Item 10. Ebola virus disease outbreak in West Africa: update and lessons learned

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In focus at AFRO/RC64

The Committee will consider the Secretariat report on EBV epidemic (AFR/RC64/9). The version posted on the regional office website (as of 21 October) is dated August 1.

PSC Chair's report

From AFR/RC64/3

> *7. The PSC discussed the Ebola virus disease (EVD) outbreak in West Africa. The members expressed concern about the inadequacy of public awareness and the embedded cultural beliefs that have prompted resistance to uptake of interventions; the weakness of health systems and the high numbers of health workers infected, creating fear among them and further hampering the ability to provide adequate response; delayed response mounted in some of the affected countries; and the negative information of some media. They acknowledged the significant contributions made by WHO and other partners in supporting the affected countries, including setting up of coordination centres, training of health workers on EVD prevention and control, deployment of experts and provision of Personal Protective Equipment (PPEs) and other equipment. They expressed concern about the closing of borders and echoed the view that the EVD outbreak was no longer a West African problem but an African problem adversely affecting the economic activities of countries. The PSC suggested that countries strengthen their preparedness and response plans including surveillance systems; reinforce the capacity of health workers to respond to the outbreak; strengthen cross-border collaboration and coordination; and promote research not only on the disease but also on potential medicines and vaccines. The PSC members also suggested that governments pay their contributions to the African Public Health Emergency Fund. The members of the Subcommittee recommended an updated document on intensifying the response to Ebola virus disease outbreak in West Africa for consideration by the Sixty-fourth session of the Regional Committee.*

Background

See WHO EVD webpages and WHO's Ebola Portal.

See also PHM's Ebola Statement.

PHM Comment

PHM mourns with the families and communities who have been devastated by the current epidemic. We salute the commitment of the health workers at the front line and honour in particular the health workers who have died.

Slowly a comprehensive response is being put in place although under-funded, under-supplied and under-staffed.

Our focus in this comment is on the report prepared by the Secretariat for the Regional Committee (AFR/RC64/9) which is out-of-date, quite unreflexive and somewhat myopic.

It is outdated in that it deals with the response to the epidemic from March to July but does not cover the period from August to October. How useful is a 'situation analysis' which is three months out of date? The PSC, meeting in September, called for an updated document but as of 30 Oct no update had been published.

The report is unreflexive. All of the five issues (and 'lessons learned') deal with the local national responses; there is nothing here about the responses of WHO's country offices, the regional office or of the Headquarters team. In speaking about 'lessons learned' it is regrettable WHO's response is not subject to any critical scrutiny. Were there delays in WHO's response? Could WHO's response have been earlier and more urgent and more effective? Was there a failure to anticipate, prevent and prepare? It needs to be taken note of that while the WHO received its first report about Ebola cases in Guinea on March 22, it took more than three months to convene a meeting of regional health ministers or open a regional coordination centre.

Hard questions also need to be asked about how the financial crisis in the WHO, which we talk about later, impacted on the WHO's ability to mount a quick and effective response. WHO's current budget saw cuts in WHO's outbreak and crisis response of more than 50 percent from the previous budget -- from $469 million in 2012-13 to $228 million for 2014-15

The report is myopic in that it completely ignores the wider, longer term context of the epidemic which has framed the vulnerability of West Africa to EVD and has also framed the inadequate preparedness and response. While the EVD epidemic itself calls for immediate and sustained responses, it is extremely unfortunate that the report restricts itself to just the context of the current epidemic. This means that there is no application of mind being attempted to remedy a situation that has been brought about by an interplay of complex circumstances that relate to the gross inequity in global power relations, that sustains many of the gaps and deficiencies in

the health care systems in countries of the region that the report points towards. It also means that the region will continue to be vulnerable to similar public health threats in the future.

We urge members of the Regional Committee to insist on full consideration of the following questions:

- Why are poor countries vulnerable to EVD and limited in their capacity to respond? Why are the three centrally affected countries poor?
- Why do people lack confidence in the public health system?
- Could WHO, globally, regionally and nationally have done more to highlight the risk of EVD in the years since 1976?
- What research has been done since 1976 into vaccine and treatment development and by whom?
- Why has EVD been ignored by both public and private pharmaceutical R&D?
- Who should have been warning and researching about the possible implications, in terms of contact with animal hosts, of mining, palm oil plantations, the displacement of people in West Africa by agribusiness?

Are there lessons to be learned from these questions? These are complex questions and PHM does not claim to know the ultimate answers but we insist that the questions must be asked.

Why are poor countries vulnerable to EVD and limited in their capacity to respond? Why are the three most affected countries poor?

Liberia, Guinea and Sierra Leone number 175, 179 and 183, respectively, on the United Nation's Human Development Index, out of 187 countries. Their poverty is a function of colonialism, structural adjustment and the continued exploitation of the region's natural resources.

Neoliberalism and the Washington Consensus have contributed to the emergence of the epidemic and undermining the countries' capabilities to manage it.

The social conditions for health and the health care of the people of West Africa are sharply constrained by the global economy, geopolitics and the increasing and unaccountable power of transnational corporations.

The WHO Commission on the Social Determinant of Health concluded that:

> *the poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally.*
>
> *Deep inequities in the distribution of power and economic arrangements, globally, are of key relevance to health equity.*

> *Dramatic differences in the health and life chances of peoples around the world reflect imbalance in the power and prosperity of nations. The undoubted benefits of globalization remain profoundly unequally distributed.*

Has the Regional Committee for Africa fully worked through the implications of these conclusions in relation to health development in the region (and the EVD epidemic in particular)?

Some of the disabilities facing health systems in West Africa are referred to by the Regional Director in his biennial report:

> *A major constraint has been the global financial crisis that has resulted in diminished resources available to WHO and further translated into inability to deliver adequately in some important programme areas. The earmarking of Voluntary Contributions has limited the WHO Secretariat's flexibility in consistently allocating resources to the priorities agreed with Member States, leaving under-funded areas such as health systems strengthening and addressing the risk factors and key determinants of health. While the increase in the number and diversity of actors in health development has helped mobilize additional financial and technical resources, it has in some cases led to fragmentation, poor coordination and duplication of support to countries, thereby increasing transaction costs.*
>
> *Other constraints WHO faced in the Region included identification of more opportunities for resource mobilization including strengthening capacity and timely reporting to donors, as well as fluctuations in transaction costs and the challenges of working with partners who have different mandates and interests. In addition, the operationalization of, and effective contribution of Member States to, the APHEF, which is an innovative way to mobilize resources within the Region, need to be accelerated.*

The rich countries, led by the USA, who have sought to hobble WHO through the freeze on assessed contributions and earmarking of donor funds carry a significant responsibility for the unpreparedness of the Ebola epidemic countries.

The hobbling of WHO is matched by a development assistance regime (sponsored in particular by the OECD countries) which seeks to legitimise an unbalanced, unsustainable and exploitative economic globalisation through vertical, disease-focused aid programs which are small in comparison to the parallel outflows (tax evasion, brain drain, resource extraction) but which fragment health systems and burden national health ministries with heavy transaction costs.

The countries of the African region should take the lead in demanding an appropriate increase in assessed contributions so that WHO is no longer held hostage to the donors.

The commitment of the African region to addressing the underlying social and economic determinants of health points to the importance of bringing economic issues onto the Regional Committee's agenda.

Why do people lack confidence in the public health system?

The failure to contain the epidemic is also a failure of the public health system. But it also needs to be noted that, in large measure, it is this public system that has mounted some form of a response to the epidemic and its consequences. The report lists a number of gaps and deficiencies in the public health system. Yet, it does not discuss the reasons for the state of the public health system, especially the fact that there has been a sustained attempt by multilateral agencies, donor organisations, and donor countries to suggest that public systems are inefficient and governments need to rely increasingly on private sector participation in health care delivery. If people today do not have faith in the system and are suspicious of its objectives, it is not merely a function of ignorance and cultural beliefs. The neglect of public services is the primary reason why people have been less than supportive of its role in the present crisis.

It is imperative that Member States deliberate upon the causes of decline of public health systems in the region (which is a trend found in other regions as well) and also set in place some concrete mechanisms that are designed to strengthen, reorient and rebuild public systems. For too long the WHO (including in its present position on UHC) has chosen to be an 'honest broker' and has chosen to remain neutral in the discussion on whether the public or the private system needs to be the primary provider of healthcare services. We urge Member States to request the Regional Committee to develop a Plan of Action to revive and revitalise public provision of healthcare in the region.

Could WHO (globally, regionally and nationally) have done more to highlight the risk of EVD in the years since 1976?

Was the DG too slow in declaring an emergency under the IHRs? The failure of WHO to foresee, prevent and respond promptly to the epidemic is in part a reflection of the continued freeze on assessed contributions and the control of WHO's agenda by the big donors. See Legge (2012); see Clift (2014); see Briand et al (2014).

The inadequate response of the country and regional offices was allegedly the focus of a confidential memo generated within the Geneva Secretariat in June. The memo has not been released but it has been leaked to journalists; see Gale and Lauerman, (2014). The Secretariat paper (AFR/RC64/9) makes no reference to any weaknesses identified in WHO's operations.

Clearly, the WHO has done almost nothing to promote more research on EVD for almost 30 years. This is a reflection of an organisation wide failure to anticipate threats to public health.

What research has been done since 1976 into vaccine and treatment development and by whom? Has EVD been ignored by both public and private pharmaceutical R&D?

The profit funded research and development model has failed to mobilise funds for the development of vaccines or treatments since EBV was first described. WHO's Commission on IP,Innovation and Public Health (and the subsequent Consultative Expert Working Group) argued for delinking pharmaceutical research and development from profits shored up by IP protection. Instead they have called for a binding treaty to mobilise the necessary funds up front so that such vaccines and treatments can be made available at the cost of production. The 10-90 gap -- i.e. the paradox that 10% of research funds are directed at conditions that affect 90% of the people and vice versa -- has been talked about for decades. Yet the WHO continues to drag its feet on the issue and has been singularly reluctant to boldly promote mechanisms for collaborative research and eschew the pernicious influence of high level IP protection on new drug and vaccine research for diseases of the poor.

The WHO at all levels, continues to be captive to the interests of rich donor countries and private foundations. This has prevented it from taking clear and decisive position on the negative impact of a research system that works within the framework of Intellectual Property Rights (IPRs). Even the recent WHA stopped short of mandating a process that would lead to a binding R&D treaty, designed to delink the cost of research from the price of medicines. We urge Member States to ask the WHO to animate its work on alternate models of drug development, which uses mechanisms that promote collaborative rather than competitive research and works on the principles of delinkage.

Who should have been warning and researching about the possible implications of mining, palm oil plantations, the displacement of people in West Africa by agribusiness?

A particular trajectory of 'Development' in the region, promoted by multilateral agencies and donors, is clearly changing the ecology of communicable disease in West Africa. Gross ecological changes have been brought about by the takeover of agricultural land by agribusiness. These changes could well be responsible for hitherto unknown pathogens , which had earlier been confined to the wild, to start infecting humans. There are good reasons to believe that prolonged dry spells in the region, brought about by massive deforestation, as well as the penetration of new roads into previously remote forest areas primarily for extractive operations, have led to easier inter-mixing between the animal population in the forests and to the desperation of humans who have been driven deeper into the forest areas for survival and sustenance.

The report entirely ignores the possible effects that environmental changes in the region have had in triggering the EVD epidemic. What kinds of health impact studies were done before large swathes of land were leased to logging, palm oil and mining? What is the role of the Regional Office and country offices in providing guidance in relation to such matters? Surely there lessons to be learned here that need to be incorporated in any comprehensive review of the causes of the EVD epidemic. We urge Member States to ask the WHO to commission a study that examines the link between environmental factors and the epidemic.

These questions must be asked

PHM does not claim to have all of the answers to these questions. However they should be seriously addressed and it appears that they are being neglected.

PHM statement on the political economy of the EVD epidemic