WHO must remain a strong global health leader post Ebola

The 2014 Ebola outbreak in west Africa has demonstrated again the urgent need for strong leadership and coordination in responding to global health challenges. As members of the global health scholarly community, we call upon all WHO Member States to recommit themselves to strengthening global outbreak alert and response by sustainably investing in the WHO, its departments, and personnel.

As members of the WHO secretariat have admitted, mistakes were made in how the organisation initially responded to the 2014 Ebola outbreak.

Ahead of the 68th World Health Assembly in May, 2015, the temptation will be to point fingers and use the extreme case of Ebola to justify further erosion of the WHO. The temptation might also be to divert voluntary contributions to other institutions. We firmly believe that any such measures must be approached with extreme care.

In international forums, a proposal is being discussed to establish a new "first responder" UN agency, which will provide emergency operational assistance in humanitarian crises by rapidly deploying trained personnel, equipment, and supplies. While an enhanced rapid response would be beneficial, a new agency would be subject to the same vagaries of institutional funding and Member State interests in delivering its mandate. Even more importantly, these are functions that the WHO already fulfils via the Global Outbreak Alert and Response Network (GOARN), which maintains a roster of experts that can be deployed to assist in humanitarian disasters. The resources to create an entirely new agency would therefore be better served by strengthening the WHO's emergency response division rather than duplicating existing functions. Resources could also be more effectively used to help Member States implement the International Health Regulations (2005) via health system strengthening.

An independent investigation of the WHO's handling of the 2014 Ebola outbreak is both appropriate and warranted. The investigation should focus on the structural and procedural elements of institutional practice, consider how recent funding cuts affected the WHO's ability to respond, and identify pathways to sustainable funding of the institution.

The WHO can provide global health leadership that is technically informed and representative. The organisation remains a fundamental element of global health governance, and provides an indispensable service as the lead technical agency in global health. While mistakes have been made, rather than engage in the further dismantling of the WHO we call on all Member States and the international community to give the organisation the resources it needs to serve its members and the populations they represent.

SH has worked as a consultant for WHO. The other authors declare no competing interests. The views expressed here are those of the authors and not necessarily those of their institutions.

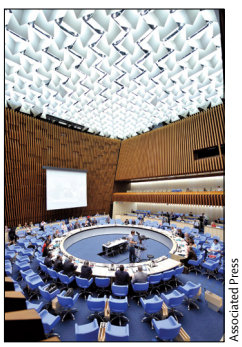
*Adam Kamradt-Scott, Sophie Harman, Joao Nunes, Anne Roemer-Mahler, Clare Wenham, on behalf of 95 signatories
adam.kamradt-scott@sydney.edu.au

University of Sydney, Sydney, NSW, Australia (AK-S); Queen Mary University of London, London, UK (SH); University of York, York, UK (JN); University of Sussex, Brighton, UK (AR-M); and London School of Hygiene & Tropical Medicine, London, UK (CW)

Interventions for intimate partner violence

We disagree with Susan Rees and Derrick Silove's Correspondence[1], which states that primary care interventions do not work for intimate partner violence.

Investigators have shown that primary care interventions for women increase identification and referrals to services for intimate partner violence in the UK (IRIS trial)[2] and increase safety discussion and decrease depressive symptoms (WEAVE trial) in Australia.[3] One primary care intervention (WEAVE) not having an effect on some outcomes does not justify dismissal of primary care for interventions against intimate partner violence. Rather, more needs to be learned from these trials about how to tailor interventions to the trajectory of abuse and help seeking, perhaps to increase the intensity of a whole-of-practice approach and stronger links with community services for intimate partner violence, as in IRIS.[2]



Associated Press

A systematic review of primary care interventions for intimate partner violence,[4] mostly from reproductive care, reported referrals as the most positively affected outcome. Interventions were brief, involving empowerment, safety discussion, and referral to community resources. In WEAVE, many women identified through primary care screening did not take up referrals as few women wanted this at the point of contact. By contrast, most women disclosing abuse through case finding to IRIS doctors consented to referral to intimate partner violence services. Both trial populations valued the acknowledgment and validation of the abuse, and the understanding by doctors that intimate partner violence is a chronic issue—key responses women say they want from health professionals.[5] As Rees and Silove[1] suggest, many women experience mental health disorders as a result of recurrent abuse,[6] with many WEAVE participants already seeing mental health professionals, and others being referred to mental health interventions when they did attend the doctor, a key pathway to care.[3]

Rees and Silove[1] argue that funding for services for intimate partner violence is inadequate, and that these community services need to be rigorously assessed; points with which we thoroughly agree. They then argue that community services are best placed to care for all survivors, despite the absence of evidence. In Australia and the UK, very few survivors directly

For the **list of signatories** see appendix

Submissions should be made via our electronic submission system at http://ees.elsevier.com/thelancet/