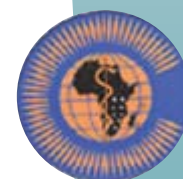


Implementing the International Health Regulations in Africa

The notification and prevention of the spread of diseases and other public health risks across borders is a longstanding area of health diplomacy. The International Health Regulations (IHR) (2005) were adopted by the 58th World Health Assembly in May 2005 to control the spread of diseases and public health risks across borders. The IHR (2005) are global standards that become legally binding in countries once they have been incorporated into domestic public health law (unless country constitutions specifically state that such international standards automatically apply). Member states of WHO, who are “States Parties” to the IHR, were given up to 2007 to assess their capacity and develop national action plans on the regulations. Countries were given up to 2012 to meet the requirements of the IHR regarding their national surveillance, reporting and response systems to public health risks and emergencies and to provide the measures set for disease control at designated airports, ports and ground crossings. Progress toward attainment of these goals depends on eight core capacities, to be in place by the year 2012. This policy brief outlines the context and content of the IHR and how far the provisions have been implemented in east and southern Africa.



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Why do we need the International Health Regulations?

Formal international cooperation to control global risks to health was initiated in the mid-19th century. European nations gathering at the first International European Conference discussed cooperation on cholera, plague and yellow fever, problems that they could not manage through national policies alone. Over the next 100 years international cooperation directed at preventing and controlling disease evolved, culminating in the establishment of the World Health Organization (WHO) and the International Sanitary Regulations in 1951. The International Sanitary Regulations were further amended by the World Health Assembly (WHA) in 1969 and in 1981. Updated International Health Regulations developed in the 2000s were adopted by the WHA in 2005.

The public health situation has changed significantly in the past 100 years. Communicable diseases have been significantly controlled in some parts of the world, although they still present as the most common disease problems in most low income countries. Vaccine and medical technologies have contributed to the

eradication of smallpox and goals are set to eradicate poliomyelitis, dracunculiasis, measles and leprosy (WHO Afro 2004). At the same time new severe or fatal communicable diseases have spread globally in recent decades, including viral haemorrhagic fevers, HIV and severe acute respiratory syndrome (SARS). From 2003 to 2011 there were 539 cases notified to the WHO of Avian Influenza (H5N1) and 318 deaths worldwide although only one case was reported in Sub-Saharan Africa (SEATINI, TARSC 2011).

These pandemic diseases, crossing national borders, have raised the profile of health as a global foreign policy issue. Fidler (2005) noted that the international spread of disease complicates and frustrates a state's pursuit of its material interests, such as in the case of bioterrorism, HIV and severe outbreaks of highly transmissible pathogens like H1N1, raising these diseases as foreign policy issues, even while other infectious and non-communicable disease problems, especially in developing countries, may remain neglected globally. The threat of accidental or intentional release of deadly biological, chemical or nuclear agents are regarded in foreign policy as threats that can only be addressed through international cooperation.



For example, in 1978, the WHO established a global commission to certify that small pox was no longer transmitted in nature. According to reports *“the last reported human smallpox cases occurred in 1978 at the University of Birmingham in the United Kingdom. A medical photographer who worked above a laboratory where smallpox virus was being studied contracted the disease from a laboratory leak. Before dying, the photographer infected her mother”* (Machemedze 2011). Resolution 33.3 of the 1980 World Health Assembly (WHA) declared the total eradication of the disease. The remaining live stocks of the variola virus (the virus that causes smallpox) are still held in the two official repositories at the US government’s Centres for Disease Control (CDC) in Atlanta and at the Russian State Centre for Research on Virology and Biotechnology (VECTOR). However as noted from the case cited above, any accidental release or leak from these two sites of the smallpox virus, a virus that killed two million people annually in the 1960s, has the potential to spread across borders, with significant risk to public health.

This diplomacy response to the threat of transborder movement of communicable diseases continues a century of responding to health in foreign policy when it poses a threat to national interests. It has been labelled by Fidler (2005) as a ‘remediation’ response to a health threat to states’ material and security interests. It is different to international interactions in the global polity that seek to make health central to shaping security, prosperity, development, and dignity globally, as articulated in the preamble of the WHO Constitution, and as reflected for example in global commitments on the right to health or the inclusion of protection of public health as an overriding principle in trade agreements.

The 2005 International Health Regulations

The revision of IHR in the 2000s responded to inherent limitations of the International Sanitary Regulations in terms of:

- The narrow scope of the notifiable diseases included (cholera, plague, yellow fever) given the emergence of new pandemic threats noted above;
- Their dependence on voluntary official notification by countries; and
- The lack of a formal internationally coordinated mechanism to prevent the spread of disease across borders. (WHO 2008)

The IHR (2005) entered into force on 15 June 2007, with the aims stated as “to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade” (WHO 2008a). The IHR (2005) are not limited to specific diseases but are applied to current and emergent public health risks. They are intended to have long-lasting relevance in the international response to acute public health risks that have the potential to cross borders, both in terms of emerging infections like Severe Acute Respiratory Syndrome (SARS), or public health emergencies such as chemical spills, leaks and dumping.

The IHR (2005) introduced a number new operational concepts. They set specific procedures for notification, consultation, and reporting of public health events. They require the establishment of permanent communication channels, 24 hours a day, 7 days a week, between countries and WHO and provide for WHO to take into account reports from sources other than official notifications or consultations. They provide for verification requests by WHO to national health authorities with regard to reports of public health events occurring within countries. They establish an Emergency Committee which provides its views to the WHO Director General on events that may constitute a public health emergency of international concern and



provides for cooperation between WHO and other “competent” intergovernmental organizations or international bodies

Article 5 of the IHR (2005) obliges states parties to “develop, strengthen and maintain, as soon as possible but no later than five years from the entry into force of these Regulations for that State Party, the capacity to detect, assess, notify and report events in accordance with these Regulations...”

Article 13 further obliges states parties to “develop, strengthen and maintain the capacity to respond promptly and effectively to public health risks and emergencies of international concern as soon as possible but no later than five years from the entry into force of the regulations.”

Progress toward the attainment of the stated goals is based on eight core capacities, shown in the box below, to be in place by the 2012.

Eight core capacities in the IHR (2005): By 2012 states should be able to

1. Rapidly determine the control measures required to prevent spread of risks;
2. Provide specialized staff, laboratory analysis of samples (domestically or through collaborating centres) and logistic assistance (e.g. equipment, supplies and transport);
3. Provide on-site assistance as required to supplement local investigations;
4. Provide a direct operational link with senior health and other officials to rapidly approve and implement containment and control measures;
5. Provide direct liaison with other relevant government ministries;
6. Provide, by the most efficient communication available, links with hospitals, clinics, airports, ports, ground crossings, laboratories and other operational areas for dissemination of information and recommendations from WHO on events in the country and in other countries;
7. Establish, operate and maintain a national public health emergency response plan, including the creation of multidisciplinary/multisectoral teams to respond to events that may constitute a public health emergency of international concern; and
8. to provide the foregoing on a 24-hour basis.

Implementing the IHR (2005) in Africa

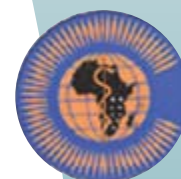
In 2011, WHO obtained information from countries to assess progress in the development of the eight core capacities, covering public health protection at points of entry and in relation to zoonotic, food safety, chemical, radiological and nuclear hazards. According to the WHO, “the data for 2011 showed States Parties making fair progress for a number of core capacities. Most progress had been made in capacities for control of zoonotic events, for surveillance, laboratory services and for the response to public health emergencies of national and international concern.

However, most regions reported relatively low human resource capacities for the IHR and low capacities at points of entry and for managing chemical events (See table overleaf).

African countries, whilst making progress in ensuring these eight capacities, have made less progress than global averages. Only 28 of the 46 countries classified within the African region had responded to the WHO survey by November 2011. While there was a similar pattern of progress in capacities for control of zoonotic events, surveillance, laboratory services and the response to public health events, African countries had significantly lower human resource capacities, and more limited capacities for legislation, policy and financing and for managing chemical and radiation events (See table overleaf). African countries face a number of constraints in implementing the IHR, including weak health systems, inadequate infrastructure and resources, and weak communication infrastructure in remote areas.



African and global capacity scores, WHO national capacity monitoring framework, 2011



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Capacities in place for	Average capacity score , Africa	Percent of countries with a score >75% , Africa	Global average Capacity score
Total responses globally = 117 Total responses for Africa = 28			
Legislation, policy and financing	28	14	60
Coordination and national focal point communications	46	14	66
Surveillance	64	54	75
Response to public health emergencies of national and international concern	52	21	72
Preparedness for public health emergencies	35	11	57
Risk communication	43	11	64
Human resources at points of entry	27	18	45
Laboratory services for public health	63	36	71
Points of entry	32	4	45
Zoonotic events	60	43	78
Food safety events	42	11	68
Chemical events	18	0	45
Radiation emergencies	25	11	51

Adapted from the WHO Implementation of the International Health Regulations (2005), Report by the Director-General EB130/16, 24 November 2011 based on responses received by WHO as at 2 November 2011: Algeria, Angola, Benin, Burundi, Cameroon, Chad, Congo, DRC, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Kenya, Lesotho, Madagascar, Malawi, Mauritania, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, Togo, Tanzania, Zambia and Zimbabwe

The implementation of IHR (2005) in Africa calls for national action. WHO Afro have, for example, proposed to implement IHR (2005) within the Integrated Diseases Surveillance (IDS) strategy, given steps already taken to build national response systems for the IDS. This implies broadening the scope of surveillance beyond diseases, and implementing event-based surveillance at all levels. The setting of the IHR does not mark the end of regional and international co-operation, which needs to continue. The provisions of the IHR need to be integrated within relevant policies, strategies and plans that are being negotiated and implemented, including those dealing with climate change and disaster risk management. Integrating the IHR (2005) provisions would be important to ensure a holistic approach.

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