



**Richard and Janet Southby Distinguished Lectureship in  
Comparative Health Policy  
The George Washington University School of Public Health  
and Health Services  
April 6th, 2010  
George Washington University Hospital Auditorium  
9am-noon**

**About the Event**

The Richard and Janet Southby Distinguished Lectureship in Comparative Health Policy is made possible by a gift from Dr. Richard and Janet Southby to the School of Public Health and Health Services (SPHHS). The lectureship is dedicated to issues in health policy that focus on aspects of domestic policy as they relate to comparative and global policy matters

On Tuesday, April 6, 2010, the George Washington University School of Public Health and Health Services (GW SPHHS) hosted the annual Southby Distinguished Lectureship in Comparative Health Policy on the “International Health Regulations.” This lectureship gave an overview of the U.S. Government’s approach to addressing the challenges, policies, and opportunities related to both domestic and international implementation of the IHR (2005).

Introductory remarks were given by GW School of Public Health faculty, including Josef Reum, Interim Dean; Professor Sara Rosenbaum, Chair of the Department of Health Policy & Hirsh Professor of Health Law and Policy; Richard Southby, Executive Dean Emeritus; and Rebecca Katz, Assistant Professor, Department of Health Policy.

The plenary speakers were Mr. Andrew Weber, Assistant to the Secretary of Defense for Nuclear, Chemical and Biological Defense Programs at the Department of Defense; Dr. Nicole Lurie, Assistant Secretary for Preparedness and Response at the Department of Health and Human Services; and Dr. Scott Dowell, Director of the Global Disease Detection Program at the Centers for Disease Control and Prevention.

The discussants were: Dr. Julie Fischer, Stimson Center; Ms. Jennifer Kates, Kaiser Family Foundation; and Dr. Stephen Morrison, Center for Strategic and International Studies.

## **Overview of Presentations:**

### **Mr. Andrew Weber**

#### **DoD sponsored IHR (2005) implementation efforts, in the context of DoD's international health strategy**

Mr. Weber addressed the Department of Defense's strategy for compliance with the IHR (2005) while also promoting the goals of the US National Strategy for Countering Biological Threats. The goal of the National Strategy is to "protect against the misuse of the life sciences to develop or use biological weapons", emphasizing early and preventive strategies as well as maintaining existing global public health partnerships. Mr. Weber identified the emerging biological threats and obstacles facing US national security, including established bioterrorism programs, emerging infectious diseases, the proliferation of unsafe bio-containment laboratories, Al-Qaeda's call for scientific expertise to develop biological weapons, and the weaknesses identified in the WMD Commission report.

Mr. Weber discussed the US Cooperative Biological Threat Reduction program, which has been amended to promote IHR 2005 compliance and to focus on prevention. These focus areas were designed to respond to the heightened need for global disease surveillance, to identify pandemics, and to broaden the definition of biodefense. Weber emphasized the importance of DoD's engagement in these areas, and spoke to the importance of the relationship between health and security.

In his final remarks, Mr. Weber promoted US expansion of the current Cooperative Threat Reduction programs through global engagement focusing on increasing global efforts to secure high risk chemical, biological, and nuclear materials, and the integration of efforts by partner organizations. Weber made clear his personal commitment to IHR (2005) implementation, his understanding of the linkages between health and security, and his plans to promote DoD's efforts in this area.

### **Dr. Nicole Lurie**

#### **"IHR (2005) Implementation efforts in the context of domestic preparedness and response"**

Dr. Nicole Lurie discussed the revised IHR (2005) implementation efforts within the US domestic context and addressed the key issues that will be of great importance for US compliance with the regulation. Dr. Lurie outlined four tenets of the IHR (2005) as risk assessment, identifying a Public Health Emergency of International Concern (PHEIC), the creation of a 24/7 communication network through National Focal Points (NFPs), and establishing core public health capacities at the international level.

While the IHR (2005) sets out to establish an international disease surveillance system and develop widespread core public health detection, reporting, and early response capacities based in science, major limitations remain. These constraints include the political realities of developing and maintaining infrastructure, the potential effects it will have on trade and travel, and the possibility of the implementation of questionable and austere health measures that have little or no value. Dr. Lurie noted that her greatest concern is that people will forget about H1N1,

rather than using the situation to recognize that something can emerge in the “backyard” of the US.

In her conclusion, Dr. Lurie suggested that the IHR (2005) international security framework can help US domestic public health by promoting early detection, quick and continuous information sharing, improving the rate of response to an event, and addressing PHEICs through multilateral, trilateral, and cross-sectional strategic partnerships.

**Dr. Scott Dowell,  
“IHR (2005) Implementation Efforts in the Context of Global Health Priorities at CDC”**

Dr. Scott Dowell discussed the implementation of the IHR (2005) within the context of the Centers for Disease Control and Prevention’s (CDC) global health priorities. Beginning with an example of the investigation of a mystery illness (Nodding Disease) in Kitgum District, Uganda, Dr. Dowell demonstrated that while some PHEICs, like novel influenza in 2009, can be readily apparent, others potential PHEICs, like Nodding Disease, are slower moving and more complex. He also raised the question of whether or not slow-moving outbreaks and disease that take time to cause morbidity and mortality should be qualified as PHEICs.

In light of that reality, Dr. Dowell stated that the challenges for international disease surveillance lie in countries’ inability to “promptly detect and report events” and the “reluctance of governments to report to the global community.”

The CDC supports the efforts of the IHR (2005) through its Global Disease Detection and Emergency Response (GDDER). This program establishes and connects GDD Regional Centers with all WHO regional partners, builds a multilateral international network through the partnership of ministries of health and US agencies, integrates surveillance activities, and strengthens “global systems through the WHO Collaboration Center.” Dr. Dowell noted that the GDD program has worked on in-depth surveillance, a global health presence (established labs in 7 countries), a worldwide disease surveillance system, a global outbreak response network, training in epidemiology and laboratory science for partner countries, and overall improved pathogen detection and outbreak responses.

Dr. Dowell concluded that while GDDER has improved the detection and containment of PHEICs, there are many barriers that prevent it from doing so perfectly. Not all PHEICs are obvious, and some require in-depth field and laboratory testing. The IHR requires detection capacity and while GDDER can help, it remains unattainable in many lower income environments. In order to close the geographic gaps in coverage, Dr. Dowell exhorted attendees to work toward a worldwide common mission and consistent metrics to facilitate achieving global disease surveillance.

**Discussion**

**Dr. Julie Fisher, Stimson Center**

Dr. Fisher focused on the need to build cooperation between surveillance systems to ensure both daily and emergency disease detection across the globe. Her analysis drew out the difficulty of

building surveillance capacity in all countries, particularly those that are not on the high-priority lists for the US and other developed nations for defense reasons. She noted that where the US focuses capacity building efforts is based on a combination of security, diplomatic, and public health priorities and that in different countries different agencies would need to take the lead. In addition, she mentioned the need for specific core capacities to attract donors, both public and private, to surveillance systems building and the need to build capacity in a way that is appropriate for the individual nation.

**Ms. Jennifer Kates, Kaiser Family Foundation**

Ms. Kates raised several questions in relation to IHR 2005. First, why is the IHR not included in the Global Health Initiative and what message does that send? Second, what differences can be observed between the SARS outbreak before the new IHR and the H1N1 pandemic with the new IHR. Third, how do you encourage compliance, since there is no “stick” option and what incentives can be used? Fourth, how does the Federalism Reservation affect the implementation of the IHR in the US and how can we work within it? And finally, are direct measures of IHR implementation the best method or should proxy measures for surveillance effectiveness be used instead? She also discussed the possibility that relationships built through other treaties and US programs might be useful for global outreach on the IHR.

**Dr. J. Steve Morrison, CSIS**

Dr. Morrison opened by reminding the audience that the IHR can be a strongly positive agreement for global health, but that implementation must be handled with care. He directly addressed issues of sovereignty in the agreement and the need to be cautious in using informal networks to achieve compliance, since they become more obvious as they become more powerful. To move past issues of sovereignty, we need to clearly argue that the IHR enhance national priorities for every nation and make it clear that the benefit is universal, not just to the developed countries. He also noted that accomplishing these goals requires clear metrics, strategies, and priorities, as well as a focus on improving the ability of the WHO to coordinate global efforts. Finally, he noted that the speakers had not discussed the communications piece of the IHR and stated that getting a cohesive message out in the age of media was a challenge that needs to be addressed in future discussions.

**Question and Answer**

The question and answer period raised several important points. Questions focused mainly on implementation and clarification of the purpose of the IHR, including how the IHR can be implemented domestically in the context of the 10<sup>th</sup> Amendment, how ASPR is moving forward with CDC, and whether or not the IHR can be applied to chronic disease or climate change. In a question for Mr. Weber, one audience member also raised concerns about dealing with sovereignty under the IHR and how the IHR can be explained to the Department of Defense to gain more internal support.

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