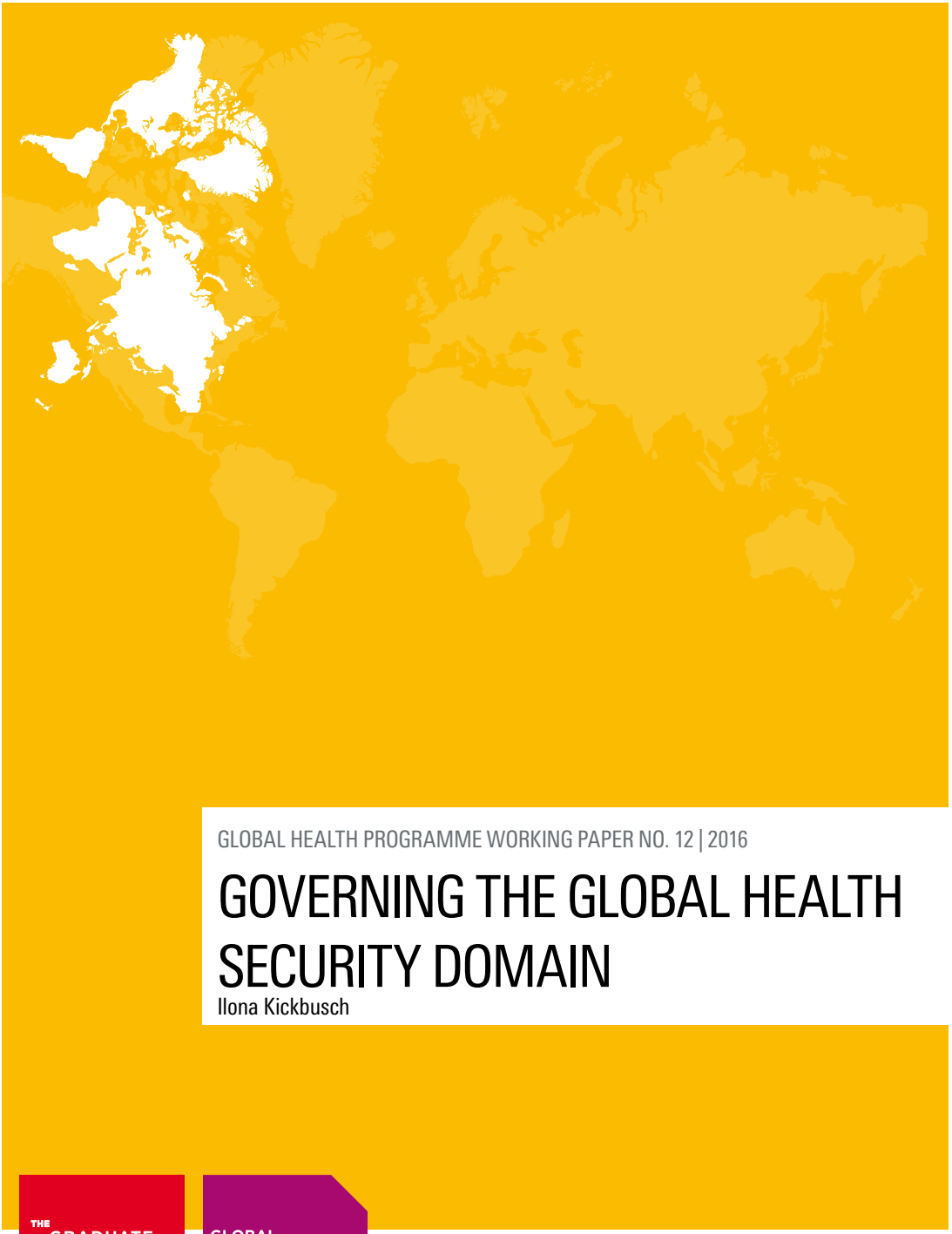

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GOVERNING THE GLOBAL HEALTH SECURITY DOMAIN

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GOVERNING THE GLOBAL HEALTH SECURITY DOMAIN

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The Ebola crisis has brought the issue of global health security back on the political and the technical agenda. There is much debate on how the governance of global health security should be reformed, especially in a context in which the shared global space of threat seems to expand and is not matched by a shared global space of responsibility. This has also become obvious in view of other global crises related to terrorism and the refugee crisis. None of these global risks have well-functioning mechanisms of global governance to ensure preparedness and response, or (as would be required) a preventative approach.

This paper outlines the present global order for preventing and responding to global health risks, especially the role of the International Health Regulations (IHR), a unique, legally binding governance mechanism that aims to protect all countries; gives a brief analysis of the significant gaps that emerged in response to the Ebola crisis; and discusses how the Ebola crisis reopened the discussion on the framing of global health security. It further presents a range of governance proposals that have recently emerged to strengthen the global health security regime. The UHC agenda has also been revisited, reinforcing the need to build health systems in resource-poor countries and to apply an integrated approach that does not separate the health security from the health care agenda.

The Ebola outbreak has underlined not only that viruses cross borders, but also that outbreaks can effect everybody; can weaken communities, destroy the social fabric and destabilise countries; can severely impact economies and trade; and can impact on the relationship between countries and peoples. It reinforced the position that no outbreak can be handled by the health sector alone. While first steps to implement the IHR should be a political priority, it has become clear that a larger shift in the global order for governing global health security will be required. Global health security will have to move out of the health space and be part of a larger global order.

Keywords
Accountability, Ebola, global health, governance, health risk, health security, International Health Regulations, IHR, Public Health Emergency of International Concern, PHEIC, WHO

ABBREVIATIONS

AMR	antimicrobial resistance
EPSMG	Ebola Private Sector Mobilization Group
FCTC	Framework Convention on Tobacco Control
GFATM	Global Fund To Fight Aids, Tubercolosis and Malaria
H1N1	Influenza A virus subtype H1N1
IHR	International Health Regulations
MDGs	Millennium Development Goals
MERS	Middle East respiratory syndrome
NCD	non-communicable disease
NGOs	non-governmental organisations
PHEIC	Public Health Emergency of International Concern
SARS	severe acute respiratory syndrome
UN	United Nations
UNMEER	United Nations Mission for Ebola Emergency Response
WHO	World Health Organization

GOVERNING THE GLOBAL HEALTH SECURITY DOMAIN

Ilona Kickbusch *

1. Introduction

Any discussion of the governance of global health security must be grounded in an understanding of the societal context in which such governance occurs. Recent challenges to global health security have shown the usefulness of Ulrich Beck's (1999) conceptualisation of a global risk society (what he terms a world risk society),[1] which finds its expression in a shared global space of threat and a shared global space of responsibility. Being at global risk is the human condition of the 21st century[2]. This notion of global risk is presently manifesting itself in a wide range of policy domains; the financial and ecological crises have dominated the public debate until recently, and the year 2015 was dominated by the discussion of global health risks based on the Ebola outbreak in West Africa and its potential to "go global". The year 2016 will in all probability be dominated by global terrorism and the global humanitarian and refugee crisis. None of these global risks have well-functioning mechanisms of global governance to ensure preparedness and response, or (as would be required) a preventative approach.

This paper aims to show that, since the beginning of the 21st century, a new regime is emerging for governing global health security. The paper will

- outline the present global order for preventing and responding to global health risks, especially the role of the International Health Regulations (IHR), a unique, legally binding governance mechanism that aims to protect all countries;
- give a brief analysis of the significant gaps that emerged in response to the Ebola crisis - and show that the debate on global health security changed significantly during this crisis as attention moved from the global public health domain to a wider political arena; this increased political attention led to heightened involvement of other actors as well to proposals and additional funding for specific initiatives;
- further discuss how the Ebola crisis reopened the discussion on the framing of global health security and present a range of governance proposals that have recently emerged to strengthen of the global health security regime *(A number of independent panels have been working on making such proposals. As their reports are due in December 2015 and January 2016 respectively, this working paper will subsequently be reworked and updated accordingly in Spring 2016).*

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Initially, the establishment of a regime for controlling epidemics was linked to trade considerations. The initiative for the first sanitary conferences came from a report commissioned by the French Ministry of Commerce in the 1830s, based on a desire to standardise quarantine requirements against diseases[3]. Even today, the stated purpose of the existing IHR regime[4] is *"to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade".*

The shift to a health security terminology and approach can be dated back to the late 20th century, originating especially in the USA and finding its symbolic expression in 2000 when the UN Security Council adopted its first resolution on health, asking countries to wage a "peaceful war" against HIV/AIDS. *"The disease is seen as a destabilizing factor, because it damages economic, social, political, military and educational infrastructures, and contributes to increased conflict within and between countries and societies."* This did not yet lead to a reconsideration of the IHR regime - but to other significant and game-changing consequences for global health governance which are beyond the scope of this paper, as for example the creation of new types of global health organisations such as UNAIDS and the Global Fund to Fight AIDS, TB and Malaria (GFATM).

Since then, the larger global health regime as well as the global health security order have been driven by crises. Indeed since the global HIV/AIDS crisis, a wide range of challenges in global health are defined as crises: the non-communicable diseases (NCD) crisis and the antimicrobial resistance (AMR) crisis are just two that are presently in focus. The global health paradigm implies that we are all at risk. Action and change happen at "cosmopolitan moments"[3]; such moments create crisis-induced policy spaces that not only bring new actors into the processes that are required to effect change, but they can also lead to a shift in mind-set and political commitment to an issue. We are in such a period right now for the response to public health emergencies of international concern; the negotiations over the next year or two will have to show if a change in the order will come about. But since the process is crisis driven, the present attention to global health security can rapidly be lost if another crisis overshadows the need for action.

2. The global order for preventing and responding to global health risks

2.1. The beginnings

Health security and trade stood at the beginning of international health cooperation following a number of serious cholera outbreaks in the 19th century. The first International Sanitary Conference took place in Paris in 1851 with 12 countries in attendance, each country being represented by both a physician and a diplomat, a pattern that we will continue to see in international and global health cooperation because of the interface of disease crises with economic and political challenges. Three diseases (cholera, yellow fever and plague) were originally to be considered, but the focus of the 1851 conference and those that followed was on the nexus of health and trade, and whether or not cholera should be subject to quarantine regulations.

This was due to pressure from major shipping companies in a period of globalisation, as there were indications that quarantine rules had been used to gain trade advantages. The major trading countries wanted to ensure a reliable regime that was applicable to all [5].

It was difficult to gain agreement, not only for political reasons but also because there was no scientific consensus on the cause of cholera. After many negotiations spreading over decades, the first international health treaty was adopted in 1892. It marked the beginning of an international order for regulating health risks that cross borders - and led to a range of institutional mechanisms which were then integrated into the World Health Organization (WHO) at its establishment in 1948. To this day, the health-trade nexus remains important to the global health security debate – but it is now overshadowed by a wide range of additional national, regional and global development and security concerns.

In 1969, the International Sanitary Regulations were revised and renamed as the International Health Regulations (IHR) and other smaller amendments followed. A historic step was taken when, due to its eradication, smallpox could be dropped from the list of notifiable diseases. In 1995, it was agreed that the IHR needed to be revised once more, because

- → the list of notifiable diseases was too narrow in the face of newly emerging infectious diseases;
- → the dependence on official country notification created problems; and
- → there was no formal, internationally coordinated mechanism to prevent the international spread of disease.

There was a clear realisation by countries and experts, especially within the secretariat of WHO, that the IHR were no longer sufficient to respond to the increasing globalisation and interdependence – but there was no trigger for action. The regulatory issue that had stood at the beginning of international health cooperation began to fade into the background, especially under the impact of the HIV/AIDS epidemic which worked to a totally different health paradigm. A new global health paradigm began to emerge, and dealing with disease outbreaks moved into the background of the debate, as disease crises were defined as development crises. From the 1990s the debate was dominated by HIV/AIDS and a group of health challenges which were then named in the Millennium Developments Goals (MDGs)[6].

2.2. The cosmopolitan moment – SARS

David Fidler[7] provides an excellent overview of the process leading from the sanitary meetings in 1851 to the adoption of the revised IHR in 2005. From 1995, countries made no progress in their negotiations on the IHR at WHO – indeed, the political focus was on negotiating another treaty: the Framework Convention on Tobacco Control (FCTC)[8]. Then SARS hit the world in 2003 and action was finally galvanised. SARS underscored the need for a new international legal framework for infectious disease control and led to a new concept of global health security. It goes beyond the intentions of this paper to describe in detail how revolutionary the new IHR was, but a few points require highlighting as they are relevant for the future governance of global health security:

- The IHR introduced a **new global health security norm** that puts the common global threat at the centre and requires countries to place global solidarity above national sovereignty. This was strongly connected to the shift WHO was undergoing from an international to a global health paradigm[9].
- It greatly **expanded WHO's authorities** in the governance of global health security, allowing WHO to declare a Public Health Emergency of International Concern (PHEIC), using not only the information provided by Member States but also using external sources of information; to make inquiries of national authorities based on unofficial information sources; and to make recommendations even in the absence of cooperation or agreement from affected Member States. At the same time, it gave WHO a major coordination role.
- The **scope of the IHR is expanded significantly** beyond a specific disease list to include any event that would constitute a PHEIC.

- → The IHR include **obligations for each country** to develop the means to detect, report and respond to public health emergencies. Reporting is based on self-assessment.
- → **Countries must notify WHO within 24 hours** of a national assessment of any event that may constitute a public health risk to other States requiring a coordinated international response. **WHO will then coordinate** communications across nations, provide technical assistance to responding nations, and work with international scientific experts to develop recommendations for mitigating the consequences of the event [10].

2.3. The new norm of global public health security

WHO itself speaks of a *turning point in public health*, linking this "cosmopolitan moment" to the adoption of the revised International Health Regulations (2005) in a globalised world defined by interdependence. The intent of the IHR is to help countries work together to identify risks and act to contain and control them. WHO states [11]: *"The regulations are needed because no single country, regardless of capability or wealth, can protect itself from outbreaks and other hazards without the cooperation of others"*. The IHR are considered to be "both a collective aspiration and a mutual responsibility" as they define new roles for WHO and required new actions by Member States [4]. Fischer, Kornblet and Katz [10] highlight that the IHR directly touch upon *"politically charged issues from individual rights to state sovereignty"*. The IHR can be seen as a successful example of "norm entrepreneurship" by the WHO secretariat [12]. Here there was a high awareness of the need for action and a changed role of WHO in the face of new challenges. This technical analysis was supported at the time by a strong and very politically astute leader, the Director General Gro Harlem Brundtland.

The revision of the IHR must also be positioned within the context of a larger political and economic concern with global risks. Davies, Kamradt-Scott, and Rushton [13] have analysed this political dimension of the IHR revision in great detail and show how global norms have changed in the context of new global health security challenges. Their conclusion is reinforced by the discussions on the IHR after the Ebola crisis: *"the remaking of the global health security regime was (and will continue to be) a highly political process, nor merely a technical fix to an ineffective international legal instrument."* In the wake of the SARS epidemic and after the adoption of the revised IHR in 2005, WHO issued [11] the World Health Report 2007 with the title *"A safer future: global public health security in the 21st century"*. The report shows that the world is increasingly at risk of disease outbreaks, epidemics, industrial accidents, natural disasters and other health emergencies which can rapidly become threats to global public health security. The global regime, which

had started with a focus on three diseases 165 years ago, had expanded significantly and WHO, the UN specialized agency for health, had received additional powers.

At first, the global health community was indeed hopeful that the IHR would ensure *"a safer future"* - and there is a significant literature that has analysed why the IHR was considered a significant step forward in global public health, or as this arena of action was beginning to be called – 'global health security'. It would seem that if there was one area where countries would be willing to cooperate it would be this, as their peoples, their economies and their health systems would be threatened. There was optimism that a common recognition that "viruses know no borders" would galvanise action.

There has been more attention to the field. For example, global health risks have featured high on the World Economic Forum's regular list of global risks. There has been a debate every time the world was confronted with one of the increasing number of outbreaks over the last decade or so: different types of influenza viruses, SARS, MERS and most recently Ebola, and a growing concern with AMR. But the concept of global public health security, as put forward in the 2007 World Health Report, did not gain traction. A significant group of developing countries as well as NGOs were opposed to the terminology – implying this was a concept of the West to protect their populations rather than to progress health developments and health systems in poor countries. They were also concerned with other seemingly more pressing priorities. In particular, the strong US focus on linking global health with national security was met with suspicion. Health development – as promoted in the MDGs – and health security were juxtaposed and there was a great fear that money would be deflected from the development to the security domain; there was severe criticism of the securitisation of health and there was no advocacy to strengthen the implementation of the IHR.

Progress to implement the requirements of the IHR at the country level was exceedingly slow and deadlines were regularly extended by the World Health Assembly for countries to fulfil their obligations. The IHR core capacities required of countries are to detect, assess, notify and report events and respond to public health risks and emergencies of national and international concern, as stipulated in Articles 5 and 13 and Annex 1 of the IHR. The most recent Ebola outbreak has shown again, as did the H1N1 outbreak in 2009, that all countries (at all levels from local to national) as well as the international community are not well prepared for global health emergencies. In both outbreaks it also became apparent that the role and authority of WHO is not fully understood – for example countries, the public, experts, decision makers and the media do not fully understand

- → what a pandemic is,
- → what the declaration of a PHEIC implies,
- → whether WHO's role is one of coordination or operational action on the ground.

An analysis [14] of the response of WHO to the H1N1 outbreak shows that the IHR has burdened WHO with an *"ambiguity of institutional roles within contemporary global public health"* – a point that also fully comes to the fore in the Ebola outbreak. The Ebola outbreak also pointed to many challenges that lie outside of the IHR and relate to much larger issues on the global health agenda, such as the lack of health systems and health professionals in many low-income countries. It not only *"blurred the lines between health and humanitarian crisis"* [15], but also blurred the lines between civilian and military and security sector actors, as well as between domestic and foreign actors. It showed the weaknesses of the IHR order but also the limits of the humanitarian response system. In summary, the Ebola outbreak showed clearly: **the governance of global health security is not working** – especially in the face of a 'perfect storm'. Indeed, David Fidler, who had so welcomed the potential of the revised IHR, stated [16] point blank: *global health security has failed*.

Following the Ebola crisis there were increasing voices 'blaming' WHO for not being able to respond adequately to global health crises, and calling for the creation of a new mechanisms, or even a new organisation, which would be able to deal more efficiently with such challenges. **The revisiting of the global health security paradigm led to the conclusion that global health security was too important to be left to the health sector alone**. Weaknesses in the instrument (the IHR) were also identified and a wide range of proposals for its revision have since been put forward. In January 2015, Member States of WHO clearly refuted the need for a new organisation on global health security – but they are actively exploring a new financing mechanism proposed by the World Bank. This is similar to the action taken with respect to the HIV/AIDS crisis – where a new financing mechanism (GFATM) was set up. Most importantly though, many countries had not fulfilled their IHR obligations, nor had they accepted the responsibilities beyond their own borders as stipulated in the global health security concept. The question now is whether the Ebola crisis will reinvigorate the norms proposed in the IHR regime or will lead to a norm change.

3. Gaps in the governance of global health security: Weaknesses of the present order

Rosenau [17] has stipulated that global governance as management of interdependence implies a system of rules, processes and institutions which functions and operates at the global level and provides the frame within which actors interact and take decisions. In the case of the Ebola outbreak it became clear that, while such a system exists for global health security through the IHR and the functions it assigns to WHO, countries and other actors, it is no longer sufficient institutionally. It also remains without a major funding mechanism. More serious, perhaps, is the fact that many countries – both developed and developing – do not adhere to the provisions of the IHR in the face of national interest and political expediency. For example, Canada joined Australia in suspending entry visas for people from Ebola-stricken countries in West Africa, a measure that clearly was not required by the IHR.

From the very beginning, each global health crisis must be recognised for its societal, political and economic dimensions. These must be understood and managed. The IHR decision algorithm is based on rational action based on medical evidence and a global public health paradigm – it does not provide for processes to deal with the highly political dimension of outbreaks and it does not provide incentives or sanctions for countries to comply with IHR provisions. To revisit the components of Beck's notion of risks [2] is especially pertinent in this context: he stipulates that being at global risk is the human condition of the 21st century and that in consequence, risks exist *"in a permanent state of virtuality"*, any place, any time. Indeed, there is a constant possibility of a global health threat and it can emerge unexpectedly from any part of the world: Ebola from Africa, H1N1 from Mexico, SARS from China, MERS from the Arab peninsula, and AMR from anywhere. In a global world, it can travel at high speed and can generate significant fear – especially if it were to be airborne. Investments in surveillance and preparedness become critical.

But in each case of a PHEIC, the rational, evidence-based algorithms reach their limit in an outbreak situation because ultimately *"risk definition is a power game"* [2] – and this is also true for WHO. What does it mean to call a pandemic and declare a PHEIC? How, indeed, is a pandemic and its phases defined? How can WHO be the holder of the dominant risk narrative? The medical/public health order of the IHR is confronted with both issues of scientific uncertainty (for example in the face of a new virus) and a rapidly shifting and highly politicised environment. WHO needs to manage both global health risks and political risks to the organisation and to Member States. These in turn need to manage not only the medical threat but also public fear and opinion. The United States is an interesting case study in this regard – where the responses to Ebola were more or less divided along political party lines.

The Ebola crisis laid bare the **weaknesses of the present order**. They include a weak WHO, a lack of political commitment at the highest level (national actors, regional bodies, political clubs, UN Security Council) and a lack of transparency, information sharing and accountability within and between countries. Countries often lack supportive legal frameworks and mechanisms to deal with health crises and at the national, regional, and global levels there is a lack of surge capacity. There is a consistent call for well-coordinated partnerships, the breaking down of silos, and of course, for financial mechanisms to ensure rapid emergency response. All of these stand and fall with the willingness to invest in health and its determinants, in public health infrastructures and in health systems. There are new initiatives - such as the "Healthy Systems – Healthy Lives" initiative by the German Government to link the health systems and the health security agenda. If successful, this could lead to a paradigm shift in global health.

3.1. Lack of clarity on the role of WHO, IHR procedures and declaration of a PHEIC

WHO

The Ebola outbreak showed significant weaknesses in relation to WHO's role. These have been spelled out in great detail in Abeysinghe's analysis [14] of WHO's response to H1N1. The exact authority of WHO and the procedures and resources in place in relation to the IHR are not clear enough. Many countries do not know or understand them. This must be addressed seriously. The sharing of information under the IHR requires more clarification – and WHO's authority to do so must be clearly underlined and coherent global norms must be established in view of global risks. It must be made known to all actors – especially beyond the ministries of health – where WHO's responsibility lies, what it is tasked to do and what are the resources available to do it.

PHEIC

Much has been made of the declaration of a PHEIC – but at present the declaration of a PHEIC is no more than a strong call to action. It does NOT at this point allow WHO or other actors to access resources – financial, political, and operational – that should come with such a declaration. Many analysts say that this must change. It must be clearly mapped out what is triggered when a PHEIC is declared – i.e. a meeting of the UN Security Council with the heads of state of the concerned countries, access by countries and organisations concerned to resources (financial, people, equipment, etc), and rapid preparedness in all countries. Surge capacity must be ensured at the national and international level. Possibly, a PHEIC could trigger a global coordination mechanism jointly chaired by the UN Secretary General and the WHO Director General.

The PHEIC is a measure of last resort - that it why it has been suggested by the WHO interim panel to introduce an intermediate level of warning which would rapidly free resources to keep an outbreak under control [18]. Financial mechanisms must be available to contain public health threats where they occur before it is necessary to declare a PHEIC. In some cases, if a country has neither the capacity nor the will to address an outbreak that has the potential of a PHEIC, political legitimacy must be available to take mandatory action, possibly approved by the UN Security Council. Formal evaluations of the response must take place at all levels and be made available in the spirit of global solidarity and transparency.

3.2. System gaps

The dissatisfaction with the present order found its expression in an array of appointed and self-appointed assessment panels which have been established to make recommendations in the aftermath of Ebola. The first was the Ebola Interim Assessment Panel established by the Executive Board of WHO and which delivered its report in July 2015. Other panels include an Independent Panel on the Global Response to Ebola convened by the London School of Hygiene and Tropical Medicine and Harvard Global Health Institute [19] and a high-level panel on the Global Response to Health Crises convened by the UN [20]. The first published its report in December 2015, the second will report by end of January 2016. In addition, the US National Academy of Medicine has served as the Secretariat for an international, independent, multi-stakeholder expert commission to create a global health risk framework for the future. This commission's report aims to recommend an effective global architecture for recognizing and mitigating the threat of epidemic infectious diseases [21]. It will also report by mid-January 2016. Finally, WHO has established a Review Committee on the Role of the International Health Regulations in the Ebola Outbreak and Response [22].

Analysing the first information available from these reports, five key gaps in the system can be identified:

1. Political gap

In a global risk society there is clearly a need to position global health security differently in order to get political buy-in from all countries. Can it move out from being an issue of North and South to one of common danger, while recognising that some regions of the world have a much higher vulnerability than others due to history, geopolitics and ecological developments? The IHR must gain new legitimacy as a unique, legally binding governance mechanism that aims to protect **all**

countries, especially the most vulnerable, from cross-border public health threats when they occur. As such, it could be defined as an instrument of global solidarity to protect all – none can be excluded and free riders cannot be accepted. For all to be safe, an investment in the weakest link and the health of the most vulnerable is necessary; the motivation for this will always be a mix of humanitarian, human rights, security and health-based arguments.

2. Preparedness gap

Ebola has also shown that even the most advanced economies and health systems are not sufficiently prepared for outbreaks – neither to contribute to international surge capacity nor to provide full security 'at home'. Necessary supportive mechanisms are bound together in a system of interdependence between the Global North and the Global South, between preparedness and response as well as treatment and care, and between different governance levels and many different sectors. Societies as wholes must be better prepared and better understand the nature of outbreaks, both to counteract unnecessary fear and to gain compliance with the community in case of an outbreak.

3. Cooperation and coordination gap

The inter-sectoral nature of preparedness and response has been made very clear by the Ebola outbreak. There was lack of regular exchanges between WHO and a wide range of other agencies to be better prepared for very different types of health crises and emergencies and to be better aware of the tasks and potential of the others. In the Ebola crisis there was difficulty in cooperation with the humanitarian system, though this can change depending on the nature of the health crisis. Countries also had to learn to work together between ministries and other actors in new ways, and with new coordination mechanisms. In many of the affected countries, trust was lacking due to their recent political history. The cooperation achieved with foreign military actors was a new dimension in a PHEIC.

4. Financing gap

The IHR requires of countries to put global health security for all – a global public good – above short-term national interests. It must be accepted that this is more difficult for some countries than others; therefore, a system of financial incentives must be developed to establish IHR compliance in all four dimensions of detect, assess, report and respond. As many countries do not have the resources to fulfil their IHR obligations, financial mechanisms need to be established to support them. In particular, political and financial support must be made available rapidly so that countries do not shy away from reporting events

If the IHR is considered a global public good that benefits all, funding mechanisms should be shared between countries and other actors, as the production of global public goods benefits both the public and the private sector. But the potential impact of the next outbreak should lead to the consideration of a reliable global financing mechanism – beyond Overseas Development Assistance – which allows resource-poor countries to access funds in recognition of their political commitment to IHR at home. While such a mechanism – the Pandemic Emergency Financing Facility[23] – is being discussed by WHO and the World Bank in relation to an outbreak, the financing gap to ensure preparedness and fulfil IHR obligations remains. The need for a new financing mechanism also applies to the financing of the research required on neglected tropical diseases, diagnostics, vaccines, treatments, technologies, etc.

5. Incentives and accountability gap

With the signing of the revised IHR, all countries agreed to report events of international public health importance. This is an act of international solidarity which countries must undertake and for which they must not be penalised, but supported. Often political and economic interests speak against reporting – and incentives as well as accountability mechanisms are lacking to help ensure transparency. Countries still pay a price for acting responsibly. Free riding should be reduced to the minimum and egotistic behaviour should be made public. While it is recognised that there are many different reasons, both political and economic, for introducing measures not called for under the IHR, it is also recognised that calling countries to account will be essential. There are increasing calls for an independent analysis of such measures. There are also calls for a more binding instrument than the IHR.

4. Expanding the global health security space: Supplementary orders and interdependence with other orders

The experience with each new outbreak allows for the revision of the instruments and mechanisms at hand and these will in turn bring quite different lead actors into the response. In some cases this leads to a totally new approach, for example the revised IHR were adopted under the strong impact of an airborne outbreak, SARS. Ebola was the first PHEIC in resource-poor settings where the response capacity was very low and quickly overwhelmed. In consequence, many other actors – especially the humanitarian system – and mechanisms were introduced ad-hoc during the Ebola crisis. Some examples include:

- A significant leadership role emerged for humanitarian actors, both local and international.
- The global health security debate increasingly moved to ministries of foreign affairs, for example Germany coordinated the response to Ebola through an ambassador in the foreign office.
- Heads of State issued strong statements on the need to reform the global order. Most emblematic of this was a move by the German Chancellor (then chairing the G7) together with the Prime Minister of Norway and the President of Ghana to request the UN Secretary General to establish a UN High-level Panel on the Global Response to Health Crises. President Obama issued statements. At country level, the Presidents of the affected countries were deeply involved in the response.
- Ebola was the second health issue to be discussed at the UN Security Council and the first ever UN special mission was established (UNMEER).
- The humanitarian actors – especially Médicins sans Frontières – called for the involvement of the military: *"To curb the epidemic, it is imperative that states immediately deploy civilian and military assets with expertise in biohazard containment. We cannot cut off the affected countries and hope this epidemic will simply burn out. To put out this fire, we must run into the burning building."* Linked to historical reasons, the USA, France and UK notably responded by sending troops for logistic support to the countries; also within the countries, security forces were involved in a myriad (positive and negative) ways.
- For the first time, emerging economies such as China became highly involved in outbreak response abroad.
- Corporate and commercial firms banded together to better coordinate efforts to eliminate Ebola, for example in Liberia. The group, calling itself the Ebola Private Sector Mobilization Group (EPSMG), was formed with the intent to support the Government of Liberia and the Liberian people during this time of crisis. In general, the private sector has been critical that it was not more involved and made use of.

These processes are now being considered and evaluated and it remains to be seen to what extent they lead to changes in the present order. The IHR review already proposed changes after H1N1, but these were not implemented [24]. The Ebola experience has initiated another review of the IHR – possibly new regimes and new approaches will be added to the existing instruments. It seems unlikely in view of the present geopolitical environment that the IHR will be reopened for negotiation.

In general, a major re-think and re-organisation of the governance of global health security will need to be considered. Even though the final reports of the various panels are not yet available, the discussions between the panels show that there is consensus on a number of basics:

- **framing matters** - the IHR and the PHEIC are still seen to be located within the health domain, which limits the response of other actors;
- **institutions matter**: investments in both Universal Health Coverage and in the IHR core capacities are critical;
- **integration matters**: health systems preparedness has two dimensions: a functioning health system accessible to all and a public health infrastructure that includes the capacities required under the IHR; too frequently they have not been seen as ONE agenda;
- **other sectors matter**: both preparedness and response require action far beyond the health sector, including other ministries, the private sector, NGOs and humanitarian actors, as well as the security sector. Both rules and realistic expectations of roles will be necessary;
- **human rights matter**: the best basis for health security is human security and social protection;
- **transparency matters**: independent intersectoral reporting on the state of global health security is still not established;
- **the UN matters**: the UN system is vital - especially WHO - but needs to be much better prepared and better financed to act effectively in global health crises. Cooperation with others – within the UN, with civil society and humanitarian actors and the private sector, and in some cases the security sector – is crucial;
- **political will matters**: health security must be on the agenda of key political clubs, the UN Security Council and heads of state;
- **context matters**: blueprints are difficult to produce; the IHR were written under the impact of SARS, but now most recommendations relate to the humanitarian-health crisis interface.

The Ebola outbreak reinforced the position that no outbreak can be handled by the health sector alone. To date, the UN and WHO have not been successful at making other sectors and actors

aware of the relevance of the IHR. The IHR was/is seen by many as a tool of the health sector only and global health advocacy groups have not been committed to IHR implementation. The Ebola outbreak has reinforced not only that viruses cross borders, but has also highlighted that outbreaks can effect everybody, can weaken communities, destroy the social fabric and destabilise countries, can severely impact economies and trade, and can impact on the relationship between countries and peoples.

While it will be difficult to implement sanctions in the present system, inappropriate or unjustified actions must be made public. In cases of significant trade impact it might be possible to take the cases to the World Trade Organization dispute panel. Should the action by the country – or other actors such as airlines – have hampered or threatened the response capacity of the international community (for example making it difficult for health workers to reach the affected areas) it should possibly be taken to the UN Security Council.

As a consequence, a very wide range of actors is challenged to understand the high relevance of the IHR and the consequences of non-compliance, including heads of state and government and political leaders such as regional organisations and political clubs. For example, AIDS as well as Ebola have been discussed by the UN Security Council and AIDS also by the UN General Assembly; many other UN organisations contribute to outbreak response in times of crisis and a special system has been established within the UN to do so; the G7 and the G20 have had global health on their agenda and have initiated major health initiatives; besides health organisations it is development agencies, humanitarian organisations, NGOs and major foundations that support responses on the ground. In the case of Ebola, the security and the foreign policy sectors were heavily involved and a special global initiative, the Global Health Security Agenda, has been established [25]. Just recently additional funding and political support was announced by the White House. Most probably health security will be on the agenda of the Munich Security Conference in 2016.

This expansion of the health security agenda into other sectors has led many in the public health community to again take up the debate about a "securitisation of health" [26] - whereas other sectors in turn are sceptical about the "imperative of health" that enters their domain [27]. The positions can be summarized as follows [28]:

> *Will public health goals be subsumed under foreign policy goals, and will development goals and the commitment to equity be trumped by geo-political and economic interests and considerations of national security?*

Or is there a larger transformation underway that makes health one of the highest political imperatives that will lead to the medicalisation of social life and will make "the body ...the new battlefield of the 21st century" at all levels of governance?

The recent analysis by Kamradt-Scott, Harman, Wenham, and Smith [15] comes to the conclusion that *"in the absence of robust health systems at the domestic level and timely civilian-led humanitarian intervention at the international level, civil-military cooperation can prove decisive in responding to health-related humanitarian crises*". Here we see a new 21st century global health security paradigm in the making which, in combination with challenges in relation to insurgent non-state actors, weak and failed states or countries at war or in civil war, can lead to new kinds of civilian-military interfaces. This has been the case in the fight against polio in Pakistan, where the army has played a critical role [29].

There is a short- and a long-term agenda: cooperation between developed and developing countries has already been highlighted throughout the previous points – all will need to be better prepared and all have something to learn from the other. This is the approach taken by the Global Health Security Agenda. Cooperation builds trust and this is probably the most important asset in the face of an outbreak. While first steps to implement the IHR should be a political priority, it has become clear that a larger shift in the global order for governing global health security will be required. Global health security will have to move out of the health space and be part of a larger global order.

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