Ministry of Foreign Affairs

Prevention is better than cure

Evaluation of the Netherlands and WHO (2011-2015)

Main findings - Unofficial English translation

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Main findings and lessons for future policy on WHO

At the request of the House of Representatives,[1] the Ministry of Foreign Affairs' Policy and Operations Evaluation Department (IOB) conducted an evaluation of the Netherlands' relations with the World Health Organization (WHO) in the period 2011 to 2015. Reasons for conducting this evaluation research are the concerns about WHO's operational capacity to deal with the Ebola outbreak in West Africa. The main research question was: *What efforts has the Netherlands made to implement recommendations made since 2011 in respect of the 2005 International Health Regulations (IHR) and WHO's performance in global health crises?*

The report sets out the IOB's findings. The following summary describes the main conclusions and lessons for each of the specific research questions from the Terms of Reference.[2]

1. *What is the Dutch government's policy on WHO and what instruments and resources were available to implement this policy in the period 2011 to 2015?*

- The Netherlands' Ministries of Health, Welfare and Sport (MoH) and Foreign Affairs (MoFA) are responsible for the formulation of the Dutch policy on WHO. Both ministries view WHO as an important source of international norms and standards in the field of public health and as a channel for implementing their own policy priorities. They both recognise WHO's role in the field of emergency preparedness and emergency response. This viewpoint is aligned with the 2011 Dutch development policy for multilateral organisations.
- At the same time, the MoH does not consider WHO's work in health care particularly relevant for the Netherlands, given the high standard of Dutch health care.
- Since 2010, the Dutch policy has been shaped by a joint multiannual partnership programme between the MoH and MoFA and WHO. This programme ties in with WHO's General Programme of Work, but within this overall framework it focuses on specific Dutch priorities, i.e. the MoFA priority on Sexual and Reproductive Health and Rights (SRHR) and the MoH priority on antimicrobial resistance (AMR). The choice for these priorities comes from a desire to focus as much as possible on the so-called 'Spearheads' of Dutch development cooperation and public health policies. Since 2011, strengthening health systems is no longer a part of Dutch development policy. Nor is it a priority theme within the Netherlands' relations with WHO.[3]
- Both ministries pay voluntary contributions to WHO as part of the partnership programme. Between 2011 and 2015 the total Dutch contribution was slightly more than €115 million, of which more than three quarters (€83 million) was voluntary. The remaining €32 million concerned mandatory contributions to WHO that were paid from the MoFA budget. Until 2013 the Netherlands was among the top ten largest bilateral donors of WHO, but due to budget cuts it lost this position after 2014.
- The voluntary Dutch contribution consists of an earmarked part for Dutch priorities and a non-earmarked part for WHO's General Programme of Work. While in absolute terms the non-earmarked part was fairly high compared to the non-earmarked contributions made by other Member States, as a share of the total contribution it decreased from 58% to 50% during the evaluation period.
- Until 2015, the Netherlands maintained a policy of zero nominal growth for its mandatory contributions to WHO. This policy applies to all UN organisations.

[1] Parliamentary Paper no. 32605-158 (2015).
[2] The Terms of Reference (in Dutch) are available through http://iob-evaluatie.nl/publications/review-nederland-en-de-who-2011-2015.
[3] Parliamentary Paper no. 32605-2 (2011: 12).

2. *What are the findings and recommendations in relation to the performance of IHR and WHO's response to global health crises?*

The IOB concluded that there was broad consensus between the findings of the various expert panels and advisory groups that examined WHO's performance in health crises in the period 2011 to 2015. The main findings were as follows:

- While there is no question that the IHR are an important international instrument for preventing and – where necessary – fighting infectious diseases, it can only function when *all* Member States meet the mandatory IHR core capacity requirements. It is clear from the available reports that this is however not the case.
- Strengthening these core capacities – particularly in developing countries – has not been given sufficient priority neither by WHO or the countries concerned, nor by other Member States and donors. Many countries were given extra time – in some cases twice – to meet IHR's requirements after expiry of the June 2012 deadline. The Netherlands has been given extra time as well, for the Caribbean parts of the Kingdom did not meet the IHR requirements. The Netherlands' government has invested considerably to improve this situation in recent years. An important milestone in this regard has been the mutual agreement for joint implementation of the IHR, which was published in June 2015.
- The Ebola outbreak and its aftermath have pointed out once more the consequences of not having IHR core capacities in place. It also highlighted the lack of a system of penalties to reprimand countries that take measures that conflict with WHO recommendations (e.g. on travel and trade restrictions). Nor are there incentives for developing countries that do timely report public health risks and that do invest in their core capacities.
- The Ebola outbreak also showed that WHO has insufficient capacity, insufficient numbers of qualified staff and insufficient resources to effectively implement its constitutional mandate on emergency preparedness and response. The organisation's culture and structure have not been developed with this mind. Rather than doing everything on its own, WHO should closely work together with other organisations. However, this cooperation has clearly been inadequate.
- The UN humanitarian and healthcare systems are inadequately aligned and coordinated. As a result, no funding can be released from the UN Central Emergency Response Fund (CERF) when an outbreak is not defined as having a humanitarian dimension. This hampers the response to health crises.

The IOB would also note that the problems WHO faces in responding to emergency situations in general, and the Ebola outbreak in particular, have several broader, structural causes. The following organisational and financial factors play an important role:

- The layered structure of the organisation, with headquarters in Geneva, six relatively autonomous regional offices and almost 150 country offices, impedes fast and resolute decision-making and action. Field staff at country offices are not properly equipped for the work they are expected to do.
- In the context of its global mandate, WHO has a limited budget, which has barely increased due to the zero nominal growth policy pursued by Member States. Financial shortfalls have affected WHO staffing levels, particularly in the area of emergency preparedness and response. As a result of budget cuts, the number of staff in this area at headquarters and the regional office for Africa has been significantly reduced.
- WHO is increasingly dependent on voluntary contributions from Member States and other donors who tend to finance issues *they* find important. Earmarking contributions in this way does not necessarily correspond with the priorities specified in the WHO General Programme of Work. This has, in particular, negatively affected WHO's ability to properly deal with the development of healthcare systems and emergency preparedness.

- The share of the budget covered by mandatory contributions – out of which the management costs of programmes funded from voluntary contributions also have to be paid – is falling. This has reduced WHO's ability to respond quickly to acute developments and emergency situations.

3. What do we know about WHO's response since 2011 to these recommendations and the results that have been achieved?

- In 2011, the first IHR Review Committee recommended to strengthen WHO's emergency response capacity, to revise the guidelines for pandemic preparedness and to improve the organisation's communication policy. In addition to this, the Committee advised to establish a Global Health Emergency Workforce – in order to ensure that medical teams are timely dispatched to emergencies and that they have the necessary skills and capacity – and a Contingency Fund with a minimum budget of $100 million that can be used for the early stages of an infectious disease outbreak or humanitarian emergency.
- The IOB concludes that WHO has only partly followed up on these recommendations. The main recommendations that have been adopted are the development of the Pandemic Influenza Preparedness Framework in 2011 and the Emergency Response Framework (ERF) in 2013. In addition, WHO has become more open about the members of the IHR Emergency Committee, who advise the Director General WHO on the declaration of a Public Health Emergency of International Concern (PHEIC).
- Recommendations concerning the funding and staffing of WHO's emergency response work have not been adopted. These concern the creation of a Contingency Fund and a Health Workforce.
- There have been several proposals on these issues before, but as the H1N1 pandemic receded into the past Member States failed to recognise the urgency of adopting them. Member States also expressed doubts about the relevance of the proposals and were not prepared to fund them. Instead, they proposed that funding was to come from WHO's regular budget, which in the end did not happen. This viewpoint only changed after the Ebola outbreak in 2014/2015, although no consensus was reached on the need for an operational role for WHO when dealing with emergency response.
- The Advisory Group on Reform of WHO's Work in Outbreaks and Emergencies established in mid-2015 made a number of key recommendations for reforming WHO's work on preparedness and response to disease outbreaks and emergencies. These recommendations are largely aligned with recommendations made by other expert panels and advisory groups in 2015/2016. The main focus of these recommendations is the establishment of a central Programme for Emergency Preparedness and Response with sufficient technical capacity, its own funding, and independent oversight.
- The Advisory Group on Reform also advised WHO to address the structural problems described above – including the existing organisational structure and means of funding – and advised the international community to take compliance with IHR more seriously. The group also called on Member States and donors to contribute to the Contingency Fund and the Health Workforce.
- To date (March 2016), WHO has not done much to act on these recommendations, even though they have been repeatedly. The problem is that in this WHO is highly dependent on Member States and the donor community, who for the time being remain cautious and divided when it comes to contributing to the Contingency Fund, raising the mandatory contributions and reforming WHO's organisational structure. The World Health Assembly (WHA), which will convene in May 2016, will need to ascertain how open to reform the Member States actually are.

4. What position does the Dutch government take on these recommendations? How does it assess WHO's response and the results achieved in the Netherlands' priority areas?

4.1 How does the Dutch government assess WHO's response to global health crises?

- The Netherlands sees WHO as an important actor in resolving global health crises, but acknowledges that the organisation is currently unable to fulfil its operational mandate in the area of emergency preparedness and response. Like many Member States, the Netherlands paid little to no attention to the problems WHO was facing in this area until a PHEIC was declared for the Ebola outbreak in August 2014. At the time neither the IHR core capacities nor strengthening healthcare systems were at the top of the Netherlands' agenda vis-à-vis WHO.
- In this case, lack of attention also meant no funding from the Netherlands; there was no funding available for WHO to provide technical support to developing countries in developing and strengthening healthcare systems and IHR core capacities. The Netherlands only contributed €5 million one-off for emergency response once the Ebola outbreak hit in 2014 as a contribution to WHO's Ebola Response Roadmap. In addition, the Netherlands contributed about €50 million to Ebola emergency response, but these funds were channelled via other organisations than WHO.
- Many Member States, including the Netherlands, have serious concerns about the organisation and funding of the WHO emergency programme proposed by the Advisory Group on Reform. The Netherlands doubts whether such a programme can be funded from voluntary contributions alone. There is also lack of clarity about the structure of this programme and the relationship with the regional offices.

4.2 Since 2011, what action has the Dutch government taken and what proposals has it made to urge WHO to act on the recommendations?

- The Netherlands was involved in drawing up the Pandemic Influenza Preparedness Framework. At the same time, like other Member States, it has taken no action to follow up on the recommendation to strengthen WHO's capacity for emergency preparedness and response. EU joint statements on the Contingency Fund demonstrate European Member States' scepticism towards the introduction of a new funding mechanism. They feared that the Fund would become highly politicized. In addition, there were doubts about the usefulness of the Health Workforce when faced with outbreaks like the H1N1 pandemic.
- The launch of the US Global Health Security Agenda in February 2014, of which the Netherlands is a member since 2014, seems to have galvanised the Netherlands' interest. The Netherlands has been actively involved in discussions on the need to reform WHO's emergency tasks. It also helped drafting the Ebola resolution of January 2015, which called on Member States to establish a Contingency Fund and a Health Workforce. The current Netherlands' position is for WHO to fully implement the reform proposals made by the Advisory Group on Reform as soon as possible.
- However, the Netherlands only fulfilled the recommendation concerning the Health Workforce in February 2016, with the inauguration of the European Medical Corps through which a coordinated European response will be given to the Workforce. Despite repeated calls for a contribution to the Contingency Fund, it remains to be seen whether the Netherlands will be making funding available and, if so, how much.
- Prior to the WHA in May 2015 the Netherlands was prepared to amend its position on zero nominal growth of mandatory contributions to the UN and make an exception for WHO. The Netherlands was not alone in taking this position. However the WHO Director General withdrew the proposal to raise the mandatory contribution by 5% and instead proposed an 8% rise of the general budget space, to be financed through voluntary contributions. Although the Netherlands initially opposed this, it did in the end agree for the sake of consensus. It is unknown if the proposal to raise the mandatory contributions – in line with the recommendations made following the Ebola outbreak – will be included on the agenda again in the near future. It is

expected that such a proposal will come up again during the budget discussions for the 2018/2019 biennium.

4.3 Has the Dutch government worked on this with other countries? How is the Dutch government's role in this partnership assessed?

- The Netherlands focuses on a joint European approach and is active within the group of EU Member States. The Netherlands also regularly consults with likeminded states – such as Norway, South Africa, the United Kingdom and the United States – which are not necessarily EU members.
- The Netherlands and the UK mediated in discussions on the Contingency Fund, which ultimately resulted in all EU Member States co-sponsoring the Ebola resolution. This active role was greatly appreciated by the European delegation and by other EU Member States.
- The Netherlands is also in favour of new, more informal forms of cooperation in the interests of achieving reforms in the area of emergency response. For example, the Friends of WHO Emergency Response was established at the Netherlands' insistence. The Netherlands is also one of the more active countries within this informal body.

4.4 How do the parties concerned assess the Netherlands' cooperation with WHO in the context of the Ebola outbreak?

- It is clear from interviews that WHO is positive about the Netherlands' contribution to address the Ebola outbreak. This applies equally to bilateral activities, the shipment of goods by His Dutch Majesty's Joint Support Ship (JSS) Karel Doorman, and the €5 million contributed to WHO's Ebola Response Roadmap.
- Nonetheless, there was little real cooperation between the Netherlands and WHO. The Netherlands of course coordinated the deployment of the JSS Karel Doorman with WHO headquarters in Geneva, but the organisation's patchy and late response to requests for information meant that each party carried out its own plans independently.
- It is clear from interviews that other Member States had the same experience: because WHO was unable to respond adequately they made their own plans. There was, in short, little actual cooperation.

5. What lessons can the Dutch government learn for future policy on WHO?

The Ebola outbreak in West-Africa in 2014/2015 has pointed out a few key issues:

- The outbreak confirmed what we knew already almost 10 years ago according to the Dutch National Institute for Public Health and the Environment (RIVM): [4] globalisation and the increased internationalisation of traffic of human beings, animals and goods that came with it has made the threat of infectious diseases more complex and more extensive. This potentially concerns a country like the Netherlands, because of its open borders and strong commercial culture. Infectious diseases can quickly evolve into a global problem.
- Moreover, the Ebola outbreak underscored once more the mutual dependence of countries – Guinea, Liberia and Sierra Leone depended on international aid for the response to the outbreak, while the Netherland' interest was that this response was effective and prevented the disease from spreading any further. The above-mentioned RIVM-report explained that since contagious diseases can have a global impact, reducing infectious diseases across the border has an impact on the Dutch situation as well. [5]
- Finally, prevention is better than cure. It is crucial for all countries to have a functioning and accessible basic health system which – in line with the IHR – can help preventing and combating outbreaks of diseases. The 2013 IOB evaluation on Dutch involvement in SRHR already pointed

[4] Mensink (2007): 1, 31-33, 83, 87, 91.
[5] Mensink (2007): 91; RIVM (2011): 25.

out that strengthening basic health systems is an essential condition for achieving the Dutch SRHR policy objectives.

An increasing number of countries, including Germany, Sweden, the UK and the US has acknowledged these issues. They have developed a government-wide, multiannual global health strategy. These strategic policies acknowledge that protecting national public health can go hand in hand with improving global public health, meeting the IHR requirements, building public health capacities in developing countries and responding to health-related humanitarian disasters. Although the importance of such a government-wide strategy was repeatedly pointed out in the past, to date the Netherlands still lacks one. In addition, despite a joint partnership programme involving both MoH and MoFA, this evaluation has found that there are few technical subjects which *both* ministries are truly involved in. Should the Netherlands decide to develop a *global health strategy* in the near future, in which also a position needs to be reserved for WHO and other funds like GAVI and the Global Fund, it could serve as a guide for the priorities that the Netherlands may want to address during its forthcoming membership of the Executive Board in 2016-2019.

The Netherlands has played an active role in the development of the Ebola resolution in January 2015. It also insisted on the full implementation of the recommendations of the *Advisory Group on Reform*, as was also requested by the Netherlands and other member states in their joint letter to WHO of February 2016. This does not only concern the specific recommendations to introduce one central programme for emergency preparedness and response. It is also about addressing the existing organisational structure, the financing of WHO and about compliance with what has been agreed upon within the framework of the IHR. Given the diverging views among the Member States, implementation in full is not to be taken for granted. The Netherlands has to remain vigilant in order to prevent that the advice will not face the same fate as the advice given by the IHR Review Committee in 2011. This will also be an important task for the forthcoming Dutch membership of the EB. In view of the limited influence of the Netherlands alone, this should be addressed as much as possible within the framework of the European Union and with the help of informal networks such as the *group of friends of the WHO emergency response*.

The emergency reforms that are also supported by the Netherlands have both short-term and long-term financial implications. One lesson from the past is that when no structural solution is found, there is a considerable risk that the problems that occurred during the Ebola outbreak will repeat themselves in the future. Implementing the recommendations of the Advisory Group on Reform not only concerns WHO as an *organisation*, but rather WHO in the meaning of *Secretariat and Member States* together. Being one of these Member States, the Netherlands will therefore need to reflect on the question whether and under what conditions it is willing and able to contribute to this structural solution.

Abbreviations

AMR	Antimicrobial resistance
CERF	Central Emergency Response Fund
ERF	Emergency Response Framework (WHO)
IHR	International Health Regulations (WHO)
IOB	Policy and Operations Evaluation Department (NL)
MoFA	Ministry of Foreign Affairs (NL)
MoH	Ministry of Health, Welfare and Sport (NL)
RIVM	National Institute for Public Health and the Environment (NL)
SRHR	Sexual and Reproductive Health and Rights
WHA	World Health Assembly (WHO)
WHO	World Health Organization