**Executive Board, 140th Session, 2017**
**Agenda Item: 7.1**
**Heath Emergencies and WHO Reform: A reality check**

Two years have passed since the peak of the West Africa Ebola epidemic that revealed the deficiencies and limitations of the global health system in the face of a virulent, lethal disease. While some actions have been taken towards the reform of WHO in emergencies – in particular the creation of the WHO Health Emergencies Program and the strengthening of the International Health Regulations and the establishment of a new blueprint to coordinate research and development for emerging infectious diseases – demonstrable improvements have not yet materialised in practice. There remains an imbalance in the system, with an overreliance on surveillance mechanisms and insufficient emphasis on response capacity. To achieve concrete change, Member States must overcome their lack of political will, dedicate sufficient and sustainable financing for emergency response, and push for change in the internal organisational culture of WHO.

Furthermore, four main challenges MSF witnessed in Ebola have yet to be properly addressed:

- Lack of positive incentives to declare health emergencies;
- Insufficient or inappropriate medical leadership in emergencies;
- Lack of responders with appropriate surge capabilities and technical expertise;
- Failure to meet real time needs for diagnostics and treatments with the assurance that emerging products are affordable and available to all in need.

## Reality check

If the current response to emergencies is taken as the indicator of progress, then the reality is that we still have a long way to go. We are collectively still struggling to respond to outbreaks and other health emergencies on the ground. From MSF's point of view from the field, two emergencies last year highlighted the ongoing difficulties to meet these challenges, both of which brought to bear serious consequences on the health of the affected populations.

*Epidemics: Yellow fever in Angola and Democratic Republic of Congo (DRC)*

On the heels of the Ebola outbreak came the resurgence of yellow fever in Angola in December 2015. The outbreak spread from the urban capital, Luanda, throughout the country and then internationally, to neighbouring DRC. Yellow fever is a well-known disease for which an efficacious and affordable vaccine has existed for the past 80 years, and is since used in the prevention and control strategy launched in 2007. In theory, no one should be dying from yellow fever today. Yet the disease spread across two countries and required huge vaccination campaigns to be halted, in part by stretching supplies with diluted doses of the limited vaccines available.

The risk of re-emergence of yellow fever has been a red flag for more than a decade. With limited vaccine supplies and producers, catch-up vaccination campaigns could not happen simultaneously, nor at scale, across sub-Saharan African countries at risk, leaving large swathes of people unprotected from the disease.

It took six weeks for the identification and confirmation of cases in Angola, demonstrating yet again that **weak diagnostic capacity** in the region remains a key challenge. The ability to conduct polymerase chain reaction (PCR) or plaque reduction neutralisation (PRN) tests is only possible in a few reference labs in Africa. Mobile labs should be dispatched much more quickly in an emergency when it is clear diagnostic capacity is limited or risk struggling against the epidemic in the dark.

The delay in recognising the disease, coupled with the inability to quickly diagnose cases and then reactively vaccinate, allowed yellow fever to take hold in the capital city and then spread. Once cases were confirmed and the outbreak was declared, it took more than eight weeks to launch the first phases of mass vaccination campaigns and more than three months since the initial cases to implement full outbreak control measures. The delay was partially linked to the **limited global stockpile of vaccines**, but not only. It is important to note the role of a failure to immunise within the Expanded Program on Immunization in this outbreak, despite the introduction of routine infant yellow fever vaccination in Angola and DRC, coverage have been so low that a large proportion of the birth cohort remained susceptible and at high risk for epidemics.

The incident management system (IMS), under the new WHO Emergency Programme, was activated only in April once two countries were already affected. The outbreak was ongoing for nearly five months before the Emergency Committee under the International Health Regulations was convened in May. International attention focused on the Zika epidemic also meant that the yellow fever outbreak went largely unnoticed in the first months. This outbreak again lay bare that **leadership roles still must be clarified** between national and international health authorities.

*Northeast Nigeria: Mass displacement, high crude mortality rates, and a late response*

Seven years of violent conflict in northeast Nigeria has left at least 20,000 people dead and has displaced more than 2.6 million people from their homes. The severity of the crisis in Borno State reached a catastrophic peak in the summer and autumn of 2016. In June an MSF team in Bama undertook a rapid nutritional screening of more than 800 children and found that 19 percent were suffering from severe acute malnutrition (SAM). In July, MSF teams working in Banki undertook a similar survey to find that one in twelve children had died and that one in fifteen children had severe acute malnutrition. In September, an MSF team in Ngala found that one in ten children had SAM.

Recently humanitarian assistance has increased and fragile gains have been made in reducing mortality in accessible areas. However, international recognition of the scale of the crisis came much too late. The WHO supports a polio programme in the region that it states is able to reach communities that others could not due to the high insecurity. Yet the single-minded focus on polio eradication in the early days of the response was a missed opportunity to raise attention early on and tackle the increasingly dire nutrition and health crisis affecting the region. While outbreak risks such as polio certainly must be addressed, attention to other major morbidities like malaria and vaccine preventable diseases in malnourished children as measles, pneumonia and cholera should run in parallel, especially when access is extremely

restricted. Recognition of all needs and proper prioritisation require **strong and unbiased medical leadership.** Response should be adapted and adjusted in a timely manner as doing otherwise leads to wasted resources and opportunities that cause more lives lost than necessary.

## The way forward

1. *Effective WHO coordination and leadership in responding to emergencies*
   The WHO must be first in line to demonstrate leadership in health. However, leadership cannot be imposed – it must be earned. The normative role of WHO has never been in question, but WHO must prove its leadership ability in epidemics. This requires sustained political and financial support. Without the strong buy-in and ownership of Member States and their recognition that WHO should be able to confront Member States when necessary to assure timely and effective emergency interventions, the programme will fail.

   - The success of the new WHO Health Emergencies Program also relies on WHO representatives and country offices and their responsibility to implement and facilitate its activities. Strong representatives at all levels with solid experience should be at the helm. MSF urges that concrete and rapid response to emergencies is prioritised and not given a backseat to the *en vogue* discourse of preparedness and IHR implementation. In cannot be stated enough that while having posts properly filled at central or headquarter or even regional levels is important, effective and timely response demands the right personnel on the ground. MSF strongly agrees with the Independent Oversight and Advisory Committee that recruitment at country levels should be expedited and prioritised.
   - The inclusion of infectious diseases events leading to IASC Level 3 activation may be a positive initiative to ensure a more effective response. However medical leadership must remain with an organisation with a health mandate. MSF will remain attentive and flag any negative consequences.

2. *Optimal partnerships and quality response*
   A number of steps have been taken thus far to implement the Health Emergencies Program through the prioritisation of platforms such as the Global Health Cluster and the Global Outbreak Alert and Response Network (GOARN), as well initiatives on specialised responders such as the Emergency Medical Teams (EMT). The primary focus of these mechanisms is to ensure a proper and effective response to health emergencies. Faced with a variety and multiplication of potential coordination and surge bodies, the right balance will have to be found between enabling the intervention of responders while not adding coordination layers of organisational burden. Teams deployed must meet the needs on the ground of the people directly affected. The Incident Management System has to be customised and adjusted according to the needs of the communities and should be inclusive in harnessing the active contribution of the community and its local capacity. Ultimately, specific attention should be paid to ensuring that there is space for independent assessment and action to fill potential gaps.

3. *Research and Development in epidemic response*
   MSF supports the efforts of WHO to establish the WHO Blueprint for Research and Development for potentially epidemic diseases and its affiliated activities. At present, MSF would like to highlight four areas for additional clarification from the Secretariat as implementation of the Blueprint continues:

i. Coherence with the Consultative Expert Working Group (CEWG) and the Nagoya Protocol: MSF would like to ensure that principles included within the reports and resolutions related to the CEWG are integrated into the WHO Blueprint. In particular, it is critical that R&D under the Blueprint is 'de-linked, needs-driven, evidence-based, considered a shared responsibility' and thereby ensures affordability, efficacy and equity of developed products. In particular, WHO should clarify two particular aspects of the Blueprint:

- To what extent are platform technologies selected under the WHO Blueprint applying standards established under the CEWG (in particular as it relates to intellectual property and affordability)?
- What are the relevant access standards that are being integrated into disease roadmaps for priority pathogens for the Blueprint? In particular, how will the Blueprint ensure new technologies will be made widely affordable and available to populations in need?

As noted in the report to the Executive Board, the Secretariat is in the process of developing material transfer agreement (MTA) templates for use in subsequent emergencies. Overall, MSF supports pragmatic efforts to template MTA. However, it is critical that WHO prioritises and accelerates discussions on the implementation and use of the Nagoya Protocol to govern such material transfer agreements and ensures that developing countries have the ability to ensure such template MTAs are consistent with evolving laws and standards related to the use and transfer of biological samples.

ii. Developing country and civil society representation: MSF hopes that as the Blueprint continues to evolve, there will be greater efforts by the Secretariat to expand and encourage representation from affected countries, civil society organisations and other developing countries for all activities under the WHO Blueprint, including the development of the Global Coordination Mechanism and various forms of standard-setting.

iii. Coalition for Epidemic Preparedness Innovations (CEPI): WHO is currently an Observer of CEPI – a new vaccine R&D partnership that seeks to finance and facilitate the development of vaccines to address emerging infectious diseases included in the Blueprint (MSF is an interim Board Member). At present, the precise relationship between the Blueprint and CEPI has not been defined. More urgently, MSF has two particular concerns:

- CEPI access standards: CEPI is in the process of finalising access standards that will apply to all R&D grants that CEPI awards. MSF is concerned that the final standards established by CEPI will not meet the goals and expectations of the CEWG – including in particular the possibility that CEPI will encourage tiered prices for developing countries, and that CEPI will not ensure that intellectual property is available on a non-exclusive basis for use by third parties to ensure the affordable and appropriate development of target vaccines.

- Role and influence of the pharmaceutical industry: At present, multiple pharmaceutical companies are on the Board of CEPI and are also actively playing a role in various decision-making and technical bodies run by CEPI.

While a balanced presence of these companies might be necessary, their current involvement in setting rules even when conflicts of interest are openly acknowledged, undermines the ability of CEPI to uphold public health standards and results in difficulties in adopting acceptable access terms. It should also lead WHO to carefully evaluate its role as an Observer and to consider the ramifications of any close link between CEPI and the WHO Blueprint.

iv. Regulatory capacity: Introducing a regulatory pathway to develop and approve medical tools for infectious diseases remains a critical challenge. MSF hopes that WHO, through the Blueprint, will continue to build upon and expand the use of the Emergency Use Assessment and Listing (EUAL) as a means to provide during outbreaks conditional use of medical tools that are not fully approved. Yet beyond the EUAL and the WHO Prequalification Program (PQP), WHO should seek to develop its own independent capacity to provide conditional approvals for medical tools. Furthermore, WHO should be allowed to exercise such regulatory capacity even when a public health emergency of international concern has not been declared. Such measures can help to safeguard the independence of WHO while also ensuring that tool development progresses in a timely fashion so that they are available for use during emergency and outbreak response.

In conclusion, in an age of complex emergencies that are becoming more and more severe and frequent, the one-size-fits-all model no longer works. Response must be tailored, customised and adapted according to the needs at hand. This requires not only the unwavering commitment of all actors and responders on the ground but also, and most critically, it demands the strong political will of the Member States, without which the system is doomed to fail.