



**INTERACTION
COUNCIL**

High-Level Expert Group Meeting

Chairman's Report on the High-Level Expert Group Meeting

**“Global Responses to
Public Health Emergencies and
Ensuring Global Health Security”**

**Chaired by
H.E. Mr. Olusegun Obasanjo**

**1 June 2015
Newport, Wales**

The Ebola crisis of 2014-2015 demonstrated once again that global public health is a crucial world priority. The InterAction Council convened some of the world's foremost experts in public health policy, some of whom had first-hand experiences fighting Ebola on the ground in West Africa, to discuss the current state of the world's preparedness and its capacity to respond to global health emergencies.

Global health security affects us all: because of international travel, no place on the planet is immune from the devastating impact of epidemics. The recent Ebola crisis illustrates this. Nine states were affected by the outbreak – Guinea, Liberia, Mali, Nigeria, Senegal, Sierra Leone, Spain, the United Kingdom, and the U.S. The Ebola outbreak is not only important in itself but it highlights general gaps in global health systems: the recommendations of this paper seek to address these concerns. Investing in global public health is not charity, it is an investment in every state's national security.

The recent Ebola epidemic has opened a window of political opportunity to provide necessary leadership and to channel political will to close critical gaps in global health security. There is an opportunity to influence the direction of the Sustainable Development Goals so that they place health issues at the forefront of the development agenda. An 18th sustainable development goal (SDG18) would focus attention on health security needs by addressing current deficits in global health capacity and would serve as a catalyst for more effective public health provisions.

The 2014 Outbreak

The Ebola crisis demonstrates that the way we live today creates an illusion that mankind lives separately from nature. When we see an infectious disease jump from the wilderness and into civilization, we are surprised by the devastating consequences.

In March 2014, the Ministry of Health in Guinea reported an Ebola outbreak. Since the discovery of the disease in 1976, it was the largest Ebola outbreak and the most disruptive and destructive. Previously, Ebola occurred in villages and rural areas; this outbreak affected cities and towns. It was the first time that Ebola had appeared in West Africa and to date, the outbreak has been the most deadly, having taken the lives of more than 11,000 people and affecting the lives of tens of thousands more. As the WHO Interim Assessment Panel

rightfully said, the affected communities “have been indelibly marked by fear and sorrow and by great sacrifice.”

By August 2014, the WHO declared the outbreak a public health emergency of international concern. In September, the UN Security Council determined it a threat to international peace and security – a first for a health crisis. This resulted in the creation of the UN Mission for Ebola Emergency Response (UNMEER), the first ever UN emergency health mission and the largest WHO emergency operation ever. During the crisis, the WHO had 800 staff employed in 60 field sites in Guinea, Sierra Leone, and Liberia, the countries most affected by the outbreak. Elsewhere, Nigeria and Mali contained the outbreak because existing protocols were implemented swiftly and effectively. The international community must now look at what could be done better by the international agencies, and consider the correct approach and whether these structures need to be reformed.

Immediate Implications of Outbreak

The humanitarian impact of this outbreak changed the way the international community viewed global epidemics. It highlighted the importance of global health security and the interconnectedness of individuals, nations, and collective security: one confirmed case of Ebola is already a problem that must be dealt with. Controlling epidemics reaches beyond the borders of the affected states and beyond the capabilities of the global health community. It is impossible, for example, for the WHO to ban international air travel on its own; coordination with IATA would be required to achieve such an end. WHO should remain at the centre of a set of global entities acting in concert and responding to health emergencies. This would include other UN agencies, such as the UNDP, the World Food Programme, as well as other agencies such as the World Bank, the IMF, WTO, and IATA.

The Ebola outbreak crippled the economies of the most affected states. According to UNMEER, by March this year the direct costs of the Ebola outbreak were USD\$6 billion and USD\$15 billion in economic losses. The World Bank estimates that USD\$1.6 billion of economic growth was lost in Sierra Leone, Liberia and Guinea alone. Economic losses would have been greater had the disease reached developed economies. For example, during the SARS epidemic in 2003, nearly 800 people died, far less so than in 2014’s Ebola outbreak, but the macroeconomic costs of the SARS outbreak were estimated between USD\$20 billion to USD\$100 billion. These losses show that the costs of epidemics are substantially greater than

the investment required to ensure prevention and preparedness. It is therefore important to explore what can be learned from the current epidemic and other recent epidemics in order to better prepare for any future emergencies.

A key factor in the prevention of epidemics is the status of national health systems and their preparedness to deal with emergencies. National health systems are better positioned than international organizations to respond to and detect epidemics and other health security threats. They are also well positioned to respond with resources locally. They can provide a guiding hand and coordination for multilateral organizations and other civil society. In order to deal with an outbreak effectively, a state must have trained personnel, stockpiles of personal protective equipment, and available isolation units among other essential tools and infrastructure. These were missing in the countries most affected by Ebola in 2014.

A key concern during an epidemic is accurate information. On the one hand, international actors brought in to deal with a health emergency must be aware of the cultural setting and the languages and literacy rates of the states where they are operating. Written leaflets produced in English are not useful in a place with low levels of literacy, and where most people do not speak English. Leaflets in local languages and with pictures are necessary. New translation and interpretation tools should be developed to assist in situations where foreign medical workers otherwise would have to work with interpreters. On the other hand, we also have to be aware that social media and new technology have changed the way people communicate. Communications have transformed from a top-down (authority-to-public) model to a horizontal (person-to-person) model. This transformation has occurred through a proliferation of mobile devices, increasingly affordable telecommunications technology, and new platforms. Citizens will communicate with one another when an epidemic is breaking out in a region. This could spread panic if the communication is not guided. While the benefits of immediate communication are evident and even crucial to early detection, we also have to foster responsible, educated, and culturally sensitive ways to communicate. The Ebola crisis saw for the first time anthropologists sent in with the first response team.

The UN response to the Ebola crisis was unique in that it led to a paradigm shift in responding to a health crisis with a humanitarian response. By declaring it a threat to international peace and security, the UN Security Council resolution authorized military assets to support efforts on the ground and made it possible to bring together a number of different agencies and actors working towards the goal of reaching zero new patients infected.

Military troops can support civilian powers and provide expertise in logistics and maintaining order under difficult and fragile situations. And even Médecins Sans Frontières (MSF) called for the involvement of the military in dealing with the outbreak.

The International Framework

The International Health Regulations (IHR) were adopted by 194 states in 2005 and entered into force in 2007. The IHR provide a framework for managing and coordinating global health crises, and it aims to improve the capacity of all states to detect, assess, notify, and respond to public health threats. For example, the IHR put in place specific procedures for disease surveillance and reporting to the WHO by states for determining whether a public health emergency is of international concern, and for coordinating international response. It is a legally binding agreement, yet 70 per cent of states have not implemented it fully. Implementation of the IHR is a challenge in many technical areas, including legislation, points of entry, surveillance and response, laboratory capacity, human resource development, and chemical/radionuclear safety. As of January 2015, only 64 states reported that they had met the core preparedness requirements, 81 States requested an extension of the deadline to comply, and 48 states did not report back at all, including the states most affected by Ebola: Liberia, Guinea and Sierra Leone. These implementation reports are self-assessments and not reviewed by independent panels. Therefore, actual compliance may be even lower than reported. The failure to implement the IHR highlights the extreme gap in capabilities to deal with health emergencies.

Moreover, it is widely considered among experts that the agreement drafted in 2005 no longer fully corresponds to current global health challenges. It is therefore suggested that the IHR not only be implemented fully, but that the international community considers redrafting and updating the regulations to ensure independence, rigorous assessment, robust compliance-monitoring, and transparency. A key opportunity would be to convene a Review Conference on the 10-year anniversary of the IHR's entry into force.

A recent effort to mobilize and coordinate global response to emergencies is the Global Health Security Agenda (GHSA). This initiative was launched in February 2014, before the Ebola outbreak was declared. The GHSA was supported by the World Organization for Animal Health (OIE) and the Food and Agriculture Organization of the United Nations (FAO), and 24 states, to advance global health priorities relevant to infectious disease threats, whether natural, accidental, or intentional in origin. The proposed collaboration among states includes

information sharing, enhancing communication, laboratory collaboration, developing mechanisms for research, and sharing medical countermeasures. While the GHSA has not purposely engaged in the Ebola response, it is addressing the outbreak by targeting capacity building in those states affected by the event, in other words creating greater resiliency for dealing with future events. The centrality of the GHSA to health security is underscored by its inclusion in the national security strategy of the United States: “As an exemplar of a modern and responsive public health system, we will accelerate our work with partners through the Global Health Security Agenda in pursuit of a world that is safer and more secure from infectious disease.”

The international community is currently in the process of developing the follow-up to the millennium development goals: the sustainable development goals. Unfortunately, global health security is not sufficiently reflected in the current debate and experts have suggested that global health security should be made its own goal on the sustainable development agenda.

Funding Capacity for Global Health

It has been said that Ebola is a disease of poverty and ignorance. Even in comparison to other previous epidemics, the Ebola outbreak was unique in that it hit hardest in states that did not even have the most rudimentary health care systems in place. For example, Liberia has in place 0.01 physicians per 1000 people compared to 2.8 per 1000 people in the U.K. or 4.3 per 1000 in Germany. Previous epidemics, such as the SARS outbreaks in Asia, occurred in states with basic health care systems and health care governance. In the end, the Ebola outbreak became a devastating epidemic due to lack of capacity and basic health care systems. It cannot be stressed enough that any efforts to combat epidemics, and to develop preparedness to deal with highly communicable diseases must be anchored in developing resilient public health systems and, ideally, universal health coverage for all. However, this raises the question of funding: funding of international response, of international structures in place to detect and protect us from epidemics, as well as funding of national health care systems.

While international structures and implementation of internationally agreed terms are instrumental, none of these aims can be achieved without sufficient funding. The capacity of the WHO to respond to this outbreak was massively limited due to recent budgetary cuts. In 2011, member states cut the budget of the WHO by USD\$500 million affecting its emergency

response unit, as its regional offices in Africa lost nine of 12 emergency response specialists. The WHO budget is USD\$3.9 billion per year. This is less than the budget for policing in New York City; a teaching hospital in the U.K. (The Leeds Trust) has a budget of USD\$1.2 billion. This demonstrates how far we are from having adequate financing for such an important priority as global health. In addition, many of the WHO's programs depend on voluntary funding from states. If states want to see a strong response from the WHO in global health emergencies, they must commit to funding the WHO budget and funding a contingency fund for emergency response. The investment in global health made upfront is more affordable than the vast economic implications of an epidemic.

In addition, creative sources of funding could be explored. One example of a creative funding arrangement is the "Solidarity Tax on airplane tickets" (Taxe de solidarité sur les billets d'avion) proposed to the UN General Assembly in 2004 by French president Jacques Chirac and the president of Brazil Luiz Inácio Lula da Silva. It was adopted by five states at a Ministerial conference held in Paris in 2005. Today it is implemented in Cameroon, Chile, Congo, France, Madagascar, Mali, Mauritius, Niger, and the Republic of Korea. It comprises of adding a sum of money to airplane fares (1€ for economy, approximately 40€ for business class) in order to raise funds for development aid. The tax raises approximately 160€ million per year and has raised 1€ billion since its conception.

On the issue of health capacity in developing states, one expert raised the problem of hospitals within the OECD weakening capacity in the developing world by recruiting medical professionals for higher rates of pay. One solution would have states make the commitment to fund scholarships on a ratio of 5:1 to replace the healthcare professionals in developing countries that were recruited. This would help ensure that affluent nations do not add to the healthcare capacity gap in the developing world.

The Ebola crisis of 2014 was a terrible moment and brought terrible pain. But it did lead to the international community using new instruments, such as a Security Council resolution, to try and combat the disease. The crisis is not over but the world has been awakened to the centrality of global public health. It remains for us to reform our institutions, invest in capacity, explore new techniques in communications, and employ science to invent new vaccines and technologies to protect us from this scourge and improve global health security.

RECOMMENDATIONS

States:

1. States should commit to building sustainable health systems today so that they have the capacity to respond during a future crisis and its most basic front line health workers must be paid as they confront the crisis. The nurses and doctors who put their lives at risk deserve our deepest gratitude.
2. States must commit to epidemics preparedness by establishing isolation units, training staff, and creating carefully maintained stockpiles of personal protective equipment.
3. States should fund research and development to improve personal protective equipment to assure that they are affordable and that their construction and utility allows safe and comfortable use in a variety of climates.
4. Recognizing that the WHO is a the centre of the world's response to health emergencies, states should affirm the important role of the WHO, ensure its viability, and fund its operations and programs.
5. States should commit to funding a contingency fund for emergency operations of the WHO.
6. Every state should follow the lead of France, Mali, and Cameroon and other countries and implement the Solidarity Tax on Airfares and provide the revenue to the fund.
7. When recruiting healthcare professionals from developing countries, affluent states should provide scholarships so as not to add to the capacity gap.

The International Health Regulations:

8. States should fully implement the current International Health Regulations.
9. A review conference should be convened to update the International Health Regulations to ensure independence, rigorous assessment, and transparency.
10. Independent panels should review compliance with and implementation of the International Health Regulations rather than relying on the self-assessment of states.

The World Health Organization

11. Though it is a model of reform within the United Nations, the WHO should continue to improve its governance and transparency and develop resources, a workforce, and the capacity to respond to crises more rapidly.
12. WHO should coordinate with universities, non-state actors, civil society, philanthropy and the private sector especially in areas related to pharmaceutical development and innovative funding models.

Global Community

13. The Sustainable Development Goals should be amended to include SGD18, focusing on health security formulated as, “Take appropriate action to reduce the vulnerability of people around the world to new, acute, or rapidly spreading risks to health, particularly those threatening to cross international borders.”
14. The World Bank, the International Monetary Fund, the World Trade Organization, and other global multilateral organizations should place health security at the centre of their policy analysis and their mission.
15. In responding to crises, communication should be done in the most appropriate language of those affected.
16. The world’s most deadly pathogens, for which there are no licensed human vaccines, should be targeted for investment and development for phase II trials. It will ensure safety and immunogenicity. A largely publicly funded common manufacturing platform should be offered. Vaccine stockpiles should be maintained in affected regions.

Non-State actors:

17. Non-State Actors can develop and share surveillance software and predictive modelling methodologies that have proved effective.

18. Data Collection requires coordination among citizens, telecommunications networks, privacy laws, and researchers. Civil society organizations have an opportunity to play a significant role coordinating disparate groups and interests.
19. Médecins Sans Frontières should be commended for their exceptional response and resilience during the Ebola outbreak.

Citizens:

20. In a crisis like Ebola we are all in this together. States and health authorities have the responsibility to provide informative and easily understood education about the crisis. It is the responsibility of citizens to access this material and behave accordingly. The InterAction Council's *Universal Declaration of Human Responsibilities* is relevant to the Ebola issue as it is to many world problems and Members should continue to use their influence to promote its adoption by the United Nations.

The InterAction Council

21. The Council should forward its recommendations to planning meetings and conferences including the UN High Level Expert Meeting on the Sustainable Development Goals (July 2015) and the Ministerial for the GHSA in Seoul, South Korea (September 2015).
22. The Council should encourage its Members to use their influence to stress the importance of a coordinated international response to global health emergencies

LIST OF PARTICIPANTS

High-Level Expert Group Meeting

1 June 2015

The Celtic Manor Resort, Wales

InterAction Council Members

1. H.E. Mr. Olusegun **Obasanjo** (former President), Nigeria
2. H.E. Mr. Andrés **Pastrana** (former President), Colombia

Secretary-General

3. Dr. Thomas S. **Axworthy**, Distinguished Senior Fellow, Munk School of Global Affairs, University of Toronto (Canada)

Special Guests

4. Ms. Jess **Camburn**, Director, Enhancing Learning and Research for Humanitarian Assistance (U.K.)
5. Prof. C.O. Onyebuchi **Chukwu**, former Minister of Health (Nigeria)
6. Dr. Rainer **Engelhardt**, Assistant Deputy Minister/Chief Science Officer, Public Health Agency of Canada (Canada)
7. Mr. Nicholas **Fogg**, former Mayor of Marlborough (U.K.)
8. Dr. Jörg **Hoffmann**, Consultant in Communicable Disease Control, Public Health Wales (U.K.)
9. Ms. Ruth **Hopkins**, Senior Lecturer, College of Human and Health Sciences, Swansea University (U.K.)
10. Prof. Iliona **Kickbusch**, Director of the Global Health Programme, The Graduate Institute of International and Development Studies, Geneva (Germany)
11. Dr. Brian **McCloskey**, Director of Global Health, Public Health England; UK Strategy Advisor, Office of the UN Special Envoy on Ebola (U.K.)
12. Prof. Colin **McInnes**, UNESCO Professor of HIV/AIDS and Health Security in Africa and Director of the Centre for Health and International Relations, Aberystwyth University (U.K.)
13. Dr. Joanna **Nurse**, Medical Adviser and Head of Department, Commonwealth Secretariat (U.K.)
14. Dr. John Wyn **Owen**, Chair, Health Protection Committee, Wales (U.K.)
15. Dr. Mark **Salter**, Consultant in Global Health, Public Health England (U.K.)
16. Dr. Quentin **Sandifer**, Executive Director of Public Health Services and Medical Director, Public Health Wales (U.K.)
17. Dr. Shunmay **Yeung**, Clinical Senior Lecturer, Global Health Department & Clinical Research Department, London School of Hygiene and Tropical Medicine (Japan)