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The United Nations and Global Health Crises. Lessons learned from the Ebola outbreak

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The Ebola epidemic in West Africa is the worst outbreak in history, with a total of 24,282 cases and 9,976 deaths (as of 11 March 2015). The weak health systems in the countries at the epicentre of the outbreak – Guinea, Liberia and Sierra Leone – played a role in its escalation into a public health emergency, but the international crisis response system clearly reached its limits as well. The emergency response initially lacked intensity, and was scaled up only when Ebola was discussed by the United Nations Security Council. This is not a viable model for the future global health crisis response: instead, existing structures centred on the World Health Organization (WHO) must be strengthened and expanded.

The genesis of an international public health emergency

The Ebola epidemic in West Africa differs in several crucial respects from previous known outbreaks of the disease, which first occurred in Central Africa in 1976. The virus had never before been recorded in West Africa, which meant that the health systems of the worst-affected countries – Guinea, Liberia and Sierra Leone – had no experience of dealing with this disease. What's more, previous outbreaks of Ebola in Central Africa had largely been confined to rural regions. This time, however, the epidemic spread to urban areas, including the capital cities. Its broad geographical spread presented a massive challenge for the already extremely weak public health systems and the international response.

Making matters worse, Guinea, Liberia and Sierra Leone are some of the world's poorest countries, with public health systems shattered by years of civil war, political instability and corruption. However, an effective Ebola response requires not only well-trained medical teams with the right protective equipment, but also specialist inpatient treatment facilities, laboratories and basic health services so that patients can be provided with the care they need. In all three countries, these systems are rudimentary in the extreme. They also lack well-functioning public disease control systems, which is why the initial outbreak in December 2013 in a remote border region of south-east Guinea went largely unnoticed at first and was able to spread unhindered to other regions and, indeed, to neighbouring Liberia and Sierra Leone. The first cases were finally notified to the World Health Organization in late March 2014.

The reason for the rapid spread across the affected region is the local population's high level of mobility: due to poverty, people have no option but to travel large distances in search of food and work, crossing back and forth across the region's extremely permeable borders. However, ritual burial practices, which involve the washing of bodies and physical contact with the deceased, emerged as one of the main routes for the transmission of the disease. The average case fatality rate for Ebola is around 50%, but have varied from 25% to 90% in past outbreaks. This meant that even if infected persons were able to travel from their villages and districts to the new treatment centres, they often never returned home. Due to a lack of knowledge about the disease and its transmission,

"Western" medicine was therefore often blamed for the many deaths, resulting in a number of physical assaults on local and foreign medical staff and, in some cases, people keeping their sick relatives out of sight of medical teams. The sometimes very inflexible approach of the overstretched public authorities in enforcing quarantine measures and restrictions on economic and social activities, without any information or awareness-raising at first, did little to increase the already very low levels of public confidence in government.

An innovation for the UN: the United Nations Mission for Ebola Emergency Response (UNMEER)

The WHO finally declared a public health emergency of international concern (PHEIC) on 8 August 2014 in accordance with the International Health Regulations (IHR 2005) and published an Ebola Response Roadmap on 28 August 2014, whose aim was to stop Ebola transmission in affected countries within six to nine months. But there was still no sign of a concerted international response. It was only when the United Nations Security Council – for the first time in its history – addressed an acute public health crisis on 18 September 2014 and defined the Ebola outbreak in Africa as a threat to international peace and security in Resolution 2177 that the UN member states and other UN agencies took more resolute action. The UN Secretary-General established the United Nations Mission for Ebola Emergency Response (UNMEER) and appointed Dr David Nabarro as his Special Envoy on Ebola in order to improve the coordination of the international response. Many countries, including Germany, also appointed national coordinators for better management of the various aid programmes.

Under the leadership of Special Envoy Nabarro, five strategic objectives – the STEPP strategy – were specified for the national and international response: (1) STOP the outbreak, (2) TREAT the infected, (3) ENSURE essential services, (4) PRESERVE stability, and (5) PREVENT outbreaks in countries currently unaffected. Plans to support the countries' transition to recovery were included from the outset. An Overview of Needs and Requirements (ONR), including funding, was drafted for this package in September 2014 and has subsequently been amended and updated. In order to mobilise the required funding, an Ebola Response Multi-Partner Trust Fund was launched alongside the participating UN agencies' existing financing mechanisms. The Trust Fund draws on the UNMEER governance structures and serves as a common financing mechanism to ensure a coherent UN System contribution to the overall Ebola outbreak. Additional funds from governments and non-governmental donors can thus be targeted towards high-priority measures. Strategic coordination is provided by the Global Ebola Response Coalition (GERC), an informal group consisting of representatives of the most affected countries, bilateral and multilateral donors, and UN agencies, NGOs and foundations. The Special Envoy on Ebola convenes the Coalition on a regular basis.

Thanks to this concerted and, above all, coordinated approach, new infections have dramatically decreased, although the goal of "zero Ebola infections" has still not been reached (as at mid March 2015). Liberia has reported no new confirmed cases for the second consecutive week, but the Ebola outbreak will only be officially over when 42 days have passed since the last confirmed case has twice tested negative for the virus. Efforts are therefore still directed primarily at combating the disease, i.e. the response. Nonetheless, plans for post-epidemic recovery in the affected countries are already in place, with a particular emphasis on developing sustainable health systems. This was the focus of a High Level Conference on *Ebola – from emergency to recovery*, hosted by the European Commission in Brussels in early March 2015.

The new goal: an effective system for the international health emergency response

The Ebola outbreak in West Africa has clearly shown that the existing structures of the international health emergency response are seriously flawed. It is, in fact, the WHO which is the directing and coordinating authority for health within the United Nations system. A framework is provided by the International Health Regulations, revised in 2005, which define compulsory measures for international efforts to control infectious diseases. In 2011, however, the Review Committee which conducted the assessment of the WHO's response to the 2009 H1N1 pandemic recommended the establishment of a contingency fund, to be available for deployment at the time of a public health emergency, along with a global public health reserve workforce. Many years of chronic underfunding of the WHO was a factor behind its failure to launch a rapid and appropriate response to Ebola last year. As a savings measure, funding for the response to epidemics and health emergencies in the current budget had been halved, meaning that the WHO was unable to implement its own contingency plan of August 2014 until it had secured funding elsewhere. Furthermore, the WHO's organisational structure, which for historical reasons consists of headquarters in Geneva and six regional offices that operate more or less autonomously, has been a cause of complaint for years. Around 75% of WHO staff work in the regional and country offices, largely beyond the reach of the headquarters in Geneva. A further frequent

complaint is that recruitment to the regional and country offices is sometimes based not on professional qualifications but on political clientelism. As a consequence, head office in Geneva was unable to rapidly mobilise the theoretically available but sometimes poorly qualified personnel for Ebola-affected countries. Indeed, faced with the lack of civilian medical capability, even Médecins Sans Frontières/ Doctors Without Borders (MSF) finally called for the deployment of military medical teams, which were then sent to the region, mainly by the US on President Obama's orders in September 2014. A few days after the adoption of the UN Security Council Resolution on Ebola, German Defence Minister Ursula von der Leyen called on personnel from Germany's armed forces, the Bundeswehr, to volunteer for deployment in Ebola-affected areas.

On 25 January 2015, the WHO Executive Board held a special session on Ebola where, in light of the various failings, it called for a number of key reforms which had not previously been addressed. According to a report by WHO Director-General Margaret Chan, there is a need for urgent change in three main areas: to rebuild and strengthen national and international emergency preparedness and response, to address the way new medical products and vaccines are brought to market, and to strengthen the way WHO operates during emergencies.

Ebola – a wake-up call for WHO reform

The organisational reforms adopted by the WHO Executive Board primarily aim to improve International Health Regulations implementation. Key measures are:

a) financing: a contingency fund for faster access to financial resources in emergencies;

b) governance: a "one WHO" approach to coordinate procedures, mechanisms, risk assessment and surveillance across all organisational levels in emergencies;

c) human resources: a public health reserve workforce at three levels: national, WHO and non-WHO;

d) management: a focus on cultural contexts and more involvement of local communities in the health emergency response;

e) better utilisation of available capacities: establishing new, and expanding existing networks such as the Global Outbreak Alert and Response Network (GOARN), in which government agencies, national scientific institutions, networks of laboratories, UN agencies, the Red Cross/Red Crescent and other international humanitarian organisations have, since 2000, coordinated their work on public health emergencies under the WHO's leadership.

The WHO has already taken practical steps to establish new networks: in order to improve its logistical capacities in Ebola-affected countries, it has formed a partnership with the World Food Programme (WFP), which will be developed for future crises. Furthermore, at the request of the WHO Executive Board, the Director-General set up a six-person expert committee in early March 2015 to evaluate the global response to the Ebola outbreak and make recommendations on further reforms. These recommendations will be submitted to this year's World Health Assembly, the annual meeting of all WHO member states, in May 2015.

Applying the lessons, strengthening the WHO: states have a role to play

The dramatic course of the Ebola outbreak in West Africa seems to have made it clear to the global health community that action is urgently needed at many different levels. The current WHO reform process was initiated some years ago by the present Director-General, Margaret Chan. However, the results are not yet satisfactory, because too many of the proposed measures have received half-hearted support from member states or because – as with the issue of the participation of non-state actors in the WHO – no decision has yet been taken on the direction of further institutional reforms. The WHO's funding problems, too, are a clear sign of member states' lack of confidence in the WHO. Nonetheless, the Ebola crises showed that the WHO is indispensable and that rigorous reform of its mechanisms and structures is all that is required to enable it to mount an effective response to public health emergencies. Establishing new global structures cannot be the default response to future health crises. The network-based approach, of which GOARN is a good example, has proved effective and should be utilised more extensively. Poor coordination between the UN agencies remains a problem, however, which is why UNMEER was established during the Ebola crisis in order to remedy this situation. Measures carried out by all the various organisations, including non-state actors, must be better coordinated, especially in emergencies. For that reason, it is essential that this year's World Health Assembly, where a new proposal on the participation of non-state actors in WHO's work is due to be presented, approves the required structures and processes.

The new fund which is currently being debated should be led by the WHO. It could be established independently of its finance and governance structures

but should link in with existing emergency response mechanisms. The German Government should advocate for this approach at the World Health Assembly and the G7 summit at Schloss Elmau in June 2015.

Notwithstanding international engagement, the prevention of public health emergencies and an effective crisis response crucially depend on well-functioning public health systems in the countries themselves. For that reason, strengthening national health systems, with the goal of universal health coverage, and developing health workforce capacities must be key elements of the new Sustainable Development Goals (SDGs) to be adopted in September 2015. A small-scale vertical approach to public health issues, as practised in the context of the Millennium Development Goals, has proved to be unsustainable. Besides health system strengthening, which is part of the global health strategy adopted by the German Government in 2013, attention must focus on the social determinants of health, i.e. the inequalities which have a negative impact on health, not only in developing countries. Working more intensively at national and international level to address these inequalities should be the next step for the German Government in exercising its responsibility for global health.

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Further information

The Ebola outbreak and the WHO (**http://apps.who.int/ebola/**).

UNMEER (**http://ebolaresponse.un.org/un-mission-ebola-emergency-response-unmeer**).

Shaping Global Health – Taking Joint Action – Embracing Responsibility. The Federal Government's Strategy Paper, July 2013 (**http://health.bmz.de/what_we_do/Sector-strategies/shaping-global-health/Globale_Gesundheitspolitik_engl.pdf**).

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