsible authorities*, and, under *Article 1 – Definitions,* the related addition of the definition of "National IHR Authority".

In accordance with amended Article 4, authorities responsible for the implementation of the IHR in the jurisdiction of a State Party are:

- the National IHR Authority (NIA) – defined in Article 1 as "*the entity designated or established by the State Party at the national level to coordinate the implementation of these Regulations within the jurisdiction of the State Party"*. The NIA's function is to "coordinate the implementation" of the Regulations within the jurisdiction of the State Party, in accordance with new paragraph 1 bis of amended Article 4.

- the National IHR Focal Point (NFP) – defined in Article 1 as *"the national centre, designated by each State Party, which shall be accessible at all times for communications with WHO IHR Contact Points under these Regulations"*. The functions of the NFP are mandated in paragraph 2 of amended Article 4, and they pertain to public health risk- and event-related communication (Articles 6 to 12 under Part II – Information and public health response; Article 22.1.(i); and Article 27.1).

- *"authorities responsible* […] *for the implementation of health measures under these Regulations"* – corresponding to the definition of *"competent authority"* under Article 1, whose functions are referred to in paragraph 1 of amended Article 4, and are further detailed in Article 22 as far as points of entry are concerned. Articles 19, 25, 27, 28, 30, 34–39, as well as Annexes 4–8 further define the role of the competent authorities.

In amended Article 4, paragraph 1 sets forth the obligation for States Parties to designate or establish the NIA, with the possibility that one institutional entity may serve as both, NIA and NFP; paragraph 1 bis mandates the function of the NIA (*"coordinate the implementation of these Regulations"*); paragraph 2 bis refers to the possibility of *"adjusting their domestic legislative and/or administrative arrangements"*; and amended paragraph 4 sets forth the procedure related to the communication to WHO, annual update, and publication of the contact details of the NIA.

The introduction of the NIA in the Regulations responds to the implementation and institutional challenges underscored by several IHR Review Committees.[1]

Notwithstanding the critical importance of sustained political support for the continuous implementation of the IHR, the institutional positioning of the NIA shall be determined by each State Party according to its national law and context.

Functions of the NIA

Amended Article 4.1 bis defines the function of the NIA as to "coordinate the implementation of these Regulations within the jurisdiction of the State Party". While it is the prerogative of States Parties to interpret the IHR, the following activities might be regarded as falling within the scope of the coordinating role to be played by NIAs:

- Policy oversight and advice – Review and advise on national policies, plans, programmes, and budget allocations relevant to the implementation of the IHR.

- Inter-ministerial and inter-sectoral convening – Align relevant aspects of the work of ministries, agencies, and other governmental entities with IHR-related responsibilities (sectors may include health, transport, agriculture, environment, foreign affairs, etc.).

- International liaison – Serve as the national authority communicating, on behalf of the State Party, with WHO on matters pertaining to the IHR – beyond public health risk- or event-related communication of NFP's pertinence – as well as with NIAs of other States Parties, including on policy and governance matters.

- Operational arrangements – Establish and maintain procedures for interacting with the NFP, competent authorities, other relevant governmental entities, including decision-makers.

Furthermore, States Parties may wish to consider whether NIAs may be involved with respect to the implementation of the following provisions, for which the IHR do not assign any role to the NFP and/or the competent authorities: paragraph 4 of Article 4 (*"4.* […] *The*[se] [NIA and NFP] *contact details shall be continuously updated and annually confirmed* […]*"*); paragraph 1 of *Article 54 – Reporting and review* (*"1. States Parties and the Director-General shall report to the Health Assembly on the implementation of these Regulations as decided by the Health Assembly"*); Articles 5, 12, 13, 17, 19–21, 35, 36, 40, 41, 43–49, 51–59, and 61–66; as well as Articles 6–11, 15, 16, 22–28, 30–34, 37–39, and 42.

[1] Report of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009 (Document A64/10 (2011)). Through resolution WHA64.1 the Health Assembly urged Member States to support the implementation of the recommendations formulated by the Committee; Report of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation (Document EB136/22 Add.1 (2015)). The recommendations formulated by this Review Committee were adopted through resolution WHA68.5 (2015); Report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response (Document A69/21 (2016)); Report of the Review Committee on the Functioning of the International Health Regulations (2005) during the COVID-19 Response (Document A74/9 Add.1 (2021)).

Designation or establishment of the NIA

Amended Article 4.1 mandates each State Party to **designate** (assigning functions to an existing institutional entity) or **establish** (creating a new institutional entity) *"**one or two entities** to serve as National IHR Authority and National IHR Focal Point"*, which is expected to:

- Be an institutional entity, not an individual.
- Be explicitly recognized through a legal and/or administrative instrument(s). New paragraph 2 bis of amended Article 4 recognizes that this may take time, since such instrument(s) is/are foundational to the functioning of the NIA, as well as of the NFP.
- Be fully empowered to discharge its functions with sufficient staffing, budget, and technical resources.

In considering whether to designate or establish the NIA within the same institutional entity as the NFP, States Parties are invited to give consideration to both the integrity of the functions set forth in the IHR and the anticipated operational effectiveness and efficiency in their implementation.

In addressing the institutional positioning of the NIA, States Parties are invited to consider taking into account, inter alia and as deemed appropriate, the following: ensuring high-level authority, ability to contribute to relevant national policies, capacity to mobilize inter-sectoral action, capacity to engage directly with WHO and other States Parties; and access to direct channels of communication with the highest echelons of national governance.

Given the diversity of States Parties' legal and administrative systems, a non-exhaustive list of examples regarding the possible institutional positioning of the NIA is provided below for States Parties' consideration, as deemed appropriate:

- Entity responsible for the relations with the Ministry of Health within the Office of the Head of State;
- Entity responsible for the relations with the Ministry of Health within the Office of the Head of Government;
- Office of the Minister of Health, or equivalent;
- Office of the Deputy Minister of Health, or equivalent;
- Office of the Permanent Secretary for Health, or equivalent;
- Office of the Director-General of Public Health, or equivalent;
- Department of International Relations of the Ministry of Health, or equivalent;
- Office responsible for Health in the Ministry of Foreign Affairs, or equivalent;
- Secretariat of permanent multisectoral national body responsible for preparedness for and response to public health events/health emergencies – as defined in the national legislation.

Communication to WHO of the NIA's contact details and their annual update

Amended paragraph 4 of Article 4 sets forth the procedure related to the communication to WHO, annual update, and publication of the contact details of the NIA.

- Communication of the NIA's contact details to WHO – As indicated in the circular letter and Appendix 1, States Parties are invited to transmit to WHO (email: ihradmin@who.int), at their earliest convenience, the contact details of the NIA and the NFP, through the relevant line ministry (or equivalent) and through an official written communication. States Parties may wish to share this written communication with appropriate entities, including, if present, their Permanent Mission in Geneva, as well as relevant national ministries (or equivalent) and their respective WHO Regional and, if applicable, WHO Country Office. Appendix 2 to this circular letter further elaborates on the desired details to be provided by States Parties.

- Continuous updating of contact details – Following the initial communication, for subsequent annual updates and when necessary, the WHO Secretariat will provide States Parties with relevant guidance to directly enter and update the NIA's contact details in the secure WHO IHR Contacts online platform.

- Publication of contact details by WHO – The WHO Secretariat will make available to all States Parties the contact details of NIAs through the secure online Event Information Site (EIS).

The WHO Secretariat will be approaching individually States Parties that, at the time of the writing, do not have the obligation to establish or designate a NIA, either due to their rejection of the 2022 and 2024 amendments, or their need for an additional 12 months to be able to implement the 2024 amendments pursuant to paragraph 3 of *Article 59 – Entry into force; period for rejection or reservations*.

Appendix 2

Communication to WHO of the contact details of the National IHR Authority (NIA) and the National IHR Focal Point (NFP)

As indicated in the circular letter and Appendix 1, States Parties are invited to transmit to WHO (email: ihradmin@who.int), at their earliest convenience, the contact details of the NIA and the NFP, through the relevant line ministry (or equivalent) and through an official written communication. States Parties may wish to copy this written communication to appropriate entities, including, if present, their Permanent Mission in Geneva, as well as relevant national ministries (or equivalent) and their respective WHO Regional and, if applicable, WHO Country Office.

- **Name of the State Party**
- **Indications about whether:**
  - The entity discharging the NIA functions is an existing entity or a newly created entity
  - The entity discharging the NIA functions is also discharging the NFP functions
- **National IHR Authority (NIA)**
  - Name of the Institution
  - Name of the Directorate and/or Department and/or Office and/or Team within the Institution
  - Central executive authority or line ministry
  - Physical address
  - Primary email address
  - Additional email addresses (up to two email addresses)
  - Mobile number(s) (up to three numbers, inclusive of international code)
  - Landline telephone number (if applicable; up to three numbers, inclusive of international code)
  - Any observation or information deemed useful to facilitate the communication between the NIA and WHO (e.g., charge and/or name of the government official responsible for the NIA; working hours or the NIA; etc.)
- **National IHR Focal Point (NFP)**
  - Name of the Institution
  - Name of the Directorate and/or Department and/or Office and/or Team within the Institution
  - Central executive authority or line ministry
  - Physical address

- Primary email address
- Additional email addresses (up to two email addresses)
- 24/7 Mobile number(s) (up to three numbers, inclusive of international code)
- Landline telephone number (if applicable; up to three numbers, inclusive of international code)
- Any observation or information deemed useful to facilitate the communication between the NFP and the WHO IHR Contact Point hosted by the relevant WHO Regional Office

Appendix 3

Case definitions for the four diseases requiring notification under the International Health Regulations (2005) (IHR)

The case definitions presented in this appendix supersede those contained in the WHO document *Case definitions for the four diseases requiring notification to WHO in all circumstances under the IHR (2005)*, 17 November 2009.

This appendix was developed in accordance to footnote 1 ("[1] As per WHO case definitions") of Annex 2 of the IHR, following the entry into force, on 19 September 2025, of the amendments to the IHR adopted through resolution WHA77.17 (2024), including the following change to the top-left box of Annex 2 – from "poliomyelitis due to wild-type poliovirus" to "Poliomyelitis due to polioviruses" –, and considering the evolution of the epidemiological landscape and laboratory technology developments since 2009.

States Parties to the IHR, pursuant to *Article 6 – Notification* and the top-left box of Annex 2, shall notify to WHO any case of the following diseases: Smallpox; Poliomyelitis due to polioviruses; Human influenza caused by a new subtype; and Severe acute respiratory syndrome (SARS).

All hyperlinks included in this appendix were accessed on 20 October 2025.

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Smallpox

[ICD-11 code – 1E70]

For notification under the International Health Regulations (2005) (IHR), a case of smallpox is defined as:

1. An individual of any age presenting with acute onset of fever (≥38.3°C/101°F), malaise, and severe prostration with headache and backache occurring 2 to 4 days before rash onset

AND

2. Subsequent development of a maculopapular rash starting on the face and forearms, then spreading to the trunk and legs, and evolving within 48 hours to deep-seated, firm/hard and round well-circumscribed vesicles and later pustules, which may become umbilicated or confluent

AND

3. Lesions that appear in the same stage of development (i.e. all are vesicles or all are pustules) on any given part of the body (e.g. the face or arm)

AND

4. Laboratory confirmation.

Note

Smallpox is caused by the variola virus (*Orthopoxvirus variola, Orthopoxvirus* genus, *Poxviridae* family). Most smallpox cases present with a characteristic rash that evolves slowly over days (with each stage lasting 1–2 days) at the same rate and is centrifugal in distribution, i.e., predominantly concentrated on face and extremities with usual involvement of the palms and soles of the feet. While asymptomatic variola virus infection is unlikely, such an occurrence has been documented.

While smallpox has been eradicated, mpox is an emerging disease caused by the monkeypox virus (*Orthopoxvirus monkeypox, Orthopoxvirus* genus, *Poxviridae* family*)* which presents with systemic symptoms and an evolving rash which can be identical to that of smallpox and which can also appear on palms of the hands and soles of the feet. Unlike smallpox, mpox is often also characterized by lymphadenopathy. The differential diagnosis for smallpox also includes *Varicella-zoster virus* infection (causing, inter alia, chickenpox) characterized by centripetal and more superficial lesions. More information on clinical diagnosis of smallpox and mpox can be found at:

https://www.who.int/publications/m/item/smallpox-clinical-diagnosis,
https://www.who.int/publications/m/item/who-smallpox-recognition-card, and
https://www.who.int/health-topics/mpox.

The case definition for the notification of a case of smallpox is based on laboratory confirmation due to the low likelihood of re-emergence of smallpox and the high likelihood of missing a case due to the widespread occurrence of mpox. The WHO interim guidance for diagnostic testing and testing strategies for mpox is available at: at https://www.who.int/publications/i/item/B09166.

In individuals matching the above clinical presentation, laboratory testing for smallpox should be considered in the absence of confirmation of other orthopoxvirus infections and/or in relation to specific unusual and/or unexpected circumstances.

In the absence of symptoms, the decision to perform laboratory testing for smallpox must be based on the context (e.g., laboratory exposure; household contacts of a case). When laboratory testing for smallpox is considered, WHO shall be immediately contacted.

Additionally, in accordance with recommendations 7. and 8. of the Global Commission on the policy for the post-eradication era, endorsed by the Thirty-third World Health Assembly through resolution WHA33.4 “Global smallpox eradication”, 1980, “Recommendation 7. […] rumours of suspected smallpox, […] should be thoroughly investigated. Information should be provided to WHO, if requested, so that it can be made available to the world community. Recommendation 8. WHO should maintain an effective system to coordinate and participate in the investigation of suspected smallpox cases throughout the world. […]”.

Poliomyelitis due to polioviruses

For notification under the International Health Regulations (2005) (IHR), a case of poliomyelitis due to polioviruses is defined as:

1. Poliomyelitis due to wild-type poliovirus

[ICD-11 codes – wild poliovirus type 1: 1C81 and XN6KZ; wild poliovirus type 2: 1C81 and XN9CF; wild poliovirus type 3: 1C81 and XN97R]

A case of poliomyelitis due to wild-type poliovirus is defined as a suspected case* with isolation of wild poliovirus in stool specimens[1] collected from the suspected case or from a close contact of the suspected case.

2. Poliomyelitis due to vaccine-derived poliovirus**

[ICD-11 codes – vaccine-derived poliovirus type 1: 1C81 and XN2T1; vaccine-derived poliovirus type 2: 1C81 and XN1XN; vaccine-derived poliovirus type 3: 1C81 and XN7UU]

A case of poliomyelitis due to vaccine-derived poliovirus is defined as a suspected case* with isolation of vaccine-derived poliovirus in stool specimens[1] collected from the suspected case or from a close contact of the suspected case.

* A suspected case is defined as a child under 15 years of age presenting with AFP[2], or as any person at any age with paralytic illness if poliomyelitis is suspected.

**VDPV can only be confirmed through laboratory testing of stool specimens[1] of a suspected case, using sequencing of viral protein 1 (VP1) gene of poliovirus genome. A poliovirus is considered as VDPV if they have following degree of divergence from vaccine prototype strain (Sabin 1, Sabin 2/novel OPV2, Sabin 3) (as per the current definition by the Global Polio Eradication Initiative (GPEI)):

(a) VDPV1 and VDPV3: $\geq$ 10 nucleotide changes from Sabin ($\geq$1%)

(b) VDPV2: $\geq$ 6 nucleotide changes from Sabin ($\geq$ 0.6%)

[1] As a standard procedure, two stool specimens are collected from an AFP case within 14 days of paralysis onset. Since polioviruses excretion in the stool decreases beyond two weeks after paralysis onset, and to increase the sensitivity of polioviruses detection, additional stool specimens from up to five close contacts are taken from AFP cases for whom two specimens collected within 14 days of paralysis onset are not available.

[2] Poliomyelitis cannot be diagnosed reliably on clinical grounds because other conditions presenting with acute paralysis can mimic poliomyelitis. Surveillance for polio eradication therefore requires the reporting of all children < 15 years with acute onset flaccid paralysis, with subsequent laboratory testing of stool specimens. Geneva: World Health Organization; 2024; available at https://iris.who.int/bitstream/handle/10665/376603/9789240089662-eng.pdf.

Note concerning the notification of wild-type or vaccine-derived poliovirus from sources other than AFP cases

Given the critical importance of high-quality surveillance in the context of eradication efforts, the GPEI implements targeted surveillance strategies to complement AFP surveillance in a systematic and strategic manner.

In addition to the notification of cases of poliomyelitis due to wild-type poliovirus and vaccine-derived poliovirus, as defined under the headings 1. and 2. respectively, the following events shall also be notified to WHO, as they fulfil at least the following two criteria in the decision instrument contained in Annex 2 of the IHR: "serious public health impact" and "unusual or unexpected":

- The isolation of wild-type or vaccine-derived poliovirus*** from any source, including human (from persons without paralysis) or non-human (from environmental/wastewater samples);
- The isolation of type 2 Sabin and Sabin-like viruses from any source, including human or non-human, in the context of the global cessation of the use of oral poliovirus vaccine type 2" (OPV2).

***VDPV can only be confirmed through laboratory testing, using sequencing of viral protein 1 (VP1) gene of poliovirus genome. A poliovirus is considered as VDPV if they have following degree of divergence from vaccine prototype strain (Sabin 1, Sabin 2/novel OPV2, Sabin 3) (as per the current definition by GPEI):

- VDPV1 and VDPV3: ≥ 10 nucleotide changes from Sabin (≥1%)
- VDPV2: ≥ 6 nucleotide changes from Sabin (≥ 0.6%)

Human influenza caused by a new subtype

[ICD-11 code – 1E31]

For notification under the International Health Regulations (2005) (IHR), a case of human influenza caused by a new subtype[1] is defined as:

A ***laboratory confirmed detection***[2] of an ***influenza A virus with the potential to cause a pandemic emergency***[3] in a specimen collected from a human. Evidence of illness is not required for the purpose of notification.

An ***influenza A virus*** is considered to ***have the potential to cause a pandemic emergency*** if it has demonstrated the ability to infect[2] a human and its haemagglutinin (HA) gene or protein is not from a seasonal influenza A virus currently circulating among humans.[4]

A detection is considered ***laboratory confirmed*** if it has been confirmed by positive results from molecular-based laboratory assays (e.g., polymerase chain reaction (PCR), sequencing), virus isolation, or paired acute and convalescent serologic tests.[5] An antibody titre in a single serum without meeting other epidemiologic or laboratory criteria is insufficient to confirm a recent infection, and should be assessed by reference to valid WHO case definitions for human infections with specific influenza A virus subtypes.[6]

Notes

[1] For the purposes of this case definition and notification under the IHR, a "**new influenza A virus subtype"** shall refer to influenza A viruses with the potential to cause an influenza-related pandemic emergency. It shall include, but is not limited to, viruses of subtypes such as A(H5N1), A(H9N2), and other new influenza A subtypes, regardless of whether a human infection with an influenza A virus of the same subtype has previously been detected by the State Party. See also footnote.[4]

[2] Confirmation of infection with an influenza A virus, as opposed to transient contamination of the nasopharynx or oropharynx following exposure to infected animals or contaminated environment, may not always be straightforward. Therefore, any laboratory confirmed detection of an influenza A virus with the potential to cause a pandemic emergency in a specimen collected from a human shall be notified.

[3] The potential to cause a "pandemic emergency", as defined in Article 1 – Definitions of the IHR, is determined by WHO pursuant to paragraph 4 of Article 5 – Surveillance of the Regulations.

[4] This shall include all subtypes of influenza A viruses that differ from the H1 and H3 subtypes currently circulating as seasonal influenza A viruses in humans; H1 or H3 viruses that originate from a non-human species; and H1 or H3 seasonal viruses containing at least one gene segment from an animal influenza A virus resulting from reassortment.

[5] Detections obtained through rapid antigen tests (RDTs) shall be confirmed by at least one of the diagnostic methods specified in the case definition above. Such confirmation shall be conducted by a WHO-recognized National Influenza Centre, a WHO H5 Reference Laboratory, a WHO Collaborating Centre on influenza, or a nationally authorized laboratory whose quality is assured through the Global Influenza Surveillance and Response System, prior to notification to WHO.

[6] Such case definitions are being developed or updated as required to meet emerging needs. As of 20 October 2025, WHO has published the following guidance: For avian influenza A(H5N1): WHO case definition for human infections with avian influenza A(H5) virus requiring notification under IHR (2005) (November 2024); For avian influenza A(H7N9): Interim WHO surveillance recommendations for human infection with avian influenza A(H7N9) virus (May 2013).

Severe Acute Respiratory Syndrome (SARS)

[ICD-11 code – 1D65]

For notification under the International Health Regulations (2005) (IHR or Regulations), a case of SARS is defined as an individual:

(i) Presenting with the following clinical signs and symptoms:

1. A history of fever, or documented fever

and

2. One or more symptoms of lower respiratory tract illness (cough, difficulty breathing, shortness of breath)

and

3. Radiographic evidence of lung infiltrates consistent with pneumonia or acute respiratory distress syndrome (ARDS) or autopsy findings consistent with the pathology of pneumonia or ARDS without an identifiable cause

and

4. No alternative diagnosis can fully explain the illness.

OR

(ii) Working in a laboratory handling live SARS-CoV-1 or storing specimens containing SARS-CoV-1.

AND

(iii) Laboratory confirmation of SARS-CoV-1 infection through:

(a) Conventional reverse transcriptase polymerase chain reaction (RT-PCR) and real-time reverse transcriptase PCR (real-time RT-PCR) assay detecting viral RNA present in:

1. At least two different clinical specimens (e.g. nasopharyngeal and stool)

or

2. The same clinical specimen collected on two or more occasions during the course of the illness (e.g. sequential nasopharyngeal aspirates)

or

3. In a new extract from the original clinical sample tested positive by two different assays or repeat RT-PCR/real-time RT-PCR on each occasion of testing

OR

(b) Sequencing that confirms SARS-CoV-1 strain.

Note

In the absence of known SARS-CoV-1 transmission to humans, the positive predictive value of a SARS-CoV-1 diagnostic test is extremely low; therefore, the diagnosis should be independently verified in one or more of the reference laboratories of the WHO Coronavirus Network (CoViNet) with experience with SARS-CoV-1.

A detailed exposure history is an essential part of the diagnostic workup for any person under investigation for SARS. More information on SARS surveillance can be found at: https://www.who.int/publications/i/item/WHO-CDS-CSR-ARO-2004.1. Infections with SARS-CoV-1 that occur as a result of breaches in laboratory biosafety/biosecurity should be fully investigated.

In addition to the notification of cases of SARS, the following events involving known, novel or re-emerging coronaviruses shall also be notified to WHO and assessed following the path of the “middle box” in the decision instrument contained in Annex 2:

- The event is caused by a novel coronavirus; or

- The event is caused by a new or re-emerging variant of a known coronavirus which exhibits increased virulence.

Appendix 4

Composition of the IHR Roster of Experts, as of 10 September 2025

Expert's name	Expert's nationality(ies)	Designated by State Party
Aavitsland, Preben	Norway	No
Mohammad, Abdelfattah Abdelmawla Abdelaziz	Egypt	No
Aginam, Objiofor	Nigeria, Canada	No
Al Awaidy, Salah T.	Oman	No
Al-Mazrou, Yagob Yousef	Saudi Arabia	No
Al-Nsour, Mohannad	Jordan	No
Amoth, Patrick Omwanda	Kenya	No
Annabi Attia, Thouraya	Tunisia	No
Apercé, Cédric	France	No
Aramburu Celigueta, Carmen	Spain	No
Bausch, Daniel	United States of America, Switzerland	No
Blumberg, Lucille Hellen	South Africa	No
Bouatiff Ben Alaya, Nissaf	Tunisia	No
Carmo, Eduardo Hage	Brazil	No
Cetron, Martin S.	United States of America	No
Chunsuttiwat, Supamit	Thailand	Yes
Damaso, Clarissa	Brazil	No
Damon, Inger	United States of America	No
de Freitas Lima Ventura, Deisy	Brazil	No
Drosten, Christian	Germany	No
Dubyanskiy, Vladimir	Russian Federation	No
Dunning, Jake	United Kingdom	No
Eltom, Akram Ali	Sudan	No
Faye, Ousmane	Senegal	No
Field, Vanessa Katharine	United Kingdom	No
Gent, Robert Nicolas	United Kingdom	No
Gomez Camacho, Juan Jose	Mexico	No
Habibi, Roojin	Canada	No
Hallum, Victoria	New Zealand	No
Haringhuizen, George	Netherlands (Kingdom of the)	No
Houssin, Didier	France	Yes
Jee, Youngmee	Republic of Korea	Yes
Jokhdar, Hani Abdulziz	Saudi Arabia	No
Kaboyo, Winyi	Uganda	No
Kalayanarooj, Siripen	Thailand	No
Khan, Anas	Saudia Arabia	Yes
Kickbusch, Ilona	Germany	No
Koopmans, Marion	Netherlands (Kingdom of the)	No
Kozlovskaya, Liubov	Russian Federation	Yes
Leke, Rose	Cameroon	No
Liu, Yang	China	No
Low, Nicola	United Kingdom, Switzerland	No

Expert's name	Expert's nationality(ies)	Designated by State Party
Mackenzie, John	Australia	No
Mellouk, Othoman	Morocco	No
Memish, Ziad	Saudi Arabia	No
Muyembe-Tamfum, Jean-Jacques	Democratic Republic of the Congo	No
Ndowa, Francis Jim	Zimbabwe	No
Ogoina, Dimie	Nigeria	No
Okwo-Bele, Jean-Marie	Democratic Republic of the Congo	No
Palliri, Ravindran	India	No
Phanuphak, Nittaya	Thailand	No
Phelan, Alexandra	Australia	No
Rahman, Mahmudur	Bangladesh	No
Rees, Helen	South Africa, United Kingdom	No
Rimoin, Anne	United States of America	No
Safdar, Rana Muhammad	Pakistan	No
Sahukhan, Aalisha	Fiji	No
Saito, Tomoya	Japan	No
Salman, Muhammad	Pakistan	Yes
Samarasekera, Sandhya Dilhani	Sri Lanka	No
Smolenskiy, Vyacheslav	Russian Federation	No
Summermater, Kathrin	Switzerland	No
Tarantola, Daniel	France	No
Tomori, Oyewale	Nigeria	No
Wenham, Clare	United Kingdom	No
Werker, Denise	Canada	No
Zambon, Maria	Italy, United Kingdom	No
