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Eight years after the IHR entered into force, the Ebola virus disease outbreak occurred in West Africa. As of June 2015, the international community’s response has been scrutinised and criticised, also with a view on the effectiveness of the International Health Regulations (IHR) in preventing such tragedies. This article argues that the IHR remains the most valuable framework that the international community has at its disposal to coordinate the international response to large-scale outbreaks. The Ebola virus disease outbreak forms a window of opportunity to make IHR fully operational and well-functioning in order to prevent future tragedies.

Keywords: International Health Regulations, Ebola, Health Security, Advancing IHR

Introduction

Ten years ago, on 23 May 2005, the 58th World Health Assembly adopted the revised International Health Regulations, commonly referred to as IHR (2005). Two years later, the IHR (2005) entered into force, adopted by 194 countries. They required countries to put in place the capacity to detect, assess, notify, and respond to public health risks and potential or declared public health emergencies of international concern (see Box 1 for an overview of obligations). Against the backdrop of the SARS epidemic in 2003, these revisions were deemed critical to enhance global health security against public health risks stemming from infectious diseases, and chemical and radiological disasters.

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#EHFG2015 Forum 8: Securing health. Importance of the implementation of the IHR

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THE POWER OF THE INTERNATIONAL HEALTH REGULATIONS

Summary: In the wake of the Ebola virus disease outbreak, the international community’s response has been scrutinised and criticised, also with a view on the effectiveness of the International Health Regulations (IHR) in preventing such tragedies. This article argues that the IHR remains the most valuable framework that the international community has at its disposal to coordinate the international response to large-scale outbreaks. The Ebola virus disease outbreak forms a window of opportunity to make IHR fully operational and well-functioning in order to prevent future tragedies.

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Eight years after the IHR entered into force, the Ebola virus disease outbreak occurred in West Africa. As of June 2015,
**Box 1: Provisions laid out in the IHR (2005)**

a) scope not limited to any specific disease or route of transmission, but covering “illness or medical condition, irrespective of origin or source, that presents or could present significant harm to humans” (Art. 1 on definition of “disease”)
b) State Party obligations to develop certain minimum core public health capacities (Art. 5, 13 and Annex 1)
c) obligations on States Parties to notify WHO of events that may constitute a public health emergency of international concern, according to defined criteria (Art. 6, Annex 2)
d) authorisation for WHO to take into consideration unofficial reports of public health events and to obtain verification from States Parties concerning such events (Art. 9)
e) procedures for the determination by the WHO Director-General of a “public health emergency of international concern” (Art. 12)
f) protection of the human rights of persons and travellers (Art. 32) and
g) the establishment of National Focal Points and WHO Contact Points for urgent communications between States Parties and WHO (Art. 4).

Source:  

more than 27,000 cases were reported and more than 11,000 people have died from the disease. On 8 August 2014, WHO Director-General Margaret Chan declared the West Africa outbreak a Public Health Emergency of International Concern (PHEIC). Accordingly, and following WHO recommendations, all countries worldwide have strengthened their surveillance and preparedness to detect potential Ebola cases and prevent further international spread of the disease. On its side, WHO has engaged in its largest emergency response ever, with WHO presences in 77 field sites and more than 700 personnel (staff and consultants) across the three most affected countries.

Apart from the fact that the three most affected countries had very specific features and history, there are underlying issues, which should be looked at more closely.

It has been commonly overlooked that in 2014, the same year that the Ebola virus disease outbreak occurred, the extended deadline for countries to fully implement the provisions of the IHR (2005) had silently passed. Initially, the target for full IHR implementation was set to June 2012. But in 2012, 118 countries asked for a two-year extension. In 2014, 81 countries had requested another two-year extension. Failure to implement the provisions laid out in the IHR was often attributed to the fact that many states simply lacked the resources and infrastructures to ensure that their national health systems could provide the surveillance and response capacities to meet the surveillance and response criteria.Correspondingly, WHO’s 2013 summary of state parties’ self-assessed status of the IHR showed that for the African continent, core capacity areas were not well-developed (see Figure 1).

While there is large variation across countries, it implies that many countries were ill-equipped to control outbreaks at the source at the onset of the Ebola virus disease outbreak. Failure to prevent Ebola from spreading was therefore not necessarily a systemic failure of the IHR framework itself, but rather a failure to follow the provisions that were laid out. Along these line, the WHO Ebola Interim Assessment Panel concluded in 2015 that: “the Ebola outbreak might have looked very different, had the same political will and resources [that were spent in responding to the outbreak] been applied to support IHR implementation over the past five years.”\(^1\) In other words: had the IHR been used and implemented to their full extent, the Ebola virus disease outbreak would have likely been detected and contained much quicker. But to date, no additional financing has been put in place and no proper accountability mechanisms have been created to accelerate the use of the IHR.

While the Ebola virus disease outbreak continues to be a PHEIC (as of June 2015), recent months have shown a dramatic decline of new infections. Even though the epidemic is not yet over, WHO and its partners, as well as other stakeholders have started to evaluate the overall epidemic response and to discuss the lessons learned and changes needed in order to better prepare for future disease outbreaks and other emergencies with health consequences. Throughout this process, critics have raised a series of questions about the effectiveness of WHO’s and the international community’s responses, and about the role and power of the IHR. How could the Ebola virus disease outbreak occur, with the IHR in place?

In the following section, we will discuss the IHR in the context of the Ebola virus disease outbreak, address the lessons learned, and put the debate in a European context to facilitate the discussion on what Europe should put on its agenda. We argue that the IHR remains the most valuable framework that the international community has at its disposal to coordinate the international response to large scale outbreaks.

**Lessons learned from Ebola**

Ebola has been only the second real major test of the IHR since they entered into force. The general perception with regards to the first real major test – the A(H1N1) influenza epidemic of 2009–10 – was that the IHR actually worked fairly well.\(^2\) So why did the IHR seem unable to prevent the initial Ebola outbreak from turning into a large regional outbreak?

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\(^2\) The experience with the Ebola virus disease outbreak has taught us an important lesson about the IHR as they currently operate. According to
they “do not effectively commit the international community to building core IHR capacities in resource poor countries to manage international public health emergencies”. In other words, strengthening respective health systems’ infrastructures for IHR implementation is currently impossible to achieve for low income countries, without respective international assistance.

The ‘IHR Review Committee on Second Extensions for establishing national public health capacities and on IHR implementation’, convened by WHO in 2014 furthermore concluded that additional impediments to IHR implementation included: insufficient authority and capacity of National IHR Focal Points; the focus on IHR deadline extensions rather than on an expansion of capacities; and the perception that “implementation” is a rigid, legal process with less emphasis on operational implications and learning from experience. “Implementation of the IHR should now advance beyond simple “implementation checklists” to a more action-oriented approach to periodic evaluation of functional capacities.”

The power of the IHR

Despite current criticism, the IHR have not lost their power or appeal. To date, they remain the only comprehensive framework that provides an appropriate base for global health security from infectious disease threats and other biological, chemical or radiological threats. Its unique advantages are substantial for the following reasons:

Firstly, it is universal in scope, with 196 State Parties having adopted the revised IHR (2005). It is therefore a politically legitimate instrument, respecting the sovereignty of countries while acknowledging the increasing mutual dependencies and responsibilities.

Secondly, the IHR provide a well-developed risk-based framework to all parties that recognises the different nature of various threats and the measures needed to address them, including a pronounced need for proportionality, as to not overly restrict travel and trade in a globalised world, as per IHR article 2 on its purpose and scope (“avoid unnecessary interference with international traffic and trade”).

Thirdly, its recognition of interdependencies between sovereign countries with respect to both threats to public health and the respective capacities of those countries to manage those threats allow the IHR (2005) to call strongly for solidarity among countries. In a hyper-connected world, global health security is only as strong as its weakest link and failure to strengthen that link through global cooperation can have implications for the whole chain.

The IHR (2005) agenda in Europe

While public fears speculated that Ebola could spread to the WHO European Region on a large scale, it ultimately did not materialise, and those cases that were imported to countries of the European Region were contained well. Subsequently, throughout the outbreak, the risk for the European Region of acquiring the disease was estimated to be very low.

Nevertheless, this is no reason to become complacent in Europe. In 2014 alone, 42 public health events with serious potential international consequences were recorded by the WHO Events Management System. Recent examples include the Balkan floods in May 2014 that had devastating consequences in Bosnia and Herzegovina, Croatia and Serbia, especially increasing the risk of vector-borne diseases; another example includes imported cases of Middle East respiratory syndrome (MERS) coronavirus infection cases in Austria, Germany, the Netherlands and Turkey in 2014.

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focused on non-capacity building issues, such as building awareness, training people in specific IHR relevant areas, and ensuring that the IHR remain operational and sustainable. In this regard the European Region is entering a new phase of working with the IHR, shifting the focus from using the IHR as a capacity development framework towards a tool that informs epidemic intelligence on a day-to-day basis. The WHO Regional Office for Europe has been playing a crucial role in providing respective support to Member States in achieving this. Through its country offices, it has been the primary source of support for many countries, supporting country level IHR implementation, as well as monitoring performance against respective indicators.

In addition, the EU Decision on Serious Cross-Border Threats to Health, which was adopted early in 2013, reconfirms the importance of the IHR and also created opportunities and raised attention among EU Member States for health security.

Advancing the IHR (2005) agenda

WHO is the world’s only agency with a mandate to act on global health matters. Under its auspices, the creation of the IHR has been a consensual and globally accepted mechanism to prevent the spread of infectious diseases and to prepare for emergencies with health consequences. And once fully implemented and utilised properly, the IHR remain to be an extraordinarily valuable framework for rapid information sharing and coordination of international response. However, to achieve global health security through the IHR, we need to make sure that the IHR are enabled to do what they are supposed to do.

Article 44 of the IHR calls for solidarity between countries in detecting and responding to health threats. Global health security can only be achieved by such solidarity among countries. In light of recognising their mutual vulnerabilities and responsibilities, high-income countries need to support the creation of core capacities in the poorest countries, in accordance with Article 44 of the IHR. Without such support, many developing states will continue to struggle to implement the IHR and to strengthen their capacities.

Furthermore, Member States need to work towards proper implementation of the IHR and fulfilling its reporting and information sharing requirements. During the Ebola virus disease outbreak, some Member States were hesitant to report cases for fear of restrictions being put on them, while others waited too long to provide medical assistance and were too eager in their response to impose travel and trade restrictions. Learning the appropriate response to the respective threat will be a major challenge in the years to come.

During the 9th European Union Development Day in June 2015, WHO Director-General, Dr Margaret Chan said in her opening remarks that the “Ebola outbreak has been a wake-up call for the international community, and that never in the future, the international community, national Governments and local authorities should not be fully equipped to respond to such threats.”

Since the IHR have been agreed upon at the World Health Assembly ten years ago, now is the time to act and to fully utilise the full power of the IHR. The emergence of the SARS outbreak in 2003 changed the political mood and allowed for the IHR to be pushed onto the highest political agenda. Currently, the Ebola virus disease outbreak forms another window of opportunity, not to push for another IHR revision process, but to make the IHR fully operational and well-functioning in order to prevent future tragedies. Given the current low rate of implementation of the IHR, it is highly likely that another disease can cause another large outbreak in the future. The international community therefore needs to learn the lessons from Ebola now and translate these into specific actions so that the world can prevent outbreaks and prepare for pandemics.

References