New Ebola Outbreak in Africa Is a Major Test for the WHO

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New Ebola Outbreak in Africa Is a Major Test for the WHO

Lawrence O. Gostin, JD

On May 8, the Democratic Republic of Congo (DRC) notified the World Health Organization (WHO) of a confirmed outbreak of Ebola in Bikoro, on the shores of Lake Tumba in Équateur Province. Ebola in the DRC is not unexpected. The first-ever-identified Ebola outbreak occurred in the DRC—then Zaire—in 1976. This is the ninth of DRC’s outbreaks, which until now have been confined mainly to rural areas. With high fatality rates, earlier outbreaks quickly exhausted where part of their manufacturing goes to building parts of weapons? To help inform him and his faculty and students, Galea said, he has invited Yach and Daube to speak at a symposium on campus in the fall.

Lessons Learned by the WHO

WHO transformed its work on pandemic preparedness and response, learning major lessons:

Declaring a PHEIC Under the IHR. On May 18, only 2 days after urban spread, the director-general convened an emergency committee under the IHR. The committee decided not to declare a PHEIC but urged the WHO to be on high alert, promising to reconvene if the virus spread internationally. The committee urged against travel or trade restrictions, which had devastated West Africa during the 2013-2016 Ebola epidemic. The region faces key challenges: cases in a congested city; multiple outbreaks in remote, hard-to-reach locations; health professionals infected, posing a risk for amplification; and logistical challenges of poor infrastructure (for example,}

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unpaved roads, lack of electricity, and limited telecommunications). The outbreak’s epicenter is remote and impoverished. These factors pose challenges for surveillance, case detection and confirmation, contact tracing, and access to vaccines and therapeutics.

**Emergency Response.** Traditionally, the WHO has been primarily a normative and technical organization, with weak operational capacity to respond to health emergencies. The organization quickly activated its Incident Management System, created in the wake of the West African epidemic, to place responders, equipment, and supplies on the ground, while coordinating local, national, and international actors. The WHO’s Global Outbreak Alert and Response Network and Emergency Medical Teams initiative will offer additional coordination and technical support. The organization released $2.6 million from the new contingency fund for health emergencies to provide vitally needed resources. It has empowered the DRC’s Ministry of Health, while partnering with international organizations (Gavi, the Vaccine Alliance; United Nations Children’s Fund (UNICEF); the International Federation of Red Cross and Red Crescent Societies (IFRC), and civil society ( Médecins Sans Frontières)). International partners have improved logistics so health workers, medical equipment, and vaccines can move to areas of critical need.

**Vaccine.** The WHO, with partners, has sent rVSV-ZEBOV vaccine to the DRC. Merck provided it without charge, while Gavi donated $1 million for health workers and logistics. The rVSV-ZEBOV vaccine is not officially licensed, but the DRC authorized its compassionate use pending regulatory approval. It proved highly effective in trials in Guinea and Sierra Leone toward the end of the West African epidemic. Subsequent trials in Africa, Europe, and the United States reinforced the vaccine’s effectiveness. Marking a turning point, vaccination transforms the response from a strategy of containment to one of prevention and protection. The vaccination campaign targets frontline responders, health workers, and contacts of infected persons. Using a “ring” strategy, vaccination creates a buffer of immune individuals to prevent virus transmission.

The WHO and the DRC also must decide whether to approve and deploy experimental medicines. During the West African epidemic, aid workers often got preferential access to investigational drugs such as ZMapp. Giving priority to foreign responders generated distrust. Another vital lesson was to give the host country greater ownership of medical countermeasures.

**2014-2016 Total Funding for Ebola Virus Disease Outbreak Response**

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<th>Humanitarian Funding, 2014-2016, US $</th>
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<td>US government</td>
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<td>Total</td>
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*Funding figures as of January 21, 2016. All international figures are according to the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) Financial Tracking Service and are based on international commitments during 2014, 2015, and to date in 2016. According to the US government, its figures reflect its commitments from fiscal years 2014, 2015, and 2016, which began October 1, 2014, and October 1, 2015, respectively.


Although vaccination could be transformational, the campaign faces enormous challenges, including surveillance, laboratory confirmation, and locating contacts. Affected populations are difficult to reach and include diverse ethnic communities speaking a dozen languages. Vaccine distribution requires cold storage (−70°C to −80°C), which requires reliable roads, electricity, and generators. Fostering public trust is essential, requiring deep understanding of local cultures and genuine listening to community concerns.

**Challenges to Emergency Preparedness**

The WHO’s Strategic Response Plan estimates that $26 million is required for DRC Ebola funding, a target already reached. The World Bank will distribute money for the first time from its Pandemic Emergency Financing Facility. The resources required to quell this outbreak through proactive measures pale in comparison to the well more than $3 billion the West African epidemic cost the global community (see table). Although the health emergencies program and contingency fund are innovative reforms, both are significantly under-funded. The United States was the top donor during the West African epidemic, yet the Trump administration is now seeking to vastly scale back pandemic preparedness. Member states need to act as stakeholders in the WHO’s success to ensure preparedness, but thus far the organization has been chronically under-funded.

Beyond global governance, robust national health systems are the foundation of global health security. The IHR requires all states to maintain core health system capacities, but most have not complied. Investing in health systems is lagging, both from domestic governments and international donors. The Joint External Evaluation to objectively assess health system capacities was another post-Ebola reform, and has assessed 67 countries. Yet significant gaps persist, affecting countries’ surveillance and response.

Countries also frequently fail to comply with IHR recommendations to avoid unnecessary quarantines and trade and travel restrictions, with many disregarding WHO recommendations during the West African epidemic. Fearing reductions in travel, tourism, and trade, governments may not rapidly report disease outbreaks.

The World Health Assembly recently underscored the urgency of containing the DRC outbreak. Beyond expressions of concern, countries must commit to a global push to implement IHR core capacities, strengthen health systems, and empower the WHO.

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