Implementing the International Health Regulations (2005) in the World Health Organization Western Pacific Region

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DEVELOPING THE INTERNATIONAL HEALTH REGULATIONS (2005)

It has been 10 years since severe acute respiratory syndrome (SARS) – the first emerging infectious disease of global significance in the 21st century – occurred in the Western Pacific Region in 2003. At that time, the revision process of the International Health Regulations (IHR) was underway.[1] However, as considered by MacKenzie and Merianos in this issue of WPSAR "perhaps the most important legacy from SARS was the additional urgency and focus given to the revision of IHR by the World Health Assembly."[2] The substantially revised IHR (2005) entered into force in June 2007 and represented a major development from IHR (1969) in the use of an international legal instrument to protect public health. Recently, IHR (2005) has been used as a global tool to collectively respond to the emergence of Middle East Respiratory Syndrome coronavirus (MERS-CoV) from 2012 and the avian influenza A(H7N9) virus in 2013.

One of the major changes of IHR (2005) was an introduction of event-based reporting, from mandating the reporting of three diseases (yellow fever, plague and cholera) under IHR (1969) to the reporting of any event that may constitute a public health emergency of international concern (PHEIC) under IHR (2005). Other significant changes included: (1) the legal requirement of Member States to develop national IHR core capacities; (2) the establishment of National IHR Focal Points (NFPs) to facilitate official communications; (3) the notification of any event that may constitute a PHEIC from NFPs to the World Health Organization (WHO) IHR Contact Points; and (4) agreed upon procedures for determining and responding to a PHEIC.[3] As one observer has commented, "establishing effective global public health surveillance is at the heart of IHR (2005)."[4]

IHR (2005) IN THE WHO WESTERN PACIFIC REGION

IHR (2005) has played a vital role in the development and strengthening of national and regional capacities required for detecting, assessing, reporting and responding to acute public health events and emergencies in the WHO Western Pacific Region. The Western Pacific Region has been a hotspot for emerging infectious diseases and remains vulnerable to future health security threats due to multiple factors such as increased international travel and trade, migration and urbanization, intensive production of livestock and illegal wildlife trade.[5] The Asia Pacific Strategy for Emerging Diseases (APSED) is a regional tool to assist countries with IHR (2005) implementation and progress has been made in establishing capacities within the APSED focus areas.[6] Although measuring capacity improvement and related health impact as a direct result of IHR (2005) remains a challenge,[7] there are certainly success stories in this Region.

As a result of developing IHR core capacities in the Region, more than 90% of Member States have now established event-based surveillance systems – one such system is described by Dagina et al. in this issue of WPSAR.[8] Most (25 of 26) Member States that responded to the 2013 IHR Monitoring questionnaire have established their coordination mechanisms between human and animal health sectors on zoonoses.[6] Modified field epidemiology training programs are now operating in Cambodia, the Lao People's Democratic Republic, Mongolia and Papua New Guinea. The majority (85%) of

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the Member States have validated their health emergency communications plans, policies and guidelines through an actual emergency or simulation exercise.[6]

As reported by Fearnley and Li in this issue of WPSAR,[9] since IHR (2005) has been in force, more than 150 diseases and public health events have been reported from National IHR Focal Points to the regional WHO IHR Contact Point under the IHR (2005) communication mechanism. Most events reported were infectious disease outbreaks, notified for early alert, information sharing, joint risk assessment and rapid response. None of the reported IHR events originating from the Region led to formal determination of PHEIC as per IHR procedures.[3]

Recent outbreak responses in the Region highlight both achievements and challenges in IHR (2005) implementation. The 2012 Cambodia outbreak of hand, food and mouth disease tested the value of IHR mechanisms and the need for continuing core capacity strengthening.[4] The recent avian influenza A(H7N9) event reported from China under IHR (2005) demonstrated improved capacities at both national and international levels for response, and it highlighted the value of past investment in IHR core capacity development.

While national and regional surveillance and response systems for emerging diseases have been strengthened, the Region is still not fully prepared for responding to future severe health security threats. A significant number of Member States in the Region were unable to meet the IHR (2005) obligations by the required June 2012 deadline. Fourteen of 27 Member States requested a two-year extension to meet the IHR core capacity requirements.[6] This June 2014 extension deadline is fast approaching, and it is expected that some Member States will ask for another two-year extension.

One challenge in meeting IHR (2005) core capacities is reported by Rosewell et al. in this issue of WPSAR.[10] The recent large cholera outbreak in Papua New Guinea highlighted a lack of trained health care workers to respond to this event, and the article describes lessons learned that may assist in meeting this IHR (2005) core capacity.[10] Similarly, another challenge identified in the Pacific Region in IHR (2005) implementation was difficulties in assessing whether the core capacities had been met using the WHO annual IHR monitoring questionnaire.[7] To assist Pacific island countries and territories in completing the questionnaire, in this issue of WPSAR Craig et al. describes how this was adapted to meet the needs in the Pacific.[11]

MOVING FORWARD

Once reached, sustaining IHR (2005) core capacities is also a key issue as "in an era of limited resources, competing priorities and political challenges, achievement of the IHR goals, even with an extension, will be a challenge."[12] Many resource-limited countries in the Region still rely heavily on external support, and the current global financial situation poses significant risks to sustaining what has already been gained. Building and maintaining the surveillance systems envisioned in IHR (2005) will require on-going substantial financial and technical resources.[13] Therefore, although the ideal is to invest in all capacity areas equally, reality calls for prioritization, or a more focused approach, to meet IHR (2005) obligations. Given limited resources, focusing on those common capacities will provide a foundation for an all-hazards approach for addressing public health emergencies regardless of causes.[12] One example of this focused approach is the strengthening and monitoring of basic surveillance and response systems that can enable early detection, timely assessment and swift response to all emerging disease outbreaks and public health emergencies.

Implementing IHR (2005) has been a collective learning process for Member States, WHO and partners and will continue to be so. The Region is still in the middle of its journey towards achieving the common regional health security goals under IHR (2005). IHR (2005) has made a positive contribution to strengthening national capacities and has fostered more timely and transparent sharing of information on health security threats in this Region.

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