Pandemic Response and International Health Regulations

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Introduction

In 1377, Venice wrote the first recorded quarantine legislation to protect itself from rats on ships arriving from foreign ports [1]. The “transnationalization” of infectious diseases across geopolitical boundaries during cholera epidemics in 1830 and 1847 in Europe, catalysed the evolution of earliest multilateral governance of communicable diseases. In 1851, France convened the first International Sanitary Conference, which laid down the basic tenet of maximum protection against international spread of infectious diseases with minimum restriction [2]. A full century lapsed before the international sanitary rules were adopted in 1951 and these were amended in 1969 to become the International Health Regulations (IHR), revised in 1973 and 1981. Three communicable diseases cholera, plague, yellow fever currently must be reported under the IHR. New diseases have been emerging at the unprecedented rate. The international response to severe acute respiratory syndrome (SARS) emphasized the need to promptly report cases with the potential of international spread.

Revision of International Health Regulations

The IHR are legally binding set of regulations adopted under the auspices of World Health Organisation (WHO), focusing on global surveillance for communicable diseases. These measures cover the travel requirements of health and vaccination certificates from areas infected with cholera, plague and yellow fever to noninfected areas; deratting, disinfecting, and disinfecting of ships and aircraft, as well as detailed health measures at airports and seaports in the territories of WHO member states [3].

An assessment of the effectiveness of the IHR in control of cholera, plague, and yellow fever reveals that WHO member states have not observed the regulations strictly. One reason could be the fear of excessive measures from other countries if a country notifies these diseases to WHO while others could be WHO’s relative inexperience in enforcing legal regimes, the inability of regulations to adopt to changing circumstances in international traffic, trade and public health, their coverage of only three diseases and the lack of surveillance capacity in many WHO member states [4].

The resurgence of cholera in parts of South America, plague in India and emergence of new infectious agents such as Ebola virus resulted in a resolution at the 48th World Health Assembly in 1995, calling for the revision of the regulations. The IHR have been revised for immediate reporting of defined syndrome representing disease occurrence of international importance and of basic epidemiological information that will be useful in the control of disease to WHO. This WHO revision was done and regular progress updates have been published in the weekly epidemiological record [5].

Disease Notification under IHR (2005)

In May 2005 [6,7], the World Health Assembly adopted the revised IHR (2005), effective from 15 June 2007. This requires the member states to notify WHO of all events that may constitute a public health emergency of international concern (Table 1) and to respond to requests for verification of information regarding urgent national public health risks. According to IHR (2005) a public health emergency of international concern refers to an extraordinary public health event which is determined: to constitute a public health risk to other states through the international spread of disease and to potentially require a coordinated international response. This definition broadens the scope of the IHR (1969) from just cholera, plague and yellow fever to cover new and re-emerging diseases.

International Law in Global Disease Control

Rapid containment of SARS is a success of public health as well as the power of international collaboration supported at the highest political level. SARS containment highlighted that existing interventions can be effectively used to contain an outbreak even in

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Table 1
International Health Regulation (2005) Decision Instrument

| Event detected by National Surveillance System | Action proposed |
|-----------------------------------------------|-----------------|
| • Small Pox                                   | Notifiable under IHR 2005 |
| • Poliomyelitis due to wildtype of polio virus|                  |
| • Human influenza caused by new subtype       |                  |
| • Severe acute respiratory syndrome           |                  |
| • Any event of potential public health concern including those of unknown cause and source |                  |
| • Cholera                                     |                  |
| • Pneumonic plague                            |                  |
| • Yellow fever                                |                  |
| • Viral haemorrhagic fever (ebola, lassa, marburg) |                  |
| • West Nile Fever                             |                  |
| • Other diseases of special and regional concern e.g. dengue fever, rift valley fever, meningococcal disease |                  |
| • Is the public health impact of event serious? |                  |
| • Is the event unusual or unexpected?         |                  |
| • Is there significant spread of international spread? |                  |
| • Is there significant risk of international travel and trade restriction? |                  |

[Simplified from annex 2 of IHR 2005 (Ref 6)]

absence of curative drug and preventive vaccine [8].

International health law, which encompasses human rights, food safety, international trade law, environmental law, war and weapons, human reproduction, organ transplantation, as well as a wide range of biological, economic, and sociocultural determinants of health, now constitutes a core component of global communicable disease architecture. For the IHR or any legal mechanism to be adopted by WHO on communicable disease control, it is a matter of argument whether the advantage of observance of maximum health measures outweigh the disadvantages (trade and other economic embargoes costing billions of dollars). What is critically important therefore is to elevate public health to a pedestal of a “global public good”.

Conclusion
Revised IHR (2005) applied to transnational infectious disease threats, the fairness of the law as an “Intermediate Public Good” must be measured by an effective delivery of radically reduced disease morbidity and mortality burden across societies in a globalised world.

Conflicts of Interest
None identified

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