

Editorial

Implementing the Revised International Health Regulations in India

On 23 May 2005, the World Health Assembly adopted the new International Health Regulations (IHR).¹ The revised IHR came into force on 15 June 2007 in 193 member countries of the World Health Organization (WHO). The goal of the IHR is to prevent the international spread of emerging infections such as severe acute respiratory syndrome (SARS), a pandemic of human influenza, as well as other public health emergencies such as chemical and industrial accidents that may affect populations across borders. The IHR (2005) are an update of the IHR (1969), which were limited to the reporting of just 3 infectious diseases—cholera, plague and yellow fever.² The IHR (2005) are broader in scope and require each country to report to the WHO ‘any public health emergency of international concern (PHEIC)’, whether nuclear, biological or chemical in nature, irrespective of the origin. In contrast to the IHR (1969), which were restricted to the passive reporting of information by governmental authorities, the IHR (2005) are proactive and include provisions that empower WHO to initiate an assessment and response based not only on government reports but also other relevant information and reports by the media and non-governmental organizations (NGOs).

Diseases reportable under the IHR (2005)

The infectious diseases reportable under the IHR (2005) include unusual diseases such as smallpox, wild poliovirus infection, human influenza (new subtype), SARS; epidemic-prone diseases such as cholera, pneumonic plague, yellow fever, viral haemorrhagic fevers, West Nile fever; and diseases of special regional concern such as dengue fever (Fig. 1). There are several recent examples of internationally notifiable infectious diseases that have occurred in India. In April 2007, in an outbreak of Nipah virus infection in Nadia District in West Bengal, 5 individuals were infected and all died.³ A total of 255 cases of poliomyelitis due to the wild-type virus have been reported in India up to September 2007.⁴ Although no human influenza cases have been reported so far, H5N1 outbreaks among poultry in Maharashtra, Gujarat and Madhya Pradesh and more recently in Manipur indicate the need for continued vigilance.⁵ Outbreaks of water-borne and vector-borne diseases such as cholera and dengue fever are also common in India.

Requirements of the IHR (2005)

The requirements that need to be fulfilled by WHO member countries to comply with the IHR (2005) include (i) designating a national IHR focal point; (ii) strengthening core capacity to detect, report and respond rapidly to public health events; (iii) assessing events that may constitute a PHEIC within 48 hours and notifying WHO within 24 hours of assessment; (iv) providing routine inspection and control activities at international airports, ports and some ground crossings; and (v) examining national laws, revising health documents/forms and certificates, and building a legal and administrative framework in line with the IHR requirements. Member countries are required to complete the assessment of existing national structures and resources by June 2009, and develop the necessary public health infrastructure and human

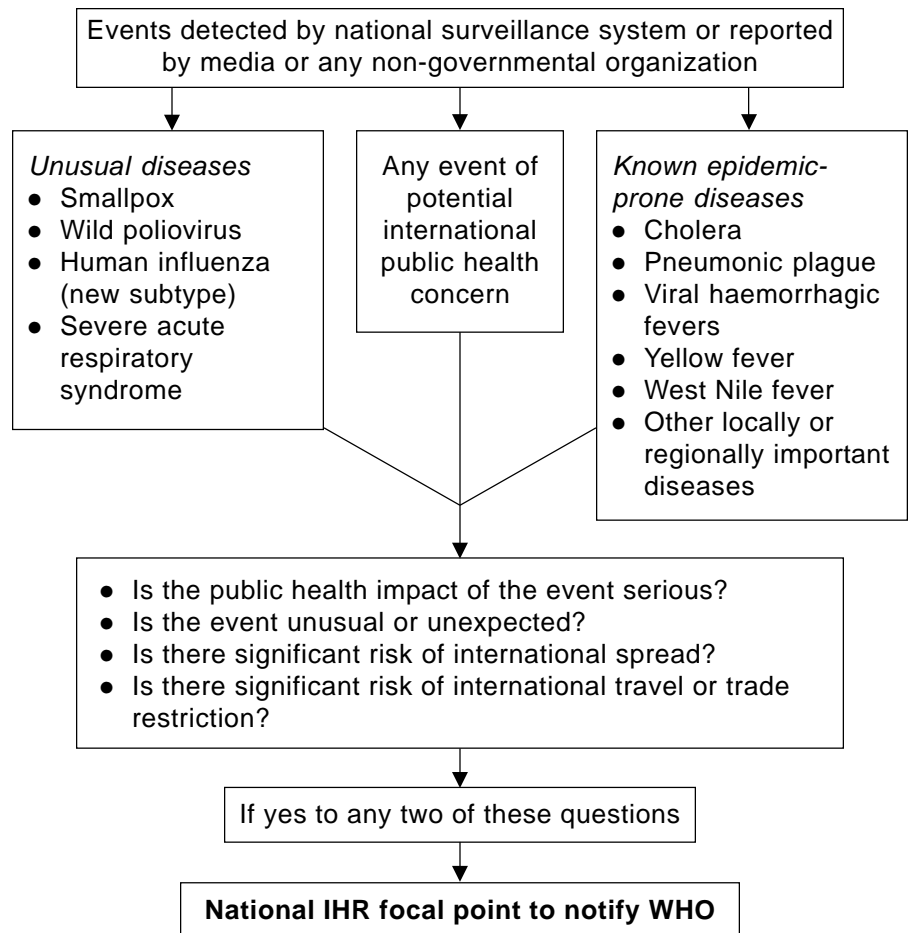


FIG 1. Simplified decision instrument for assessment and notification of events that might constitute a public health emergency of international concern under the International Health Regulations (IHR) 2005

resources to meet the IHR requirements by 2012. Concerned about the public health risk from human cases of avian influenza, several countries including India volunteered to implement in advance some provisions of the IHR (2005).¹

Progress in implementation of the IHR (2005) in India

IHR requirements are being actively implemented in India. The Government of India has designated the National Institute of Communicable Diseases (NICD) as the national focal point for IHR; state-level and district-level focal points are being identified. Strengthening national surveillance systems is at the heart of IHR (2005). The Government of India has allocated Rs 4.08 billion (Rs 408 crores) over 5 years for the Integrated Disease Surveillance Project (IDSP) to build infrastructural and human capacity at the district and state levels. Under this project, nearly 20 000 medical officers, 115 000 health workers and more than 4000 laboratory technicians have been trained so far in procedures for rapid detection and response to disease outbreaks in 22 states. As envisaged in the National Rural Health Mission, accredited social health activists (ASHAs) can play an important role in reporting unusual events to the local authorities. Improved diagnostic capability through functional laboratories is a prerequisite for the identification and surveillance of new pathogens. Towards this goal, 2 biosafety level (BSL)-3 laboratories have been established—one at the NICD, Delhi and the other at the National Institute of Virology, Pune. Networking between laboratories of different capacities has been planned at various levels in India.

Information technology is being harnessed to facilitate rapid communication from the districts upwards. In collaboration with the Indian Space Research Organization,

the National Informatics Centre and Bharat Sanchar Nigam Limited, districts are being connected electronically through satellite and the terrestrial network for transmission of surveillance data, videoconferencing and distance learning.

Another important obligation of the IHR (2005) is to provide routine inspection and control activities at international airports, ports and ground crossings. Each year, more than 25 million international passengers pass through India via 21 international airports, 12 ports and 3 major land border crossings. The Public Health Act of India has been drafted and the Indian Port Health Rules and Indian Aircraft (Public Health) Rules are currently being examined for their compliance with IHR (2005).

Challenges to implementation in India

While implementation of the IHR (2005) is being systematically planned, several challenges are anticipated in its operationalization in a country as large and diverse as India. A strong public health infrastructure and participation of all governmental organizations and NGOs are important prerequisites for successful implementation of the IHR (2005). Reporting of and responding to public health emergencies in a timely manner requires the full participation of and commitment from every health professional, whether in the public or private sector, or from civil society or the media. Moreover, as many emerging infectious diseases are zoonotic in origin, there is a need for close collaboration between the veterinary and human health sectors. As health is a state subject in India, the local and district administration, and state governments will have to be fully involved and committed to operationalizing the IHR (2005) in their areas of jurisdiction. Failure to share information in a timely manner by local public health authorities undermines the IHR and can be detrimental to the national economy. Another important challenge is that huge financial resources will be required to fully comply with the IHR (2005) requirements. Unless the level of government investment in public health infrastructure is enhanced substantially, the essential capacity required to detect and contain infectious diseases and other public health emergencies will remain limited.

Opportunities provided by the IHR (2005)

The many challenges in implementing the IHR (2005) can also be seen as opportunities for strengthening public health systems in India. Working within a multilateral framework based on partnership and collaboration, India stands to benefit from the IHR (2005) by improving national surveillance capacity, building on current systems to quickly respond to public health emergencies, encouraging the use of modern communication tools, and increasing commitment to public health. The IHR (2005) also present an important opportunity for the international donor community to make a long term investment in India's public health infrastructure. Strengthening core capacity for surveillance so that public health emergencies are detected rapidly, verified and reported can help in ensuring national and international health security.⁶

Conclusion

The IHR (2005) is a historical development in public health. The Regulations offer an expanded scope to prevent and contain the international spread of infectious diseases and other emergencies. Turning the vision of IHR (2005) into a reality in India may be a challenge but brings unparalleled opportunities to work together to further fortify the foundations of public health systems in India.

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JAI P. NARAIN
*World Health Organization
Regional Office for South-East Asia
New Delhi
narainj@searo.who.int*

S. LAL
*National Institute of Communicable Diseases
New Delhi*

R. GARG
*World Health Organization
Regional Office for South-East Asia
New Delhi*

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—Editor