Dr Margaret Chan, Director-General Geneva, Switzerland, 24 August 2015

Mr Chair, distinguished members of the Review Committee, ladies and gentlemen,

Good morning, and a very warm welcome to Geneva. Thank you for giving us your time and your expertise.

You are asked to provide a critical review of how the International Health Regulations performed during the outbreak of Ebola virus disease in West Africa.

The review takes place at a time of nearly universal agreement that the international response to the outbreak was inadequate. When the number of cases in Guinea, Liberia, and Sierra Leone began to increase exponentially, all responders, including WHO, were overwhelmed.

Since Ebola first emerged in 1976, WHO and its partners have responded to 22 previous outbreaks of this disease. Even the largest were contained within four to six months.

In West Africa, WHO, and many others, were late in recognizing the potential of the outbreak to grow so explosively. Some warning signals were missed. Why?

Our challenge now is to look for improvements that leave the world better prepared for the next inevitable outbreak.

Managing the global regime for controlling the international spread of disease is a central and historical responsibility of the World Health Organization. We need to pinpoint the reasons why the response fell short,. We need to learn the lessons. We need to put in place corrective strategies just as quickly as possible.

The IHR is a principal instrument for doing so. These regulations are the only internationally-agreed set of rules governing the timely and effective response to outbreaks of infectious diseases and other public health emergencies.

If its legally-binding obligations on States Parties are not being met, change is urgently needed. If WHO is not exercising its full authority under the regulations, change is urgently needed.

Your job is not an easy one. Emerging and re-emerging infectious diseases have become a much larger menace under the unique conditions of the 21st century, with its unprecedented volume and speed of international travel and the radically increased interdependence among nations.

Every day, nearly 100,000 flights carry 8.6 million passengers and $17.5 billion of goods to their destinations.

The dynamics of virus spread in West Africa had many exceptional features. But it would be a mistake to forget that many other countries also have extremely weak health systems and infrastructures, a history of conflict and civil unrest, highly mobile populations, and entrenched high-risk cultural practices.

Ebola in West Africa was the largest, longest, and most deadly event in the nearly four-decade history of this disease. But it was not a worst-case scenario.

Preparedness for the future means preparedness for a very severe disease that spreads via the airborne route or can be transmitted during the incubation period, before an infected person shows tell-tale signs of illness.

Ladies and gentlemen,

As you undertake this review, you have the views and recommendations of three expert groups as guidance.

First, the review committee that assessed IHR performance during the 2009 influenza pandemic. Second, the review committee that looked at IHR core capacities. And most recently, the report of the Ebola interim assessment panel, chaired by Dame Barbara Stocking. These expert groups have identified three main weaknesses in the performance of the IHR.

First, compliance with the obligation to build core capacities for event detection and response has been dismal. Eight years after the IHR entered into force, fewer than a third of WHO Member States meet the minimum requirements for core capacities to implement the IHR.

Why? Is this because health security is not a priority for governments and the international community? Is this because SARS was contained within less than four months, and the long-dreaded influenza pandemic turned out to be so mild? Did everyone relax?

Or is it a matter of not having sufficient financial and human resources? As you know, the IHR wording, that “States Parties shall utilize existing national structures and resources to meet their core capacity requirements,” places resource responsibilities squarely on the shoulders of individual governments.

Are the minimum requirements set out in the IHR too demanding? Should we lower the bar? Surely not.

But perhaps we should change our whole approach to the way progress is supported and monitored.

I have heard broad agreement that the practice of relying on self-assessments needs to be replaced with a more rigorous and objective mechanism. You may want to further explore options for doing so.

Many factors have been cited as contributing to this poor compliance with core capacities.

In a number of countries, implementation of the IHR is regarded as the sole responsibility of ministries of health, with very little engagement from other relevant ministries, such as those responsible for finance, trade, tourism, agriculture, and animal health.

National focal points often have limited authority and very little access to a country's true power base. Misunderstanding of the IHR as a rigid, legal process further constrains compliance.

Ladies and gentlemen,

At the very least, the Ebola outbreak in West Africa provides dramatic proof of the importance of having minimum capacities and infrastructures in place before a severe disease becomes established in a population.

Ebola in Guinea, Liberia, and Sierra Leone was an extreme stress test that saw the virtual collapse of health services.

The national responses in Nigeria, Senegal, and Mali show the good results possible when health officials are on high alert and the health system is well-prepared. But overall, national and international responses show how far the world is from achieving global health security. Overall, these experiences provide a stunning example of all that was missing, all that can go wrong.

The IHR call for national capacity "to detect events involving disease or death above expected levels for the particular time and place in all areas within the territory".

But how can countries that routinely experience deaths from diseases like malaria, Lassa fever, yellow fever, typhoid fever, dengue, and cholera recognize an unusual event in the midst of all this background noise from difficult and demanding diseases?

Maybe this is another truly fundamental problem that keeps the IHR from working as intended.

The Ebola virus circulated in Guinea for three months, undetected, off every radar screen, with no alarms sounding, misdiagnosed as cholera, then thought to be Lassa fever.

Even in Sierra Leone, where health officials were on high alert, the virus spread undetected for at least a month, sparking numerous chains of transmission that rapidly multiplied.

The earliest cases to reach the health system were managed as gastroenteritis, again with a diagnosis of cholera presumed.

Within six weeks, three hotspots of intense virus transmission were firmly established.

As we learned, cases at the start of an outbreak, when containment has the best chance of success, will be missed in the absence of sensitive surveillance, rapid laboratory support, and good information systems shared by the public health and clinical sectors. If the two arms of

the health system are not talking or sharing information to raise awareness and take rapid action, we have seen what can happen

As I always say, what gets measured gets done. What can't be seen can't be measured or managed.

As we learned, when new cases occur that cannot be linked to a known chain of transmission, an outbreak is out of control.

Ladies and gentlemen,

As a second weakness, many countries imposed measures, such as restrictions on travel or trade, that went well beyond the temporary recommendations issued by the Emergency Committee last August.

These measures isolated the three countries and vastly increased economic hardship for some of the world's poorest people. All three ran short of food and fuel.

Just as important, travel restrictions, including the many airlines that suspended flights to West Africa, impeded the arrival of desperately needed response teams and equipment.

If countries are punished in this way, where is the incentive for rapid and transparent reporting?

Whether and under what circumstances countries should be permitted to implement health measures beyond those recommended by WHO was a politically charged issue when the IHR were negotiated.

At present, WHO does not have a mechanism for enforcing compliance with its recommended measures. This has to change.

A third weakness is the absence of a formal alert level of health risk other than the declaration of a public health emergency of international concern, or PHEIC. This is a recommendation from the Stocking report for you to consider.

Establishing a formal intermediate level of alert of health risk would require an amendment to the IHR.

Another option is illustrated by the Emergency Committee convened to assess the MERS situation.

Although many meetings under this Committee were held, none declared a PHEIC, yet their reports consistently set out advice aimed at reducing the number of cases and preventing further international spread.

Ladies and gentlemen,

Some other recommendations from the expert groups would also require amendments. The IHR has provisions for making amendments.
But as this is a matter of international law, the procedures are strict and they take time.

In the best possible case, any amendments proposed now would take several years to come into force. Is this what you want? I defer to your suggestions.

Other options can be used to move forward much more quickly. Nor are you in any way obliged to consider only those recommendations made by the three expert groups.

Let me also share with you what I have been hearing. Some analysts have argued that a risk approach to capacity development might support more rapid progress.

For example, we may need to be smarter in identifying where improved surveillance and response capacities are most badly needed.

Systematic studies conducted over decades have shown that the emergence of new diseases follows a non-random global pattern.

From these studies, we also know that nearly 72% of all new human pathogens originate in wildlife, and most frequently at lower latitudes. Can mapping of geography, climate, and cultural behaviours pinpoint hotspots for the emergence of new diseases?

Can we give the international community a list of priority countries ranked as likely to experience outbreaks? Some countries may see this as stigmatizing.

In other words, not lower the bar for core capacities, but narrow the list of countries in urgent need of support.

As WHO knows from its experience with vaccines for yellow fever and epidemic meningitis, the promise of assistance can be a powerful incentive for building surveillance and reporting capacity.

The aftermath of the Ebola outbreak likely represents our best chance ever to transform the world's response to epidemics and other health emergencies.

The image of people dying on the grounds of overflowing hospitals should have left an indelible mark on the world's collective conscience. This is also a window of political opportunity.

I ask you to be critical in your assessment, bold in your thinking, and far-reaching in your recommendations.

I value your expertise, and your advice, and I wish you every success in your deliberations.

Thank you.