

## THE INTERNATIONAL HEALTH REGULATIONS (IHR)

### What are they?

The International Health Regulations (IHR) were adopted in 1969. Previously known as the International Sanitary Regulations, the IHR are a legally binding code of practises and procedures to prevent the spread of disease. The IHR set out roles and responsibilities for the World Health Organisation (WHO) and individual countries, for responding to a limited range of disease outbreaks.

### Why are they being revised?

The current IHR have weaknesses in global outbreak alert and response activities. There has been a great increase in cross border travel and trade since 1969 and, as such, new challenges have arisen in the control of emerging and re-emerging infectious disease. There is also an increased concern of the possibility of the deliberate use biological or chemical agents to cause harm.

The current IHR requiring the reporting of just three diseases (Cholera, plague and yellow fever) does not address the varied public health risks of today's world. The draft revision of the IHR broadens the scope of the regulations, requiring the notification of existing, new and emerging diseases, whilst maintaining the protection offered by the existing regulations.

The draft revision of the IHR contain **four** major changes from those adopted in 1969. **These are:**

#### → **Public Health Emergencies of International Concern**

States will be required to notify all events potentially constituting a public health emergency occurring in their territory irrespective of the cause, including accidental, natural or suspected intentional release of pathogens, chemicals or radio-nuclear material. This would enable WHO to ensure appropriate technical assistance for effective protection and management of emergencies.

#### → **Epidemic alert and Response**

The draft revision of the regulations will act as a legal framework for WHO's global health security epidemic alert and response strategy

#### → **National IHR Focal Points**

The regulations will require the establishment of National IHR Focal Points, these will act as a contact link from States to WHO. The nominated National Focal Points provide and receive official information to and from WHO, 24 hours a day.

#### → **Core Capacity Requirements**

The revision also outlines the minimum core surveillance and response capacities at the national level in order to detect, report and respond to any public health risk of international concern. In addition, specific capacities for the implementation of routine measures are outlined in the revised IHR for points of entry (i.e. Airports).

**European Regional Consultation on Revision of the  
International Health Regulations  
Regional Office For Europe Copenhagen, 9-11 June 2004**

The meeting, which was part of a process started in 1995 to revise the **International Health Regulations (IHR)**, was intended to provide the member states in the WHO European Region with the opportunity to become familiar with the draft revision of the new IHR document and to identify problems and discuss solutions.

**Dr Gudjón Magnússon** welcomed the participants on behalf of **Dr Marc Danzon**, WHO regional director for Europe. **Mr Anthony Kingham** chaired the consultation.

**Dr Guenael Rodier**, Director, Communicable Disease Surveillance and Response department, WHO headquarters explained that similar meetings had taken place or were to take place in other WHO regions. The idea behind the IHR is to provide some ground rules that countries and international organisations such as WHO can follow to respond effectively to global disease events. The aims of reducing the spread of the disease whilst not unnecessarily interfering with travel and trade.

The highest priority in the European region, the delegates were told, was to provide technical support **to strengthen surveillance systems and early warning and response capacity at the national level**. Currently the surveillance systems of the 52 countries in the WHO European region differ greatly. The EU25 countries are working with the directives of the European Commission to harmonise their surveillance. The countries of the former USSR shared similar structures and principles, and the change to a market economy had affected these systems in many ways. Many countries were taking steps to review and revise their surveillance systems.

Other priorities included strengthening regional capacity for outbreak alert, and addressing a number of disease groups not currently covered by other WHO programmes, such as **epidemic-prone diseases, zoonotic diseases (diseases transmitted between animals and humans) and antimicrobial resistance**.

The participants of the consultation formed **six** working groups to discuss the current draft in detail. The groups highlighted:

- **The need for accuracy in translations of the IHR.** The main issue was with Russian translation, which did not match English text on several occasions.
- **The need to review the definitions of a number of terms used;** terms such as 'medical examination', 'without delay' and 'suspected traveller' and 'core capacity', it was decided, may require standardisation or precise definitions as they were misinterpreted, particularly in translation.
- **The scope of the IHR, which may be too broad at least with regard to response:** It was felt that the scope of the notification of events was broad involving, biological, chemical and radiological agents. As to response, however, a number of countries pointed out that other agencies should be involved, particularly when the events are related to radiological or chemical sources.
- **The need to consolidate the different terms used for member State structures,**

**with a few exceptions:** There was confusion over the different terms used for authorities in each member state. It was suggested that a single term be used to describe the national authority and that each member state could then organise their internal structures as they wished.

→ **The need to clarify which regulations are binding;** The use of the words shall and should, and which legal terminology was binding. The conclusion was that the clearer the IHR were, the more probable it was that optimal use would be made of them.

## **Closing Remarks**

**Dr Max Hardiman**, Group Leader, International Health Regulations Revision Project, WHO Headquarters, reported that further consultations with international groups would take place. These included organisations involved in tourism and travel, the Food and Agriculture Organisation of the United Nations and the World Trade Organisation.

**Dr. Rodier**, Director, Department of communicable disease Surveillance and Response, WHO, stated that many valid points had been made, although it would not be possible to take all into account the Member States should be satisfied by the final draft of the IHR. The IHR should strike a balance between regulation and public health instrument.

**Dr Danzon** concluded the meeting by stating “.....WHO uses its global dimension, its global capital. We are all working in the same organisation – but from the point of view of the region [Europe] it must have a specific vision.”

After the regional consultations, the comments of the member states will be used by WHO in the redrafting of the IHR. It is anticipated that this will be presented to the Member States in late September for further review and comment. It is hoped that the final draft will be endorsed at the **Intergovernmental Working Group in Geneva on November 9-12** and presented to the World Health Assembly for adoption in May 2005.

**This briefing note was prepared by James Hender for the EPHA Secretariat.**