Ebola lessons for global health

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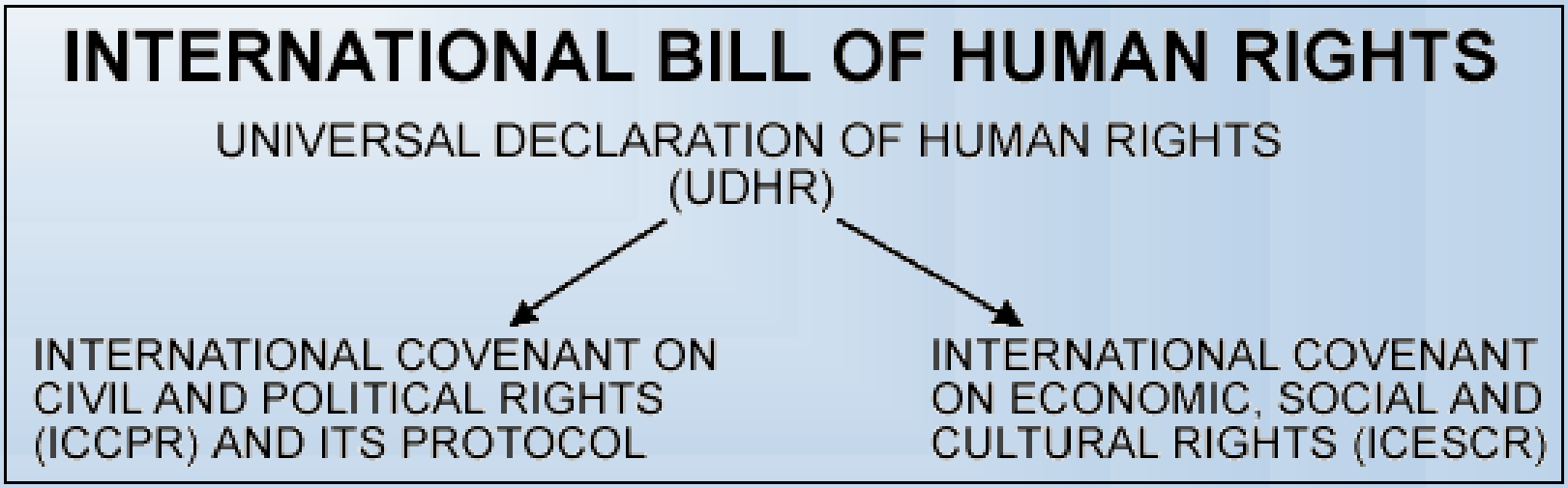
Overview

- What should have been done
  - International Covenant on Economic, Social and Cultural Rights
  - International Health Regulations
- What has been done
- What should be done

Universal Declaration and International Covenants



Progressive realization – international assistance

Article 2(1) of International Covenant on Civil and Political Rights:

"Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."

Article 2(1) of International Covenant on Economic, Social and Cultural Rights:

"Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures."

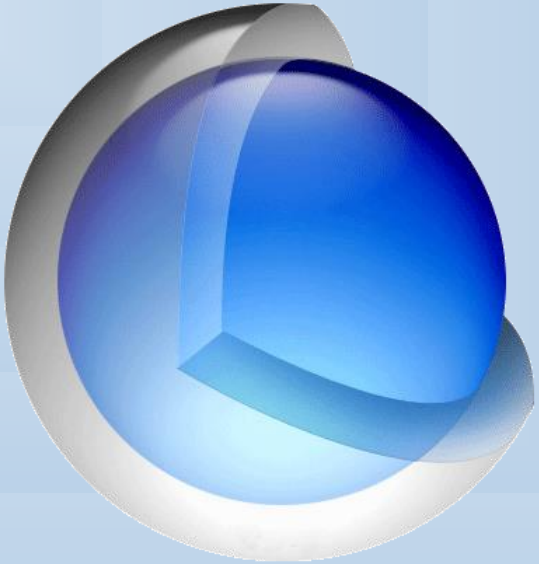
Right to health and core content (core obligations)

Article 12(1) of International Covenant on Economic, Social and Cultural Rights:

"The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."

General comment 14:

"It should be stressed, however, that a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations"



Extraterritorial Obligations of States in the area of Economic, Social and Cultural Rights

http://www.etoconsortium.org/en/library/maastricht-principles/

32. Principles and priorities in cooperation

In fulfilling economic, social and cultural rights extraterritorially, States must:

a) prioritize the realisation of the rights of disadvantaged, marginalized and vulnerable groups;

b) prioritize core obligations to realize minimum essential levels of economic, social and cultural rights, and move as expeditiously and effectively as possible towards the full realization of economic, social and cultural rights;

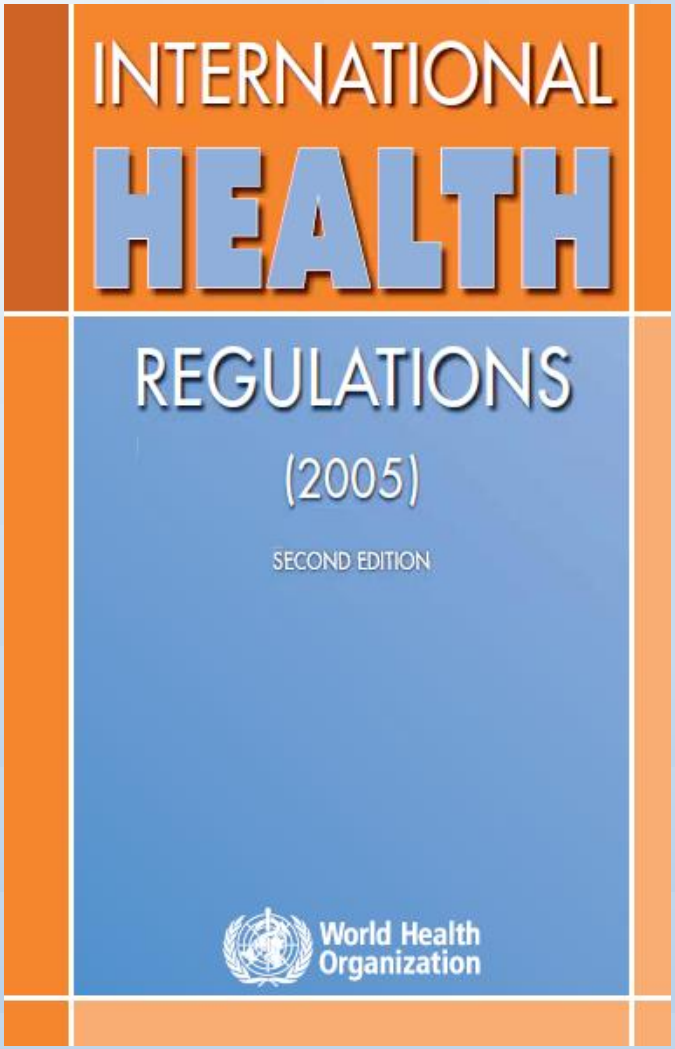
c) observe international human rights standards, including the right to self-determination and the right to participate in decision-making, as well as the principles of non-discrimination and equality, including gender equality, transparency, and accountability; and

d) avoid any retrogressive measures or else discharge their burden to demonstrate that such measures are duly justified by reference to the full range of human rights obligations, and are only taken after a comprehensive examination of alternatives.

30. Coordination and allocation of responsibilities

States should coordinate with each other, including in the allocation of responsibilities, in order to cooperate effectively in the universal fulfilment of economic, social and cultural rights. The lack of such coordination does not exonerate a State from giving effect to its separate extraterritorial obligations.

International Health Regulations



Article 13 Public health response

1. Each State Party shall develop, strengthen and maintain, as soon as possible but no later than five years from the entry into force of these Regulations for that State Party, the capacity to respond promptly and effectively to public health risks and public health emergencies of international concern as set out in Annex 1. WHO shall publish, in consultation with Member States, guidelines to support States Parties in the development of public health response capacities.

Article 44 Collaboration and assistance

1. States Parties shall undertake to collaborate with each other, to the extent possible, in:

(a) the detection and assessment of, and response to, events as provided under these Regulations;

(b) the provision or facilitation of technical cooperation and logistical support, particularly in the development, strengthening and maintenance of the public health capacities required under these Regulations;

(c) the mobilization of financial resources to facilitate implementation of their obligations under these Regulations; and

(d) the formulation of proposed laws and other legal and administrative provisions for the implementation of these Regulations.

2. WHO shall collaborate with States Parties, upon request, to the extent possible, in:

(a) the evaluation and assessment of their public health capacities in order to facilitate the effective implementation of these Regulations;

(b) the provision or facilitation of technical cooperation and logistical support to States Parties; and

(c) the mobilization of financial resources to support developing countries in building, strengthening and maintaining the capacities provided for in Annex 1.

3. Collaboration under this Article may be implemented through multiple channels, including bilaterally, through regional networks and the WHO regional offices, and through intergovernmental organizations and international bodies.

http://www.who.int/ihr/publications/WHO_HSE_GCR_LYO_2013.1.pdf

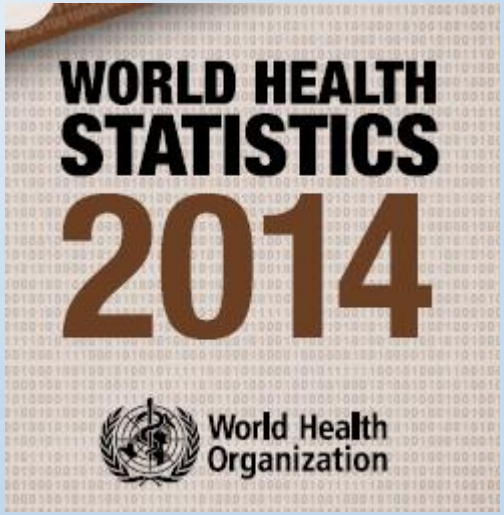
5.6. Resource mobilization

Resource mobilization in the context of the IHR is a continuous process of identifying and using a wide range of available resources to sustain the implementation of the IHR. It requires action-oriented resource gathering (which should also allow problems to be addressed), a concrete strategy for achieving the desired outcomes, and should reflect a coordinated, joint effort by government and non-governmental entities.

Resource mobilization efforts should be a country/ government-led process. Development partners should align and harmonize their work so it fits with and within the government's plans (see the Paris Declaration and the Accra Agenda for Action).[2,3]

The aim of mobilizing resources for the IHR is to obtain adequate, timely, predictable funding and support in order to effectively accelerate the implementation of the IHR. These efforts should result in funding and other resource mobilization from various sectors, as well as funding grant agreements and memoranda of understanding (MoUs) with national stakeholders and international partners.

What has been done



	Density of health workforce (per 10 000 population)				
	Physicians[a]	Nursing and midwifery personnel[a,b]	Dentistry personnel[a,c]	Pharmaceutical personnel[a,d]	Psychiatrists[e]
	2006–2013				2006–2010
Guinea	…	…	…	…	<0.05
Liberia	0.1	2.7	<0.05[j]	0.8	<0.05
Sierra Leone	0.2	1.7	<0.05[j]	0.2	<0.05
African Region	2.6	12.0	0.5	0.9	<0.05
Low income	2.4	5.4	0.3	0.5	<0.05

Per capita health expenditures[a]								
Per capita total expenditure on health at average exchange rate[d] (US$)		Per capita total expenditure on health[e] (PPP int. $)		Per capita government expenditure on health at average exchange rate[d] (US$)		Per capita government expenditure on health[e] (PPP int. $)		
2000	2011	2000	2011	2000	2011	2000	2011	
19	27	43	62	4	7	8	15	Guinea[f]
11	59	18	92	3	18	4	27	Liberia[f,j]
28	82	121	192	6	13	26	31	Sierra Leone[f]
35	99	89	158	15	49	39	76	African Region
10	30	28	64	4	11	11	25	Low income

5. Fiscal Space and Sustainability:
Towards a Solution for the Health Sector

Mick Foster, Paris, November 2005

Executive Summary

Reaching the MDGs in low income countries will require substantial increases in public expenditure that can only be financed with much higher development assistance sustained over many years. Donors have responded by promising big aid increases, with global aid expected to increase by over 60% between 2004 and 2010 while aid to Africa is expected to double. The fundamental problem addressed in this paper is that donor commitments to individual countries remain short-term and highly conditional and do not come close to reflecting these global promises of increased aid, while donor disbursement performance remains volatile and unreliable. Governments are therefore understandably reluctant to take the risk of relying on increased aid to finance the necessary scaling up of public expenditure. The paper discusses options for addressing five issues that are critical to tackling the problem.

What should be done

Ebola: towards an International Health Systems Fund

A dedicated International Health Systems Fund would build national capacities not only to respond rapidly to public health emergencies, but also to enable low-income and some middle-income countries to deliver comprehensive health services. Governments themselves would be expected to allocate domestic funds, and fulfil the 2001 Abuja Declaration pledge by African heads of state to allocate at least 15% of national budgets to the health sector. A sustainable International Health Systems Fund would help low-income and some middle-income countries to build capacity to serve their entire populations.

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What should be done

The Next Epidemic — Lessons from Ebola

Bill Gates

The New England Journal of Medicine

Strengthening health care systems not only improves our ability to deal with epidemics, but it also promotes health more broadly. Without a functioning health system, it is very hard for a country to end the cycle of disease and poverty. Health is so fundamental to development that even if there were no chance of another epidemic, building and improving health systems would be a worthwhile — and lifesaving — investment. The fact that they also bolster our ability to confront epidemics is all the more reason to invest in them.

Through the United Nations, some global institution could be empowered and funded to coordinate the system. The United Nations and the WHO are studying the lessons from the Ebola epidemic and ways to improve international crisis management; these evaluations can provide a starting point for discussions of ways to strengthen the WHO's capacity and about which parts of the process it should lead and which ones others (including the World Bank and the G7 countries) should lead in close coordination. The conversation should include military alliances such as NATO, which should make epidemic response a priority. The final arrangement should include a reserve corps of experts with the broad range of skills needed in an epidemic.