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EBOLA, THE WORLD HEALTH ORGANIZATION, AND BEYOND: TOWARD A FRAMEWORK FOR GLOBAL HEALTH SECURITY

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The West African Ebola epidemic has taken over 11,000 lives. By contrast, AIDS, tuberculosis and malaria together kill approximately 3.5 million people every year. Given the relatively low death toll, why has Ebola changed the paradigm for global health security? There are no fewer than four global commissions to learn the lessons of Ebola—the United Nations, the World Health Organization (WHO), the National Academy of Sciences, and the independent panel by Harvard and the London School of Hygiene and Tropical Medicine.

The United Nations has convened a high-level panel on the Global Response to Health Crises. Chaired by the President of Tanzania, Jakaya Kikwete, and drawing on the lessons of Ebola, the panel will recommend ways to strengthen national and global systems to prevent and manage health crises in a report to the Secretary-General in December 2015. The WHO panel, convened in March, has already issued an interim report. Meanwhile, the US Global Health Security Agenda continues apace, with funds now being disbursed, such as a \$15 million three-year commitment to Cameroon. On June 7-8, Angela Merkel will host the G7 summit, with global health security at the top of the agenda.

The reason for the intense search for a new global health framework is that an entirely preventable epidemic reached exponential growth in the world's poorest region, with key global health actors such as the WHO failing badly in their



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leadership functions. Although Liberia has been Ebola free for several months, Ebola activity in Guinea and Sierra Leone has become more intense since May 10, when the region saw cases hit a 10-month low.

The World Health Assembly (WHA) this year was critically important to the future of the WHO. The 68th Assembly did act to improve global health security, but it failed to address the deep structural problems facing the Organization. It set in motion a reform agenda but if it does not meet global expectations, it could threaten the WHO's legitimacy for a generation. Given the high stakes, what did the Assembly actually decide, is the reform likely to transform its ability to function effectively, and what did the Assembly entirely ignore to the detriment of the Organization?

The WHA took four major steps to shore up its epidemic response: combine its outbreak and emergency response programs; create a \$100 million emergency contingency fund; develop a new global health emergency workforce; and launch a reform process for the International Health Regulations (IHR). Here, we assess the strengths and weaknesses of these proposals. More importantly, we explain what the Assembly has *not* done, which is to address the deep structural problems that have plagued WHO for decades.

INTEGRATING WHO'S OUTBREAK AND EMERGENCY RESPONSE PROGRAMS

Margaret Chan, the WHO Director-General, announced plans to create a single in-house program for health emergencies, combining the existing outbreak and emergency response units. The Assembly went further, asking the Secretariat to "unite and direct all WHO outbreak and emergency response operations ... under the direct supervision of the Director-General."

The fact that outbreak and emergency response fell under separate organizational structures in the Secretariat was incoherent, as these need to be seamless functions. The new combined unit will be designed for speed and flexibility, with program performance benchmarks "showing what must happen within 24, 48, and 72 hours, not months," according to Dr. Chan. The new unit will partner with United Nations agencies, states, and nongovernmental organizations (NGOs), such as Médecins Sans Frontières (MSF).

From an organizational perspective, the new unit would be more rational and designed for rapid response. Yet, there are no new funding sources to support outbreak and emergency response. If Dr. Chan were to shift funding from her core budget for epidemic response, she risks further weakening already badly underfunded programs such as for non-communicable diseases and mental health.

The WHO is not known for moving at the speed that outbreaks require. Will the new unit be different? Or will the WHO need to take one more step, establishing the unit as a semi-autonomous structure? Only days before the WHA, German Chancellor Angela Merkel proposed a semi-autonomous entity within the WHO with dedicated funding, a high degree of independence, an external advisory board, and its own director, who would report to the



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Director-General. Outside the ordinary WHO structures and committed to transparency, it would be freer to frankly assess how states were meeting their responsibilities under the IHR.

Such an approach has something to offer, combining the WHO's credibility with ministries of health, global relationships, and IHR responsibilities with an independence that mitigates the political obstacles and bureaucratic processes that can hinder WHO action. The various post-Ebola review committees should give it serious consideration.

THE GLOBAL HEALTH EMERGENCY WORKFORCE

The absence of a robust domestic workforce represented a signal failure of the West African Ebola response. The 3 post-conflict countries – Guinea, Liberia, and Sierra Leone – had among the world's lowest health worker-to-patient ratios, and lost more than 500 doctors, nurses, and other health workers to the epidemic. Although NGOs such as MSF and foreign workers filled some of the gap, the paucity of human resources significantly impeded the response.

The Organization is doing very little to build human resource capacities in low and middle income countries, which would be far more effective at preventing, detecting, and responding to future outbreaks. However, the Assembly endorsed the D-G's plan to launch a global health emergency workforce, reporting back to the Executive Board on progress in January 2016, a function consistent with Article 2(d) of its Constitution: "to furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of Governments."

The new outbreak and emergency response unit will coordinate the emergency workforce, drawn from existing networks including the Global Outbreak Alert and Response Network (GOARN), the Global Health Cluster, foreign medical teams, and NGOs. The D-G also announced that WHO is strengthening its own emergency staff, adding logisticians, medical anthropologists, and experts in risk communication.

What the Ebola response vividly demonstrated is that an effective response requires a range of human resources: clinicians (e.g., doctors, nurses, and community health workers), public health professionals (e.g., to conduct surveillance, laboratory analysis, and contact tracing), and experts in communications, culture, and behavior to gain insight into local belief systems. These work skills need to be ensured through comprehensive training and certification, which will be crucial to the success of the workforce reserve.

A global health workforce cannot be effective unless barriers to their effective deployment are dismantled. It will be important to ensure that visas for foreign workers are expedited and permits are issued rapidly to allow entry of essential medical and humanitarian supplies. At the same time, it will be necessary to ensure that health workers have adequate supplies of personal protective equipment, essential medicines, and well functioning clinics. If they fall ill, there is an ethical duty to provide the most effective available treatment and, if necessary, medical evacuation. Despite the critical importance of training, medical supplies, and logistics, the WHO is implementing the emergency workforce without any new dedicated funds. It is hard to conceive how such a vital



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operation can be conducted without a major injection of sustainable resources.

Done right and properly resourced, a global health public workforce will be much more than a mechanism for global outbreak response. Training for the global health workforce would bolster countries' capacities to deal with national and regional epidemics. Well-trained health workers would serve their communities, being deployed elsewhere only when needed to quell a major outbreak.

THE AFRICAN CENTERS FOR DISEASE CONTROL AND PREVENTION

The African Union (AU), with 54 member states, is about to launch the [African Centers for Disease Control and Prevention \(ACDC\)](#) with the US CDC's technical assistance. The West African Ebola epidemic became the tipping point for the formation of the ACDC, based initially at the AU headquarters in Addis Ababa. It will coordinate pan-African research on public health threats, and reinforce countries' capacities for preventing and responding to outbreaks, including a rapid response force. A logical role of a new ACDC would also be to bolster local response capacities.

The ACDC is expected to launch soon, likely next month, with a mandate that encompasses just this – improving countries' ability to prevent and respond to epidemics, such as through a continental rapid-response force – along with providing health data and coordinating research on public health threats in Africa. Yet with a budget of \$6.9 million for its first 18 months and only 11 staff, its mission vastly exceeds its own capacity.

This mismatch between mission and resources has echoes of the [African Public Health Emergency Fund](#), which last year began disbursements to countries to help them respond to public health emergencies, including disease outbreaks and natural and manmade disasters. Yet while the fund began seeking \$50 million per year from its members beginning in 2012, it had [less than \\$4 million by mid-2014](#). While there are more resources within Africa that can and should be mobilized, the international community ought to provide more support to both these initiatives.

A \$100 MILLION EMERGENCY CONTINGENCY FUND

In 2011, the independent WHO Review Committee on IHR functioning in the aftermath of the Influenza H1N1 pandemic proposed a \$100 million contingency fund. Even though the Committee found that the world is "[ill-prepared](#)" for a major epidemic, the WHO never adopted its recommendation. The D-G's strategy was to [mobilize international funding when an emergency strikes](#), believing that rich states and philanthropists would react quickly to exigent circumstances. Yet, the Organization should have realized that once a rapidly moving infectious disease emerges, it would be too late to first begin resource mobilization. That turned out to be the case with Ebola, as WHO appeals for funding took too long to materialize.

[Article 58 of WHO's Constitution](#) stipulates that a special fund to be used at the discretion of



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the Executive Board shall be established to meet emergencies and unforeseen contingencies. Following Ebola, the Organization plans to launch a “specific, replenishable contingency fund ... with a target capitalization of \$100 million.” Notably, the fund will be financed by flexible voluntary contributions, but not additional core funding through mandatory assessed dues. The contingency fund, while vitally important, appears to be too little. If one considers the billions of dollars in humanitarian assistance and the anticipated loss of approximately 12% of the GDP in 2015 alone in the most affected countries, \$100 million seems incommensurate with the need.

The trigger point for deployment of the fund is also important. The D-G was heavily criticized for delays in declaring a Public Health Emergency of International Concern (PHEIC) under IHR. Wisely, release of the contingency fund would not be tied to a PHEIC declaration. Instead, the agency plans to use the Emergency Response Framework grading system as the trigger for drawing down the contingency fund. For example, the fund could be deployed following the designation of a grade 2 emergency under the Framework, or the trigger point may be more dynamic and flexible. The Assembly ultimately left the decision to the D-G to determine when to deploy the emergency fund.

To be effective, a contingency fund must be commensurate with the need, sustainable, available for rapid use, and of global reach. The goal of a WHO contingency fund should be to prevent an event from escalating into a PHEIC or a Grade 2 or 3 emergency. Yet, the size of the fund, as suggested above, is too low, particularly for events that are not stopped in their early phases, and it requires voluntary contributions from member states or other donors. Adding new resources to the WHO’s core budget would have been more viable and sustainable.

Meanwhile, having proposed what would be a potentially significantly larger source of funding to respond to an outbreak, the World Bank continues to hold discussions about the Pandemic Emergency Facility (PEF) with a range of partners, including WHO, governments and other development partners, and the private sector. The Bank envisions PEF as a mechanism to prevent epidemic outbreaks from becoming pandemics, channeling funds to all actors that are part of the response, including WHO, UN agencies, governments, and NGOs. It would follow an insurance model, aiming to incentivize countries to develop the capacities they require to prevent and respond to outbreaks, such as by linking premium payments to the degree to which countries have met their obligations under the IHR.

With World Bank President Jim Kim keen on the possibilities of this new financing mechanism and convinced of its urgency – including the need to have it up and financed before the next major outbreak strikes – we can expect to learn more details soon, such as the size of the fund, when it expects to become operational, and exactly how it will be structured to encourage preparedness even as it funds emergency responses. The linkage between preparedness and premiums would have to be designed in a way to ensure that the countries with the fewest resources to develop core capacities aren’t penalized with higher premiums, yet still encouraging these countries to develop these capacities even as funds come largely from wealthier nations.



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THE INTERNATIONAL HEALTH REGULATIONS

The IHR are the key international legal instrument for governing outbreaks of international concern, including core capacities to detect, assess, notify, and respond to potential global health emergencies. Yet, the Ebola epidemic revealed deep flaws in IHR compliance and effectiveness. The 68th Assembly directed the D-G to establish an IHR review committee to assess their functioning, transparency, effectiveness and efficiency. Despite well-understood deficiencies, however, the Assembly took no decision on IHR reforms and allocated no resources to supporting IHR implementation. Here are the critical choices for fundamental IHR reform:

Core capacities. The IHR require states to develop core health system capacities, yet only about a third have done so: among 196 states parties, only 64 informed the Secretariat that they achieved these core capacities, 81 requested extensions, and 48 did not even communicate their status or intentions. Beyond failure to meet critical capacities, the IHR allow states to self-assess, without any independent evaluation. The IHR should be amended to require states to invest in building capacities, and require WHO to rigorously evaluate their performance.

Transparency and accountability. The D-G did not declare a PHEIC until 4 ½ months after the international spread of Ebola was first detected, and well over a month after MSF called for a “massive deployment of resources.” Leaked internal documents demonstrated that the D-G was under political pressure not to declare an emergency. The composition and deliberations of the IHR committee that advises the D-G are not disclosed, undermining the transparency and public accountability required of an international organization. Three reforms are required to insulate the D-G from political constraints and to open the process to greater scrutiny. First, instead of an all-or-nothing declaration of a PHEIC, there should be a graduated response as an outbreak becomes ever more serious. Second, there should be open disclosure of IHR committee deliberations. Third, an independent “shadow” committee should be developed to advise the D-G, particularly on when to convene the formal IHR committee.

IHR recommendations. When the D-G declares a PHEIC, she is required to make recommendations to member states. In past global emergencies Dr. Chan asked states to develop capacities to respond, and cautioned against overreactions, such as bans on travel and trade and the use of quarantines. Yet, the H1N1 and Ebola emergencies demonstrated that states routinely ignore IHR recommendations. There are no incentives, no compliance mechanisms, and the D-G does not single out states that fail to adhere to their international obligations. The IHR need to be reformed to create compliance-enhancing features, such as public evaluations of compliance and potential sanctions for failure to implement IHR recommendations.

DEEPER STRUCTURAL REFORMS NEEDED

There are at least three major structural deficiencies at WHO that has been widely known. Yet, the Assembly did nothing to change the agency's underlying fundamentals.

Budget and assessed dues. The WHO 2016/17 budget will be \$4.385 billion, a 10.3% increase



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over the previous biennium. This level is wholly incommensurate with its worldwide mandate, lower than the budget of major hospitals in the United States. In the proposed budget, moreover, mandatory assessed dues remain at their 2012/13 level, representing zero nominal growth, and account for just 21% of the program budget. Voluntary contributions by member states and large donors (e.g., the Gates Foundation) account for the remaining 79%. The WHO's budget, therefore, is not only inadequate to meet global health needs, but the D-G controls a small portion of her budget so that external donors influence the Organization's priorities and action agenda. No agency can operate when it has so little control over its work program.

Worldwide incoherence. During the Ebola outbreak, WHO headquarters and the African Regional Office (AFRO) were in tension, with AFRO and African country offices sometimes blocking visas for foreign aid workers and failing to rapidly issue permits to offload critical medical supplies. If the WHO is to fulfill its constitutional mandate to lead and coordinate the global response, there needs to be greater coherence between the Organization's different levels. Yet the Assembly did not alter the method of appointing the Regional Director or put in place concrete reforms to ensure greater worldwide coherence in operations.

Civil society engagement. Although the Secretariat is exploring new ways to harness the creativity of civil society and avoiding conflicts of interest with vested business interests, the Assembly did not address governance reforms. The Global Fund, GAVI Alliance, and UNAIDS all include civil society in their governance decisions, but the WHO remains an outlier. What the AIDS experience taught us is that harnessing the creativity and advocacy of civil society can lead to transformational change.

I propose that the Assembly create a special Chief Operating Officer to report on fundamental reform of the Organization's funding, governance, and civil society engagement. It is clear that the D-G is too politically influenced by member states to take the bold decisions needed to belatedly bring the WHO into the 21st century and assure its future.

Without this kind of push from the outside, the WHO's future leadership is not assured. To be sure, the Organization has improved its ability to put out fires in the form of rapidly emerging infectious diseases. Although there is a better fire brigade, there is precious little the Assembly has done to prevent fires from erupting with ever-greater frequency in every region of the globe ●