HOUSE OF COMMONS

International Development Committee

Oral evidence: Responses to the Ebola crisis: Follow-up, HC 338

Wednesday 25 November 2015

Ordered by the House of Commons to be published on 25 November 2015.

Listen to the meeting: Wednesday 25 November 2015

Members present: Stephen Twigg (Chair); Fiona Bruce; Pauline Latham; Jeremy Lefroy; Wendy Morton

Questions 48-62

Witnesses: ***Dr David Nabarro***, United Nations Secretary-General's Special Envoy on Ebola, gave evidence

Q48 Chair: **Chair:** Thank you very much indeed for joining us here this morning, as part of our follow-up inquiry on Ebola. I know that you met informally with some of the members of the Committee, when we were in New York for the global goals summit in September. Thanks for being with us. We have a number of questions to put to you over the next hour, and hopefully generate some good discussion, so let me pass over to my colleague Pauline Latham.

Q49 Pauline Latham: Could you tell me why you think the World Health Organization and the wider community were so slow to react to the Ebola crisis? Where does DFID fit into your position on that?

Dr Nabarro: Thanks very much indeed. The retrospective analysis shows that the first case of this outbreak occurred in December 2013 in Guinea. During 2014, in the first few months, there were reports of unusual illness in Guinée forestière, but it was not until about March or April that the diagnosis of Ebola was reached. In May, when the President of Guinea actually came to Geneva and met with the Director-General of the WHO and others, the understanding was that this had actually burnt out the outbreak. Certainly there were no cases being reported. At that time, therefore, although there had been some engagement of international experts in the early part of the outbreak, there was a sense that the outbreak had in fact subsided.

In June and July, it became clear that it had returned and the international community, headed by the World Health Organization Africa regional office, issued a number of alerts about a serious Ebola outbreak developing. At the same time, Médecins Sans Frontières was heavily invested in providing services to people who were affected in Guinée forestière and then, as the disease spread across the border into Liberia and then into Sierra Leone, in what

is called the Kissi triangle, where the three countries meet, it was clear in late June and early July that a major outbreak was occurring.

The question is whether or not the organisations concerned sounded the alarm loudly enough. I have to stress that there is not, in the World Health Organization nor indeed in the UN, a big reserve force to deal with this kind of problem. Ebola outbreaks in the past have been really quite small, perhaps 50 people infected in localised areas in Uganda, in Democratic Republic of Congo and in Congo-Brazzaville. When this started to really increase, particularly as people moved in July into the capital cities of Monrovia and Freetown, and also into the towns of Guinée forestière of Nzérékoré and Guéckédou, partly because of some really unfortunate funerals that led to mass infection—usually deaths of healers or religious leaders—this was an unprecedented thing.

I ask myself all the time, "What was it that meant that the actual recognition of the severity of the problem only became intense in the minds of international leaders in July, when Médecins Sans Frontières in particular, but also others that were working in the region, particularly missionary groups, had identified something serious going on since early June?" I cannot give a direct answer, but I will give some context.

There were other crises and emergencies underway in the world at the time. I know that the World Health Organization was particularly anxious about something called Middle Eastern Respiratory Syndrome, and there were big questions being asked of WHO about why it was that there was so little information about the nature of the outbreak. Intense work was underway in the Kingdom of Saudi Arabia at that time, involving senior personnel, to try to get on top of it. One could argue that minds were distracted.

Secondly, the WHO regional office in Africa, headed by Luis Sambo, had made a number of statements about what they perceived to be the severity of this problem and had appealed for resources. As far as I can understand, those resources were not really forthcoming. There is a figure for the amount of money that WHO received to help with the outbreak by early August, which is amazingly small. It is less than $10 million. With that kind of financing, it is really hard to have a big response.

Thirdly and perhaps most importantly, the World Health Organization's outbreak and emergency operations have been declining in terms of capacity for many years. I would like to explain the reason for that. The World Health Organization has two budgets. One is what is called the assessed contribution budget and the other is the extra-budgetary funding, which is money provided by donor agencies like the United States Agency for International Development or DFID, and also foundations like the Gates Foundation. The current situation is that the assessed contribution is less than $500 million per year, $929 million per biennium. It has increased by about $100 million over the last 14 years. The organisation has essentially been on a standstill budget, but the actual spending of the organisation has increased fourfold, and the extra money has come from the donor agencies.

If you look at how the health priorities in the world have evolved since the early 1990s, they have gone more and more into issues that cause the greatest suffering and death in the world—diseases of childhood, diseases around maternity, AIDS, tuberculosis and malaria, and more recently non-communicable diseases, like cardiovascular and similar. Through the governance of the WHO, there has been a steady shift away from preparedness to deal with these quite rare events of outbreaks.

There was a pandemic in 2009-10 of what was called swine flu or influenza H1N1. An inquiry of WHO's response to that showed that it was ill prepared to deal with a pandemic, and suggested a number of changes. However, the governing bodies of WHO still chose to

encourage the organisation to prioritise the high-mortality conditions, which is a very sensible governance decision, and money for these outbreaks was not preserved.

In summary, there were certainly problems because eyes were not focused on the Ebola outbreak, particularly in June/July. There were announcements made, but they were not pushed hard enough by the organisation and, in retrospect, all of us feel, if only there had been a louder shouting three months early, the situation would have been much better. The organisation has had to experience a decline in its resources for outbreaks and emergencies. Those are in part due to the governance decisions and the financing structure of the organisation, where money is attached to particular priorities by the donors.

The result of all this is that, as I will explain if you ask me later, we have been trying to establish a system to completely transform not only the WHO, but the whole international system so this does not happen again.

Q50 Pauline Latham: We as a Committee went out to Liberia and Sierra Leone in June. I had read about it and said I was extremely concerned about even being there. I was told by DFID people on the ground there and by people accompanying us that I was really rather silly, because you could not catch it; it was almost impossible to catch and I was making a bit of a fuss. Actually, I knew that, if you did get it, it was pretty deadly. I was concerned then, but nobody else seemed to be at the time. What did you feel DFID could have done better to have responded to it more quickly? Is it again because people did not shout about it?

Dr Nabarro: There are two sides to it. Obviously you have to shout about something and the right people have to shout about it. Certain voices are not heard as clearly as other voices, so one really needs to get shouting from the presidents of the countries. One needs shouting from senior international figures, particularly within the World Health Organization in Geneva, and then perhaps there will be more hearing. It is extremely unfortunate that the words of Médecins Sans Frontières, which were quite shrill by the time you were there, were not heard. I believe one day that we need to try to understand that, because it is a rather odd phenomenon. I can think of proverbs that describe that kind of thing and I feel that that needs to be explored. I know MSF is looking at that.

Now, you were there. You had read about it. You knew it was contagious. You know it is a high-fatality disease, yet people on the ground said that it is not that serious. Like you, I wonder why. Here are some hypotheses. First, when you went it was not much in the capitals. It was mostly out in the rural areas.

Pauline Latham: We were going into the rural areas. I refused to go. They went into the rural areas, the rest of them, but I would not go.

Dr Nabarro: Kenema and Kailahun were the hot spots in Sierra Leone, and Lofa was the hot spot in Liberia. Many of the people who were describing the issue in capitals at that time, June and July, were not necessarily coming face to face with the reality of what was happening—hypothesis 1.

Hypothesis 2, and perhaps more importantly, this is not a disease that is very common. Very few people have actually encountered it, even though quite a lot have heard of it. My hypothesis is that you do not find it easy to internalise in your head something that is not within your experience. Even the experts—even myself—are not schooled in Ebola in a way that we have now had to learn to be.

I have these two possibilities. One is that people were not aware because they had not necessarily been in the places where it was and, secondly, they were not necessarily used to seeing it spread like this. These are the only explanations I can have. I do believe, on the

basis of my previous work on avian influenza, that if you do not know about something it is very hard indeed to know how scary it is.

Q51 Wendy Morton: I just wanted to go back. You made reference to the time when the Ebola was really starting to take a hold when there was Middle Eastern Respiratory Syndrome, which the World Health Organization was putting a lot of effort into. Now I am not a medical expert, but what does it really need to trigger a diverting of resources away from a disease that appears to me—correct me if I am wrong—not to be infectious in a country that is relatively well-off, to get that response in a country where there is a disease that is infectious, very little is known about it and it is in a much lower income, more vulnerable country? Is there a process or is it literally people having to shout and make a case for it?

Dr Nabarro: The World Health Organization has always prided itself on having the capacity to do continuous assessment of global threats relating to an analysis of risk that is informed by information received, both from reports from countries but also through rumours that come through the media or through other sources. I personally think that that risk assessment service has not been operating as intensively as it should have been in the last few years. Quite simply, you need people to do it. You need an organisational capacity to do it. It is expensive in terms of human power and it requires a great deal of discipline to sustain.

One can safely say that that obviously needs to be ramped up and a permanent risk assessment capacity needs to be in place, which is linked not just to governments, but also to institutions like the European Centre for Disease Prevention and Control, the United States Centers for Disease Control and shortly the African Centres for Disease Control, which is going to be set up.

Number two, you need an open mind to do this kind of work. All of us who deal with rumour and who respond to alerts have a habit sometimes of tuning out information that comes from a particular source. I do not want, in any way, to suggest that this was the case but, as I said in response to Pauline Latham, I believe that sometimes the open mind is not maintained when information comes from sources that tend to be the providers of alerts on a lot of occasions. You get a kind of discounting capacity in your head. It is the same in other forms of intelligence, and so the maintenance of an open mind is absolutely critical and all of us need, as a result of this, to be much more ruthless in purging ourselves of any discount factors when information comes from one or other source.

Thirdly, it is having a high and, frankly, possibly over-sensitive sense of suspicion. We need to be much better at no regrets. I was involved in H1N1. I was involved before that in H5N1, the two influenzas. One was swine flu; the other was bird flu. I had a role in trying to prepare the world for a bird flu pandemic from 2005. It is amazingly hard to maintain and sustain not only the sense of suspicion, but the willingness to invest in preparedness and in early response, when you get a small cluster. Trying to sustain the no-regrets approach is one that we are going to have to do, certainly for the next few decades until forecasting gets better.

WHO was hit on H1N1 in 2010. Enquiries suggested that they had overreacted to the threat, and this has led to unnecessary purchasing of vaccine. A number of fairly unpleasant things were said about the relationship between the organisation and vaccine manufacturers. Somehow, all of us need, as we do in other global threats or local threats, to introduce a stronger no-regrets approach.

Q52 Jeremy Lefroy: Good morning, Dr Nabarro. It is a pleasure to see you again. I very much underline the point that my colleague Pauline Latham has made. I was there when she made those very points, so I remember it very well.

Dr Nabarro: Did you travel?

Jeremy Lefroy: I did. We were together, yes.

Pauline Latham: He travelled into the country. I was not going to go there.

Jeremy Lefroy: I recall going to Bo, and I met a colleague from my previous life in business, who had come from Kenema that day and had been stopped at various points along the road. This was in mid-June, so there was beginning to be some kind of government response at that time, but it was fairly low key at that point.

I recall when we were in Pakistan a few years ago with the Committee. We were told about an outbreak of dengue in Lahore, in 2010 or 2011, and it had hit a lot of people. There were about 300 deaths. As a result, the chief minister had instituted a programme of ensuring there was no standing water at all in the following dengue season, and there had been no deaths. Of course that underlines the point you were making; this happened in the capital of the Punjab. It happened to people who were in areas that were relatively wealthy and people wanted that sorted out. How do we ensure that, in areas that are remote, where there is not the kind of political influence that people have in the capital, we get early warning so that they are taken seriously?

Dr Nabarro: In Liberia, I was very impressed by the way in which local political leaders, the senators, were involved in the response, as a direct result of the efforts of the President, but also a number of key people in Liberia really took seriously the business of working at county level. I noticed in Liberia that, because of this involvement of local leaders, there was much greater intensity of local-level response and of community involvement than I had seen in other parts of the region. In Sierra Leone, things started to turn when President Koroma involved the chiefdoms—the 149 tribal chiefs who actually provide the governance of the country.

Increasingly, I have become convinced that it is no good relying on governments alone to provide the alert and infrastructure, and indeed to be the primary responders in these kinds of issues. Just as in any other kind of threat to people's safety and wellbeing, it has to be through engagement of communities, their ownership of the issue and the involvement of local leaders in the organisation of the response.

Indeed, I go further and I say that, unless local leaders actually own the issue and own the response—and there is a huge but subtle difference between involvement and owning—then it is very difficult indeed to implement it. What do I mean by that? By "owning", I mean they have to be able to actually take some of the decisions themselves. Even if those decisions are not necessarily in line with every aspect of what the centre says, they should at least be given their chance to do it.

That means that sometimes in Liberia and in parts of Sierra Leone, once the decentralisation started, the responses at local level were quite tough. That is something we have to accept. You cannot, on the one hand, say there is a very dangerous thing brewing in Kailahun or in Lofa and then say, "But we are going to be the ones who decide what you do about it." If you delegate the response to the local community and they are a bit stronger in terms of controlling movements and restricting people coming out of their homes than you might otherwise have expected, so be it. The second part of this is to decentralise and have local ownership. Secondly, do not get too fussed if things are sometimes a little bit harder

than you might want because, in the end, unless that kind of ownership is taken, there will not be good action.

Even when I was intensively involved in August, we faced people within the countries, and certainly people within Africa and globally, who would still look at this and say, "You are making a great fuss about this. You are doing it because you are being paid for it. What you are doing is self-serving." The other thing we need to work on is the natural sense, among some, that we over-exaggerate the dangers to suit our own professional or personal needs. Linked to the no-regrets policy, I believe we need to have a precautionary principle where we encourage, at least at the beginning, a much higher degree of suspicion and anxiety about danger than would otherwise happen.

In summary, localise; involve communities; involve local leaders; find ways to enable them to own it. Certainly accept with them that there are minimum standards that have to be imposed. If they go a bit further, do not rap them over the knuckles. Let the thing grow from below.

The one point that I found when I was with President Sirleaf in Liberia is that we had to deal with the moment when quarantine was imposed by the military in one part of Monrovia, in West Point. Again, a decentralisation of action took place and a decision was taken to use military force. Unfortunately, somebody was shot. I was there the day after that happened. I sat in the Cabinet and listened to the President say very clearly, "We will deal with this problem by restricting movement, but we will do the following. One, no lethal force. Two, we will make sure that, when people are quarantined, they have water, sanitation and food." In a way, the role of the centre in these circumstances, particularly when communities are moving forward with isolation programmes, is to make sure that people's basic rights and minimum needs are properly taken care of. That was where we in the UN were able to be helpful, with the World Food Programme and others actually getting stuff straight to the people who were in quarantine.

Q53 Jeremy Lefroy: What you said is incredibly helpful. If I can come on to the UN architecture, the UN set up its first ever emergency health mission, UNMEER. What were the advantages or disadvantages of this particular model, as against direct action by the WHO through national governments?

Dr Nabarro: Is it alright if I just give a little bit of background before I go into that?

Jeremy Lefroy: Of course.

Dr Nabarro: I was appointed as Senior Coordinator, as a result of a joint agreement between Margaret Chan of WHO and Ban Ki-moon, the Secretary-General, early in August. In the first week I was in WHO. That was from 8 August, because I came back from holiday to do this. The first thing I noticed was that there was a continuous recalibration going on in the minds of Dr Chan and her senior leaders about the severity and potential impact of this problem. I want to describe that.

Basically, over time, you watch very senior and experienced people starting with one perception about the likely projection of the thing and where it is going to go, and then, after 24 or 48 hours, probably not sleeping, you realise that they have shifted their mental projects and they are thinking differently. It was at that time, during the week of 8 August to 15 August, with Dr Chan and then working with the Secretary-General, that we started to realise that all the sense that we had about the extent of this problem and its potential growth was wrong, and we had to change our thinking completely.

The first way we had to change our thinking was to recognise that the outbreak was increasing geometrically. That meant it had a doubling time. We were not sure what the doubling time was. At the beginning, we thought it was four weeks and then we reduced the interval to three weeks, in that period at the beginning of August. The difficulty with a geometrical increase in a problem is that responding is really difficult because, almost always, responses increase in a linear fashion, especially when they involve many different what we call mission-critical actions.

We identified 12 things that had to be in place in the region for the response to work. It was extremely complicated. As well as treating people, we had to make sure that bodies were buried. We had to make sure that supplies could get out. We had to make sure that essential services were maintained and communications were good. The list was 12.

It was at that time, visiting the countries in the region, talking to the presidents, talking with leaders in the United Nations, spending virtually every three or four days cloistered with Dr Chan and the senior advisers, and a lot of travel in the triangle between Africa, New York and Geneva, that I, together with others, reached a conclusion that we had to ramp up the global response twentyfold in the space of three months to get in front of a problem that was increasing geometrically, with a doubling time of three to four weeks. That kind of thinking and that kind of challenge, in an atmosphere that, as Pauline Latham has described, is stunningly dangerous, where nobody really wants to go and expose themselves to the danger—and that includes seasoned people who work inside the UN—is a huge undertaking.

I then spoke with Valerie Amos, the Emergency Relief Coordinator for the UN, as well as Ertharin Cousin in the World Food Programme, Tony Lake of UNICEF and the leader of the Department of Field Support, at that time Ameerah Haq. Together sitting with the Secretary-General during the last weeks of August, having in our hands the request from the presidents for the UN to take a leadership role, we thought, "What do we have in our system that is capable of providing the infrastructure and the leadership for a twentyfold scale-up in response, which will mean us calling on countries all over the world to provide people, to provide treatment facilities and indeed to provide cash to ensure that the necessary elements are put in place, including simple things like refuelling, helicopters or other services—boats?" What do we have that can provide that kind of measure of what we then called a platform, which will enable multiple actors to respond?

By that time, we also had a projection from the US Centers for Disease Control that, by the end of the year, the number of cases might well reach 1 million. We also had anxiety that the spread was going to go not just into Nigeria, but also into other countries in the region and perhaps beyond. That was when the UN Secretary-General, discussing with his senior advisors at the end of August, having taken advice and received a lot of support from the leaders of the United States, the leaders of the United Kingdom and of France, the head of Médecins Sans Frontières, the head of the Red Cross and a lot of time with Dr Chan, always sitting with me nearby, reached the conclusion that we needed to find a very strong leadership model, which the UN could provide, plus the capacity to surge in the region. That led to the concept of UNMEER being developed in early September.

By that time, I had done my second visit to the region and spoken to the presidents about our concept of a robust platform with powerful leadership and strong coordination. They all said, "The sooner you can do this, the better. We are feeling abandoned. We are feeling anxious. We know that you are doing your best, but your best is not enough." The difficulties were as follows.

First, we wanted to have a base for this operation very close to the affected countries. We could not do that in Senegal. At the time, I had strange days, like spending many hours flying around in a little aeroplane trying to land in Dakar, getting permission, having it refused, getting permission, having it refused. We decided that, with that and with Médecins Sans Frontières also not being able to use Dakar as a staging post, we had to find somewhere else and Accra was chosen. All of us felt that was a substandard choice. It was too far away.

Secondly, we had another difficulty, which was that, although there were thousands of UN staff who wanted and expressed interest in coming to work in various capacities within the mission, all sorts of problems emerged in moving from people wanting to work to people actually coming to work and then people actually working. It was slower than we wanted. I do not really want to go into every aspect of the detail, because I do not know it—it is one of the things we are looking at—but we do not have, anywhere in our system, procedures for really rapid deployment of hundreds of people. Yes, we managed to get 2,500 people into the countries in the region, some employed locally, some employed on international contracts. They were supplemented by thousands of people from the African Union and from other countries, including of course the British military, but it took us three or four months to ramp it up. If the outbreak had continued expanding exponentially, in the way that it was in the middle of September, we would have been in really big difficulty. We just had good fortune, because the communities in Liberia initially—they were much slower in western Sierra Leone and slower still in Guinea—themselves started to play their part and the transmission rate slowed.

In summary, it was the right thing to do something very powerful in the UN. Even if we had used existing processes and given them every single bit of encouragement we could, it would have been difficult to get the leadership and also the coordination capacity in place quickly. It would also have been problematic with funds as well. At least with the mission, we were able to get a budget approved pretty quickly for the spending of between $50 million and $90 million tranched in two phases.

The thing we have to do next time is to have the arrangements pre-planned, have the financing pre-planned and, most importantly, have the systems for rapid deployment of key staff, especially crisis managers to work at local level in the regions, much quicker. If we had not had the excellent inputs from the UK in Sierra Leone, from the US in Liberia and particularly from the non-governmental organisations, and this total coming-together of United Nations donor governments and NGOs, if we had not had that combination, plus the leaders of the presidents, and if the communities had not managed to slow the outbreak, we would be looking at a much worse situation than we are now.

Q54 Wendy Morton: I would like to move on to be a bit specific now about the World Health Organization. Are the World Health Organization and the International Health Regulations really fit for purpose for dealing with public health emergencies? I know it is a rather direct question.

Dr Nabarro: Fortunately others have said it. The independent report on the WHO's response to the Ebola crisis, which was released in June, undertaken by a committee headed by Barbara Stocking, said that they are not fit for purpose, and they did not mince their words. They identified several of the challenges in the organisation and their report was accepted by the Director-General, who also indicated, both in her speech to the World Health Assembly in May and then in her response to the Stocking inquiry in July, that she felt that it was not good enough and that changes had to be put in place.

The organisation, as it stands at the moment, is not fit for purpose; "purpose" in my mind means dealing with up to 25 different kinds of crisis at any time: 15 complex emergencies, like we have in Syria, Yemen, Iraq, the Central African Republic or South Sudan; five outbreaks—though at the moment Ebola is not so pronounced, it was at one stage at least as big as three or four outbreaks that you normally have, and there are also other kinds of outbreak; we have a viral haemorrhagic fever in Sudan, there is always meningitis and there is still MERS—and then five natural disasters. We have floods occurring in a number of occasions right now, Myanmar and so on, and we have had an earthquake in Nepal, which is still a major problem for that kingdom. The WHO needs to be able to deal with that workload.

It needs to be able to perform its role as a member of the global humanitarian response. There is a thing coming together called the Inter-Agency Standing Committee, which consists of the non-governmental organisations that do humanitarian work, plus different parts of the international system. WHO has not been a full partner in that process, despite attempts to do so ever since I was in charge of emergencies there, between 2002 and 2005.

Thirdly, WHO needs to have much greater capacity to deal quickly with outbreaks. At the moment, every time there is an outbreak, certainly when I am sitting in the different centres in WHO, I feel the organisation is straining; it is at breaking point. You sometimes feel that, if somebody was not able to travel and do their work, the elastic would break and things would get out of control. There needs to be a much greater level of strength and depth, capacity to surge and capacity to rotate staff; new business processes, so that staff can be taken on and moved quickly; new financing processes, so that quite large amounts of monies can be moved to the country; new logistical capacity so that fuel, transportation and warehousing can be done. Some of this can be done in co-operation with others, but there are difficulties if you do not have your own basic capacity. If others are doing it, you always worry that they will prioritise their stuff over yours.

The need for these elements came through in the Stocking report, but it became particularly clear after Dr Chan asked me, as her second choice initially to Valerie Amos, to chair the Advisory Group on Reform of WHO's Work in Outbreaks and Emergencies. We started work in July, receiving the Stocking report and receiving some of the internal recommendations of WHO's governing bodies. We have now had four meetings by telephone and two days face to face. There are 19 in our group, one-third humanitarians, one-third infectious disease and one-third heads of different organisations or Ministers. We have reached the unanimous conclusion that the organisation needs a total revamp of its Work in Outbreaks and Emergencies, a single programme across the six regional offices and headquarters that is centrally managed for dealing with all parts of the emergency cycle, from preparedness to alert to response to recovery and to prevention, and that it needs substantial increases in personnel and in finance. We have come out with some fairly detailed plans on how that should be done.

We have also said that the organisation needs to change its culture and its posture. It must be always seen to be impartial, and never somehow co-opted by political interests, be they national or global, to try to play something down. It must never be seen to be timid, because of anxieties that it might get bad press for exaggerating a problem when the subsequent analyses are done, and it must never be seen to be in any way restricted to the thinking of the

medical profession. It must take a whole-of-society and a community-based, people-based approach to dealing with problems. Lastly, it needs to have a set of checks and balances, some kind of independent monitoring board that is there, and Barbara Stocking proposed this with her team in her report, and others are proposing similar things, which is linked within the WHO's structure, but is fully transparent and whose findings could be made clear to everybody.

We believe that we have a set of suggestions. They will be expensive, but we also believe that the world will finance this, if they see the changes being made. We presented the first report of our advisory group on 16 November to Dr Chan. She has accepted the whole thing and she has already started making changes. I believe that, unless there are constraints that stand in the way, this will be fully implemented.

The constraints could be, one, the rather strange internal governance structure of WHO, where regional offices are headed by elected personnel from constituencies of countries that are in their regions. There are always uncertainties about the degree to which the centre is able to tell the regions what to do and also the degree to which budgets are fragmented and controlled in the regions, perhaps outside the control of the centre. We have said that, at least for outbreaks and emergencies, this system will not do. An incident management approach needs to be applied, with central control of finance and central control of personnel. Activities can be delegated to the regions, but they still have to be under the total responsibility, authority and accountability of the Director-General. Secondly, the problem is whether the money will be forthcoming. As I said just now, I believe it will, provided the reforms are introduced.

All this is done on the basis of a really rather good treaty called the International Health Regulations. It is the second of the big treaties that have been negotiated through the World Health Organization and it was agreed in 2005, but there is one flaw. That is that countries can, in various ways, opt out of complying with the International Health Regulations if they choose. First, they do self-assessment of their compliance with the regulations, which includes a number of issues that would have actually helped to deal with the Ebola outbreak, if they had been put in place. Secondly, if they are reporting on their compliance, they can ask to defer their reports. As you know because we have discussed it before, there are 80 countries that have actually deferred their reporting. This is a good treaty, but its implementation is soft.

There is a group, headed by Didier Houssin, which is looking at ways to toughen it up. Can it be made fit for purpose? The only difficulty is that it will require agreement among member states to get it right and there is still, even among some of the wealthier nations, a bit of an anxiety about WHO having the right to enter to make judgments about how you handle diseases of public health importance, if that goes against what the national governments want. As with many other issues that we have in global governance, this just has to be addressed head-on. There is no global police who can deal with this stuff. It requires world leaders saying that this is too big a threat to be left to individual countries.

Chair: We are not even halfway through the questions and we have 15 minutes, so can I ask you just to draw your answer to this question to a close?

Dr Nabarro: Sorry for that. I do believe that this will get better, because there are heads of state and government who want to make it right. The G7 agreed to take it forward. The G20, under the leadership of Germany, are likely to give this priority and we will see huge pressure to get the IHR right in the next two years.

Chair: Thank you very much. I know there is a lot of ground to cover, and I am grateful to you. You have actually answered the next few questions, to some extent, but Fiona, would you like to?

Q55 Fiona Bruce: Thank you, Chairman. Good morning, Dr Nabarro. You have indeed talked quite a lot about the WHO's funding limitations impacting upon their response to the Ebola crisis. Could you give us a little more detail about the review that you have undertaken and the funding that you think it will take to resolve the issues that WHO has in this respect?

Dr Nabarro: Number one, the recommendations of our advisory group have been accepted. These are about implementing what the Stocking report and also the governance of WHO have asked for, and our recommendations go into quite a lot of detail on structures, functions, business processes and authorities.

Number two, from discussion with WHO senior managers including the regional directors, I believe that they will agree to the implementation of these changes. They will require a lot of clarification, but we will reach a point where these agreements are in place before the next meeting of the executive board, which is around 25 January next year.

Number three, the new chief of the combined outbreaks and emergencies group has been appointed, as an interim. You are seeing him this afternoon. He has been asked by the Director-General to take forward the reforms and to establish the necessary advance plans for putting them in place. I am meeting with him and with the Director-General once a week to check to see how that is going. I believe that, again by late January, as much as possible of the early implementation will be in place.

Number four, it will require, in my estimates, which I have not been public about—so now this is on the record I think I have to give them to you—probably a total spend of around $500 million to put in place. Our early estimates suggest that the current spending within WHO on these activities is less than half that sum. In addition, a lot of that money is fragmented. It is very hard to pull it together, and so two things need to happen.

One, extra money is needed now and I call that baseline money. It is money to put the different steps in place. It is not a contingency fund to deal with individual outbreaks. The baseline money is going to be needed and, secondly, some centralisation of existing spend is absolutely critical. I believe that that process of mobilising the baseline money, with some of it coming from foundations and some of it coming from governments, and dealing with the fragmentation can at least be initiated in the first six months of next year. We will do the groundwork, or WHO with our advisory committee support will do the groundwork, in the next six weeks, but it is not going to be easy work. It is going to need continuous observation by WHO's governing bodies to make certain that it is done. I hope there will be a strong agreement at the executive board that existing money needs to be defragmented and new money needs to be mobilised.

The last point is that the Director-General does have power at the beginning of the biennium to hold back some money that goes to other functions in the organisation. It is my understanding that she is ready to do a hold-back of a percentage of the budgets to other aspects of the organisation, in the biennial budget 2016-17, to help provide some of the early money that is necessary for this to happen.

Q56 Chair: It sounds quite encouraging in terms of the prospects for reform and for the funding for reform, in terms of the evidence that you have just given us. Can you say a little bit more about an issue that you have touched upon, which is around the way in which appointments are made for the directors of regional offices and, in particular, how far you think this had a direct impact on the slow response initially in Africa?

Dr Nabarro: Personally, I do not think the problem is the way the appointments are made. I think the problem is the way that the way decentralisation of these regional bodies works and the impact that that has on communication of information across the organisation, on systems for working across the organisation and on lines of authority for decision-making across the organisation. I do not personally want to see everything sucked back to Geneva. I do not believe that that is the right way to run a modern organisation, but I do think a modern organisation, even when there is this degree of federalisation, needs to have systems for total control across the organisation when dealing with matters of global import.

It is not easy. If you look at any decentralised nation, for example Canada, for example Australia, for example India, dealing with issues that are normally handled at state or province level, when they turn into national emergencies, is not easy. What you need to have and what WHO must have now is a set of protocols that will lead to organisation-wide management of issues whenever those are seen to be serious enough to warrant a change. I do not personally think that the organisation is quite ready for that switch mechanism, so I, together with the advisory group that I chair, have encouraged the creation of this programme with an operational platform that works differently from everything else in the organisation. It works like an organisation within the organisation, and does not have this separation into different compartments that comes with the regionalisation.

We have seen the difficulties in trying to get the six plus one to work as one in the past. There have been all sorts of attempts done, which I saw when I was working for WHO between 1999 and 2005. I saw how hard that was, and my colleagues, the same in our 19-person group. We have suggested an alternative, which is to create a special organisation within the mothership. This was done at the beginning when the World Food Programme was created in the 1960s. It was initially started as an entity within the food and agriculture organisation. It did move out and that is all right; you try something and, if it does not work, you have to create a separate entity. There are lots of reasons why we do not want to create a separate entity.

One, it really helps, because WHO is owned by its 194 member states, to have the organisation operating within that political envelope. Number two, in dealing with outbreaks, you are never dealing with something that follows a text book. There are always surprises, like with Ebola in this virus survival in the semen of surviving men for much, much longer than we thought it would and the dangers associated, and other aspects of viral persistence. You have to have the scientists working alongside the responders in health crises so, for those reasons and others that are perhaps not important to mention, we would like to keep this operational organisation that we are seeking to construct inside the mothership, as I have said.

Q57 Chair: I understand that, at the launch of your report, the editor of *The Lancet*, Richard Horton, talked about leadership in WHO and he suggested there would be an advantage to having a politician leading WHO. What do you think of that?

Dr Nabarro: First, there are two things that have come out recently. One that was very important, with quite a lot of publicity at the beginning of this week, was an independent report produced by the London School of Hygiene and Tropical Medicine, and Harvard, with a lot of quite far-reaching recommendations and quite strong political recommendations, including comments on the leadership of WHO. Richard Horton particularly identified Gro Harlem Brundtland's style of leadership as being something that was to be commended.

I want to be very clear that I have not and will not make anything other than totally positive remarks about Dr Margaret Chan's leadership, which has been courageous, scientifically sound and, when necessary, extremely tough. This was a really massively challenging issue, which did not just require extraordinary leadership; we also needed a whole stack of things that we have never needed before, including brains that could think in terms of something much larger than anything within our experience, which is not easy to do. I have absolutely no criticism of Margaret, but what Richard Horton and indeed what is in the Harvard/London report are things that may or may not be true. A politician is not necessarily going to do what is a really complex leadership task dealing with member states, dealing with other partners, dealing with immense challenges on the ground, making very tough choices continuously. I would just say that you need people with extraordinary multi-faceted leadership skills. They do exist. Dr Brundtland certainly had them. Dr Chan has them and I want to be sure that the next one has them.

Q58 Jeremy Lefroy: We did a report in the last Parliament on the importance of strengthening health systems, and many witnesses to this inquiry have talked about the importance of that. What do you believe health systems should look like to cope with public health emergencies such as this within individual countries?

Dr Nabarro: This is a really important issue that you are digging into. As I know you are short of time, I will be telegraphic. Health systems can do lots of different things. The term "health system" describes something that can handle everything from individual problems, when somebody breaks a leg, through to collective problems to do with early mortality in childhood, through to public health challenges like measles or very rare and highly dangerous conditions, like Ebola or Marburg. A person running a health system has to make continuous choices, because there is never enough money to do everything you want. In countries that spend a thousand times less on healthcare per person than Britain, the choices are awful. You will never have enough hospital care. You will certainly never have enough local health posts to deal with people who are sick and you never have enough money for public health.

The only way that a health system can remain strong enough to deal with these kinds of threats is by identifying a number of core functions to do with surveillance, to do with analysis, to do with laboratories to be able to look for possible pathogens and to do with having rapid response capacity, and all the time doing this within the context of a profound focus on community ownership and risk communication. Those functions have to be identified, they need to be ring-fenced and it must be impossible for anybody to shift money away from those functions to other priorities, even if a president declares that it should be shifted. There also needs to be regular audit to check that they are in place.

That is ideally how the International Health Regulations ought to work and, in my evidence to the IHR review committee, I have said that there needs to be independent audit of these complaints if this work is going to be done, looking forward, with ring-fenced money, systems of annual accounting on whether or not the necessary standards are in place, and a really tough naming and shaming process, if countries divert resources away from these essential functions.

Chair: Thank you. Pauline, Dr Nabarro has touched upon an answer to your question, but please put it.

Q59 Pauline Latham: You have touched on it and you have been very full in all your responses, which has been welcome. How do you think we can ensure that countries take their international legal obligations, with regards to public health, seriously and ensure implementation?

Dr Nabarro: In the international system, we really only have one mechanism where we can globally take action when countries do not do what they ought to do. That is chapter 7 in the UN charter. It is an action that can be authorised by the Security Council, it has never been applied to a public health issue and I very much doubt it will. The techniques that we have to use involve careful and honest analysis of what is happening, the use of open reporting, fearless reporting that is not in any way limited by political or other considerations, and leaders being prepared to identify others who are not fulfilling their obligations in a public way.

I have been involved in this in the nutrition space where through a combination of different processes—an annual report that is now in its second year, the setting-up of a global movement of nutrition that actually embraces and gets commitment from leaders, and then processes like Nutrition for Growth, which was led by the British Prime Minister together with the Brazilians, which will have its second outing in the Olympics next year—it is possible to assess what countries do against commitments their leaders have made. If you involve civil society, that can become very noisy. That is as far as we can go.

I personally do not think that we will get much further. I am not at all keen on the application of any kind of measures that might be seen as punitive. Sometimes I have seen bans on trade or bans on travel applied when they do not have scientific justification, and the feeling when I look at it is that this is some kind of collective negative action against a country, because there is a sense that they have not done a thing properly. I will continue to argue that that will not help us at all. That merely creates a disincentive for people to report.

Q60 Fiona Bruce: Our key role is to scrutinise the work of DFID and the UK Government's response to issues like this. I wonder if you could give us your impression of the contribution that DFID and the UK made to this crisis, when the international community was alerted to the reality of the challenge it faced.

Dr Nabarro: I described how it was in WHO at the beginning of August. There was a recognition, cyclical thinking, that this is much worse than we thought, and a shift to another level of response. Then it was gradually upping it and working with the Secretary-General, saying we have to increase twentyfold, which is an alarming level of need to intensify.

A bit the same happened in my discussions with people in the British Government. At the beginning, there was a sense in DFID that we would do what we could do, where we had capacity to do it, but we would not bend over further, because that would be exposing us and the British to the possibility of things that might not be helpful, and we do not want to make big mistakes. That was the correct response of public servants.

Then the politicians got engaged. It got above the civil servants. It was when Justine Greening and then Philip Hammond and then the Prime Minister, obviously together with others in the upper level of the apparatus, got engaged. It happened very quickly at the beginning of September, stimulated often by bilateral dialogue between, for example, the Prime Minister and the President of the US, or trilateral dialogue involving the Secretary-General of the UN, who spoke to both separately and, on some occasions, jointly. It was then that the position shifted; we will put in a much bigger response, because we appreciate the need to get massively scaled up to get ahead of this geometrical increase in the outbreak. That occurred in the first two weeks of September.

It would be very hard to prescribe a means to get this kind of political scale-up in any kind of document. It is something that only occurs when politicians engage and say, "We must do more". We have seen the same in connection to something else in recent weeks. That was what happened. It took the issue above DFID. Justine Greening took it to the Foreign Secretary. The Foreign Secretary took it to the Prime Minister, and then a different kind of stance was taken. I am massively grateful for this. It is absolutely impossible to find the words to express it. If anybody ever makes any disparaging comment about it, and I heard one remark at the event on Monday, a silly remark, I just said, "Cut that. This was what had to be done. This was good political leadership."

Then what happens is the instruction comes back to DFID. The instruction goes to the Ministry of Defence and the instruction goes to Public Health England and the Department of Health. Of course, you have great people in Sally Davies particularly, and Mark Lowcock and team in DFID, working under Justine Greening, and colleagues in the Ministry of Defence who quickly got mobilised. It was a superb operation. In particular, it recognised that you need good quality co-ordination at district level. You cannot do it all sitting in the capital. This concept of the district Ebola response centre, which was developed jointly by Sierra Leone, which also used their military, the Republic of Sierra Leone army, led by ex-minister of defence Paolo Conteh, with the British military, was absolutely brilliant. I would seriously like to encourage this kind of work to go on next time as well.

Q61 Jeremy Lefroy: When you spoke to us informally in New York, you spoke about the quality of the work and leadership exercised by British military personnel that you had seen first-hand. Perhaps you would like to say something like that on the record.

Dr Nabarro: On the record, I would like to say that everything I saw showed the kind of leadership that I believe needs to be demonstrated in these kinds of situations. When you are working in a situation like this, in a highly under-resourced district, with no electricity and very poor communications, in terms of certainly cell phone coverage and also road and water communications, a lack of air, what you need are people who can come and facilitate the joint working of teams that are made up of lots of different organisations, with their different mandates, and ensure that they will work in synergy.

That means a combination of procedures and the discipline of regular morning briefings, evening briefings, tasks being allocated between different people and workflow, plus at the same time willingness to be open and inclusive, when there are problems to identify them quickly, and not to blame those who are creating the problems, but instead to go and find out what their problem is. There is often a very good reason for it. Most importantly, if people are anxious, suspicious or perhaps even sometimes violent, respond with a soft understanding, rather than with a tough or what people sometimes say is a militaristic response.

I have said to people repeatedly that what you have to understand is that the military gets their best results through the use of persuasion, co-ordination, synergy, encouragement and open arms, rather than through use of bossing, aggression, violence and force. That is not how the military really works, but very few people understand that. I had the chance to see this very early on in northern Iraq, in the early 1990s at the end of the invasion of Kuwait, when I was sent to do some work there and we had military involvement. It was the same and probably more sophisticated than I saw there, often young officers, majors perhaps in their 30s, able to show that kind of leadership. They had obviously been very well trained. I hope that, when the story is written and films are made, these will be some of the stars, together with their Sierra Leonean counterparts.

Q62 Pauline Latham: This obviously was a tragedy for the people who died and their families, but would you say that, because of our influence, both with the military but more particularly with the health professions that went in, it has actually left the countries' health system stronger because of the example that was set by the people who went in or has everything just reverted to normal?

Dr Nabarro: There are two things. One is that it is really important to remember that the majority of the work in these countries has been done by the national staff. In each treatment unit, you would get perhaps 20% of the staff or less international and 80% national. Secondly, many of the people who did go in and help were Africans, so a lot of this has been Africans helping Africans. Thirdly, yes, there has been international involvement that, in many cases, has been exemplary.

My own view is that these countries are much better off to deal not just with health issues, but to deal with disasters and emergencies. However, they are poor. I really hope and will continue to advocate for sustained partnership with them, not just for two or three years, but for 10 to 20 years, to help them build up the strength they need to have. It is not just them; it is other countries as well. It reminds me always of the importance of solidarity of the kind that is good development assistance, long-term, with agreements between all parties of the milestones for what has to be achieved, zero tolerance of any kind of diversion and a real understanding of the challenges that are faced. You cannot just do it with hospitals and health centres. You need the infrastructure. You need the telecommunications and internet. Most importantly, you need the community engagement. I think it will happen.

Chair: Dr Nabarro, can I say thank you very much indeed for a truly brilliant evidence session? I think all of us have learned an enormous amount. It has been extremely helpful for our inquiry. I am grateful to you for giving us so much time today.

Dr Nabarro: Thank you, sir. I am sorry for being longwinded.

Chair: Not at all. You were not longwinded. You just have a lot to say.

Dr Nabarro: I was probably a wee bit informal, but I was not quite sure what the protocol was.

Chair: Thank you very much indeed.