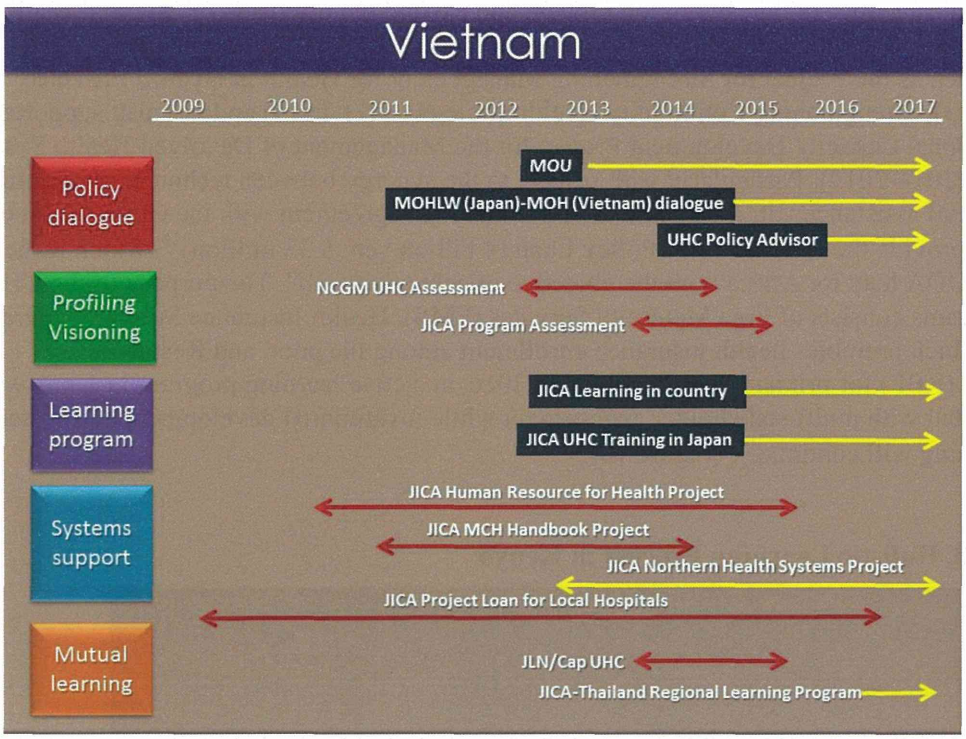
Figure 11, Holistic Learning Process in Vietnam



5. Conclusion

In the era of the SDGs, global governance is facing many challenges in power fragmentation, systemic complexity, and uncertainty. The rapid development of economic globalization and deepening interdependence of cross-border activity prove the relative absence of governance mechanisms capable of effectively tackling global public policy issues[21]. Across policy domains, there is an increasing presence of public and private actors engaged in core governance functions and generating much more uncertainty over predicaments.

Indeed, global governance for health is not just a matter of pandemics. It is a matter of global well-being and of the future of mankind. The relationship between good governance and well-being is significant and it is said that "the effects of good government remain as the single most important variable explaining international differences in life satisfaction in the full global sample, while international differences in per capita incomes are frequently insignificant[22]".

This is why we need to cherish the important aspect on "learning" and "transformation" in building smart governing systems. Japan has rich active learning resources and can lead the global community in building new governance mechanism through providing transformative platforms, in which all the stakeholders can engage in the process of defining and implementing solutions. This article articulates Japan's new direction for global health cooperation, which signifies multi-stakeholder engagement in the holistic learning process to transform individual countries as well as the globe. Active learning resources in Japan explore experiential and substantial knowledge to tackle new global challenges posed by inequitable and unsustainable patterns of development. It is truly expected that Japan should show leadership to promote global movements through emerging dialogues and transformative processes toward realizing the SGDs. Commitment is never too late, even if starting today.

Column 1

UHC Profiling and Spectrum approach

The Japan–World Bank Partnership Program on Universal Health Coverage articulated 11 country case studies and categorized countries representing a range of income levels and health systems. Group 1 countries are still setting national policy agenda for moving towards UHC; group 2 countries have made substantial progress toward UHC but still face substantial gaps in coverage; group 3 countries have recently achieved many UHC policy goals but face new challenges in deepening and sustaining coverage; and group 4 countries have mature health systems with UHC but still need to adjust their national policies to meet changing circumstances (Table 3).[23,24] Even low-income countries with limited service coverage (typically belonging to group 1 above), according to the Japan-World Bank report, can start building institutional capacity, learn from the experiences of other countries, and adapt innovative approaches toward attaining UHC.

The guidelines for Japan's Strategy on Global Health Diplomacy issued by the Government of Japan in June 2013 proposes a framework for differentiating UHC support in accordance with the status of development of developing countries focusing particularly on the physical, social and financial barriers to accessing health care.

In order to visualize and operationalize the framework, we have conducted a data-based categorization of countries that Japan put particular emphasis on collaborating with in the field of health: 12 developing countries with which Japan's Ministry of Health, Labour and Welfare (MHLW) signed memorandums of understanding (MoU) for bilateral collaboration (Cambodia, Lao PDR, Viet Nam, Myanmar, India, Turkmenistan, Turkey, Bahrain, Brazil, Mexico, Iran and Qatar), other ASEAN member states (Thailand, Philippines, Indonesia and Malaysia) and four African countries (Kenya, Ghana, Senegal and Zambia). We also included notable developed countries (Japan, UK, USA, France and Sweden) as references.
Countries were scatter-plotted by indicators of health service access, namely % of deliveries by skilled birth-attendants (%SBA) and another one of health social security and financial protection, % of out-of-pocket payment among total health expenditure (%OOP). %SBA was used because it varied widely across different developing countries and was thus considered sensitive to physical and social barriers of access to health services

Figure 1 shows the result of the scatter-plotting. It identifies four groups of countries: (1) countries with poor service access and medium OOP% (Kenya, Lao PDR, Senegal and Zambia);(2) those with medium service access and high OOP% (India, Myanmar and Philippines); .(3) those with good service access and medium OOP% (Indonesia, Mexico and Viet Nam); and those that generally attained UHC (Bahrain, Qatar, Thailand and Turkey).

Figure 1 OOP% and deliberies attended by SBA

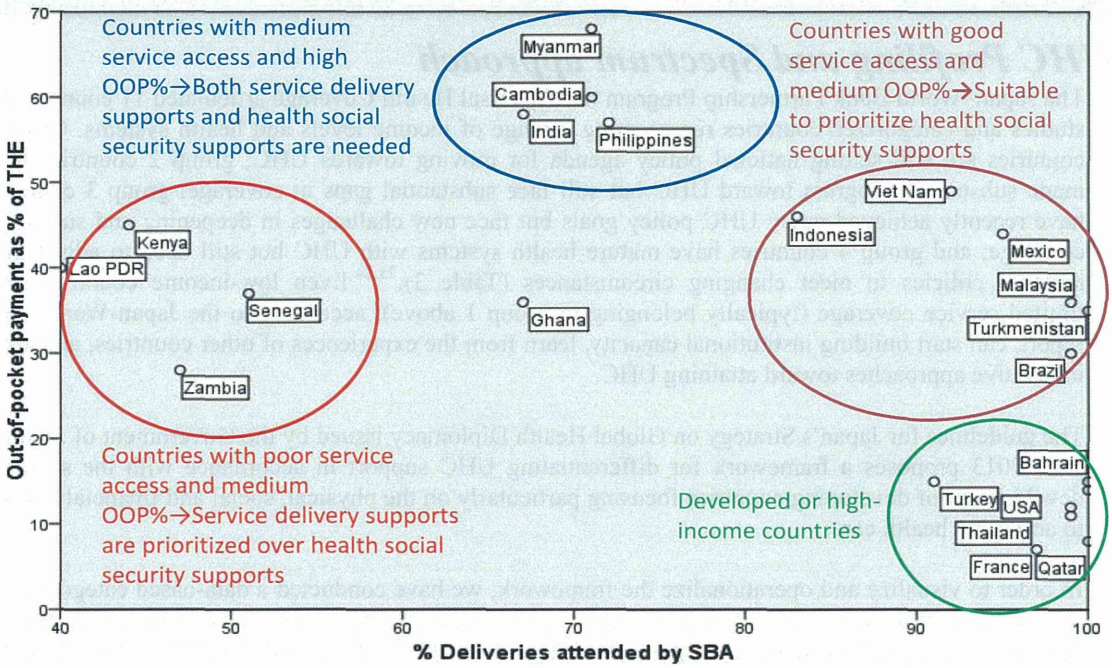


Table 1 presents a framework of differentiating UHC support, as originally proposed by the guidelines for Japan's Strategy on Global Health Diplomacy, reflecting country categorization based on the above analysis. It provides a practical direction for how to formulate support toward UHC according to where different countries are in health development. For different country categories, different foci of Japan's UHC supports can be set as following:

- Countries with poor service access and medium OOP% (corresponding to Group 1 in the Japan-WB study): UHC supports should focus on expanding health service coverage among the poor and vulnerable populations. However, designing and introducing health social security in the mid- to long-term should be considered. For this category, public financing including grant-based official development assistance (ODA) and development loans (where appropriate) will be the key financing mechanisms for support.
- Countries with medium service access and high OOP% (a subset of Group 2 in the Japan-WB study): UHC supports should focus both on further expanding health service coverage and establishing a health social security scheme. As in the case of the above category, public financing will be the key financing mechanism.
- Countries with good service access and medium OOP% (a subset of Group 2 in the Japan-WB study): UHC support should focus on establishing a health social security scheme. Considering their middle-income country profiles, public financing should be effectively linked with private financing (e.g. ODA to support institutional development for risk-pooling health financing schemes, while private companies provide technical solutions in the field of information and communication technology (ICT) to operationalize it).
- Countries that have generally attained UHC (corresponding to Group 3 in the Japan-WB study): UHC support should focus on maintaining and improving established health social security schemes. Given their quasi-developed status, public financing will only play a catalytic role, and private entities will play the major role.

Country profiling with other indicators derived by new data platforms such as the Primary Health Care Performance Initiative (PHCPI) and those of demographic and epidemiological transitions will enable further elaboration of the UHC support strategy. However, in actual project formation, country-by-country approaches with careful policy dialogue will be required.

Table 1: Framework of differentiating UHC support in accordance with the status of health development with country categorization by coverage of skilled birth attendants and degree of health social protection*

Category	Profiles	Case country	Focus of Japan's supports	Note
Category 1	Countries with poor service access and medium OOP%	Kenya, Lao PDR, Senegal and Zambia	Expanding health services coverage among the poor and vulnerable population (consider designing and introducing health social security in mid to long-term).	Corresponding to Group 1 in the Japan-WB study
Category 2	Countries with medium service access and high OOP%	India, Myanmar and Philippines	Further expanding health service coverage AND establishing health social security scheme.	Corresponding to Group 2 in the Japan-WB study
Category 3	Countries with good service access and medium OOP%	Indonesia, Mexico and Viet Nam	Establishing health social security scheme.	Corresponding to Group 2 in the Japan-WB study
Category 4	Countries that generally attained UHC	Bahrain, Qatar, Thailand and Turkey	Maintaining/improving health social security scheme.	Corresponding to Group 3 in the Japan-WB study

Note: *Measured by % of out-of-pocket payment among total health expenditure (%OOP)

Column 2

Synergies with other global partners

The World Bank in collaboration with Harvard University has offered training on "Health Sector Reform and Sustainable Financing" since 1996 and restructured its course focusing on UHC from 2013. The eight day course offers lectures and discussion on how to improve health system performance to meet UHC goals. While its focus is on health financing, it also covers political economy, health systems management and human resources, and equity aspects were covered in an optional session. While the course provides substantial time for discussion and group work using county cases, it tends to limit country specific questions and answers, as the course targets participants from different countries, and less represented countries have to join larger country teams for group work.

The WHO commenced an "Advanced Course on Health Financing for Universal Health Coverage for UHC for low and middle income countries" in 2014, based on its health financing course (Barcelona course) targeted to European countries. The five-day course specifically focuses on function of health financing—revenue collection, pooling, and purchasing—and requires advanced knowledge and experience in health systems. Again, as this is a global course, it faces similar challenges of being able to dive deep into country specific challenges.

There are several other technical expertise and learning networks concerned with UHC. P4H, the Social Health Protection Network, has since 2014, starting with a team of six African countries, designed three regional modules for in-country support that focus on practical expertise required to implement UHC-related leadership reform, situation analysis, management, and commutation. Cap UHC (Capacity building on Universal Health Coverage), hosted by Thailand provides tailored workshops based on county needs and specific request to offer practical solutions based on the experience of Thailand. The Joint Learning Network (JLN) with 22 member countries offers different types of learning opportunities, aiming to bridge theory and practical implementation of reforms through a knowledge portal, with occasional face-to-face meetings.

In general, the majority of the trainings and learning opportunities provided have focused more on health financing aspects with less focus on service delivery. While global trainings offers theories plus group work, they face limitations in practically answering the countries' specific needs. P4H focuses on practical skills rather than health financing theory, and Thailand custom makes trainings based on the participating country's needs and its own experiences (Table 2).

In May 2015 Japan signed the global compact under the International Health Partnerships Plus (IHP+)[25]. Japan's ODA has been encouraged to promote aid effectiveness both at the country and global levels according to the Paris Declaration and Busan Partnership Agreement. Those global collaborative works have to be incorporated into Japan's new ODA schemes to promote more synergetic effects in country assistance programs.

[1] Japan International Cooperation Agency Team (*Yoshiharu Yoneyama, Ikuo Takizawa, Maki Ozawa, Tomoko Ono*)
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Table 2 Global UHC training program and collaborative

	World Bank	WHO	P4H	CapUHC (1)	CapUHC (2)
Title	Health Systems Strengthening and Sustainable Financing: The Challenge of UHC	Advanced Course on Health Financing for Universal Coverage for low and middle income countries	Leadership for UHC: Supporting Leaders to Deliver Result	- Capacity Building - experience sharing of Thai case study (2015-2017)	(Tailor-made) Workshop
Duration	8 days in December, 2013 * 5 days training was held as a short version for Asian region in March, 2014	- First: 5 days in September, 2014 - Second: 5 days in June, 2015	As a total, 12 months mixing attendance based learning (3 modules) and practice sessions with on-the-job application phases.	- Third in 2012: 6 days in November, 2013 - Training in 2015: 5 days in August	2-6 days (duration is not fixed as the training is tailor-made according to the needs and levels of trainees)
Venue	- 2013: Tokyo, Japan - 2015: Washington, USA (unfixed)	- 2013: Tunis, Tunisia - 2014: Barcelona, Spain	- Module 1: South Africa - Module 2: Kenya - Module 3: Turkey	Bangkok, Thailand	Bangkok, Thailand
Number of Trainees and Target Members	73 members from 23 countries participated in the training in 2013. Many of them were from ministries and educational institutions such as universities.	About 50-60 members are expected to participate in each training. 55 members from 27 countries attended in the second training. Major targets are policy makers, advisors and analysts in the health and social sectors, senior managers of service provider organizations and health insurance funds, and other relevant actors in government	39 trainees from 6 countries (Kenya, Ethiopia, Nigeria, Uganda, Zambia, South Africa) participated in 2014. Many of them were at director level in ministries of health, labor or finance. Others are in leadership positions in national health or social insurances, as well as civil society organizations.	25- 30 members from low and middle income countries are expected to participate in each training. First in 2012: 12 members from 4 Asian countries Second in 2012: 36 members from 7 Asian countries Third in 2012: 35 members from 7 Asian countries Many were from ministries of heath and health insurance bureau.	Participants are encouraged to apply as a group of at least 3 people from same country for effective group discussion using participants country experiences as inputs in program learning activities.
Contents	The course provides opportunities to analyze the best design of health systems and financing according to the country's respective condition ● Definition	●	The followings are the main objectives of the course. ● Defining the resources in and the challenges of UHC work, e.g. values and trade-offs ● Analyzing the UHC	The followings are introduced as the contents of the annual international training course on UHC in 2005, 2006 and 2007. ● Introduction of Thai UC scheme	The workshop will be suitably designed according to the needs and levels of participants (policy level and technical level) with the selected contents. ● Overview of Thai

	• Different strategies • The Flagship framework • Ethics and the political economy • quality, efficiency and access • Financing options • Paying and reimbursing providers • design of benefit packages • Setting priorities and controlling expenses • Health promotion and prevention in making UHC feasible • Improving performance in the public sector • The private sector: contracting and regulation • Leadership for implementing change	reform environment, e.g. interests, allies, and sources of opposition • Gaining skills to build effective alliances and broker consensus and commitment • Applying modern management techniques in implementing a UHC change project • workshops and on their job site, in which they are finally expected to come up with actual plan of their collective action.	• Calculation and adjustment of government budget requirement for Thai UC Scheme • Application of close-end budget provider payment methods i.e. capitation and DRG with global budge in Thai UC Scheme to public and private health care providers • Quality assurance and people's satisfaction, • Monitoring and evaluation system • Information System to support the movement of UC Scheme	Health system and UHC • Population coverage expansion • Policy process towards UHC • Policy implementation • Design of benefit package • Effective purchasing and provider • payment methods • Capitation, DRG • Intelligence of health systems • Heath information systems • Monitoring and evaluation of outcome • Governance of insurance fund • Field visit to various organizations • Quality of healthcare

Remarks	The course gives more weight on health financing and includes practical contents related to leadership, governance and political analysis. It applies 5 control nobs framework as flagship model to analyze countries' UHC and health systems.	The focus is on policy and strategic decision making, rather than the details of how to implement reforms. As this is an advanced course, participants are expected to have extensive and relevant work experience and knowledge of health financing policy, and previous training in health systems and policy	The course has unique structure having attendance based workshops and on-the-job application phases in between. Another characteristic is to target country team consisting of members from different background (government, social health insurance body, CSO etc).	The course provides opportunities of concrete learning from Thai UHC experiences and covers not only health financing but wider range of topics than other UHC training.	Remarkable point is that the contents can be arranged in a way to fit to the needs and levels of participants.
Other Notes	The flagship course started in 1996 and provided the opportunities to learn about health systems strengthening. Topics related to UHC have been included in the course since 2012.	The course on health financing started in 2011. UHC have been focused in the course since 2013.			
Source	http://wbi.worldbank.org/wbi/event/challenge-universal-health-coverage2013-global-flagship-course-health-system-strengthening-	http://www.who.int/health_financing/hfcourse/en/	http://p4h-network.net/global/cpd/ http://health.bmz.de/events/In_focus/Leading_the_way_to_Universal_Health_Coverage/LeadershipTwoPager_v2.pdf	http://www.ihppthaigov.net/capuhc/images/Activity_2012_-_1_Workshop_27_Feb_-_3_March_2012.pdf http://www.ihppthaigov.net/capuhc/images/Activity_2012_-_2_Workshop_23_-_28_July_2012.pdf http://www.ihppthaigov.net/capuhc/images/Activity_2012_-_3_Workshop_19-24_Nov_2012.pdf)	http://www.ihppthaigov.net/capuhc/images/brochurecapuhc%20a4.pdf

Group 6 - Challenges in global governance

The members of the Group 6 have worked on the issue of Global Health Governance based on lessons learnt from the Ebola responses. Two papers were produced - one on the analysis of broad global health governance issue and the other more focused on the PPPs (Public Private Partnerships) especially of research and development (R&D) during an emergency.

The first paper, Global Health Governance: Analysis and Lessons Learned from the Ebola Virus Disease Outbreak and the Identification of the Future Response Options, written by Hideaki Shiroyama, Yasushi Katsuma and Makiko Matsuo, aims at providing a broad analysis of the process of the Ebola response and present options for responding the potential future outbreaks.

The paper revealed that although much criticism was directed towards the shortcomings of WHO responses (i.e. delayed PHEIC, lack of leadership, lack of coordination mechanism at 3 levels etc), issues were not limited to the issues of WHO itself but also the issues concerning the affected countries (i.e. fragile health system, reluctance of the government etc) as well as the lack of utilization of existing UN frameworks (UNDP, OCHA, UNICEF, WFP etc) at the country/regional and international level).

The paper present following response options for the future possible global health crisis. To enhance response capability during the emergency, paper makes four points. First, it proposes to introduce a multi-staged framework as opposed to binary PHEIC decision making. Second, it supports the recent WHO decision to put in place integrated programme for emergency. Third, it explored cross-sectoral coordination patterns in accordance with the situation categories and emphasized the importance of the role of "switching function". Fourth, it supports the movement of building the financing mechanism for the emergency (i.e. WHO contingency fund for emergency and World bank's Pandemic Emergency Facility). In addition, in order to prevent the health crisis, the paper considers it important to strengthen health system under normal conditions. For that purpose, it is strongly suggested that the IHR core capacity be implemented. Countries and international organization including those beside health sectors (i.e. trade, development and aiding framework etc) should all cooperate to engage in building frameworks to support IHR implementation. There should also be a comprehensive funding mechanism for health system.

The second paper, Public-Private Partnerships for Strengthening Global Health, is written by Sayako Kanamori, Jonas Kemp and Charlotte Sauter.

One of the major lessons learned from the recent Ebola outbreak and its response is the importance of developing an effective and efficient global research and development (R&D) framework during an emergency.

In this paper, we performed an analysis based on the 7-S Framework, which evaluates how well the resilient global R&D framework can be developed to effectively counter infectious disease threats: (1) structure; (2) style and skill; (3) stakeholders and staff; (4) shared value; (5) strategy; (6) system; and (7) size. Based on the analysis, we propose four recommendations.

Firstly, the World Health Organization (WHO) should lead in establishing an independent Pandemic Product Development Committee (PPDC), supervised by the Technical Governing Board (TGB). The PPDC should remain independent primarily to promote private-sector involvement. The committee should include public health/ regulatory and R&D experts of major pharmaceutical manufacturing countries and representatives from each WHO regions, with a size of less than 15 members respectively. The TGB should be comprised of representatives from the UN Family, regulatory agencies, industries and research organizations.

Secondly, the PPDC should work to define priorities, map global R&D progress, raise and manage the budget including gap analyses, and draft a pandemic-preparedness plan that illustrates R&D`s role, responsibility, and operations during an emergency.

Thirdly and the most presumably important, the PPDC should focus to lead design-institutional arrangements on various regulations for R&D, including approval, during an

emergency. Given the fact that it is extremely important to swiftly counter pandemics, it is reasonable to redesign existing protocols and frameworks: especially during clinical trials, manufacture, and approval of medical products as these three phases often require the most time and investment.

Lastly, the PPDC should work to secure and deploy a minimum of US $1 billion per year, which is relevant to half of the annual budget for global PDPs, to implement operations described above.

Global Health Governance: Analysis and Lessons Learned from the Ebola Virus Disease Outbreak and the Identification of Future Response Options

Group 6

Hideaki Shiroyama[1], Yasushi Katsuma[2], Makiko Matsuo[1]

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1. Background and Purpose of This Paper

1.1 Ebola Virus Disease Outbreak Across National Boundaries

The number of deaths from Ebola hemorrhagic fever, or Ebola virus disease, which spread mainly throughout three countries in West Africa (Guinea, Sierra Leone and Liberia), has reached 11,299, and the number of those infected with the virus (including suspected cases) has totaled 28,598 as of November 2015[1]. Since 1976 when the Ebola virus disease was first discovered, the recent outbreak has proven to be the most serious and complex[2].

Early on, Médecins Sans Frontières (MSF) issued warnings, stating that the "geographical expansion (of Ebola) was unprecedented" (March 2014) and "uncontrollable" (June 2014)[3]. However, insufficient attention was paid to these warnings at the 67th World Health Organization (WHO) World Health Assembly held that same year, and an international response was not developed. More specifically, it was not until August that the outbreak was recognized as a "public health emergency of international concern (PHEIC)" as prescribed by the International Health Regulations (IHR)[4]. However, by the time a PHEIC was declared, it was already impossible for the WHO to coordinate countries' efforts to control the epidemic.

Faced with such a situation, the United Nations Secretary-General initiated a response. In September, the UN Mission for Ebola Emergency Response (UNMEER) was established in accordance with General Assembly Resolution 69/1 and Security Council Resolution 2177 (2014), which would be the first mission ever to respond to a global health threat, surpassing responses executed under previous frameworks. Based on the UNMEER appeal, the United Nations, concerned international organizations, NGOs, and other partners came together to meet in Accra in October to determine how roles and operations should be divided between them. This process put in place a structure for an international response with UNMEER at the core. Previous individually-deployed responses and information were consolidated and the necessary resources secured and reallocated. Subsequently, the number of people infected decreased dramatically.

The end of the Ebola outbreak was declared on May 9, 2015 for Liberia, but a renewed outbreak was reported in November. In Sierra Leone, an end to the outbreak was declared on November 7. In Guinea, although there were reports of infected persons, numbers have stayed low.

UNMEER was closed at the end of July 2015 as its mission had ended[5]. Authority for overall management was subsequently handed over to the WHO. Currently, the international community's interest has moved on to a phase where the lessons learned from the response in the three countries are taken into account in reviewing issues that need to be addressed in how a response should be executed in future emergency situations involving health crises as well as the building of sustainable healthcare systems.

1.2 Review of Prior Research

A variety of analyses and proposals have been undertaken regarding issues brought to light in the Ebola outbreak crisis response, and how global health governance should be structured. Some of the issues that the Ebola crisis brought to the forefront are also issues that had previously been repeatedly debated about global health governance, and that were once again demonstrated tangibly. For instance, as pointed out by Frenk and Moon (2013), the inherent tension between national sovereignty and international response, the challenge posed by cross-sectoral interdependence, and the issue of the accountability of intergovernmental organizations and non-state actors were seen in this international Ebola emergency response, as well as the issue of governance deficit (Fidler, 2010)[6] as a consequence of the regime complex (Raustiala and Victor, 2004). In addition, the global delay in responding to the Ebola outbreak has also been discussed at great length, particularly in the context of the IHR recognition of a PHEIC and the issue of financing for the building of core capacities, which may be attributed to IHR's defects as have been discussed previously (Fidler and Gostin (2006), Baker and Fidler (2006), WHO (2009)).

On the other hand, this case has brought to the forefront new and unique issues. These include the importance of treating healthcare horizontally as a system, and that communicable diseases may have consequences in a variety of fields, including security.

A variety of actors are currently debating the Ebola response and reviewing the global health governance precipitated by the outbreak[7]. The has WHO set up an independent panel on the Ebola response, and the report of the WHO Ebola Interim Assessment Panel ,was released in July 2015, setting forth recommendations. Based on these proposals, various reforms have already begun being initiated (WHO Secretariat, 2015). First, concerning WHO's internal reforms, (1) the WHO presented a "A Roadmap for Action" in September 2015 (WHO, 2015c), (2) the emergency response has been discussed by the Advisory Group in order to reform the WHO's work in outbreaks and emergencies with health and humanitarian consequences, under the leadership of the WHO Secretariat Director-General and chaired by Dr. David Nabarro who is the United Nations Secretary-General's Special Envoy on Ebola (WHO Advisory Group, 2015), and (3) the effectiveness of the IHR in facilitating the Ebola response is now being assessed and debated by the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response.

In addition, the UN Secretary-General has established a high-level panel for the purpose of conducting a review that is not limited to the Ebola outbreak response, but that also considers global and national health governance more comprehensively. In addition, research institutions, universities, and international NGOs have conducted reviews from their own perspectives. These include a review by the National Academy of Medicine (NAM)[8], a joint initiative by Harvard University and the London School of Hygiene and Tropical Medicine (Moon et al, 2015), a review by an independent panel set up by the Bill and Melinda Gates Foundation, a review by MSF (2015), and others.

1.3 Purpose and Organization of This Paper

This study provides a broad analysis of the process of the response to the Ebola outbreak. In doing so, it identifies points that need to be addressed for global health governance reform while maintaining an awareness of what has been debated and what has not. The purpose of this study is to (1) analyze the process and issues of the Ebola response at the national and international levels, and (2) set forth lessons to be learned and present options for responding to potential future outbreaks, providing implications about the way in which global health governance should be structured. In so doing, the paper presents proposals to feed into the G7,Summit agenda, whose role in global health has continued to increase (Kirton and Mannell-G8 Research Group, 2005).

The research methods employed are principally studies of documents (primary documents,

secondary documents, academic papers, etc.) and interviews conducted both inside and outside Japan. As far as research performed overseas, interviews were conducted in July and November 2015 with relevant departments of the WHO, relevant organizations of the United Nations (UN Secretariat, UNMEER, OCHA, UNDP, UNICEF, UNFPA, etc.), the World Bank, research institutes (NAM), think tanks (Council on Foreign Relations, Center for Strategic and International Studies), the Bill and Melinda Gates Foundation, and others.

2. Analysis of the Process of the Response to the Ebola Virus Disease Outbreak

As stated at the beginning of this paper, MSF and other organizations issued several warnings early on about the spread of the Ebola virus disease. WHO could not have been unaware of these warnings (Farrar and Piot, 2014). Much criticism has been leveled at the delay in declaring a PHEIC[9], the lack of leadership (WHO Ebola Interim Assessment Panel, 2015), and other shortcomings of WHO responses[10]. As will be discussed below, issues were identified at different levels of the WHO (level of relationships among departments within the Headquarters, and level of relationships between the Headquarters and regional offices). In addition to issues pertaining to the WHO, there are also issues concerning the affected countries themselves as well as issues in the lack of utilization of UN frameworks for coordination, which are already embedded at the international and national levels. In other words, the fact is that the Ebola outbreak was the product of complicated issues intertwined among a variety of factors in a complex matter.

The subsequent analysis is from two perspectives; (1) from a spatial perspective (local and national levels, as well as regional and international levels), and (2) from a temporal perspective (the phase until a decision is made on a response, and stage of implementation of the decision made). Responses at the local and national levels are analyzed in section 2.1, and those at the regional and international levels in section 2.2. For each part, both the stage up to when a decision was rendered and the implementation stage are discussed.

2.1 Responses and Issues at the Local and National Levels

Important factors, which are related to the delays in country responses to the Ebola virus disease outbreak, include insufficient collection of information in the field and prioritization of political, economic, and social considerations over the need to respond to the health crisis. Governments worried about negative repercussions (travel restrictions, impact on trade, etc.) if they reported on the actual state of the infection and a PHEIC was subsequently declared by the WHO. The acquisition of accurate information is essential for deciding on measures to counter an infectious disease, but, as MSF found in its review, the governments of Guinea and Sierra Leone in particular were very reluctant to cooperate initially (MSF, 2015, p. 8). It has also been reported that, despite the infection having crossed the border and shifted to Sierra Leone in March, the government of Guinea did not communicate such information (Garrett, 2015).

Although there were a number of intentional factors, a fundamental major factor was the fragile health systems of the most affected countries, which were the result of not having thoroughly systematized IHR core capacity items as discussed later. Local governments and communities lacked surveillance capabilities and laboratory services. They were also deficient in terms of personnel, knowledge, and experience, and it was difficult for them to ascertain the true state of the situation. For example, the number of physicians particularly in Liberia and Sierra Leone was extremely low. According to the WHO data of density of physicians[11], for every 1000 people Liberia had only 0.014 physicians (in 2008), Sierra Leone had only 0.022 (in 2010), Guinea only 1 (in 2005), while the US and Japan had 2.452 (in 2011) and 2.297 (2010) respectively.

At the stage when the response was executed, many of the already insufficient numbers of

health workers had fallen victim to the infection, which made the response even more difficult. The spread of this disease led to 881 people becoming infected and 513 dying in three countries in West Africa (as of September 2015). Also, the lack of laboratories within these countries held up prompt determination of the infectious disease and also hindered efforts to trace people who had come into contact with the infection. It has also been pointed out that because the initial contact tracing for Guinea was insufficient, it allowed further spread of the infection (Briand et al, 2014). Furthermore, what made the response even more difficult during the implementation stage was a lack of active cooperation at the local level, a scope that encompasses local governments and communities. The continuation of civil war had developed a strong distrust of the government (Piot, 2014), and that hindered the engagement of local communities, which the government as well as international institutions—MSF and other outside aid organizations—were attempting to promote. Moreover, aid organizations in some cases were even frequently attacked.

UN Country Teams (UNCT), which were in each country, could have strengthened the response at the national level. In fact, the UN as One framework was not completely absent. Within the United Nations Development Assistance Framework (UNDAF), under the overall lead coordination of the Resident Coordinator, it would have been possible to coordinate the health sector to strengthen a response under WHO leadership. Coordination was also considered using the health cluster led by the WHO under the overall coordination of the Humanitarian Coordinator of OCHA, which has a responsibility within the framework of the Inter-Agency Standing Committee (IASC) for coordinating emergency assistance regarding international humanitarian issues resulting from natural disaster and conflict[12]. Nevertheless a sufficient response was unable to be meted out through these frameworks.

The main factors were the small WHO presence in such frameworks, insufficient leadership by Resident Coordinators, absence of any switch from Resident Coordinators to Humanitarian Coordinators, and the failure to develop responses employing liaisons among existing field institutions to form an organic network. Particularly, at the beginning, there was also a lack of awareness within the humanitarian community. The number of people infected with Ebola virus disease initially, according to the humanitarian community, was not considered to be so large that it could be called a state of emergency (WHO Ebola Interim Assessment Panel, 2015, para.71). Furthermore, Resident Coordinators prioritize issues from the perspective of development, while OCHA and Humanitarian Coordinators from a humanitarian perspective, and an Ebola virus disease response from the perspective of health was not their priority. In addition, it has also been pointed out that the Resident Coordinators in the three countries were not able to make such a determination because sufficient information was not provided by the countries or by the WHO.

2.2 Responses and Issues at the Regional and International Levels

2.2.1 WHO: Issues Pertaining to the Regional Office for Africa (AFRO), the Relationship Between AFRO and Headquarters, and Factors within Headquarters)

The factors that led to the delay in the WHO's international response include problems with the Regional Office for Africa (AFRO), insufficient coordination between AFRO and WHO Headquarters, and factors within the WHO Headquarters itself.

(1) Issues Concerning AFRO Capacity and Insufficient Coordination between AFRO and Headquarters

When one considers that the Western Pacific Regional Office (WPRO) played a significant role during the SARS epidemic (Omi, 2011), the role played by AFRO in failing to contain the infection in the region cannot be ignored. Among the factors cited as contributing to AFRO's malfunction are a shortage of human resources and budgetary limitations. There were not even

10 personnel in AFRO's department handling emergency responses at the time and it had also been limited by budget cuts in recent years. It has been pointed out that AFRO's functions for surveillance and support of countries where outbreaks of infectious diseases occur did not function adequately (WHO Ebola Interim Assessment Panel, 2015, para.45). Furthermore, roughly 80% of the staff had been hired from within the African region[13], and the majority were technicians employed in the field known as national professional officers (NPO), so they maintained a cohesive and closed structure with the governments of their home countries.

In addition, the insufficient working relationship among the affected countries, AFRO, and WHO Headquarters was presumed to be one of the factors that delayed the response. It has long been pointed out that insufficient coordination between the Headquarters and regional offices has hindered the WHO's effectiveness (Lee 2009, p.33)[14]. Regional offices are highly independent and operate based on rules under an organizational structure that is unique to their respective regions.

On July 24, 2014, the Sub-regional Ebola Operation Coordination Centre (SEOCC) was established with AFRO at the core to serve as a platform supporting countries in West Africa where the infection had developed. This was a framework in which not just the WHO, but also OCHA, WFP, UNICEF, the Centers for Disease Control (CDC), and other organizations participated. However, in mid-August, an initiative at the UN Headquarters in New York was launched, and the SEOCC with AFRO at its core no longer played a central role. The SEOCC was consequently closed down with the establishment of UNMEER (WHO Ebola Interim Assessment Panel, 2015, para.80, 81).

(2) Issues of Coordination and Gaps in Information and Recognition Inside the WHO's Geneva Headquarters

The following points have been indicated as factors causing a delay in the initial response as well as a delay in PHEIC declaration by the WHO Headquarters in Geneva.

First, information was insufficiently communicated due to insufficient implementation of IHR monitoring on account of a lack of human and budgetary resources. The budget for IHR implementation was reduced by approximately 50% following worldwide economic stagnation resulting from the 2008 financial collapse[15]. It has been pointed out that at the end of April when figures of infection temporarily trended downward, foreign aid was withdrawn based on a mistaken understanding by the CDC that the situation was under control (Garrett, 2015), but this might have been prevented if there had been more robust surveillance systems at the local and national levels.

Second is the gap between the role as perceived by the WHO Director-General, and the role that the international community demanded of WHO, as well as the lack of leadership exercised during the emergency. As symbolized by the criticism (Gostin, 2014 and others) of the WHO Director-General's statements that the "WHO is a technical agency" and "governments have the primary responsibility" (New York Times, 2015), there was a discrepancy between the role that the international community expected of the WHO and the WHO's own perception of its role. Clearly, even though it is correct that the countries should have primary responsibility, there was room for the WHO to exercise leadership based on information provided by third parties such as MSF. At the Global Outbreak Alert & Response Network (GOARN) meeting held in July, MSF pleaded for an immediate international response, but it was not taken seriously (MSF, 2015, p.8)[16]. This delayed the timing for convening an IHR committee meeting and declaring a PHEIC.

Third, there was a negative perception of the declaring of a PHEIC within the WHO. Specifically, issuing a PHEIC was (1) considered a last resort (Garrett, 2015) because there was concern that it would impose de facto restrictions on the target country[17], (2) there were concerns that intervention would be seen as interference in the domestic affairs of a sovereign state,, and, moreover, (3) there was hesitation on account of criticism that had been leveled in the past about the H1N1 response[18], which was the first PHEIC case, that it was an overreaction

by WHO. Such factors were present in the background and are thought to have delayed the PHEIC declaration. In addition, the fact that there were no intermediate means for adopting a full-scale international response prior to invoking a PHEIC is considered to have significantly contributed to the delayed response.

One issue in terms of internal coordination within WHO Headquarters during the implementation stage is the coordination exercised among different departments. As the WHO itself has also acknowledged, the systems which handled health security and humanitarian issues operated separately (WHO Secretariat, 2015, para.17). Actually, coordination between the department for health security (IHR, GOARN), department for humanitarian and emergency responses (polio, FMT[19]), and department responsible for the long-term building of health systems did not function well initially.

Specifically, there were two broad frameworks for physicians active in the field: (1) GOARN and (2) FMT (Foreign Medical Team). Within the WHO, the departments handling these teams were different. GOARN has been set up for the main purpose of responding to infectious diseases and the WHO serves as its secretariat. It is a network of partner organizations. Many of the staff dispatched are technical personnel and they have been effective in responding to SARS and other outbreaks in the past (Mackenzie et al (2014)). It was set up in the Department of Global Capacities Alert and Response (GCR). On the other hand, FMTs have been established in the Emergency Risk Management and Humanitarian Response Department that mainly deals with trauma-related disasters due to natural or human-induced factors (Burkle, 2014). The reason why collaboration was difficult between these departments within the WHO needs to be further explored, however, it is conceivable that the heads of the respective departments did not communicate or that there were delays made in issuing decisions and instructions by supervisors in both departments. In order to solve the above problems, in recent organizational restructuring, these two departments were merged into one cluster.

2.2.2 Coordination within the UN Family

There was initially a search for the possibility of utilizing existing frameworks to coordinate in the field when a response began to be considered by the UN Secretariat.

If a response had been initiated earlier, it might have been possible for Humanitarian Coordinators supported by OCHA to be dispatched under the IASC framework. However, because intervention was called for after the situation had acutely worsened, and because the Ebola virus was disease that the humanitarian community was unfamiliar with the handling, it was determined that a response would be difficult using the cluster approach with OCHA at the core. In addition, rapid access to a large amount of funding was imperative at that time, but that would have been difficult using OCHA's usual funding process. It was also considered that more time would be required to form a consensus to agree to use the Central Emergency Response Fund (CERF) for the Ebola virus disease response, which is a use that is different from ordinary natural disasters and armed conflict.

In the ultimate response to this situation (that is to say, September 2015), a recognition was broadly shared that the establishment of UNMEER could be justified based on the UN Secretary-General's initiative to mobilize resources, procure funding, and coordinate UN organizations in a top-down manner over a short period of time[20].

However, this is not to say that there were no issues to be addressed in the UNMEER response. More specifically, (1) the construction of a new organization gave rise to problems such as coherence and overlapping issues with the aforementioned existing frameworks (overlapping with OCHA and the UN Development Group coordination frameworks present at the international level, as well as with Ebola response frameworks established by national governments, etc.). (2) Initially, because the operation was conducted in a top-down manner and emphasized military-like logistics, there was also confusion from the field (comments were voiced that cultural factors in the field should also have been emphasized). (3) Although UNMEER made it possible to take swift action with a clear division of labor, time was also

needed until the process began to operate substantively (it was in October when the Accra meeting was held that the division of responsibilities among international organizations was completed and substantive deployments initiated).

The above analysis shows that the factors resulting in the delayed response to the Ebola virus disease, leading to a more serious situation, were issues pertaining to coordination and issues involving gaps in information and perception among a variety of actors at a variety of levels intertwined in a complex manner.

3. Response Options for Global Health Governance

Taking into account the above analysis of the process of responding to the Ebola outbreak, the following response options along two broad topics are proposed. One is strengthening the capability to respond during an emergency and the other is strengthening health systems during ordinary times. The success of emergency responses depends on the health system, which ensures that information is collected and responses implemented during ordinary times. The systematic infrastructure for collecting information for an emergency response as well as for responding to it can be also utilized during ordinary times. In addition, increasing the efficiency of emergency responses spares resources and allows for expanded access to be secured within a health system during ordinary times. In that sense, these two topics are closely related. Below, response options related to these two topics from three perspectives are presented: (1) strengthening organizational capabilities (improving capacity), (2) strengthening coordination among organizations, and (3) strengthening frameworks for procuring funding.

3.1 Strengthening Response Capabilities During an Emergency

3.1.1 Strengthening Organizational Capability

(1) Construction of Frameworks Enabling Progressive Stages of Response and Systems for Collecting Information

As indicated in section 2.2.1, one factor leading to a delay in the response was that there was no intermediate stage between ordinary times and a PHEIC. PHEIC determination was a clear choice between two alternatives, and there was no framework allowing for progressive stages of response. In order to execute progressive stages of response, (1) the construction of a framework for making progressive determinations about the situation, and (2) strengthened capabilities to gather information to support such judgments are required.

With regard to (1), multiple stages need to be established to allow for progressive stages of response between the current PHEIC and non-PHEIC situations[21]. In the IHR, there is a provision (Article 8) that consultations with the WHO on appropriate measures may be conducted through the National IHR Focal Point even for information not required to be reported, particularly for events for which there is insufficient information available to complete a decision on whether it constitutes a PHIEC. Such a provision should be utilized to build an operational framework for collecting a broad range of information and making stage-based situational determinations. It is also important to strengthen the WHO's risk assessment capability and staffing to allow for the operation of such framework. However, care needs to be taken so that the criteria for judgments can operate with some flexibility.

With regard to (2), the IHR (2005) allows for the use and analysis of information sourced not only from countries, but also from other sources (Article 9.1) including international institutions, non-state actors, and a variety of entities. This was the strategy to overcome two potential limitations of surveillance under the IHR (1969): inadequate capacities at the local and national levels to fulfil surveillance, and government reluctance to comply for fear of the adverse consequences of reporting (Baker and Fidler, 2006, p.1062). However, such WHO authority and capabilities are not sufficiently utilized. Pursuant to this provision, the WHO

should consider the development of a mechanism for collecting a broader range of information to adopt necessary measures, including in cases where there may not be a clear indication of a PHEI and also from a variety of sources that are active at the grassroots level, such as MSF.

In all of the above-mentioned judgment stages, it is also fundamental to acknowledge that the governments and leaders of the countries concerned have the primary responsibility and should play a leading role. Such an awareness must be sought to be improved.

(2) Strengthening Organizational Capability to Respond to Diverse Situations: Provision of Flexible and Integrated Programs

In this response to the Ebola virus disease outbreak, operations were deployed on a large scale in both the emergency disaster and humanitarian community, and the health security community. However, unlike in the case of the Polio response in which both communities collaborate on a daily basis, there were no routine procedures and protocols for the Ebola response. Cultural and organizational differences between the two surfaced, rendering cooperation difficult. A system is needed that allows for stage-based and flexible collaboration in responding to a variety of situations as has been discussed above.

The need for an integrated program for emergencies was recognized and a decision was made to establish such a program at the 68th WHO General Assembly in 2015. The proposal of an Advisory Group on Reform of WHO's Work in Outbreaks and Emergencies is in line with this direction (WHO Advisory Group, 2015)[22]. The WHO appears to have adopted the direction of organizationally bringing together humanitarian and health security communities. In many review reports, differences between humanitarian and health security communities have been highlighted and there has been much debate calling for strengthened coordination and merging of the two (for example, the WHO Ebola Interim Assessment Panel, 2015). The WHO secretariat is now reviewing a variety of framework liaisons such as GOARN and FMT, which have previously been handled by separate departments, to be merged into one cluster. It may be worthwhile to note that at the regional office level, for example in the case of WPRO, both humanitarian and health security departments are dealt with under the Division of Health Security and Emergencies.

However, whether or not organizational merging of two different departments by itself constitutes a sufficient solution requires further analysis. Cooperation and coordination among departments is of course important, but it is also true that each has their own legitimate purpose and functions. The issue is to operate in such a manner that collaboration can be carried out in response to circumstances in a way that makes use of their respective merits. It is important that a variety of tools be available during times of emergency. Training and something along the lines of a set of protocols and manuals for interaction are needed to enhance the ability to collaborate and coordinate.

3.1.2 Ensuring Cross-Sectoral Coordination and Cooperation Among International Organizations According to Situational Categories

Every emergency occurs under different conditions, and coordination and cooperation are required based on each circumstance. As a result, the coordination and cooperation necessary differs depending on the type of situation. A "switch function," which enables the change of the lead agency of coordination and cooperation in response to a situation is critical in the utilization of situation and stage-based framework.

(1) Diverse Situational Categories for Emergencies and Patterns of Coordination and Cooperation

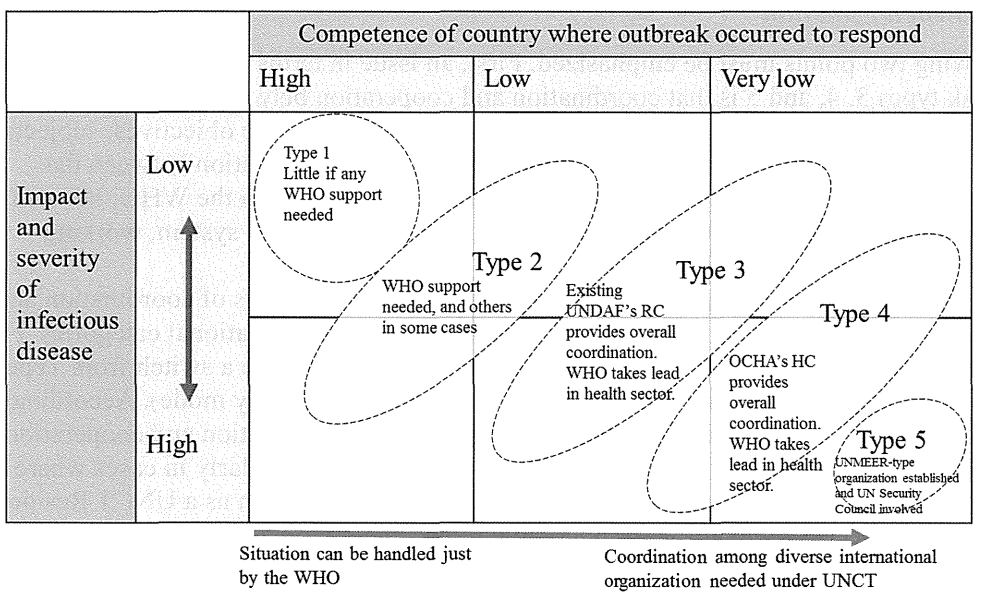
As seen in section 2.2.2, there is a clear necessity for developing situation-based flexible partnerships for coordination and cooperation among international institutions (relationships

between WHO and the humanitarian community in the field, development community, security community, etc.). Clearly, the WHO is the only actor that can perform the central leading role in providing technical and medical recommendations concerning a health crisis, and there is no doubt about this. However, as was evident in the lessons learned from the Ebola outbreak, health crises often entail situations that cannot be dealt with by just providing technical knowledge, guidelines, and a limited deployment of technical and medical experts. Consequently, diverse international emergency situations need to be anticipated and diverse patterns for coordination and cooperation among international institutions for each situation need to be prepared.

The patterns of coordination and cooperation differ depending on the competency of the affected country and the type of infectious disease. Therefore, as to the question of who should develop what sort of initiative at the international level, the following options can be considered depending on situational categories which are based on (1) the capability of the country where an infectious disease outbreak has occurred requiring the response, and (2) the type of infectious disease (scope of impact and magnitude of severity).

Table. Coordination Patterns by Situation-based Typology

Diverse Emergency Scenarios and Coordinating Actor Patterns



Type 1 cases, in which the country where the outbreak has occurred maintains a high response competency and the degree of severity of the infectious disease and the scope of its impact are low, responses may be handled by the country concerned with minimal support from the WHO. In Type 2 cases, the country and the WHO are central in handling the situation, and support from organizations other than the WHO may also be necessary in some situations. In Type 3 cases, under the existing UNDAF framework, the Resident Coordinator provides overall coordination, within which the WHO leads the health sector and a response is extended while obtaining the cooperation of a variety of international organizations of the UNCT. In Type 4 cases, there is a greater sense of urgency and more humanitarian elements are required than afforded by development frameworks for ordinary times. In these cases, a framework is implemented in which OCHA deals with the humanitarian crisis, and the Humanitarian Coordinator exercises overall coordination under an IASC framework where the WHO plays a central role in leading the health cluster. Lastly, Type 5 cases are those where it is determined that a response is beyond OCHA or other existing frameworks' capabilities and are handled by