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Opinion piece: what we have learnt about the World Health Organization from the Ebola outbreak

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Commentary: What we've learnt about the WHO from the Ebola outbreak

Abstract:

WHO's reputation has become irrefutably damaged during the Ebola outbreak, with the general consensus in the global health community that it fell short of its leadership responsibilities. This commentary offers a brief synopsis of the WHO's role during the outbreak and suggests that the disease outbreak demonstrates tension that exists between the organisations normative and operational role in health crises. Whilst the WHO did offer some normative leadership during the Ebola outbreak, as per its constitution, it did not provide an operational response, albeit without a mandate to do so. This division between the normative and operational was further highlighted by the discrepancy between what the global community expects the WHO to do in a health emergency, and what it is able to do with financial and organisational constraints. Finally, the commentary considers the introduction of the WHO Health Emergency Programme, but suggests that this too suffers from the same structural concerns as the whole organisation which need to be addressed if the WHO is to continue in the role the global health community expects it to play as both a normative and operational leader in global disease control.

Keywords:

Ebola, Leadership, Security, World Health Organization, Normative, Operational, Health Emergencies

Ebola

The Ebola epidemic in West-Africa (2014-5) was catastrophic. Previously successful infection control mechanisms for haemorrhagic fevers were not enacted quickly enough, or to the extent required to bring the outbreak under control. The outbreak soon overwhelmed epidemic response mechanisms at national, regional and global levels. Piot[1] (amongst others) has suggested that a perfect storm of factors contributed to the scale of disaster caused by this outbreak. These factors included the unprecedented size of the outbreak, the lack of sufficiently trained personnel, limited resources, weak national health systems, the spread of the outbreak to urban settings, a time lag between the initial appearance of the pathogen and the reporting of it to the national and international communities, the highly porous international borders, mis-trust of government and health officials, the virus' first appearance in West Africa, an exodus of international health providers and a structural failure of global health governance[2]. The result was over 28,000 cases and 11,000 deaths totalling more than all previous outbreaks[3]. Beyond the alarming number of cases, the outbreak has had a considerable socio-economic impact on the lives of millions of survivors and unaffected people, through the indirect consequences of lack of routine healthcare facilities, disruption to routine education provision, decline in employment rates and food insecurity[4].

Since the outbreak, several reviews have sought to understand the failures which contributed to the inability of the national and international communities to stop the spread of the virus and to avoid the humanitarian disaster which unfolded[5]. All reviews attribute some blame to the World Health Organization (WHO) for its delay to take action and for a lack of an operational response in the outbreak. However, whilst the WHO made some pivotal mistakes, as it itself admits[6], the outbreak exposed tensions between the normative and operational role of the WHO, and furthermore between what the WHO is able to do (suffering from financial and organisational constraints), and what the global community expects the WHO to do.

Key moments for the WHO during the outbreak

The WHO first received news of the virus' emergence in March 2014[7]. In response, the organization sent field epidemiologists to West Africa, who established initial response efforts such as contact tracing, laboratory support and infection control mechanisms to the outbreak, mirroring that which they had implemented in previous Ebola outbreaks. Yet, it has been suggested that those sent had little knowledge of Ebola and had even broken WHO protocols for disease outbreak management[8]. Kamradt-Scott[9] has suggested that the many criticisms received by the WHO of their initial activity may not be a fair representation of the organisation's response to the outbreak, in that it was its largest deployment of field epidemiologists (112 experts by May 2014[10]) who acted commensurate with the level of the threat which was believed to be posed by the disease at that time[11]. Vitally, however, the WHO failed to take into account the range of factors which contributed to Ebola transmission, and provided an inadequate response to the second wave of the outbreak appearing in May 2014[12] (p.7). As the organization has suggested its own shortcomings at this time were numerous:

The initial response was slow and insufficient, we were not aggressive in alerting the world, our surge capacity was limited, we did not work effectively in coordination with other partners, there were shortcomings in risk communication, and there was confusion of role and responsibilities at the three levels [Headquarters, Regional Office and Country Offices] of the organisation[13]

With mounting public pressure[14], the WHO finally declared Ebola a Public Health Emergency of International Concern (PHEIC) on 8th August 2014. This PHEIC occurred 5 months after the WHO first received information about the Ebola threat, by which point there had already been

1711 cases and 932 deaths[15]. Such delay undoubtedly contributed to the unprecedented scale of the outbreak. It has been suggested that the delay in declaring a PHEIC was due in part to placating delicate political and economic situations in West Africa[16] (p.1307) highlighting the tenuous position the WHO occupies in the global health mosaic. After the PHEIC declaration, the WHO sought to coordinate and mobilise the necessary response to eliminate disease spread. However, funds allocated for emergency response had been drastically reduced in previous years[17] (p.6), and despite the launch of a WHO Roadmap in August 2014, strategizing the end of the epidemic within 6-9 months, a coordinated international response with WHO at the helm failed to materialise[18] with the outbreak rapidly developing into a humanitarian emergency.

However, after the initial errors in downplaying of the outbreak[19], the WHO did maintain continued activity in tackling Ebola. The WHO documents its role in training healthcare workers and burial teams in infection control, community engagement activities and providing epidemiological data[20]. Furthermore, the organisation published numerous technical guidance documents, hosted a series of meetings on vaccine options, developed diagnostic tools and expanded laboratory services[21] (p.1309). Yet none of these activities provided direct patient care, strategic managerial oversight or the infection control that the outbreak response needed. Ultimately, due to a vacuum of international leadership in the operational response (which several in the international community expected the WHO to perform) the patient care, infection control and management was left to others, including MSF, a new UN body (UNMEER) and the even domestic and international militaries[22].

Tensions between the Normative and Operational Role of WHO

As the only United Nations (UN) agency tasked exclusively with health, the WHO conceives itself to be:

"the directing and coordinating authority in international health work"[23] (p2).

Moreover, for disease outbreaks, the WHO acknowledges:

"a central and historic responsibility [for the WHO] has been the management of the global regime for the control of the international spread of disease"[24] (p1).

From such a constitutional position, it is unsurprising that the global community looked to WHO, as the apex of the global health landscape, to mount a response for the outbreak. Yet, these tasks that the WHO assumes are both normative in function and they do not prescribe the WHO an operational role to provide the on-the-ground response at time of crisis. Lee[25] describes the work of the WHO as a leader in global health, shaping research and knowledge, setting norms and standards, providing technical support and monitoring health situations (p. 20). As McInnes highlights (p1305)[26]:

"*The operational ability to act in a crisis is notable by its omission.*"

As has been noted by Gostin & Friedman, Yach and McInnes[27], this distinction between normative and operational roles of the WHO has been missed in several of the analyses of the WHO's failure to respond to the Ebola outbreak.

Normatively, the WHO did respond to the outbreak, through the declaration of the PHEIC (albeit it delayed), the production of technical advice, community engagement activities, the sharing of epidemiological data, support with the development of vaccines and healthcare worker training activities. It could even be argued that the framing of the disease by the global health community and the media as a security threat, and the ultra-securitised response of deploying domestic and international militaries is a consequence of WHO's normative agenda to encourage a discourse of global health security for infectious disease control more broadly.

However, these normative achievements have been overlooked by the global community's assessments of the WHO's activity during the outbreak, and instead the focus has been on the operational, notably that the WHO did not provide a sufficient operational response to the Ebola outbreak. Yet, this global community (including NGOs, civil society and the media) who had such high expectations for action are not the member states which the WHO represents and it is interesting to observe that the affected states (Guinea, Liberia and Sierra Leone) have not voiced such criticisms about the organisation. As such, there appears to have been a mismatch between the expectations placed on the WHO by the global community, and what the WHO is mandated (and able) to do.

As WHO Director General Margaret Chan stated:

"*It was a fantasy to think of the WHO as a first responder ready to lead the fight against a deadly outbreak*"[28]

WHO works within a Westphalian system which expects states to provide a response to health needs of their citizens[29] with the WHO providing (normative) technical advice and recommendations to support state activity. As the affected states suffered from chronically underfunded, weak health systems and had not met their commitments to the International Health Regulations (2005)[30], they were unable to respond on their own. The WHO did not have operational authority or resources to respond on their behalf, with this role being assumed by other actors in the global health landscape better equipped and resourced to do so, including MSF (offering over 4000 staff and spending over EUR 96million to the response effort) and domestic and international militaries (deploying over 5000 personnel at a cost of US$2billion)[31]. .

WHO Challenges

Beyond the tension between the normative and operational role that the WHO should have played during the outbreak, the organisation currently does not have the capacity or organizational culture to deliver substantially on either goal (p.6/15)[32]. For the past two decades, the WHO has been in the process of reform, trying to address concerns of politics and priority setting, financing, governance, and managerial challenges. These institutional weaknesses further played a role in the WHO's inability to lead the response to the Ebola outbreak.

As suggested by Harman and Rushton[33] leadership in global health is often driven by money and the ability to fund global health projects (p. 2). No agency can manage an outbreak either normatively or operationally when it controls only a small, depleted budget[34] (p.1324). One of the key challenges the WHO has faced has been its precarious financing mechanisms[35](p. 41), and notably the reduction of funds available to respond to an outbreak has been severely reduced[36] . Divergence between the distribution and conditionalities of voluntary and assessed contributions mean that the WHO is limited in its ability to manage its own budget, with funding for health security apparently not being the focus of donor resources[37] (p.41-2). This has been further compounded by the organisation's policy of zero nominal growth resulting in even less purchasing power for its routine emergency activities[38] (p.6). Even if the WHO had the remit to launch an operational response to the Ebola outbreak, without commensurate funding, the organization would not have been able to do so and therefore its budget constraints impacted the operational role which the global community expected. A second challenge for the

organisation is its own structure, with several commentators recognising the weaknesses in the organisation's set up and tensions between headquarters, regional offices and country offices[39]. This has become even more important in the wake of Ebola, where differing activity emerged from the Geneva, AFRO regional and in-country offices without a coherent strategy[40].

WHO Health Emergencies Programme

Moving on from the criticisms faced by the Ebola crisis will be hard for the WHO. As suggested by the LSHTM-Harvard panel

"the WHO is going to need fundamental reform to ensure that it can gain back the confidence from its members and the global health community.[41]"

Importantly, the WHO has listened to the many concerns raised from its handling of the Ebola outbreak and the organisation has been revisiting its reform deliberations. Perhaps the most pertinent of these in the wake of Ebola has been the establishment of the new Health Emergencies Programme[42]. The focus of this activity is for the WHO to have a coordinating body for disease outbreaks with:

"one programme, with one workforce, one budget, one set of rules and processes and one clear line of authority".

This programme offers a notable shift in the role of the WHO to date, explicitly including an operational role for the organisation in responding to health emergencies, when a state is unable to show the necessary operational leadership and management on their own[43]. Whilst the programme incorporates many of the functions that the WHO currently performs in disease management (such as through the Global Outbreak Alert and Response Network) the inclusion of a mandate for operations is new, and a direct reflection of the criticisms it faced during the Ebola epidemic. Interestingly, this departure suggests that the WHO is evolving to meet the expectations placed on it by the global community, rather than maintain the focus on its role in 'coordinating and directing' (i.e. the normative) as per its constitution[44] (p. 2). The success of this initiative will only become apparent when the next global disease concern emerges. Yet, even despite the commitment at the World Health Assembly to operationalise a response to global health emergencies[45], this programme is facing a funding gap between financial contributions and required funds for activity[46]. Accordingly, this new programme may suffer from the same

challenges as the organisation faces more broadly and any operational activity responding to health emergencies too may fail, or face criticism from the global community, given the ongoing lack of funds[47].

Conclusion

The WHO's reputation has become irrefutably damaged during the Ebola outbreak, with the general consensus in the global health community that it fell short of its leadership responsibilities[48]. This commentary has shown a synopsis of the WHO's role in the epidemic, but has suggested that beyond the widespread criticism, we must remain reticent of the WHO's abilities to respond to an outbreak from both a normative and operational perspective. Whilst there is some evidence of the WHO performing a normative role during the crisis, albeit patchily, it is apparent that the global community also expected an operational response from the WHO. However, as the WHO was unable to provide this on-the-ground response in West-Africa, this allowed other actors, notably MSF, militaries and UNMEER to perform this function. These efforts offered the global community further ammunition for their WHO criticisms.

This does not mean that the WHO does not and should not strive to be a leader in global health. As stated by Gostin and Friedman in their analysis of leadership in the Ebola outbreak:

A global health leader steers the overall direction of epidemic response, drives consensus towards a coherent strategy, ensures necessary functions are satisfied and coordinated many participators[49] (p. 1903).

Such a position equally suggests that there is a normative role for the WHO a leader in future outbreaks, without insinuating that there must be a simultaneous operational role. However, the WHO, through the creation of the Health Emergencies Programme, has sought to bridge the divide between the normative and operational, offering a response mechanism to future emergency disease concerns. Yet, the challenges that the WHO faces from financing and organizational divisions will not be overcome with this new programme, and therefore for the WHO to be in a position to actually respond to an outbreak, these fundamental structural concerns will need to be addressed comprehensively to allow the WHO the resources and power to perform the role that the global community expects.

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Competing Interests

I have no competing interests.

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