

IHR and Ebola

Introduction

1. In 1969, the World Health Assembly (WHA) first adopted the International Health Regulations (IHR) covering four diseases. The Regulations were then amended in 1973 and in 1981 after the eradication of smallpox, to focus on three diseases: cholera, yellow fever and plague. In 1995, the WHA called for a substantial revision in recognition of increasing international travel and trade, the emergence and re-emergence of infectious diseases and the risk of the international spread of such diseases and other health threats. The revised Regulations, which were adopted in 2005 and entered into force for most Member States on 15 June 2007, extended the scope of the IHR to more broadly cover public health risks (biological, chemical or radiological or nuclear in origin) irrespective of the cause.

2. The IHR are an international legal instrument and are binding on 196 States Parties including all the Member States of WHO. The Regulations aim is to strengthen global health security by requiring countries to report certain disease outbreaks and public health events to WHO, and by obligating and facilitating the international community to prevent and respond to acute public health risks with the potential to cross borders and threaten people worldwide.

3. The IHR also define the rights and obligations of countries and establish procedures that the WHO Secretariat must follow including the obligation of all States Parties to have or develop minimum core public health capacities to implement the IHR effectively. A monitoring framework covering nine core capacities: legislation, coordination, surveillance, response, preparedness, risk communication, human resources, laboratory, points of entry, plus four specific hazards: zoonosis, food safety, chemical and radionuclear hazards, has been developed to facilitate the assessment of core capacities.

Challenges of the IHR implementation

4. The Ebola crisis highlighted three key concerns with the implementation of the IHR. These are related to the development of core capacities, timely sharing of information and the institution of additional measures by State Parties.

Development of core capacities

5. The current Ebola situation has highlighted both the continuing gaps in core capacities among States Parties and the inadequacy of current methods to accurately monitor their development and status. These gaps constitute a major ongoing vulnerability in global health security.

6. The establishment of IHR core capacities is monitored through self-reports provided to the Secretariat on a yearly basis. As of 11 December 2014, 78 States Parties have provided the Secretariat with a completed self-assessment questionnaire sent in March 2014. A sizable number of States Parties have not, as required under the IHR, established the minimum core capacities needed to detect, assess, notify, report and to respond to public health risks and emergencies. To date, 64 States Parties have informed the Secretariat that they have achieved these core capacities.

7. Countries in every Region still face significant challenges to fully implement the IHR. Key impediments to IHR implementation include: insufficient authority/capacity of NFPs; the misconception that implementation of the IHR is the sole responsibility of ministries of health; limited involvement/awareness of sectors other than human health; limited investment of national financial and human resources; high staff turnover; ongoing complex emergencies/conflict; the specific needs of small island states and States Parties with overseas territories; the focus on IHR extensions of the deadlines rather than on an expansion of capacities; a perception that implementation is a rigid, legal process with less emphasis on operational implications and learning from experience; and limited international solidarity to support the weakest countries in building capacities.

Timely sharing of information

8. The Ebola outbreak has highlighted the importance of the timely notification to WHO of information on events that could result in a potential public health emergency of international concern so WHO can quickly ensure technical support and communicate critical and accurate information to other State Parties through the IHR protected site (EIS). Article 11 of the IHR requires WHO to share certain public health information as soon as possible with other States Parties, in confidence, providing it consults with the State Party as to its intent to make information available. WHO may also make information available to the public if information about the same event has already become publicly available and there is a need for the dissemination of authoritative and independent information. Nonetheless, in practice the IHR National Focal Points often insist on their need to clear any statement that WHO is publishing which can result in the perception that WHO is late in releasing information and is not playing its global alert role. Moreover, on a number of occasions States Parties have released information to the media before notifying WHO, which has generated uncertainties and confusion and affected the role of WHO in managing such information for public health purposes.

Additional Measures

9. During the Ebola outbreak, more than 40 countries have decided to implement health measures, additional to what was recommended by the Emergency Committee. Under the IHR, State Parties have the right to introduce additional measures, but the measures should not be more restrictive or intrusive than reasonably available alternatives and must be based on scientific principles and available scientific evidence. If a State Party implements additional health measures that “significantly interfere with international traffic,” the Party is required to provide WHO with the public health rationale and relevant scientific information for such additional measures, and to notify the WHO Secretariat within

48 hours of their implementation. WHO may request the State Party to reconsider the application of the additional measures. State Parties must review measures within 3 months of implementation.

10. During the Ebola crisis, these requirements under IHR proved difficult to implement. Very few countries informed WHO that they were implementing additional measures significantly interfering with international traffic and when requested to justify their measures, few did so. The IHR provide the secretariat with little leverage in relation to the implementation of the temporary recommendations or the justification of the implementation of additional measures, such as closing borders, with a high potential to disrupt travel or trade, or the introduction of measures which may be discriminatory towards individuals travelling from affected and neighbouring countries. This situation is putting the entire IHR at risk.

Next steps

11. The IHR constitute the most important international framework for strengthening global health security including the development of health systems and other capacities. Optimizing the IHR and their implementation is a critical step for reducing the impact of emerging, re-emerging and other public health emergencies of international concern. Given their central importance, the range of issues related to their implementation, and the considerable differences among countries and regions in relationship to their implementation, regional meetings could be held in 2015 under the coordination of the WHO Regional Offices and the global IHR Secretariat as part of a global process, including in IHR Review Committee, to further identify issues and to formulate potential solutions for consideration at the 2016 Executive Board and the World Health Assembly.

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