

2014 Ebola virus disease outbreak and follow-up to the Special Session of the Executive Board on Ebola

Ebola Interim Assessment Panel

Report by the Secretariat

In line with resolution EBSS3.R1, the Director-General has the honour to transmit to the Sixty-eighth World Health Assembly the first report of Ebola Interim Assessment Panel (see Annex).

ANNEX

EBOLA INTERIM ASSESSMENT PANEL

First Report of the Panel

1. During the special session of the Executive Board on Ebola in January 2015, Member States adopted a resolution calling for an interim assessment, by a panel of outside independent experts, on all aspects of WHO's response in the Ebola outbreak.¹ In response to the resolution, the Director-General established a panel to undertake this work in early March 2015. Since this time, the Panel has reviewed significant numbers of reports and met with key people within and outside WHO, including senior WHO staff, representatives of the United Nations Mission for Ebola Emergency Response, international nongovernmental organizations and Member States. By the time the Health Assembly meets, the Panel will also have carried out visits to the severely affected countries and to the Regional Office for Africa. This report has been prepared in advance of the visits, and does not yet encompass the information gained by the Panel in the countries themselves or at the regional level. The final report will incorporate lessons learnt, including what has and has not worked in the field.

2. The Panel is committed to adhering closely to its mandate and terms of reference,² beginning with an assessment of the roles and responsibilities of WHO at the three levels of the Organization. However, it should be underscored that the Organization consists not only of the Secretariat, but also the Member States. Member States are responsible for their own actions and statements, especially with respect to their obligations under the International Health Regulations (2005). They have key decision-making roles in relation to WHO priorities, resources and the Secretariat's mandate. Many of these responsibilities go beyond the remit of Ministers of Health; other government ministries and Heads of State also bear responsibilities, especially in times of crisis. The Panel therefore welcomes the establishment of the United Nations Secretary-General's High-level Panel on the Global Response to Health Crises to examine these broader issues.

3. The Panel considers this a defining moment for the work of WHO. Together, the WHO leadership and the Member States need to take determined action to address the challenges at hand. "Business as usual" or "more of the same" is not an option. Although there may be responsibility on the part of individuals for the way in which the response to the Ebola outbreak has been handled, it is necessary to identify and correct the structural causes of any shortcomings. In doing so, it must be recognized that there is an increasingly complex nexus of health, humanitarian and security crises that requires the United Nations system to find new approaches that go beyond institutional silos.

4. The Panel is acutely aware that the Ebola crisis began and continues in local communities. These communities have been indelibly marked by fear and sorrow and by great sacrifice. The toll on their own health workers has been extraordinarily high, and local people are also integral to ensuring safe and dignified burials, staffing treatment centres, and performing contact tracing. Many international workers, including WHO staff at all three levels of the Organization, have likewise put themselves at great risk for the good of the global community. The panel acknowledges with deep

¹ Resolution EBSS3.R1.

² See Appendix.

gratitude their work and generosity of spirit, and that of the huge number of people working in their own countries to bring this crisis to an end.

PRELIMINARY OBSERVATIONS

5. The Ebola Virus Disease outbreak, which began in 2013 in West Africa, is the largest and most complex Ebola outbreak on record. Widespread and intense transmission has devastated families and communities, compromised essential civic and health services, weakened economies and isolated affected populations. The outbreak also put enormous strain on national and international response capacities, including WHO's outbreak and emergency response structures. The Panel is extremely concerned about the grave health, social and economic costs of the Ebola outbreak. In light of the unpredictable nature of outbreaks and other health crises, and the mounting ecological changes that may trigger them, improving WHO's response to events such as these is critical. Systems and measures that are put in place need to be able to deal with extreme complexity, especially in relation to outbreaks in fragile States with weak institutions.

6. The Panel is cognizant of the many other public health and humanitarian crises that were competing for the attention of WHO and the broader United Nations system during this period. For WHO, these included outbreaks of Middle East respiratory syndrome coronavirus (MERS-CoV), poliomyelitis, and avian influenza H5N1 and H7N9 virus infection. For WHO and the broader United Nations and humanitarian system, Level 3 humanitarian emergencies during 2014 included the crises in the Central African Republic, Iraq, South Sudan and Syrian Arab Republic. The Panel recognizes that once the full extent of the risk was understood and resources were mobilized, it was possible to better control the Ebola outbreak, and that the worst-case scenarios concerning projected numbers of cases did not come to pass.

7. This outbreak was particularly challenging because of the characteristics of the virus and because health care systems and public health infrastructure in all three affected countries were extremely fragile, suffering – among other things – from structural weaknesses, inadequate surveillance and few laboratories. Additional complications included underlying mistrust within the communities, highly mobile populations, porous borders, and the urban context of the epidemic. It was within this setting that an Ebola outbreak was able to become a large-scale emergency. All the organizations involved faced new challenges related to the scope and the nature of their respective roles.

8. There were serious gaps in the early months of the outbreak in terms of engaging with the local communities. Traditional cultural practices, including funeral and burial customs, contributed to virus transmission, yet culturally sensitive messages and community engagement were not prioritized. Essentially, bleak public messaging emphasized that no treatment was available and reduced communities' willingness to engage; medical anthropologists should have been better utilized to develop this messaging. It must also be realized that the fact that communities were already in a post-conflict situation manifested itself in high levels of distrust in authority. Owing to an extent to a lack of involvement on the part of the broader humanitarian systems, the nongovernmental organization resources, such as community development workers and volunteers, many from the countries and communities themselves, were not mobilized in the early stages. Given WHO's extensive experience with outbreaks, health promotion and social mobilization, it is surprising that it took until August or September 2014 to recognize that Ebola transmission would be brought under control only when surveillance, community mobilization and the delivery of appropriate health care to affected communities were all put in place simultaneously.

9. It is still unclear to the Panel why early warnings, approximately from May through to July 2014, did not result in an effective and adequate response. Although WHO drew attention to the “unprecedented outbreak” at a press conference in April 2014, this was not followed by international mobilization and a consistent communication strategy. The countries most affected, other WHO Member States, the WHO Secretariat, and the wider global community were all “behind the curve” of the rapid spread of the Ebola virus. Many of the nongovernmental organizations that were on the ground in the affected countries, running development or humanitarian programmes, were faced with having to respond to a situation for which they were not well prepared; they lacked normative guidance and no adequate coordination mechanisms existed. The Panel is continuing to explore reasons for this delay, including political, cultural, organizational and financial factors.

10. The International Health Regulations (2005) constitute the primary international framework for strengthening global health security. However, in the Ebola outbreak, there were issues about the timely sharing of information, resulting from multiple factors, including clearance at many levels. Anxiety about the consequences of notification in the countries affected was high and subsequently justified by the response of other countries, airlines and business leaders. Under the International Health Regulations (2005), a Public Health Emergency of International Concern was announced only on 8 August 2014. The declaration served to mobilize resources for the response, but also resulted in significant numbers of countries implementing measures additional to those recommended by WHO. These measures interfered with international travel and trade. As a result, the countries affected faced not only severe economic consequences but also barriers in receiving necessary personnel and supplies. In these complex circumstances, lines of communication between WHO and decision-makers beyond the ministries of health, such as heads of state and government, become ever more critical.

11. It is well understood that WHO leads the health cluster in major humanitarian crises. It is unclear, however, how a public health emergency fits into the wider humanitarian system and at what point an outbreak becomes a humanitarian emergency that requires a broader United Nations-wide response which would include coordination with the many nongovernmental organization actors on the ground. One of the difficulties is that the risk assessment of public health emergencies and so-called humanitarian emergencies differs, because of uncertainty in assessing the likelihood of disease spread. In a humanitarian emergency, staffing and other resource needs can often be more directly assessed. Notwithstanding these challenges, given the need to bring together WHO and the broader United Nations system in the Ebola response, it is important to consider how these systems should interrelate; the Panel will revisit this matter in its final report.

12. Although WHO has considerable numbers of policies and procedures in place, notably the International Health Regulations (2005) and the Emergency Response Framework, these were activated late because of the judgments declaring the Public Health Emergency of International Concern and the Grade 3 emergency. These delays were related to many factors, including the following: a late understanding of the context and nature of this Ebola outbreak, which was different from previous outbreaks; unreliable reporting on the spread; problems with information flow within WHO; and difficult negotiations with countries. All these factors need to be addressed. Leadership by the Director-General, organizational alignment and clarity of decision making are paramount.

13. The very same issues made it difficult for WHO to communicate as the authoritative body on the crisis. Although an emergency media team was put in place to manage WHO’s messaging and content, the communication strategy was not able to counteract the very critical reporting on the work of the Organization. This problem was reinforced by the delayed declaration of the Public Health Emergency of International Concern, misleading Twitter messages and leaked documents. It is still unclear why WHO was not able to engage in a high-level media response with greater command over the narrative.

14. There is a strong, if not complete, consensus that WHO does not have a robust emergency operations capacity or culture. Further, in this emergency, before August 2014 WHO did not appropriately seek support from other United Nations agencies and humanitarian actors in the United Nations Inter-Agency Standing Committee system. At an earlier stage these resources could have been made available and known systems put in place; these might have averted the crisis that led to the need to establish the United Nations Mission for Ebola Emergency Response.

15. In September 2014, the United Nations Secretary-General's leadership, through the establishment of the United Nations Mission, was essential in galvanizing the global community into a response, particularly in generating political and financial commitment by donor countries, as well as in prompting the deployment of military personnel by some countries. However, the Panel plans further analysis to determine whether a similar mechanism would be the appropriate model for managing future large-scale health emergencies, as it functioned by cutting across existing mechanisms, rather than engaging the United Nations cluster system. It is clear that governance processes in the United Nations system need to be appropriate for different crisis situations.

16. Overall, WHO needs to improve its ability to engage in partnerships in its emergency preparedness response. There have been signs throughout the crisis that WHO's ability to partner with the United Nations, the private sector and other non-State actors has not been strong. These relationships cannot be established during crises, but need to be developed when building preparedness. At the same time, it is important to keep in mind that such preparedness has to be built in relation to all emergencies with health consequences.

PRELIMINARY RECOMMENDATIONS

17. Health is primarily the sovereign responsibility of countries, but the means to fulfil this responsibility are increasingly global. International collective action is therefore required. Such collective action has several main goals: to protect people's health, to prevent the international spread of health risks, and to ensure a robust response to global health threats when they occur. International collective action is essential for the effective and efficient governance of the global health system.

18. Each global health crisis has shown the tragic consequences, including those in the social and economic spheres, of the failure of countries to invest in global public goods for health. Those failures are then mirrored as weaknesses in WHO, as the Organization suffers from a lack of political and financial commitment by its Member States despite the global health risks they face. The Ebola outbreak might have looked very different had the same political will and significant resources that were spent in responding to it been made available to Member States and the WHO Secretariat over the past five years in order to support three key areas of action: ensuring global health preparedness at country level in implementing the International Health Regulations (2005); supporting countries to establish or strengthen primary health care systems; and developing diagnostics, vaccines, and medicines for neglected tropical diseases.

19. Now is the historic political moment for world leaders to give WHO new relevance and empower it to lead in global health. A strengthened, well-funded WHO can support all countries as they prepare to meet the challenges of increasing global interdependence and shared vulnerability. In response, the Secretariat needs to take serious steps to earn this leadership role in relation to outbreaks and emergency response and to regain the trust of the international community.

20. At present, WHO does not have the operational capacity or culture to deliver a full emergency public health response. A number of options have been suggested by different organizations and individuals: (i) a new agency should be established for health emergencies; (ii) the emergency part of the health response should be led by another United Nations agency; or (iii) investments should be made so that the operational capacity of WHO for emergency response is fully in place.

21. The panel recommends that the third option should be pursued with vigour. Establishing a new agency would take time to put in place and substantial new resources would be required to establish its basic administrative systems, and operational response capacity. A new agency would, in any case, have to rely on and coordinate with WHO for public health and technical resources, creating an unnecessary interface. Similarly, if another United Nations agency were expected to develop health operational capacity, it too would need to coordinate in depth with WHO, especially with respect to the International Health Regulations (2005). All this suggests that, as WHO already has the mandate to deliver on operational response, it would be a far more effective and efficient use of resources to make WHO fit for purpose. This will require the resources and political will of the Member States.

22. The Panel puts this recommendation to the Health Assembly now so that the overarching strategic direction is clear and that change can be driven forward quickly. If Member States agree to this strategic direction, then matters such as the Global Health Emergency Workforce and the proposed Contingency Fund can immediately move to implementation, so that the world is better placed to respond to significant public health emergencies.

23. A WHO that is capable of adequately responding to public health emergencies requires deep and substantial organizational change. The reaffirmation of WHO's mandate in these emergencies should not be given lightly. This will require accountability and monitoring. Below we set out the key implications.

Organizational culture

24. When an emergency occurs, there must be an ability to shift into a command and control structure with rapid decision-making. It will require adapting and adjusting resource allocation, methods of work and information practices. Member States also have to be flexible, recognizing that some ongoing work of the Organization may be delayed or postponed in an emergency. In WHO's own capacity in large-scale emergencies, the biggest skill gap continues to be found in the area of crisis coordination and leadership, and this needs to be addressed. Wherever possible, however, in-country coordination should be led by the governments of the affected countries themselves; this should include taking into account their own assessment of needs.

25. Complete commitment is needed from Member States and WHO's leadership about what emergency response requires. All WHO staff must be aware of the implications of emergency response, and those likely to be deployed must be thoroughly trained, including through simulation exercises. As previously recommended,¹ the Organization should establish "an internal, trained, multidisciplinary staff group who will be automatically released from their duties for an unspecified duration, with a relief rotation after a designated interval."

¹ Document A64/10.

Changes to systems, structures and processes

26. It will be critical to have a single, unified entity within WHO for emergency response. The outbreak and humanitarian/emergency response activities should be merged. This should be supported by new, streamlined systems and processes in administration, human resources management, and procurement that would allow rapid action and deployment.

27. The Panel understands that an appropriate structure for an emergency operations capacity is being developed and costed, and the Panel would be pleased to review it. It should be stressed that the core capacity at all three levels of the Organization does not need to be huge but it does need to be sufficient. First, in an emergency, many of the WHO deployments will come from its internal staff and the Global Outbreak Alert and Response Network (GOARN), standby partners, and the Global Health Cluster or, in the case of health care delivery, through the agreed availability of foreign medical teams and, in the future, through the Global Emergency Health Workforce. In addition, WHO does not need to build up an emergency capacity entirely separate from the other United Nations agencies. For example, while the Organization needs internal logistical skills and experience, these are more likely to be for specification rather than for direct material handling. WHO should have standing agreements with other agencies, certainly with WFP, to provide practical logistical capacity in relation to purchasing and transport. It might also consider an agreement with UNICEF for community engagement on public health. Similarly, there may be other areas where capacity does not need to be built separately; these should be fully explored. WHO should continue to use its technical competence in promoting normative guidance for policy and practices to be used by all actors.

28. The Panel recommends that this new structure should be put into place as quickly as possible, and work should be reported to the Executive Board in 2016. The necessary resources should be provided from increased Member States core contributions. The Secretariat's capacities for surveillance and technical support as required under the International Health Regulations (2005) also need to be urgently reviewed, and the relevant departments need to be supported by an adequate base budget.

International Health Regulations

29. A second area of concern is the direct responsibilities of Member States themselves. This begins with preparedness. The International Health Regulations (2005) set out a number of core surveillance and response capacity requirements. Although the International Health Regulations (2005) entered into force in 2007, not all Member States have these core capacity requirements in place. As of January 2015, 64 States Parties have informed the Secretariat that they have achieved these core capacities; 81 States Parties have requested second extensions through 2016; and 48 States Parties did not communicate their status or intentions. In addition, there are serious concerns about the reliability of the self-assessments that Member States complete on their implementation of the national capacity requirements. This leaves these countries at high risk, and increases the risk for the international community.

30. WHO should propose a thorough but prioritized and costed plan to develop the core public health capacities for all countries in respect of the International Health Regulations (2005). This plan should be put to donor agencies, Member States and other stakeholders for funding. To propose this plan WHO will need reliable information about the current situation in each country. This requires some form of peer review or other external validation. At present only self-assessment is used. It is in the countries' own interest to have a thorough and objective analysis; the Panel recommends that ways to do this be explored. Although the focus is on public health systems, health care systems across all

countries need to be in place. This again requires significant funding by Member States and possibly new types of financing mechanisms. The Panel would support this being a strong part of the post-2015 development agenda and the financing of global public goods.

31. It should be noted that the direct responsibilities of Member States under the International Health Regulations (2005) cover the individual governments' own responsibilities in acknowledging a public health emergency, but also require countries not directly affected to behave with appropriate responsibility towards the international community. At present there are significant disincentives for a government to be transparent about a public health emergency. During the Ebola outbreak, more than 40 countries implemented additional measures that significantly interfered with international traffic, outside the scope of the temporary recommendations issued by the Director-General on the advice of the Emergency Committee. The International Health Regulations (2005) impose restrictions on such measures, but this proved difficult to enforce as very few countries informed WHO of these additional measures, and, when requested to justify their measures, few did so. While the Panel recognizes that each Member State is a sovereign country with as its first priority the health of its own citizens, in our globalized world, where the health of one State is so interconnected with that of others, governments nevertheless also have a responsibility to act as global citizens. Accordingly, it is important to examine this weakness of the International Health Regulations (2005).

32. The Panel requests that the full IHR Review Committee assessment of the Ebola crisis should examine again the responsibilities of States Parties in notification and in other relevant matters, including border closures, trade and transport. Where possible, incentives need to be found for countries to declare public health emergencies. The Panel also emphasizes the importance of considering indemnification options, in order to address the severe economic penalties that affected countries may experience. Fear of travel and trade restrictions is a serious deterrent to reporting outbreaks, and addressing these concerns will improve transparency and encourage early reporting. There may also need to be some form of sanctions when countries take measures beyond those deemed necessary for public health; such precedents exist in the practices of WTO. If the current situation continues, WHO has little ability to enforce Member States' obligations under the International Health Regulations (2005).

33. At present, there is only one level of declaration – Public Health Emergency of International Concern (PHEIC) or not PHEIC. The Panel suggests that the IHR Review Committee consider whether there should be different levels of alert, as this would make it possible to alert and engage the wider international community at an earlier stage.

Financing

34. At present only 25% of WHO's biennial programme budget comes from assessed contributions. The remainder comes from voluntary funds that are largely restricted for purposes specified by donors. There are no core funds for emergency response as such, although every year a considerable amount of money is spent as donor contributions for emergencies. WHO is put at a severe disadvantage by the fact that the core funds are so limited and do not allow an appropriate base for response. On a related note, the resources that underpin the Secretariat's capacity to monitor the International Health Regulations (2005), and provide related technical support, have been reduced to a level that the Panel believes is now inadequate. More broadly, the zero-nominal growth policy for assessed contributions that has now been in place for many years has eroded the work of the Secretariat.

35. Beyond WHO's core funding, proposals for a Contingency Fund are currently being developed. Such an arrangement should highlight prevention, rather than simply response, and therefore should be available at an early stage. Clear arrangements on decision triggers for the release of funds must be made. The Panel appreciates and supports the four characteristics – flexibility, transparency, alignment and predictability – for the Fund. While the proposed Contingency Fund is largely directed to WHO, the Panel would find it helpful if the Director-General had some discretion for payments to countries for staffing issues, including hazard pay and insurance for, and evacuation of, health care workers.

Workforce

36. The Panel welcomed the plan for an expanded and stronger global health emergency workforce. It strongly supports strengthening the national components of the workforce, especially by building national capacity through training and simulation exercises. The Panel also supports proposals for increasing standby capacity across WHO and/or partners and having pre-agreed arrangements for foreign medical teams. This will require the strengthening of partnerships with a variety of actors. WHO also has a role to play in developing and implementing workforce protocols and training materials, as well as managing workforce information.

FUTURE WORK

37. By the time the Health Assembly takes place, the Panel plans to have made initial visits to severely affected countries and the Regional Office for Africa. In addition, over the next weeks, Panel members will have met with other United Nations organizations, partners and other agencies involved in the response. In countries, Panel members will meet with government officials, international and local health care workers and communities. The aim is to gain as much understanding as possible about what did and did not work in the field, so that the Panel's recommendations are grounded in evidence and experience. During the latter part of June 2015, the Panel will hold its third and final meeting. The final report will be released shortly thereafter. The Panel will work closely with and inform the work of the United Nations Secretary-General's High-level Panel on the Global Response to Health Crises, and will provide guidance to the work of the forthcoming IHR Review Committee.

Appendix

COMPOSITION OF THE PANEL

1. Dame Barbara Stocking was appointed to chair the Panel. She was formerly Chief Executive of Oxfam GB, where she led major humanitarian responses. Currently she is President of Murray Edwards College, University of Cambridge, United Kingdom. The other Panel members are: Professor Jean-Jacques Muyembe-Tamfun, Director-General of the National Institute for Biomedical Research, Democratic Republic of the Congo; Dr Faisal Shuaib, Head of the National Ebola Emergency Operations Center, Nigeria; Dr Carmencita Alberto-Banatin, independent consultant and advisor on health emergencies and disasters, Philippines; Professor Julio Frenk, Dean of the Faculty, Harvard T. H. Chan School of Public Health, Boston, Massachusetts, United States of America; and Professor Ilona Kickbusch, Director of the Global Health Programme at the Graduate Institute of International and Development Studies, Geneva, Switzerland.

OBJECTIVES AND TERMS OF REFERENCE

2. Resolution EBSS3.R1 requested “the Director-General to commission an interim assessment, by a panel of outside independent experts, on all aspects of WHO’s response, from the onset of the current outbreak of Ebola virus disease, including within the United Nations Mission for Ebola Emergency Response, in implementing the WHO’s Emergency Response Framework, and in coordination, including resource mobilization, and functioning at the three levels of the Organization, to be presented to the Sixty-eighth World Health Assembly”. The Panel’s terms of reference are to:

- assess the roles and responsibilities of WHO at the three levels of the Organization in responding to the outbreak and how these evolved over time;
- assess the implementation of the tools at WHO’s disposal (in particular the Emergency Response Framework, and the International Health Regulations [2005]) to carry out its mandate before, at the onset of, and during the outbreak;
- assess WHO’s actions at the onset of the outbreak and during the outbreak (timeliness, appropriateness, scale, effectiveness), including (i) coordination within the Organization and with Member States, in particular the directly affected countries, and other partners, (ii) resource mobilization and (iii) communications;
- assess WHO’s role within and its contribution to United Nations-wide efforts (within UNMEER);
- assess the strengths and weaknesses of those actions, determine lessons learnt that could be applied to the existing ongoing situation and for the future (including capacity, tools, mechanisms including coordination and communications, structures, ways of working, resources);
- provide recommendations to guide the current response and to inform future work, including with regard to the strengthening of organizational capacity to respond to outbreaks and the establishment of a contingency fund.

TIMELINE AND PROCESS

3. The Panel met on 30 March–1 April 2015 in WHO headquarters in Geneva. The agenda included: a review of the scope of the interim assessment and interactions with other assessments; and determination of the method of work and the work plan for the duration of the process. Briefings were given on: WHO's mandate and financing, implementation of the 2011 IHR Review Committee recommendations, WHO's role within UNMEER, and the current performance audit being conducted by the Office of Internal Oversight Services. The Panel heard presentations on activities that took place throughout the outbreak, and plans for a Global Emergency Health Workforce and a Contingency Fund. The Panel interviewed, by videoconference, Mr Tony Banbury, Former Special Representative of the Secretary-General, First Head of UNMEER; Dr David Nabarro, United Nations Special Envoy for Ebola; and, in person, Mr John Ging, Director, Coordination and Response Division, United Nations Office for the Coordination of Humanitarian Affairs. The Panel also held a session with interested Member States, during which the Chair briefed Member States on the ongoing work and plans, and heard views on, and their expectations of the Panel's work.

4. The second meeting of the Panel was held from 19 to 21 April 2015 in Geneva. This meeting heard further briefings on the Global Emergency Health Workforce and the Contingency Fund, and also received an update on the performance audit being conducted by the Office of Internal Oversight Services. There were also briefings on Communications in support of WHO's Ebola efforts and an update on ongoing research and development activities. The Panel met with a number of other organizations which were involved in Ebola work in the affected countries, including Médecins Sans Frontières (MSF), the International Federation of Red Cross and Red Crescent Societies (IFRC), the International Organization for Migration (IOM), the Steering Committee for Humanitarian Response (SCHR), the International Council of Voluntary Agencies and Save the Children. At a session with the Member States, the Panel heard perspectives on WHO's role during the outbreak, in particular the strengths and weaknesses in its response, key lessons learnt during this period and areas for improvement in WHO.

5. Panel members plan to travel to the three most severely affected countries, and to the Regional Office for Africa, within the coming weeks. They will also meet with officials of United Nations agencies, governments, and partners involved in the response. The Chair will provide a briefing on the Panel's work to the United Nations Secretary-General's High-level Panel on the Global Response to Health Crises at its first meeting.

UPDATE ON WORK COMPLETED

6. The Panel determined that while a careful analysis was required of what happened, why it happened, and what could be improved in future, it should not focus solely on Ebola outbreaks. This was to ensure that the Panel's recommendations would help WHO to be ready for the unexpected in the future, rather than just able to deal with the last major emergency.

7. The Panel also stressed that its assessment is to be a learning exercise. The Panel's overriding concern is to understand what happened and to advise on the resources, systems, people, and changes in the organizational culture needed to improve future performance.

8. The Panel was asked to assess WHO's role and contribution to efforts across the United Nations system, and its interface with other parts of the global health and global humanitarian systems. The Panel will not, however, review these directly, as the United Nations Secretary-General has established a high-level panel, chaired by Tanzania President Jakaya Kikwete, to examine the response of the wider international community. Given that WHO is called upon to direct and coordinate these wider systems in matters of health, the Panel is reviewing how well WHO carried out this broader role. The Panel will complete its work as soon as possible after the Health Assembly, so that its findings can feed into the Secretary-General's high-level panel.

= = =