

COVID-19 and global health governance: Building upon the positives

Sara E. Davies

The World Health Organization (WHO) received the first report of a suspect novel coronavirus in Wuhan city, China, on 31 December 2019. On 10 January 2020, it announced that a novel coronavirus had been detected. Self-isolation was recommended for 14 days for all persons who may have come into contact with persons infected with the virus or travelled in the affected area. The WHO Director-General declared the outbreak a Public Health Emergency of International Concern (PHEIC) on 30 January 2020 under the International Health Regulations (IHR). Six months forward, in early July, there are over 10 million confirmed cases and over 500,000 confirmed deaths. The virus has spread across the world and even in countries with low numbers of confirmed cases, continued vigilance is required to keep infection clusters from escalating.

The outbreak of COVID-19 has caused immense political, economic and health impacts across the world. In many instances, the instinctive response of states was to do the opposite of the WHO's recommendations during a public health emergency: they imposed travel measures that locked down borders and, in some instances, attempted to slow or redirect trade in vital equipment including personal protection equipment (PPE). The economic consequence of locking down entire countries has led to unparalleled quantitative easing and state spending measures. Finally, the strength of health systems has been exposed and found wanting in unexpected places, including high income countries with records of research excellence in infectious diseases. This Spotlight asks what lessons ought to be learned

from the international response to COVID-19 to date and suggests what should be the global governance priorities moving forward.

Many challenges ...

Cooperation was not the first instinct of many states, including the Permanent Five of the UN Security Council (UNSC) (who were, collectively, important leaders in response to the Ebola outbreak in West Africa in 2014-2015). Engagement within multilateral institutions – Group of 7 (G7), Group of 20 (G20), UNSC or UN General Assembly – to which states turned to discuss their response to the crisis has not always produced consensus on the COVID-19 collective governance priorities. While investment in vaccination discovery was an undisputed priority among states, consensus and collective action on the economic management of the crisis, coordinated trade and travel or creating a shared pool of resources (from testing to PPE), have been harder goals to reach.

In the early months of the outbreak (and to this day), there were attempts to discredit the WHO executive response to the outbreak. In May 2020, the World Health Assembly agreed to an investigation into the outbreak but the commencement of this investigation is pending. The United States is progressing its retreat from the WHO and other UN bodies. There are concerns that vaccination discussions are now taking on nationalistic and competitive rather than collaborative tones. Meanwhile, the first wave of the

COVID-19 outbreak has not yet passed, some members within the G7, the G20 and the UNSC are still responding to the continued rise of the first curve while the second wave may be already underway.

... but don't overlook the positives

While the difficulties in achieving a collective response to the COVID-19 pandemic are obvious, it is important to also identify the positives that may be observed in the first six months of the global response to this outbreak. They may not be equal in strength to the challenges, but they can call our attention to areas where cooperation is possible and could be further strengthened. Below I identify four such areas where positives can be found amongst the challenges: surveillance, human rights, information, and international, regional and technical cooperation.

Surveillance

In 2005, states established an international legal framework to govern situations like COVID-19. In order to achieve better international cooperation in response to public health emergencies of international concern (PHEIC), the International Health Regulations aim to: 1) build countries' capacities to detect, assess and report public health events, 2) invest in WHO's coordinating role to build this capacity, and 3) in the event of a PHEIC, agree to specific measures at ports, airports and ground crossings to limit the spread of health risks, and prevent trade and travel restrictions so that the open reporting of outbreak events does not lead to unnecessary and punitive trade and travel restrictions. The revised IHR provide 'rules and processes designed to increase compliance' with trade and travel measures that the WHO Director-General could recommend on the basis of scientific evidence.

The COVID-19 outbreak has revealed that the majority of states are willing to detect, assess and report public health emergencies. The high degree of surveillance and reporting for COVID-19 is similar to the high degree of states' observation of the need to detect and report during the H1N1 "Swine Flu" outbreak in 2009. The problem then, as with COVID-19 today, has been the minority of states that delay reporting or refuse to report cases at all. On the whole, few states have been 'beaten' to their public announcement of outbreak detection by a non-state public health information surveillance network such as PRO-Med Mail or the Johns Hopkins University COVID-19 Dashboard. The failure by some states to report early has been catastrophic in most cases (i.e. Iran, Indonesia and Russia). Delayed reporting appears to be followed by a failure to scale up the necessary testing. Indeed, some states have refused to try and overcome their inadequate first response (i.e. Belorussia, Brazil, United States).

The greatest concern at the moment is the persistent lack of adequate testing in these countries and additional sites including the Latin American continent, Saudi Arabia, Oman and Pakistan. Recently, Nigeria, South Africa, Bangladesh and India have been added to the list where there is growing concern about how they will scale up the testing necessary to beat the rise in the COVID-19 curve. In fact, the chair of South Africa's Ministerial Advisory Committee for COVID-19 has publicly said that the infections in his country will go up and scaling up testing will be affected under these circumstances. The global demand for testing materials and the human resources required to test at the appropriate scale is enormous. Even in a high income public health system such as Australia, the state of Victoria has had to request federal government support to sustain testing and contract tracing capacity.

Sustaining surveillance will be the next normative challenge for the WHO. Some of the afore-mentioned states experiencing an upsurge in cases while lowering rates of testing were ones that detected and reported their first outbreaks early. These states are starting to experience human resource, testing material and health system strain after months of mitigation and testing measures. It will be vital to support these states instead of condemning them for detection failures in this phase.

The IHR were constructed to combat past failures to report. COVID-19 has revealed that the WHO managed to shift underlying norms on reporting: Most states are reporting more fulsomely and more quickly than they did before the IHR. But of course, there are also states that have failed to report. These states have been widely identified as leaderless, untrustworthy and irresponsible sovereigns. They do not prove the IHR were wrong to promote detection and reporting under an international system of cooperation and trust. These states prove that political systems and leaders are fallible, and that wherever there are rules, there are people willing to break them. The tragedy is that populations within these countries are suffering the consequences.

Human rights

In 2014, there had been many concerns about the delayed response of the WHO Executive to the outbreak of Ebola in West Africa. An outbreak that began in Guinea in December 2013, and then spread to Liberia and Sierra Leone in March 2014, did not provoke the convening of an IHR Emergency Committee until 6 August 2014. As the months went by, there was an increased sense of urgency and desperation, communicated by individuals such as Dr Joanne Liu, then International President of Médecins Sans Frontières (MSF), for WHO and states to act. There were nearly 1,000 recorded deaths before a PHEIC was declared in August 2014. This outbreak would become the largest Ebola outbreak recorded.

For the first six months of the outbreak, the international community collectively failed to prioritise the right to health of the populations who were exposed to a disease with a 50% fatality rate. The 2015 review of WHO's response led by Dame Barbara Stocking noted that the IHR were meant to be implemented with full response for the dignity, human rights and fundamental freedoms of persons. This did not occur during the Ebola outbreak. The political response was heavily securitized, healthcare workers were threatened with imprisonment if they did not turn up to work and they were also threatened if they spoke out against their government. Schools were closed, markets were shut, violence against women rose, and existing health morbidities increased. The realisation that not every individual had agency and power in response to this outcome eventually led to improved health advice and risk communication, but the economic and social damage was immense.

Compared to the West African Ebola outbreak in 2014, and even the Zika outbreak in 2016, there has been more discussion and focus on particular groups at risk of neglect and discrimination during the COVID-19 pandemic. There is greater collective awareness and advocacy that individual human rights must not be compromised by the COVID-19 response. The UN has provided a series of factsheets and reports on groups at risk of discrimination during this outbreak, including individuals with disability, refugees, migrant workers, and women. Where funding has been made available, there has been a consistent message from the UN and the World Bank that it should focus not only on immediate relief but should also support longer term sustainable development with the creation of an international funding campaign to assist low and middle income countries with preparedness.

Globally, there have been active advocacy campaigns to identify violations of economic, social and civil rights during this outbreak such as social media campaigns calling out instances where ethnic Chinese were targeted for racist and xenophobic abuse; media reports on women experiencing a higher volume of unpaid care duties and higher risk of job losses; calls for governments to address the higher risk of intimate and family violence during self-isolation or quarantine; the health risk to low income workers and migrant workers living in cramped living conditions; the income vulnerability of casual workers now facing risk of wage loss and unemployment; the elderly and disabled who were not prioritised for intubation and intensive care.

However, these examples of human rights advocacy cannot hide the fact that human rights have been abused during this pandemic in silent, pernicious ways. In many places, people – including frontline medical workers – who have challenged authority and spoken out against government messages that are dangerous, discriminatory or neglectful have faced threats of violence, censorship and even

imprisonment. There are serious concerns about the use of emergency laws to implement lockdowns, the shutdown of political parties and civil society groups under 'spreading misinformation' laws that were introduced to support the public health response, and the securitized enforcement of emergency laws.

As the COVID-19 outbreak continues, we will need to count the human rights toll: the direct impact of COVID-19 on human rights, and the indirect impact of the COVID-19 on rights fulfilment. There is a need to ensure that public health regulations and laws rapidly introduced during this pandemic do not compromise the civil, political, economic and social rights of individuals. A human rights lens will be vital to ensure continued population trust in contact tracing (trust in being found), in agreeing to vaccination calls, and in coming forward to testing. Human rights are vital for ensuring public trust in the COVID-19 response.

Information

This outbreak has spurred the need to debate and, in some cases, create information channels that fight against the 'infodemics'. The UN issued a Communications Response initiative, and the "Verified" campaign which was supported by 130 member states. There have been WhatsApp groups dedicated to sharing risk communication practices, sharing best research practices and establishing direct lines of information exchange between government and citizen. The communities that have communicated best have adopted a multiple streams approach and delivery – short video messages from a Prime Minister on Instagram, a two sentence explanation on the rate of community transfer of the virus, a free downloadable picture book on coronavirus in multiple languages. More information from trusted sources mitigates the alarmist messages that frighten and induce panic.

However, information black holes and censored media have persisted during this outbreak. There is legitimate fear that contact tracing applications for smart phones and tablets open the potential for a surveillance state or surveillance private company that will monitor individuals without their permission or knowledge. Just as vaccination hesitancy has compromised herd immunity from measles to polio, there should not be complacency that information hesitancy and disbelief will not increasingly emerge as a challenge to public health information and messaging. Trust in institutions is earned. This requires political institutions in particular to be shown to be engaged and deliberative in their testing, contract tracing and risk mitigation.

International, regional and technical cooperation

The immediate absence of a global coordinated effort to address COVID-19 has not defeated attempts by the UN to build and create consensus. The UN

General Assembly achieved some success with a Resolution 74/274, “International cooperation to ensure global access to medicines, vaccines and medical equipment to face COVID-19” (A/74/L.56), adopted on 20 April 2020. This resolution adopted 5 recommendations: call upon states to support the WHO; address shortfall in supplies to respond to the outbreak, especially in low and middle income countries; encourage a vaccination discovery, production and supply partnership; and the creation of an inter-agency task force to brief the UN General Assembly. In contrast, the UN Security Council could not agree on a resolution on COVID-19 until early July when it finally supported the UN Secretary-General’s call for a global ceasefire amongst conflicting states and parties. Avenues for global health cooperation seem to be diminishing. New avenues will have to be opened – some promising ones have been highlighted in this Spotlight.

One area where surprising levels of activity has emerged is from regional organisations – from ASEAN to the EU, from the African Union to the Pacific Island Forum. Despite the beleaguered situation of some states within these regional organisations (i.e. MERCUSOR and the Arab League), there have been efforts to meet, organise and issue statements: on sharing information, creating shared fund mechanisms and distribution channels for essential medical supplies. Of course, there are different levels of cooperation from each of these institutions due to their Charters. There are suspicions that some of this activity detracts from the failures occurring within some of these states and serves to legitimise illegitimate regimes. However, the shift to regional organisations as a venue for health diplomacy is a turn that should be watched carefully – as a mechanism to perhaps introduce cooperation and consensus on areas from surveillance, to vaccination and digital protocols.

A final area for potential cooperation is amongst research institutions around the world. States tend to take matters into their own hands when they don’t trust that the international process is capable of protecting their interests. Cooperation in areas of technical endeavour, i.e. science, mapping, weather, health or digitalisation, is political but it can also serve as functional pursuits that enhances international cooperation in spite or because of the differences amongst the political actors. COVID-19 has revealed the best of our collective scientific endeavours: it began with the scientists in China and Thailand ensuring the

public release of the virus in January. Creating channels of communication and discovery amongst vastly different political regimes and health systems will matter more and may be our only push against the rogue states willing to risk it all.

Conclusion

It is unknown what lies in store for the future. We need careful analysis not just of what failed but of what worked, to ensure the right lessons are learned. This can help identify the areas for cooperation to prevent that COVID-19 infects the institutions we have created to build a more just and secure world.

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Further reading

Fitri Bintang 2020, COVID-19 Apps: Fear of Tyranny by Data, <https://www.csis.or.id/publications/COVID-19-apps-fear-of-tyranny-by-data>.

Sara E. Davies 2020, Managing Asia’s coronavirus response, <https://www.eastasiaforum.org/2020/02/16/managing-asias-coronavirus-response>.

John Kabia 2017, What lessons can human rights funders learn from the Ebola outbreak?, <https://www.alliancemagazine.org/blog/lessons-can-human-rights-funders-learn-ebola-outbreak>.

Anastasia Kalinina 2020, What the world can learn from regional responses to COVID-19, <https://www.weforum.org/agenda/2020/05/COVID-19-what-the-world-can-learn-from-regional-responses>.

OHCHR 2020, COVID-19 Guidance, <https://www.ohchr.org/EN/NewsEvents/Pages/COVID-19Guidance.aspx>.

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