



EPHA Briefing on the International Health Regulations

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In our increasingly interconnected world international travel is more common for more people and over longer distances, leading to greater concerns over the threats posed by infectious disease outbreaks. There has long been recognition of the need to put in-place a systematic approach for authorities to respond to such in the form of agreements on international cooperation on infectious diseases. These agreements have evolved from being rather straightforward and covering a limited number of diseases to being more complex and covering a greater number of threats. This briefing details these agreements – International Health Regulations – and reviews their current status.

What are the IHR?

In 1951 the member states of the World Health Organization, the UN specialised agency for health (WHO), adopted the first International Sanitary Regulations, which in 1965 were renamed the International Health Regulations (IHR); since then they have been amended and modified four times, most recently in 2005.

The IHR is an international legal instrument legally binding on all WHO Member States who have not rejected them and also on non-WHO States that have accepted them. It contains mandatory procedures and practices in order to ensure maximum security against the international spread of diseases with a minimum interference to world traffic. It is up to Member States to implement many of the provisions of the IHR, although there are many actions that are delegated to WHO, and enforcement of the provisions of the IHR also rests with the WHO.

See: <http://www.who.int/csr/ihr/howtheywork/faq/en/index.html#whois>

What do they require and how has this been modified ?

The IHR requires Member States to formally notify the WHO of disease outbreaks that potentially pose a threat to international public health. At their inception in 1969 this related to the notification of outbreaks infectious diseases thought to pose the greatest international public health threat - at this time limited to three diseases; cholera, plague and yellow fever.

Modification of the IHR was necessary so as to include new diseases given that a focus on



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just three diseases did not address varied and new public health risks, such as Ebola haemorrhagic fever in Africa and plague in India. Since their amendment the emergence of further threats such as SARS (Severe Acute Respiratory Syndrome, for the WHO recommendations on SARS see <http://www.who.int/csr/sars/en/>) and the potential for a influenza pandemic (for WHO latest information and recommendations on avian influenza see: http://www.who.int/csr/disease/avian_influenza/en/) have underscored the need for IHR to be adapted so as to be responsive to future new public health threats.

The purpose and scope of the IHR (2005) are to prevent, protect against, control and provide a public health response to the international spread of diseases. The main obligation of the States who have accepted IHR is to notify to the WHO all events that may constitute a public health emergency of international concern, notification is no longer limited to specific diseases.

Under the IHR, the new key obligations for States are:

- to designate a National IHR Focal Point charged with maintaining a continuous official communication channel between WHO and States Parties. In addition to this legal requirement, the National IHR Focal Point will have to ensure the analysis of national public health risks in terms of international impact and distribute information to other members.
- to assess events occurring in their territory and to notify WHO of all events that may constitute a public health emergency of international concern.
- to respond to requests for verification of information regarding events that may constitute a public health emergency of international concern.
- to develop, strengthen and maintain the capacity to detect, report and respond to public health events.
- to provide routine inspection and control activities at international airports, ports and some ground crossings to prevent international disease transmission;

How does that apply to the EU members?

IHR is automatically binding on all WHO members unless they reject it or submit a



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reservation¹ to WHO and additionally on other nations that voluntarily submit to them. 192 states are currently WHO members, including the 27 EU Member States. This means that all EU countries have to respect the IHR as single members of WHO and not as part of the EU, as the EU itself is not a WHO member (even if its role as a regional economic integration organization is recognized in IHR). However exclusive competence for some relevant policy areas rests with the Community. For example, if the WHO were to recommend states refuse entry or departure for certain goods under the IHR, the EU would have to act collectively, at the initiative of the Commission, as EU single market legislation prevents MS from taking unilateral action (e.g. on bans on movements of poultry products following an avian influenza outbreak).

The Commission, EU agencies and bodies, as well as the Member States, will work together to optimise IHR implementation in the context of EU policies and health related actions and initiatives. In particular, the European Centre for Disease Prevention and Control (ECDC), and the EU Early Warning and Response System for public health threats (EWRS), will help to implement the IHR in a stronger, more coherent way across the EU.

The Network for the Surveillance and Control of Communicable Diseases was the EU body established to facilitate cooperation between Member States and the European Commission, on prevention and control of disease outbreaks. This Network included the EWRS which brought into permanent communication the Commission and the competent public health authorities in each Member State responsible to determine the measures required to protect public health.

What does the European Commission intend to do?

On September 2006² the Commission adopted a Communication to the European Parliament and the Council outlining how implementation of the IHR were to be coordinated between Member states and Community institutions. It outlined the following:

- The Commission will draft, negotiate and sign a Memorandum of Understanding on the IHR between the Community and the World Health Organization, clarifying the role of EWRS and ECDC in IHR implementation.
- The Commission proposes nominating the same national focal point for EWRS as for IHR.
- Simultaneously informing EWRS and WHO about events within their territory which are notifiable under IHR.

¹Unilateral statement made by a State, when signing, ratifying or accepting a treaty, whereby it excludes or modifies the legal effect of a treaty in their application to that State.

² http://ec.europa.eu/health/ph_international/documents/comm_ihr_552_2006_en.pdf



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- Informing the EU Communicable Disease Network in advance of making a formal IHR notification of a potential disease.
- Using EWRS and to help coordinate health risk management and response prior to communicating with WHO.

The revised IHR (2005) are due to enter into force on 15 June 2007, and full implementation of all the provisions are due by 2016 at the latest. However in May 2006 the World Health Assembly called upon State Parties to comply immediately, on a voluntary basis, with the IHR provisions considered relevant to the risk posed by avian and potential human pandemic influenza. The World Health Assembly has therefore signalled the degree to which implementing the provisions of the IHR should be viewed as a public health priority as well as the potential for a further strengthening of their provisions should events signal such a need.

IHR Relevance to broader Public health concerns and EPHA Members

With the increasing mobility of people and goods it is important to ensure that protective, strategic and coordinated policies are in place to allow authorities to effectively respond to outbreaks of infectious diseases. However, this does not mean that such outbreaks represent the most significant threats to public health in the coming years. Only if nothing is done to effectively implement IHRs, both here in the EU and across the world, will such infectious disease outbreaks pose a primary threat to public health. In this respect, it is important that richer regions of the world not only ensure domestic implementation of IHRs, but also that they fund and facilitate the strengthening of health systems in the poorest countries as a response to the public health threat posed by new infectious disease outbreaks in our interconnected world.

Members of the European Public Health Alliance will be variously active in the implementation of IHRs, whether it be in the form of public health practitioners or whether it be in a policy advocacy role urging full and speedy implementation. Whatever role EPHA members and the secretariat play they must not lose sight of the other public health threats which IHRs will not be able to address such as chronic diseases.