

THE *LANCET* COVID-19 COMMISSION
GLOBAL HEALTH DIPLOMACY AND COOPERATION
TASK FORCE

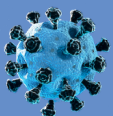
Global diplomacy and cooperation in pandemic times: Lessons and recommendations from COVID-19

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The *Lancet* COVID-19 Commission

Global Health Diplomacy and Cooperation Task Force



THE *LANCET*
COVID-19 COMMISSION

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For more information about the *Lancet* COVID-19 Commission, please go to covid19commission.org.

The following report has been posted online by the Commission Secretariat, and has not been peer-reviewed or published in *The Lancet*, nor in any other journal. This reports intends to bring together expert views on key topics as the COVID-19 pandemic unfolds.

INTRODUCTION

From the time it was first declared a pandemic in March 2020, the novel coronavirus known to the world as COVID-19 has constituted an urgent and rapidly evolving threat to global health. As of the writing of this report, there have been approximately 262 million confirmed cases of the disease, and over 5 million deaths,¹ though the actual figure may be significantly higher.²

Vast as these figures may be, they fail to capture the full extent of this catastrophe. COVID-19 has profoundly disrupted essential health services across much of the world, through the emergency redirection of medical resources. This “secondary health crisis” has manifested itself in everything from reduced vaccination rates to reductions in life expectancy.

In addition, the pandemic has represented the severest challenge to the global economy since the Great Depression. Here too, COVID-19 has undone decades of progress, eroding hard-won gains in fighting poverty and advancing global development. The economic burden of the COVID-19 pandemic in the United States (US) alone is currently estimated to be more than USD 16 trillion,³ and could amount to between USD 17 trillion and USD 94 trillion over the next decade, but it will be years before we have an authoritative tally of businesses shuttered; careers forestalled; and revenues lost nationwide and around the world.

These hardships have not fallen evenly across the world economy. Both between and within countries, the economic consequences of the pandemic have been especially harsh for the poor and the middle class, with severe implications for generations to come.⁴⁻⁷

Low- and middle-income countries (LMICs) that are dependent on informal employment, tourism, and remittances have suffered worse than advanced economies.^{8,9} Women, already in a weaker economic position than men, have been likelier than men to lose their jobs and livelihoods. Hundreds of millions of students and young adults have been forced out of school by the pandemic, with especially severe long-term effects for those whose families can’t afford digital-education programs or private tutors.

In parallel with the ensuing global economic crisis, the COVID-19 pandemic has also led to a crisis in global governance, as manifested in ineffective institutional responses, rising nationalism, and acts of unilateral self-interest.

In short, the COVID-19 pandemic has been a multilayered

crisis, one with no end in sight. For the world to successfully confront it, a new level of international cooperation is essential. The pandemic is a global challenge that can only be overcome with coordinated global action, and a stronger sense of transnational solidarity in the face of a common threat that does not respect national borders.

The challenges that a virus like COVID-19 presents – such as vaccine development and distribution; the emergence of new variants; and the shortage of skilled health workers – are global. There is no single country, region, institution, or sector that is able to address the consequences of this pandemic and future threats by itself. No one is safe until everybody is safe. Or, as United Nations Secretary-General (UNSG) Antonio Guterres put it, “We are only as strong as the weakest.”

Yet even as we continue to battle the current pandemic, we must become better prepared to combat future emergent diseases, especially as climate change increasingly generates heavy flooding, extreme heat, deforestation, biodiversity loss, and other conditions that could promote the spread of illness.

These pandemics – both present and future – pose fundamental threats to the core values for which the United Nations has stood since the post-World War II era. These values include the basic health and safety of the individual; the solidarity of nations against common threats; and the protection of the most vulnerable.

It is in the name of these values that we present this report from The *Lancet* COVID-19 Commission’s Task Force on Global Health Diplomacy and Cooperation. Our aim is to contribute to building and enhancing the multilateral institutions capable of taking collective action to address global-health emergencies such as COVID-19. In doing so, we seek to uphold the highest research standards. The *Lancet* COVID-19 Commission is independent, scientific, and non-governmental in character, and our final report is subject to peer review.

CORE VALUES

The following universal values should guide states, international organizations, civil-society actors, scientific-research bodies, and the private sector in preparing for and responding to future pandemics.

1. SOLIDARITY – TOGETHER WE ARE BETTER.

The Universal Declaration of Human Rights calls on everyone to act toward one another in a spirit of brotherhood.¹⁰ This is better conveyed in today’s

lexicon as “solidarity.” Within nations, this spirit of solidarity manifests as an awareness of the multiple and intersecting forms of inequality that breed injustice and unnecessary suffering, including for the poor; for the socially marginalized; for racial and ethnic minorities; for women and girls across social categories; and for refugees and the displaced.

We recognize that cultures and societies can have widely differing views on the proper balance between individual freedom and collective security – and on the role of multilateral institutions in defining or enforcing such values. In response to this reality, we call for all participants in national and transnational decision-making to uphold a most basic form of solidarity – that of an open and mutually respectful discussion of differences, and a commitment to the peaceful resolution of those differences.

Following from the above is the conviction that the most vulnerable countries,¹⁰ and the most vulnerable individual members of societies, require special consideration and attention. This value should guide the actions of all countries as they conduct international responses to pandemic prevention and recovery.

2. ALL HUMAN BEINGS ARE EQUAL IN DIGNITY AND RIGHTS.¹⁰

The experience of COVID-19 has amply demonstrated how the world has fallen short in living up to the values of human equality and basic dignity. National and multilateral responses to this and future pandemics must ground themselves in the human-rights principles and norms generally accepted by the international community.

The Sustainable Development Goals (SDGs) have been conceived and couched in the language of human rights – and they have been subscribed to by 193 countries. Therefore, upholding the protection of human rights as a foundational principle of the global response to a pandemic simply means holding nation-states at their word.

This means, in practice, that in the context of responding to a pandemic, any restrictions on fundamental rights and freedoms should be temporary; proportional to the emergency at hand; directly connected to the nature of the crisis; and subject to oversight, including by international bodies entrusted with the role of monitoring compliance with human rights. No pandemic should serve as *carte blanche* to undermine principles that are part of our common human heritage.

3. TRANSPARENCY, THE FREE FLOW OF INFORMATION, AND A COMMITMENT TO TRUTH.

One of the lessons of the current pandemic is that transparency, and the free flow of information among and within countries, must be a valued priority if the nations of the world are to have any chance of preventing and addressing future outbreaks. The suppression of the free flow of information is contrary to the Universal Declaration of Human Rights and various treaties, and undermines effective policy responses.¹⁰

In formulating policy, decision-makers should uphold a commitment to discovering and speaking the truth. Action, including precautionary action, should be based on the best information possible, with a lack of full certainty not being a sufficient reason to postpone potentially life-saving measures.¹¹ To ensure the availability of accurate and relevant information, the values of academic freedom and open scientific inquiry must also be upheld. Scientists and others who sound evidence-based warnings about potentially dangerous conditions or circumstances should do so free from the fear of prosecution.

It is clear that the world must find ways to contend more effectively with the challenge posed by the deliberate (and even the inadvertent) spread and use of false information. The responsibility of protecting freedom of information while countering the spread of disinformation requires greater responsibility on the part of social-media companies, news organizations, public officials, educators, and the news-consuming public.

4. HEALTH BEFORE PROFITS.

There is broad scope for the private sector to play a constructive role in the response to current and future pandemics. Collaboration between governments, scientists, and the private sector has been one of the primary reasons for the success in developing effective vaccines in record time.

Yet there should be some prudential limits to the protection of pharmaceutical companies’ intellectual-property rights (IPR) in the face of a global emergency. A new approach is needed toward the patent regimes; licenses; and trade-secret protocols applicable in pandemic periods.

In line with the 1995 Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), calls have already been made to waive patent protection and allow the production of biosimilar and interchangeable biological products that could bolster the supply of available COVID-19 vaccines.^{12,13} One potential modification to

the current system would be to ensure that patent and licensing arrangements are optimized to enable the most efficacious possible response to potential pandemic situations – including the needs of LMICs. Another is for the legal statutory duties of pharmaceutical companies to be more strictly enforced.

In addition, the World Health Organization (WHO) could have a larger, more formalized role in providing health-related insights to inform trade decision-making and support technology-transfer centers, like the one set up in the South Africa Consortium. Foreign manufacturers need to be incentivized to share techniques and know-how with local institutions. Business practices need to be adapted to pandemic demands, and should address any lack of transparency that could favor corporate interests at the potential expense of public health.

5. THE VALUE OF MULTILATERALISM.

Multilateral institutions were put to a stern test in the pandemic, and in many respects have been found wanting. While the world saw numerous well-intentioned efforts to bring multilateral operations to bear against COVID-19, it is nonetheless clear that a failure to revamp current multilateral rules, institutions, and processes could result – once again – in millions of lives lost.

Just as we learned that beggar-thy-neighbor responses had disastrous effects during the Great Depression, and thus were largely avoided during the 2008-2009 recession, we need to find ways to prioritize efficient and effective public-health responses within or outside the scope of national sovereignty. Regional institutions, such as the African Union's Center for Disease Control and Prevention (CDC), may provide a necessary bridge between strictly national responses and a more robust form of multilateralism.

LESSONS LEARNED

The task force has identified a series of “lessons learned” from the current pandemic, which are offered as weapons for the battle against COVID-19, and against any future pandemics. This section of the report outlines those lessons in detail.

LESSON 1: Faced with the gravest public-health crisis of our times, the multilateral system was not prepared and has largely fallen short, with consequences that will be felt for decades to come.

In spite of repeated calls by the UNSG for solidarity and cooperation to address the COVID-19 pandemic, and the many resolutions from the World Health Assembly (WHA)

and the UN General Assembly (UNGA), the response of the multilateral system has, for the most part, not lived up to the depth and magnitude of the crisis.

Although UN operations continued to respond to social, environmental, and health issues during the early days of the pandemic, the UNGA did not meet (even in a hybrid session to agree on a common UN-wide approach immediately upon the pandemic declaration), and therefore delayed the urgent integrated response necessary for the crisis. The absence of global coordination led to an almost complete collapse in supply chains for personal protective equipment (PPE), diagnostics, and other essentials in early 2020.

The UNGA, the chief deliberative body of the UN, adopted nine resolutions to address the COVID-19 pandemic and related socio-economic impacts between March 2020 and April 2021. In the UN Security Council (UNSC), two resolutions have been adopted (Annex 2). However, these resolutions do not clearly define a global roadmap, or provide guidance on how individual nations should coordinate a whole-of-government and whole-of-society global response to the pandemic. In addition, the problem of unilateral measures – such as the imposition of barriers and restrictions on international trade in medical equipment – went unaddressed.

The most comprehensive and far-reaching resolution is the Omnibus Resolution of September 11, 2020, but even this did not advance a global plan to address the pandemic, and the lack of decisive language on crucial aspects of coordinating a strong collective response makes it a very limited instrument for the provision of nation-level policy guidance in response to the pandemic. In sum, the UNGA resolutions on COVID-19 have not sufficiently promoted the multilateral response the world truly needed, and have remained in the realm of good-faith principles.

Another feature of the collective response to the pandemic has been the lack of international solidarity. This situation is most evident in the unequal access to COVID-19 vaccines. As of November 2021, a striking 75 percent of vaccines have gone to high- and upper-middle-income countries, while only 0.6 percent of doses have been administered in low-income countries (LICs).¹⁴

COVAX – jointly managed by WHO, Gavi, and the Coalition for Epidemic Preparedness Innovations (CEPI) under the Access to COVID-19 Tools Accelerator (ACT-A) – is a potentially useful instrument for improving vaccine access for LICs. However, it lacks the resources or leverage to achieve this objective in a timely way. It remains underfunded, and of the 1.4 billion doses that it aims to supply in 2021, mostly to LICs, only 4.6 percent

had been delivered as of August 2021.¹⁵

This is the result of rich countries closing bilateral deals with pharmaceutical companies at high prices in order to ensure preferential access. Such a deficit of solidarity and cooperation profoundly limits the multilateral system's capacity to overcome the present crisis.

LESSON 2: Appeals for pandemic-relief financing fell far short of targets. However, leading multilateral financial institutions did take extraordinary measures to address the COVID-19 pandemic and its socio-economic and humanitarian effects.

In March 2020, the COVID-19 Global Humanitarian Response Plan (GHRP) was launched to contain the spread of the pandemic and decrease morbidity and mortality among the most vulnerable groups, such as migrants; refugees and asylum seekers; internally displaced persons; and people in humanitarian crises and situations of conflict.¹⁶ The global call was for USD 10.31 billion in 2020 – a fraction of the domestic allocations of rich nations – of which only USD 2.48 billion was raised.¹⁶

In April 2020, the UNSG established the UN COVID-19 Response and Recovery Fund which, as part of the UN Socio-Economic Response Framework, is a UN interagency-fund mechanism for helping LMICs respond to the pandemic. A budget of USD 1 billion was established; however only USD 58 million was raised from public government donors, as the US, European countries, and other advanced economies focused primarily on their own economic-recovery packages.¹⁶

Furthermore, of the USD 13 billion requested by the UN System in 2020 to address the health, humanitarian, and socio-economic aspects of the pandemic through the GHRP, the COVID-19 Response and Recovery Fund, and the WHO Strategic Preparedness and Response Plan (SPRP), only USD 4 billion was raised for these funds, leaving a financing gap of USD 9 billion at the end of 2020.¹⁶

The International Monetary Fund (IMF) and multilateral development banks (MDBs) did not have the resources and mechanisms to provide the necessary critical emergency relief to LMICs. In August 2021, the IMF approved the equivalent of USD 650 billion in Special Drawing Rights (SDRs), and these allocations helped make liquidity available immediately. However, only some of that liquidity goes to developing countries.

Despite these shortcomings, we acknowledge that there have been several extraordinary multilateral efforts to address the financial aspects of the crisis. For its part, WHO has emphasized global financial solidarity during

the pandemic. In April 2020, it established the COVID-19 Solidarity Response Fund,¹⁷ which as of May 2021 has raised more than USD 250 million, helping to support WHO's work in combatting COVID-19 through allocations decided by the SPRP.

There have also been notable initiatives led by multilateral financial institutions themselves. For example, the World Bank announced USD 14 billion in fast-track support for COVID-19-related relief efforts on March 17, 2020, in alignment with the SPRP. The first 25 countries received approvals on April 2, and within less than 100 days, more than 105 countries had received funding for their emergency responses from the World Bank.

The World Bank also approved USD 12 billion in October 2020 for countries to buy vaccines and deliver them through their national health systems. World Bank support for COVID-19-related health, food-relief, and poverty-relief measures has thus far totaled USD 150 billion. This is among the largest and fastest crisis responses ever waged by a multilateral organization.

Additionally, regional development banks (RDBs) have played an important role in mobilizing financing for COVID-19 response. For example, the Inter-American Development Bank (IDB) mobilized USD 1 billion to help Latin American and Caribbean (LAC) countries acquire and distribute COVID-19 vaccines, and the African Development Bank (AfDB) deployed USD 10 billion to the COVID-19 Rapid Response Facility to provide flexible support for sovereign and non-sovereign operations.^{18,19}

If anything, though, these noble efforts and scattered successes only accentuate the overall lack of adequate multilateral coordination. Such alignment is essential if the multilateral system is to have a chance of addressing future emergencies more successfully.

LESSON 3: Even as individual nations were largely eschewing multilateralism in favor of their own perceived best interest, their domestic responses to the pandemic were, in many cases, dangerously insufficient. The nations that have had the most success against COVID-19 have tended to be those that already had strong universal health-care systems in place.

Regardless of any UN efforts, the final responsibility for tackling the health emergency and its socio-economic consequences was on the member states themselves.²⁰ But true coordination and solidarity have not featured prominently in most nations' response to the pandemic. Most countries took a long time to recognize the threat of COVID-19, and the world lost valuable time before the general consensus on a global pandemic was reached.

In the month following the WHO declaration of the Public Health Emergency of International Concern (PHEIC) on January 30, 2020, many countries downplayed the threat of the virus, and took a wait-and-see approach rather than enacting an aggressive containment strategy.²¹ Additionally, WHO advised countries not to ban travel, when in fact it should have encouraged countries to do precisely that. One result was a delayed response to the early stages of the pandemic – including within highly developed nations such as Italy, the UK, and the US.

As the virus emerged onto the global scene, countries with initially low infection rates underestimated the threat and limited their ambitions and priorities. Additionally, national governments had varying opinions of the threat the virus posed, and how to respond to it. They tended to underestimate real-time situational information about COVID-19, in part because in the early stages of the pandemic, the lack of test kits hid the true number of confirmed cases, and variant information could not have been recognized quickly.

For example, some national governments did not anticipate the virus spreading to or within their own borders and others simply didn't believe in its existence. National decision-makers showed significant hesitancy toward adopting measures such as lockdowns, mask mandates, and social distancing.

As COVID-19 spread around the world, few nations managed to cope successfully with it. There have been notable exceptions: Bhutan has kept the pandemic at bay in part due to a highly successful call for volunteers and additional health workers at a crucial juncture.²²

This brings us to a truth made plain by the COVID-19 experience: Even a highly responsive non-governmental organization (NGO) community or brilliantly innovative business sector cannot serve as a substitute for an effective, universally accessible system of primary health care. Such a system, supported and funded as needed by the public sector, is a common denominator of virtually all of the nations that responded most effectively to COVID-19, including New Zealand, South Korea, Finland, and Bhutan.

The approach favored by many of the most successful national anti-COVID-19 programs in the early stages of the pandemic was one of disease elimination, as opposed to the more incrementalist mitigation strategy adopted by the US, most of Europe, and many other nations. Some considered elimination a valid strategy when the means are available, this might not have been the case at the early stages of COVID-19.²³

The elimination route is not a guarantor of perfect success, as South Korea has seen with recent outbreaks there.²⁴ However, this strategy does appear, on balance, to have correlated with somewhat greater overall success in contending with the pandemic – and that success is directly attributable to the presence of strong pre-existing national health systems that offer universal care. As a US National Institutes of Health (NIH) study noted, “An elimination strategy requires highly functioning public health infrastructure.”²⁵

The value of universal health care – particularly in the context of potential pandemic – is hardly a new lesson for the world community. In October 2019, just before the disease that became known as COVID-19 went global, the UNGA adopted a resolution on the importance of universal health coverage (UHC). Paragraph 72 of the document resolved to “[p]romote strong and resilient health systems, reaching those who are vulnerable or in vulnerable situations ... ensuring pandemic preparedness and the prevention and detection of and response to any outbreak.”

A bit over a year later, as if to underscore the heightened relevance of that finding, the UN adopted a resolution titled “Global health and foreign policy: strengthening health system resilience through affordable health care for all.”

This resolution affirmed “the importance of national ownership and the primary role and responsibility of governments at all levels to determine their own path towards achieving UHC, in accordance with national contexts and priorities, which is critical for minimizing public health hazards and vulnerabilities as well as delivering effective prevention, surveillance, early warning, response and recovery in health emergencies, and emphasizing the essential role of resilient health systems in disaster risk reduction.”

The Global Health Security Agenda (GHTSA), founded in 2014 in response to a new era of pandemic threats in an age of rapidly increasing globalization, has called for national action to build local pandemic-response capacity in LICs. The GHTSA intends that by 2024, more than 100 countries that have completed evaluations of health-security capacity will have undergone planning and resource mobilization to address any identified gaps.²⁶ This would represent a meaningful step toward more universal coverage, particularly in pandemic or epidemic contexts.

However, much more is needed to ensure the kind of coverage that prepares a nation's people to face the full spectrum of potential health threats. It is this, rather than pandemic preparedness per se, that truly empowered

certain nations to experience relatively reduced negative outcomes as COVID-19 spread worldwide.

LESSON 4: Operating between the global-multilateral and the national levels, regional collaboration in Africa demonstrated the potential of cross-border action in the face of a pandemic – even in relatively resource-constrained areas.

The African Union (AU) and its continental CDC subsidiary have used an innovative model to respond to the pandemic, and it is now considered a possible example for other regional organizations. The model promotes a greater engagement of existing capacities, and focuses on local action instead of duplication of (or overreliance upon) global standards and international organizations.²⁷

Through its Africa Joint Continental Strategy for COVID-19 Outbreak, the AU – which is not part of the UN system – aimed at preventing severe illness and death from COVID-19 infection among its member states, and at minimizing social disruption and economic dislocation.

To achieve these goals, the strategy sought “to coordinate efforts of member states, AU agencies, the WHO, and other partners to ensure synergy and to minimize duplication and to promote evidence-based public health practice for surveillance, prevention, diagnosis, treatment, and control of COVID-19.”²⁸

In addition, the AU launched the COVID-19 Response Fund, which aimed to raise resources to strengthen the continental response to COVID-19 by supporting pool procurement of diagnostics and other medical commodities.

In another regional response to the pandemic, the Africa Task Force for Coronavirus (AFTCOR) was established. Promoting pan-African solidarity, the task force’s main goals are rapid detection and containment. Confirmed cases and contacts were reported through AFTCOR and policy recommendations were discussed.²⁷ Participating countries were able to mobilize and respond quickly as a result of these collaborations.

In addition, the Regional Disease Surveillance Systems Enhancement Program (REDISSE), is a World Bank-funded USD 670 million operation across 16 countries in West and Central Africa, established in 2016 after an Ebola epidemic.²⁹ It was mobilized with singular efficiency in response to the COVID-19 pandemic.^{29,30}

LESSON 5: Despite resolutions affirming WHO’s role in pandemic response, its member states failed to give it the clear mandate and authority required to fulfill that role.

Although various UN resolutions call out the “crucial,” “leading,” and “key leadership” role of WHO in responding to pandemics, COVID-19 has shown that the organization has been hampered by constraints imposed by its member states, as well as by institutional shortcomings.

For instance, WHO was not granted the power to conduct an independent investigation of the origin of COVID-19; to monitor state compliance with the 2005 International Health Regulations (IHR 2005); or to share important information for mitigating the spread of the virus.

Similarly, UNGA could have called upon WHO to establish a state-led institutional platform for the equal distribution of vaccines, diagnostics, medicines, and equipment for combating both the pandemic and other epidemics. But this didn’t happen. Nor was there any authorization or guidance to move the existing UN system’s resources around to save lives in the poorest countries, and to empower WHO action at the country level.³¹

Despite these missed opportunities, in the early months of the pandemic WHO worked with other UN agencies to deliver almost 1 billion items of PPE and diagnostics. This achievement, however, further underscores the reality that WHO could have achieved more, for more people in urgent need of assistance.

LESSON 6: NGOs and civil society organizations (CSOs) displayed remarkable resourcefulness and adaptability in filling gaps in global pandemic response.

Non-governmental organizations and foundations have played an important role in mitigating the health crisis. Several have shown impressive flexibility and aptitude in formulating and executing ambitious plans to help those in need. The world global-health community would do well to study these responses and consider how to maximize the unique strengths of NGOs and CSOs in any future pandemic.

NGOs and CSOs have shown leadership across a broad range of pandemic interventions. NGOs around the world have been at the heart of the COVID-19 emergency relief. To cite but a few of countless examples, Action Against Hunger has been providing food and essential supplies, such as medicine and PPE, to people globally.³² Doctors Without Borders has been helping build the COVID-19 health-care workforce while also maintaining non-COVID-19-related health services.

Many previously established health organizations and initiatives have shifted focus to the COVID-19 pandemic. The Global Fund to Fight AIDS, Tuberculosis, and Malaria (the Global Fund), a partnership that arose in 2000, responded to the call for help during the COVID-19 pandemic. In 2020, the Global Fund provided nearly USD 1 billion to 106 countries to reinforce COVID-19 response.³³ It also partnered with countries to reprogram up to 5 percent of their current grants towards supporting their COVID-19 responses.

The Bill & Melinda Gates Foundation provided financial support to KU Leuven in Belgium for pharmacological substance testing against COVID-19, and the Jack Ma Foundation donated 500,000 testing kits and one million masks to the US.³⁴ The flexible budget structure of these mega-foundations allowed them to redirect their resources to respond to the crisis in a manner that WHO and the UN System could not due to their budgetary and administrative structures.^{35,36}

In addition to these contributions from highly prominent global NGOs, it's worth noting that CSOs have played a crucial role in mitigating the consequences of the pandemic at the community level; donating food and primary-hygiene products; delivering educational resources; and providing much-needed social and psychological support – often in coordination with local and other subnational government entities (see Recommendation 2).

LESSON 7: Scientific collaboration – including collaboration with the business sector – has been one of the bright spots of the worldwide pandemic response.

As early as January 24, 2020, The Lancet had published a series of papers on the epidemiological characteristics of the novel coronavirus, and warned the world in a commentary written by researchers from China, the UK, and the US that “We need to be wary of the current outbreak turning into a sustained epidemic or even a pandemic.”³⁷

In the months since, the global scientific community has served as an example of successful collaboration, including through the acceleration of cross-border research.³⁸ A safe and effective vaccine was developed eight months after the declaration of the pandemic – an impressive example of collaboration between the public and private sectors.

The targeting of public and private resources, and the sensitization of global regulatory agencies to the need for careful yet rapid analyses, were crucial elements for this historic outcome. Within a few weeks of declaring

COVID-19 to be a PHEIC, WHO published a document identifying major gaps in scientific knowledge – many of which were addressed over the months that followed.

Academic institutions across the globe have participated in intensive collaborations to provide vaccines and treatments. One example is the innovative partnership between AstraZeneca/Oxford and Fiocruz on vaccine importation and production in Brazil.

The international response to the pandemic has also seen increased collaboration among research institutes in the US, the UK, China, Italy, Canada, France, Germany, Spain, the Netherlands, Switzerland, Australia, and several other nations.³⁸ Pandemic research results were frequently and publicly shared. At Oxford, vaccine researchers were able to utilize animal-testing results that were shared by the NIH's Rocky Mountain Laboratory.³⁹ Research at Massachusetts General Hospital has been carried out in cooperation with Xijing Hospital in China and two hospitals in Italy.³⁹

The international scientific community has established many information-sharing digital platforms, providing access to datasets and research findings. Some examples of these platforms include Worldometer, the Institute for Health Metrics and Evaluation (IHME), the Johns Hopkins Coronavirus Resource Center, and Our World in Data. These websites feature data visualizations of infection rates; daily and cumulative case counts; mortality rates, and more, increasing public awareness of the evolving nature of the pandemic.

No accounting of the global vaccine-development effort would be complete without acknowledging the role of private industry, often acting in collaboration with academic and governmental research institutions. In response to the pandemic, with at-risk funding guarantees from governments, AstraZeneca, BioNTech/Pfizer, Moderna, and Johnson & Johnson produced effective vaccines within an extraordinarily short time frame.

Legitimate concerns may be raised about the intellectual-property frameworks under which private industry generates vaccines; the delays in providing those vaccines to lower-income nations; and the business practices that too often place such considerations as market share, confidentiality, and pricing over equitable access to life-saving treatments at a time of urgent global need. However, it is clear that any future efforts to address those concerns must also recognize the capacity of the private sector to respond innovatively and nimbly to emergent pandemics, and their potential to rapidly accelerate the production of vaccines.

LESSON 8: The pandemic has shown, more clearly than ever before, the global health system's acute reliance on female health workers and caregivers – and their marginalization.

In most countries, the pandemic has led to praise for health and care workers – the majority of whom are women. Just how large that majority is varies from place to place; it's at least 70 percent, but in some places is upwards of 90 percent of the overall health workforce.⁴⁰

This is an issue not just of gender, but overlaps with class and ethnicity. According to a 2015 research study by the Commission on Women and Health, the poorest women in the world currently subsidize health systems with their unpaid work – a fact that has been exposed clearly by the pandemic.⁴¹

Female health and care workers face discrimination at work on a number of levels – on average they earn 28 percent less than their male colleagues.⁴² The gender pay gap in the health sector is, in reality, much higher because half the USD 3 trillion women contribute to healthcare each year is in the form of unpaid work.⁴²

Women – particularly ethnic minority, immigrant, lower-caste women, and women of lower socioeconomic status -- are also more likely to be cast into lower-status roles and under-represented in leadership. A Women in Global Health survey of 115 national COVID-19 task forces in 2020 found that 85 percent had majority-male membership.⁴³

In addition, medical services have been curtailed in ways that have affected women specifically, and which may possibly have been avoided were more women represented in medical leadership. For example, sexual and reproductive health and rights (SRHR) services were disrupted in 68 percent of the countries that responded to WHO's survey on what services had been compromised during the pandemic.⁴⁴ In addition, according to WHO, "antenatal and especially delivery care services were rarely severely disrupted, but 53 percent of countries reported partial disruptions in antenatal care services and 32 percent in facility-based birth services."⁴⁵

In collaboration with WHO and the French government, Women in Global Health launched the Gender Equal Health and Care Workforce Initiative, which is gathering commitments to drive change on leadership, pay, safety, and decent conditions for female health workers.

In a very real sense, all of this is simply a matter of health-system preparedness; WHO and the World Bank have projected the creation of 40 million new health and social-care jobs by 2030, and a need for 18 million additional

health workers, mainly in low-resource settings, "to attain high and effective coverage of the broad range of health services necessary to ensure healthy lives for all."⁴⁶

The world therefore has a vested interest in ensuring that women of all backgrounds continue to enter the field and are treated fairly without prejudice. Ensuring equality of pay, treatment, and advancement would be a prudent health-system strengthening measure and would be aligned with the WHO Global Code of Practice on the International Recruitment of Health Personnel and the core UN international human rights treaties.

LESSON 9: The "infodemic" is real – and constitutes a serious threat to public health.

The "infodemic" – the fabrication, dissemination, and specious legitimization of false or deliberately misleading information – is a prominent feature of modern society, and it has played an important, entirely negative role in shaping public responses to the pandemic.

It has jeopardized proper collaboration; deepened distrust toward vital institutions; and all too often even been deployed as a pretext for vilifying and threatening scientists and health leaders, especially those in crucial public-information roles.

The sheer abundance of information, and the way it is disseminated on social media, makes it difficult for the public at large to distinguish between evidence-based information and outright falsehoods. This makes access to high-quality journalism especially important, though in some communities the media itself is increasingly a target of disinformation, harassment, and even threats of violence.

The scientific community has made efforts to address particular problems. To confront the infodemic and the politicization of the origin of the virus, for instance, The Lancet has called for a worldwide investigation, openness, and cooperation.^{47,48} In particular, it stresses that "investigations into the origins of SARS-CoV-2 should be carried out by scientists on the basis of science alone, without interference or coercion from political forces."⁴⁷

There have also been some multilateral and governmental efforts along the same lines, though it is difficult to gauge their impact. In a bid to parry misinformation in the media and in social networks, the UNSG launched the "Verified" campaign, showcasing authoritative information on the pandemic.¹⁶

For its part, WHO established an information network for epidemics for COVID-19.⁴⁹ This network, known as EPI-WIN, provides information and issues updates as

epidemics unfold, debunking myths that emerge on social media and other sources.

WHO's Independent Oversight and Advisory Committee (IOAC) points out that risk communication is not consistently treated as an essential component of epidemic management, despite its critical importance, and is consequently underfunded.

The IOAC also expressed deep concern regarding the high level of toxicity and incivility on social media against WHO and its staff members: "The Committee strongly condemns personal attacks against the Director-General and WHO staff members and warns that toxic messages can distort public opinion on WHO and public health measures and divert staff attention and resources away from more urgent tasks in the midst of a pandemic."

As information technologies continue to become more ubiquitous and immersive, it will be vital for governments, health agencies, media organizations, and technology companies to recognize the harm that such campaigns can do, especially in times of pandemic or other major health crises.

The ideal time to prepare for such circumstances is well before they actually occur. As more national governments introduce legislation on social media, this is an opportune time for them to consider the consequences of health misinformation, and to include regulatory provisions to address it. It is also a good time to increase both the risk communication capacity at all levels and to implement the principles of open science.^{50,51} Both may be complementary actions to the law as counter-measures and eventual neutralizers of fake news.

RECOMMENDATIONS

Drawing from the lessons laid out in the previous section, the task force provides the following recommendations to strengthen government and diplomatic responses to COVID-19 – and to future pandemics:

RECOMMENDATION 1: The global nature of the pandemic calls for a global policy response and strategy based on cooperation and coordination, led by an effective multilateral system.

Global crises cannot be left in the hands of individual nations. Pathogens cross national borders, greenhouse gases emitted by one country affect the climate in all countries, and every economy depends on resilient global supply chains. This high degree of interdependence requires a shared global strategy.

The multilateral system needs the instruments and tools to manage global public goods and services, and the system should be well-equipped to do so. While the private pharmaceutical sector has justly received praise for its inventiveness and skill in generating highly innovative vaccines, it should also be remembered that public-sector action was crucial in encouraging businesses to move ahead with this research; without the at-risk funding guarantees from governments, companies would not have moved forward as swiftly as they did with next-generation vaccines to counter a wholly new and still somewhat unpredictable disease.

Government policy, then, is crucial to establishing effective responses to a pandemic – and when the threat is inherently international, effective government action must have a strong multilateral component. This was not the case in early responses to COVID-19, in which the US, Europe, and other powerful actors focused primarily on addressing the emergent outbreaks within their own national borders or continental systems, rather than demonstrating the political will necessary to implement a truly multilateral response.

A more robust commitment to the multilateralist system – which along with the UN includes the Bretton Woods institutions, international financial institutions, and regional organizations – is essential if the world is to respond more successfully to future pandemics.

Recommendation 1.1: Provide the UN the resources it needs to act effectively in response to public-health crises.

In spite of the repeated calls by the UNSG for solidarity and cooperation to address the COVID-19 pandemic, and the many resolutions that have emanated from the WHA, UNGA, and UNSC, the UN multilateral system was not equipped nor empowered to live up to the depth and magnitude of the crisis. While there have been significant efforts to use multilateral instruments such as the ACT-A to address the crisis, global coordination has been notably lacking.

The UN's ongoing reform efforts aim to reposition it as an entity that member states invest in and rely on, particularly in times of crisis.⁵² If the UN is to be an effective participant in global health – and particularly in emergency responses to global pandemics – the organization does need to be strengthened in some fundamental ways. The UN needs to establish adequate contingency-planning mechanisms to enable operations during a pandemic or other lockdown scenario. See Annex 3 for additional steps the UN could – and should – take to better address emergencies of this magnitude.

To attain an effective coordinating role, the UN should work together with other high-level coordinating mechanisms, such as the G20 and G7, and engage their support for mobilizing the massive financing needed to address global crises. It should be equipped to mobilize more funding for crisis response, similar to UN peacekeeping.

The UN should heed the G7 leaders' call to "strengthen and formalize coordination arrangements among the WHO, the UN and other relevant partners in global public health emergencies, while strengthening existing coordination systems including the Inter Agency Standing Committee (IASC) Cluster System led by [the Office for the Coordination of Humanitarian Affairs]."⁵³⁻⁵⁵

There is also a need for a contingency coordination mechanism between the UN and international financial institutions that can be activated in situations of global crises. The Emergency Platform proposed by the UNGA in his last report, *Our Common Agenda*, represents a step in the right direction.

Recommendation 1.2: Empower WHO to swiftly identify and counter incipient pandemics and address global-health issues.

COVID-19 has starkly illuminated both the urgent necessity of a fully functional WHO and the ground that must be covered before the organization is capable of reliably operating at such a level – even after the mid-2017 unveiling of reforms intended to make the organization more "fit for purpose." In particular, the WHO needs an operational plan to carry out its swift-response function, through a well-supported mechanism of alerts and protocols for information and communication regarding potential outbreaks.

WHO should be definitely identified as the authoritative source of health information to other multilateral bodies, financial institutions, and member states. It could establish an institutional platform to ensure equitable distribution of vaccines, diagnostics, medicines, and equipment for combating pandemics and epidemics. In this way, political, economic, and health-system decisions would be grounded in authoritative health information from relevant experts.

The WHA should give the WHO the power to investigate viruses and other microbes with pandemic potential, including short-notice access to relevant sites, provision of samples, and standing multi-entry visas for international epidemic experts visiting outbreak locations.²¹ Future declarations of a PHEIC should be based on the precautionary principle where warranted (as in the case of respiratory pathogens), and on clear,

objective, and published criteria.²¹

The WHO's health-system surveillance capacity should also be strengthened, and its periodic assessments of countries' pandemic preparedness should contribute to the preparedness evaluations conducted by the IMF, MDBs, and the Voluntary National Reviews that countries present at the UN Economic and Social Council (ECOSOC) on progress towards the implementation of the SDGs. The Universal Periodic Reviews on Health Systems and Preparedness policy recommended by the "Our Common Agenda" report provides a sound starting point.⁵⁶

WHO country offices should be equipped to support national governments' requests for pandemic preparedness and response assistance, of which a critical component is building resilient, equitable, and accessible health systems that promote primary care, UHC, and healthier populations.²¹

Strengthening national health systems and supporting collaboration between national health systems and WHO country and regional offices will improve global progress on achieving SDG 3: Good Health and Wellbeing – not only because it will support pandemic preparedness, but because it will help identify gaps and bottlenecks in nations' health-care policies and mobilize financing to address them.

Recommendation 1.3: Learn practical lessons from a success story – the ongoing global campaign against influenza.

Policymakers and researchers would do well to recognize the relative effectiveness of the global influenza preparedness-and-response system, and take it into account for any redesign of current COVID-19 strategies, or for the planning of a future pandemic-control architecture.

There's much to recommend from influenza programs worldwide. These include highly sophisticated genetic-sequencing and lab-exchange arrangements, as well as the equitable sharing of benefits of biologically diverse material through the UN Biodiversity Convention's *Nagoya Protocol*.

The Global Action Plan for Influenza Vaccines (GAP), including enhanced research and development (R&D) for better vaccines and expansion of production capacity across LMICs, provides a model for the development and equitable distribution of vaccines.

Additionally, there is an elaborate global system of separate but interrelated agreements and programs, such as the Pandemic Influenza Preparedness Framework

(PIP), Standard Material Transfer Agreement-2 (SMTA2), Global Influenza and Surveillance and Response System (GISRS), Influenza Virus Traceability Mechanism (IVTM) and the Vaccine Manufacturers Supply Task Force (IFPMA IVS), which ensures the early production of vaccines in sufficient quantity to meet anticipated global needs.

Most of these global arrangements for influenza response work reasonably well around the world. They provide potential models for efforts to halt and contain other pandemics, including COVID-19. But they also provide hopeful evidence of our ability to cooperate effectively in blunting and containing a potentially lethal virus.

Recommendation 1.4: Strengthen regional health organizations to adequately fulfill their role as facilitators between global and national systems.

In recent years, regional organizations such as the Association of Southeast Asian Nations (ASEAN) and WHO's six regional offices have become meaningful participants in a range of global-health initiatives. But while these entities could, in theory, produce more viable and effective responses to pandemics than any top-down global effort could muster, in practice this is not the case (as noted in the Lessons section, Africa represents at least a partial exception to this finding, as well as a salutary example to other regions worldwide).

In order to fulfill this potential, these organizations would need very significant strengthening and likely structural repositioning in terms of ownership; legal authority to intervene at national and local levels in their member states; enhanced managerial and technical capacity; long-term funding and budget security; and, ultimately, shared or joint political power.

One example of a change in this direction would be to significantly reposition the regional organizations vis-à-vis their member national governments. Currently, regional health organizations work primarily, if not exclusively, through national ministries of health. But in a pandemic, this relationship – while surely important – isn't enough.

To act meaningfully in response to such a crisis, the regional organization would need robust engagement structures not only with the ministry of health, but also with other ministries such as social affairs, defense, finance, and interior, which often take on heightened responsibility and importance in times of crisis.

Another potential strategy for strengthening regional pandemic response would be to encourage Regional Development Banks – such as the African Development Bank (AfDB), Islamic Development Bank (IsDB),

Interamerican Development Bank (IDB), and Asian Development Bank (ADB) to assume a more prominent role, in close coordination with WHO regional offices.

Currently, none of these have distinct pandemic responsibilities. In the wake of COVID-19, the RDBs could well be envisaged to play a more significant role in creating finance modalities that would integrate essential pandemic preparedness and responses interdependently across countries and institutions. There have been some intriguing successes involving such a model, such as the Pan American Health Organization (PAHO) Revolving Fund, which has provided vaccines across several countries in Latin America and the Caribbean.⁵⁷

RECOMMENDATION 2: Build on effective local pandemic-preparedness measures and infectious-disease interventions, reinforcing investment in localized, bottom-up approaches – while balancing the need for effective central regulatory oversight.

National, subnational, and local health systems are key pillars of effective global pandemic preparedness and response system. A global strategy to address pandemics should be informed and reinforced by successful bottom-up pandemic response. Local and subnational (that is, state, provincial, and departmental) authorities have been at the front lines of the pandemic, often responding with creativity and determination to the challenge of providing health care and ensuring the supply of vital goods and services.

The United Cities and Local Governments (UCLG) *Cities For Global Health Initiative* has compiled numerous examples of such local and subnational leadership. Belo Horizonte, Brazil, has instituted several innovative policies, including the installation of public hand-washing sinks at key pedestrian locations. Incheon, South Korea, developed a 24-hour hotline to assist residents suffering from anxiety, depression, and other mental illness during the pandemic.

In addressing COVID-19, a localized, bottom-up approach has proved to be important, if sometimes underestimated. Some evidence suggests that even relatively underfunded bottom-up local efforts performed well, leading governments to rethink their centralized approach.^{58,59}

This was hardly the first time that a top-down campaign ceded ground to a more bottom-up approach. The fight against onchocerciasis (river blindness), was initially led by World Bank President Robert McNamara and Merck. However, over time this centralized strategy has gradually given way. In Uganda, the distribution of treatments has shifted since 2014 to the community level, where

local women ensure that everyone in the circle of their family and friends received river-blindness information and medication. Another, more general, example of the power of localized approaches is the community health workers' program in Ethiopia.⁶⁰

WHO recommends that national governments spend an additional 1 percent of GDP or more on health to achieve UHC and consequently be better prepared for future pandemics. For LMICs, there is an urgent need for international financial institutions to complement domestic investment and to rapidly scale up assistance when a pandemic is triggered.^{61,62}

We recommend considering the establishment of a funding mechanism with a clear mandate for health-system strengthening, which includes investment that supports public-health systems; health-care access; and supply-chain resilience.

RECOMMENDATION 3: Improve international regulatory mechanisms to expedite the evaluation and approval of safe and effective diagnostics, drugs, and vaccines.

The glaring inconsistencies among the world's health-regulation bodies have been highly damaging to an effective pandemic response, be it with regard to vaccines, PPE, diagnostics, or therapeutics. This approval chaos is still continuing. There is a clear need to establish effective global-health regulatory mechanisms that both address concerns about inconsistencies and enable more rapid response.

There is also an urgent need for improvement in infrastructure and processes for validating diagnostics, therapeutics, and vaccines. Throughout the pandemic, a lack of access to clinical materials caused delays in developing and testing potential solutions. The completion of randomized clinical trials was also delayed as case numbers waxed and waned from one location to another, and new variants emerged.

One way to address such problems could be the establishment of an International Health Regulatory Agency, under whose auspices independent scientists would produce protocols, guidance, and oversight in emergency situations. This agency would, among other tasks, establish standardized international approval for vaccines and treatment. It could collaborate with the various national or regional health-regulatory agencies, or have them as constituent members.

An international regulatory agency – operating under WHO and dedicated to enabling international clinical trials – would reduce morbidity and mortality by

expediting the approval, manufacturing, and distribution of rigorously proven assays, drugs, and vaccines. This agency would also facilitate the vetting of potential pharmaceutical therapeutics and the identification of false panaceas like hydroxychloroquine and ivermectin – the promotion of which has led to large investments that wasted resources; undermined confidence in public-health authorities; and raised public hopes about the efficacy of “treatments” that in reality were ineffective and potentially toxic.

An alternative means of establishing a new global authority could be to focus upon strengthening already-existent organizations that have similar mandates. Examples of such bodies include the International Coalition of Medicines Regulatory Authorities (ICMRA).⁶³ Alternatively, an assembly or council of global regulatory agencies, as well as national and regional regulatory bodies, could be formed through WHO.

Still another possibility would be to propose a Joint Special Programme, along the lines of such successful past precedents as the Special Programme for Research & Training for Tropical Diseases (TDR) and the UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP).

Such an entity, supported by the UN and its agencies, could be structured around three functions: pharmaceutical and medical-product development and approval; epidemiological surveillance and pathogen identification; and the facilitation of research, development, and innovation. Each of these functions would support better coordination across national agencies such as the US Food and Drug Administration (FDA), CDC, and NIH.

Even without such entities as the ones outlined above, governments could agree on a greatly enhanced collaboration among existing national and regional regulatory bodies, compelling governments to ensure that their national agencies cooperate more actively with their foreign colleagues, with express provision for incorporating the participation of health officials from LMICs.

In addition, a continuous surveillance of potentially dangerous pathogens in known risk areas around the world would significantly benefit from frequent (ideally daily) collaboration among the world's CDCs. As a start, the four current CDCs (US, European Union, China, and Africa) as well as Ministries of Health with similar mandates should be encouraged to create a joint epidemiological and scientific-surveillance system.

Such a system would not be globally comprehensive, as it would leave regional blank spots across Latin America and the bulk of Asia (a reality that argues in favor of a new global CDC-like body with the authority to serve such areas). Over time, research institutes or national agencies in these areas may fill the gaps. However, the lack of universal coverage today should not serve as a pretext for delaying necessary collaboration among the CDCs that presently exist.

RECOMMENDATION 4: Reform the intellectual-property regime governing access to vaccines and other technologies central to the prevention and elimination of pandemic threats.

There is an urgent need to adapt and reform the current intellectual-property system for a world that is prone to new and recurring epidemics and pandemics. Pharmaceutical companies have broken profit records during this period, but the discussions of the true price and cost of innovation have been insufficient.⁶⁴ This is hardly a situation arising anew with COVID-19; a full five years ago, a report by The Lancet Commission on Essential Medicines Policies included the following passage:

“The Lancet Commission on Essential Medicines Policies rightfully addresses the need to guarantee access to essential medicines for all. However, we cannot achieve any real progress without acknowledging that the current patent-based business model and the way we apply international patent rules need to change. The system is broken.”

And broken it remains, even amid the extraordinary human toll of COVID-19. The only medicine or vaccine that benefits patients is one that they actually have access to. However, the broad standards of the current intellectual-property regime, from the World Intellectual Property Organization (WIPO) to the World Trade Organization (WTO), have deepened the technological dependence of LMICs, and led to millions of lives lost due to lack of access to medicines, vaccines, and diagnostics.

By now, it is clear that the TRIPS Agreement has failed to respond effectively to the greatest public-health crisis of our generation. It is urgent to remove essential medicines and health technologies from the scope of that accord. Stimulating innovation in the field of essential health goods must be done with a view toward radically expanding access; reducing prices; and creating collaborative and open-source research environments.

RECOMMENDATION 5: Explore options to better address global crises, including the development of a Global Health Convention.

Recommendation 5.1: Consider the Development of a Global Health Convention.

The G20, the Independent Panel for Pandemic Preparedness and Response and several policy think tanks are advocating for the potential development of a new international treaty on the prevention and management of pandemics. For example, the Pan European Commission on Health and Sustainable Development has called for a global pandemic treaty that entails inventive mechanisms for encouraging governments to pool some sovereign policy-making functions.^{21,56}

In a similar vein, the Independent Panel report COVID-19: Make it the Last Pandemic calls for a senior Global Health Threats Council led by heads of state and government, as well as a Pandemic Framework Convention to address gaps in the international response, a pandemic treaty, and a routine pandemic preparedness assessment conducted by the IMF and the World Bank.

Similarly, the G20 has sought the establishment of a Global Health Threats Board to ensure sustainable financing for pandemic preparedness and response, as well as a multilateral Global Health Threats Fund that would mobilize USD 10 billion yearly, and serve to catalyze financing for the broader global-health system.⁶²

For its part, The Lancet published in May 2021 a call for a global public-health convention for the 21st century in response to the health-coverage gaps that COVID-19 had so ruthlessly exposed worldwide:

“Although the International Health Regulations provide a framework of binding legal obligations for pandemic prevention, preparedness, and response, many countries do not comply with these regulations. There is a need for a renewed framework for global collective action that ensures conformity with international regulations and promotes effective prevention and response to pandemic infectious diseases.”

While led by public-sector health entities, a global public health convention would require inputs from – and collaboration with – a wide range of private-sector entities, such as the medical-technology, pharmaceutical, and health-care industries; agriculture and food companies; travel and transportation companies; scientific-research organizations; CSOs and NGOs; and women’s advocacy groups. Financial institutions both public and private – including treasuries and central banks; the IMF and RDBs;

major insurance companies; investment-management firms; and sovereign-wealth funds – should also be included in consultations.

Such a convention would require safeguards for conflicts of interest, but could represent a valuable opportunity to further strengthen frameworks for the gathering and sharing of data, research, and other scientific knowledge – not only in the crucial field of vaccine development, but also in findings from social science and the humanities in such fields as trauma psychology; group and community dynamics; the socio-economic impacts of pandemics; the effects of disinformation; and other areas of potential relevance. It would facilitate collective action and multisectoral collaboration, and also guide governments on pandemic preparedness and response.

Recommendation 5.2: Enhance scientific collaboration and improve the science-policy nexus to systematically address pandemic risks.

Scientific collaboration has been one of the bright spots of the global pandemic response. Without basic research and established networks of trust, we would not have been able to understand and react to this crisis as rapidly as we did. Blue-sky research needs to receive adequate attention, and scientific values need to be supported globally.

Mechanisms to sustain and expand scientific collaboration should be further enhanced, drawing from the experience of the Intergovernmental Panel on Climate Change (IPCC), and prioritize transparency and trust.^{65,66} The establishment of the WHO's new Hub for Pandemic and Epidemic Intelligence is a meaningful step in this direction.⁶⁷

Recommendation 5.3: Explore institutional options at the UN to address pandemics and other non-military crises at the highest level of decision-making, with enforceable mandates similar to those of the UNSC.

The risks posed by pandemics and other global-health crises – including natural disasters and the accelerating impacts of climate change – are inherently uncertain in their effects, and largely unknowable in their timing. These risks can, however, be mitigated through concerted, collaborative effort.

Unfortunately, the UN system lacks an operational body that can effectively deliberate and act on non-military global threats. Whether it is responding to a pandemic, climate change, or food insecurity, there is no equivalent body to the UNSC with the authority to enact a large-scale collective response to these crises.

Such threats are becoming ever more prominent in our globalized world, and jeopardize the well-being of individuals and communities everywhere. The term “human security” is an accepted part of the UN vocabulary, and is used to describe those threats that do not fit into the traditional peace and security definitions,⁶⁸ including threats to economic security; health security; food security; livelihood security; and climate and environmental security.

We recommend that an institutional mechanism such as a UN Global Resilience Council be considered to deal with such “soft” or “human” security threats.⁶⁹ This body could function at the level of heads of state or government to meaningfully create whole-of-government approaches to these complex challenges. This is the only level at which action can be taken across all sectors to confront today's interconnected global risks. Only at this level could all the relevant UN system agencies and similar intergovernmental organizations be effectively brought to bear.

The council could have a variety of tools available to address global crises, such as directing intergovernmental financial, trade, and monetary bodies to consider innovative financial mechanisms and accountability measures.

The proposed Repurposing of the Trusteeship Council policy contained in the Our Common Agenda report could be an interesting avenue to advance the idea of non-military threats to human security, and the best mechanisms for addressing them.

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ANNEX 1

LOCAL AND REGIONAL GOVERNMENT RESPONSES TO THE COVID-19 PANDEMIC.¹

a. Housing and stay-at-home policies

Local and regional governments have worked to ensure that stay-at-home policies did not exacerbate existing vulnerabilities. Barcelona, for example, housed people at risk of homelessness in the city's empty housing units, and developed partnerships with the private sector to identify and occupy vacant housing.

Vienna worked early on to ensure that confinement and mandatory stay-at-home regulations did not severely impact mental health, by developing psychosocial assistance initiatives. The Cocody commune of Abidjan, Cote d'Ivoire, has launched initiatives to deliver fresh groceries to many communities that could no longer preserve food at home.

Digital technologies and local media have been essential for local and regional governments in helping to keep individuals and families afloat beyond the outbreak. Culture has been critical to maintaining people's well-being, and will need to be protected and fostered, with special attention paid to the continued economic sustenance of cultural workers.

Novosibirsk, Russia, developed the "museum quarantine" project, which made the projects of the Novosibirsk City Museum available online. Buenos Aires and Mexico City jointly engaged in the "*cultura en casa*" (culture at home) initiative, to coordinate joint cultural initiatives that could be broadcast to people's homes. The city of Xi'an, China, made online education available in all schools early on, and ensured that even kindergarten students are able to continue learning from home.

b. Maintaining public services

Local and regional governments have been critical to ensuring that public transport continued to work in the midst of the pandemic, and carried out measures to ensure communities could travel safely. Increasing access to information on the status of the subway or bus services, as well as consistently disinfecting public transport, has been a priority of several cities, such as Banjul, Gambia. Kigali, Rwanda, has carried out measures to ensure safe and equal access to public transport for people who need to use it to get to work, and to allow all

members of society to feel safe aboard public transport.

c. Addressing gender-based violence

Cities have also come together to deliver measures that would protect women from the unintended effects of lockdowns in which they were now more vulnerable to domestic abuse. To curb gender-based violence, Quito, Ecuador, has engaged in strategies to ensure it reaches vulnerable women, including to curb psychological and patrimonial violence. Iriga, in the Philippines, has worked to harness the solidarity aspect of the outbreak to tear down barriers and strengthen social acceptance of gender equality.

d. Support to informal workers

Cities have provided access to water, food, and health materials for vulnerable populations and informal workers to ensure that staying at home is a viable possibility for them. Freetown, Sierra Leone, developed rainwater-harvesting systems to ensure the poor could have access to water and sanitation in the midst of the pandemic. Subang Jaya, Malaysia, coordinated food donations and delivery for informal workers. It also disinfected markets and ensured hygienic measures were in place for food handlers.

ANNEX 2

DESCRIPTION OF THE MOST RELEVANT UN RESOLUTIONS ADOPTED BETWEEN OCTOBER 2019 AND APRIL 2021 TO ADDRESS UHC AND THE COVID-19 PANDEMIC.

Resolution A/RES/74/2 "Political declaration of the high-level meeting on universal health coverage," 10 October 2019

This resolution called upon member states to optimize budgetary allocations on health, sufficiently broaden fiscal space, and prioritize health in public spending, with a focus on achieving universal health coverage while ensuring fiscal sustainability. It encouraged countries to review whether public-health expenditure is adequate to ensure both sufficiency and efficiency of public spending on health and, based on such review, to adequately increase public spending, as necessary, with a special emphasis on primary health care, in accordance with national contexts and priorities, noting the WHO-recommended target of an additional 1 per cent of gross domestic product or more.

¹ We acknowledge the written contribution provided by UCLG, United Cities and Local Governments on good practices and success stories.

Resolution A/RES/74/270 “Global solidarity to fight the coronavirus disease 2019 (COVID-19),” 2 April 2020

This resolution called for intensified international cooperation to contain, mitigate, and defeat the pandemic, including by exchanging information, scientific knowledge, and best practices, and by applying the relevant guidelines recommended by WHO. It also called for the UNSG to mobilize a coordinated global response to the pandemic and its adverse social, economic, and financial impacts.

Resolution A/RES/74/274 “International cooperation to ensure global access to medicines, vaccines, and medical equipment to face COVID-19,” 20 April 2020

This resolution requested that the UNSG collaborate with WHO and other UN agencies, and that international financial institutions identify and recommend options to rapidly increase manufacturing and strengthen supply chains for ensuring global access to medicines, vaccines, and medical equipment to face COVID-19, especially in developing countries.

It also encouraged the formation of public-private partnerships to increase R&D funding for vaccines and medicines; and the strengthening of international scientific cooperation for the rapid development, manufacturing, and distribution of diagnostics, antiviral medicines, PPE, and vaccines. It also called upon states to fight speculation and undue stockpiling.

Finally, it called upon the UNSG to establish an inter-agency taskforce in collaboration with WHO to coordinate efforts to ensure global access to medicines, vaccines, and medical equipment.

Resolution S/RES/2532, “Maintenance of international peace and security” (global cease-fire resolution), 1 July 2020

Through this resolution, the UNSC recognized that the unprecedented extent of the COVID-19 pandemic is likely to endanger the maintenance of international peace and security, and therefore demanded a general and immediate cessation of hostilities in all situations on its agenda, supporting the efforts undertaken by the UNSG and his special representatives and special envoys in that respect, and called upon all parties to armed conflicts to engage immediately in a durable humanitarian pause for at least 90 consecutive days, in order to enable the safe, unhindered, and sustained delivery of humanitarian assistance.

The resolution requested the UNSG to help ensure that

all relevant parts of the United Nations system accelerate their response to the COVID-19 pandemic, with a particular emphasis on countries in need, including those in situations of armed conflict or affected by humanitarian crises. It also requested the UNSG to instruct peace-keeping operations to provide support, within their mandates and capacities, to host-country authorities in their efforts to contain the pandemic.

Finally, it called for concrete actions to minimize the impact of the pandemic on women and girls and ensure the full, equal, and meaningful participation of women and youth in the development and implementation of an adequate and sustainable response to the pandemic.

Resolution A/RES/74/306 “Comprehensive and coordinated response to the coronavirus disease (COVID-19) pandemic,” 11 September 2020

This resolution recognized the obligation of states under the UN Charter to cooperate with one another, as well as the right of every human being – without distinction of any kind – to the enjoyment of the highest attainable standard of physical and mental health.

It also emphasized the obligations of states to ensure that all human rights are respected, protected, and fulfilled while combating the pandemic, and that their responses to the COVID-19 pandemic are in full compliance with their obligations under international law.

In its operative part, the resolution called for intensified international cooperation and solidarity to contain, mitigate, and overcome the pandemic and its consequences through responses that are people-centered, gender-responsive, and fully respectful of human rights.

It called on states to put in place a whole-of-government and whole-of-society response, outlining both immediate and long-term actions, with a view to sustainably strengthening their health and social-care systems, as well as preparedness and response capacities. It also called on states to maintain the continued functioning of the health system and the strengthening of primary health care, and the uninterrupted and safe provision of population-level and individual-level basic services.

The resolution also included a gender perspective by exhorting states to ensure the right of women and girls to the enjoyment of the highest attainable standard of health, including sexual and reproductive health, along with reproductive rights.

Furthermore, the resolution recognized the role of immunization against COVID-19 as a global public

good, and urged states to enable all countries to have unhindered, timely access to safe, efficacious, and affordable diagnoses, therapeutics, medicines, and vaccines.

It encouraged states to work in partnership with relevant stakeholders to increase R&D funding for vaccines and medicines; leverage digital technologies; and strengthen scientific international cooperation to combat COVID-19. It also encouraged states to support the Access to COVID-19 Tools Accelerator (ACT-A).

Importantly, the resolution urged states to refrain from promulgating and applying any unilateral economic, financial, or trade measures not in accordance with international law. It also called on states to ensure protection for those most affected, including women, children, youth, persons with disabilities, people living with HIV/AIDS, older persons, indigenous peoples, refugees, internally displaced persons, migrants, and other marginalized segments of the population. It also called for measures to recognize, reduce, and redistribute women's and girls' disproportionate share of unpaid care and domestic work.

It sought the enactment of policies necessary to address the economic crisis and minimize the negative effects on livelihoods, urging donors and other stakeholders to support countries that lack the capacity to implement such measures, especially in least-developed countries, landlocked developing countries, and small-island developing states, as well as in other LMICs.

It called upon member states to reaffirm the critical importance of connected global supply chains in ensuring the unimpeded flow of vital medical and food supplies and other essential goods and services across borders. It also emphasized the need to strengthen development cooperation and to increase access to concessional finance, but without any clear mandate. It called upon states and international financial institutions to provide more liquidity in the financial system and examine the use of SDRs.

It also urged states to develop recovery plans that promote sustainable development, and to drive transformative change towards more inclusive and just societies. It asked states to adopt a climate-responsive and environment-responsive approach to COVID-19 recovery efforts, including by aligning investments and domestic policies with the 2030 Agenda for Sustainable Development and the Paris Agreement.

The resolution encouraged the United Nations development system and UN country teams to support responses to the pandemic and its consequences based

on countries' program needs and priorities, including by building on the United Nations Framework for the Immediate Socioeconomic Response to COVID-19, and helping to develop preparedness capacities to prevent, detect, and respond to ongoing and future public-health threats. It also urged the strengthening of international cooperation at all levels, including North-South, South-South, and triangular cooperation.

Resolution A/RES/74/307 "United response against global health threats: combating COVID-19," 11 September 2020

This resolution called for the first time for implementing the International Health Regulations (IHR 2005), and for intensified international cooperation and multilateral efforts in handling disease outbreaks. It emphasized the need for the UN system – as well as relevant regional and international organizations and financial institutions – to collaborate in order to ensure that the adverse social, economic, humanitarian, and financial impacts of COVID-19 are addressed.

It stressed the need for engaging with front-line international organizations – notably the United Nations, WHO, the IMF, the World Bank, and regional development banks – to deploy robust, coherent, coordinated, and rapid financial packages to strengthen financial safety nets.

The resolution also reaffirmed the necessity to support economies; protect workers; sustain small and medium-sized businesses; and shield the vulnerable through adequate social protection. It highlighted the need to address risks of debt vulnerabilities in developing countries, including least-developed countries, landlocked developing countries, and small-island developing states.

Resolution A/RES/75/130 "Global health and foreign policy: strengthening health system resilience through affordable health care for all," 14 December 2020

This resolution affirmed "the importance of national ownership and the primary role and responsibility of governments at all levels to determine their own path towards achieving universal health coverage, in accordance with national contexts and priorities, which is critical for minimizing public health hazards and vulnerabilities as well as delivering effective prevention, surveillance, early warning, response and recovery in health emergencies, and emphasizing the essential role of resilient health systems in disaster risk reduction."

Resolution A/RES/75/156 “Strengthening national and international rapid response to the impact of the coronavirus disease (COVID-19) on women and girls,” 16 December 2020

This resolution emphasized the need to ensure meaningful engagement with civil society in protecting the human rights and fundamental freedoms of all women and girls during the response to, and recovery from, the COVID-19 pandemic.

It also called upon states to identify and seize opportunities to promote gender equality and women’s economic empowerment, and urged states to prevent, respond to, and eliminate sexual and gender-based violence, in particular domestic violence.

The resolution also called attention to threats arising in digital contexts; harmful practices such as child marriage, forced marriage and female genital mutilations; and human trafficking. It called for increasing emergency helplines, shelters, and awareness-raising campaigns.

Finally, the resolution also called upon states to ensure that girls are protected and supported in returning to school; to take the appropriate measures in order to ensure the availability of learning materials and remote-learning platforms during the pandemic; and to bridge the digital divide in order to provide distance-learning opportunities.

Resolution S/RES/2565, “Increased Global Cooperation to Facilitate COVID-19 Vaccine Access in Conflict Areas,” 26 February 2021

The UNSC called for strengthened international cooperation to facilitate equitable and affordable access to COVID-19 vaccines in armed conflict and post-conflict situations, and during complex humanitarian emergencies.

The resolution recognized the role of extensive immunization against COVID-19 as a global public good for health, and stressed the need to develop international partnerships, particularly to enhance manufacturing and distribution capabilities, in recognition of differing national contexts.

It also requested that the UNSG provide a full assessment of the COVID-19 response, including vaccination programs, in situations of armed conflict and complex humanitarian emergencies.

Finally, it emphasized the urgent need for solidarity, equity, and efficacy, inviting donation of vaccine doses from developed economies and all those in a position to

do so to LMICs and other countries in need, particularly through the COVAX Facility.

**ANNEX 3
WHAT COULD THE UN HAVE DONE TO RESPOND TO COVID-19?²**

The UN system could have responded to the WHO COVID-19 pandemic announcement quite differently. The failure to do so was – and is – both a failure of imagination and a failure to use the tools of multilateralism to confront major governments and the international business sector. This note portrays how the flow of activities could have occurred at UN level.

Initial Actions

The Director General of the WHO (the DG) briefs the UNSG and the President of the General Assembly (the PGA).

The UNSG could have taken five immediate steps, all within his current authority:

1. Invited all the UN System Chief Executives Board of Coordination (CEB) heads to attend an emergency meeting to be briefed firsthand by the DG of WHO (the internal UN-system response – see Step A below);
2. Sent a *note verbal* to the heads of state and heads of government (HOS/HOG) reinforcing the DG’s message to the international community (the whole-of-government response – see Step B below);
3. Co-signed an emergency financial appeal to governments to provide WHO with the resources necessary to address the crisis, and convened a joint WHO-UN meeting to appraise the resources needed to meet the global humanitarian consequences of the crisis (the funding response – see Step C below);
4. Convened with WHO the heads of public-media offices in the UN system to develop a common integrated educational and communication strategy (the crisis-outreach response – see Step D below); and
5. Sought emergency authority from the General Assembly for the Economic and Social Council (ECOSOC) to act as a temporary equivalent to the UNSC for this non-military global crisis, and for the UN to require member states to provide an extraordinary

² Prepared by Harris Gleckman, board member at Foundation for Global Governance and Sustainability (FOGGS)

increase in the regular budget obligations to underwrite crisis response (the emergency-authority response – see Step E below)

The PGA could have taken an innovative intergovernmental step, one which is also within his current authority:

1. Convened a meeting of the presidents and chairs of the Charter Bodies, regional intergovernmental bodies, and relevant parties of international conventions to provide them the relevant knowledge and seek their organizations' engagement in responding to the crisis (the presidents and chairs response – see Step F below).

STEP A: THE INTERNAL UN-SYSTEM TRACK

The DG could have shared the conclusions and projections of WHO experts with the UN CEB heads. As such a crisis impacts a cross-cutting range of UN responsibilities, the CEB heads could have asked to discuss the crisis with the chairs of their governing bodies, with a view to putting the issue on the agenda of the next executive board or annual intergovernmental meeting, and to examine their existing internal organizational resources that could be called upon to address the causative or consequential impacts of the crisis.

As soon as possible afterwards, the CEB heads could have briefed the WHO DG on the results of the intergovernmental and secretariat assessments of the impact of the crisis and, if necessary, requested from WHO additional health-related information on the potential impacts of the crisis.

The CEB could have established expert-level working groups involving, as appropriate, non-state actors and specialized national health agencies to (a) prepare an assessment of the needs and current inventories of related medical supplies and technologies, drawing on the country resident representatives; (b) formulate emergency market-disclosure standards; (c) propose globally oriented priorities for vaccine distribution, taking into account high-risk populations, irrespective of ethnic, national, gender, and class considerations; and (d) develop international transportation, travel, and customs recommendations jointly with the International Civil Aviation Organization (ICAO), International Maritime Organization (IMO), UN Conference on Trade and Development (UNCTAD), and UN World Tourism Organization (UNWTO).

STEP B: THE WHOLE-OF-GOVERNMENT TRACK

UNSG could have extended an invitation to heads of state and government on a regional basis to attend a high-level policy and program-planning session. The goals of the meeting could have included (a) opening channels to share the latest scientific information on national-level threats; (b) providing a framework for intergovernmental cooperation in combatting the threat; and (c) showcasing to national and global publics that joint multilateral action is the best way to confront a crisis with global implications.

In preparation for these regional HOS/HOG meetings, the UNSG and the DG could have reached out to five key global constituencies for input: international civil-society organizations; the international medical and scientific community; representatives of high-risk populations;³ the international finance and banking sector; and international and regional industrial associations. Each constituency could have been asked to prepare a policy brief that could be shared in advance with the HOS/HOG.

The first part of the agenda of each regional HOS/HOG meeting could have been open to public media. It could have consisted of an oral presentation by WHO and spokespersons from the five advisory groups. The second part of the agenda could have been a discussion of the impacts of the crisis on each country, and presentations of the recommendations from each HOS/HOG on what they could do jointly to contain the virus.

The reports of the five global constituencies, as well as any revised DG report on the state of the emergency, could have been circulated to the presidents and chairs as soon as practical.

STEP C: THE HEALTH-FUNDING TRACK

UNSG and the DG could have requested that the Department of Humanitarian Affairs, Bretton Woods Institutions (BWIs), UN Development Programme (UNDP), UN Department of Economic and Social Affairs (DESA), UNCTAD, UN Industrial Development Organization (UNIDO), and other economic and humanitarian bodies forecast the level of resources that would be needed by governments to address the crisis, and the possible sources of these funds, materials, and personnel.

UNSG and the DG could have advised (a) the head of WTO

³ In political terms, this could include those in migrant camps, those in zones of conflict, those from disadvantaged minorities; in health terms it could include those from organizations articulating the needs of high-risk co-morbidity communities.

of their assessment of the need and scope of a health waiver under TRIPS; (b) the heads of the BWIs of their support for a debt-scheduling procedure for severely impacted countries, and for a call for health-crisis special drawing rights (SDRs); and (c) the heads of the UN and UN system bodies of their support for a re-orientation of their work plans and budgets to develop a global financial-support framework.

STEP D: THE CRISIS-OUTREACH TRACK

The heads of the communication and public-affairs offices of WHO and the UN could have convened a meeting of their equivalent colleagues across the UN system to develop a clear and consistent set of media messages and educational campaigns.

Based on this strategy, UN-system communication heads could have met with media CEOs to ask (a) their global and national networks to provide time and space to bring the global message to all the appropriate national and local media markets; and (b) to cover live the relevant first sections of the HOS/HOG meetings.

STEP E: THE EMERGENCY-AUTHORITY TRACK

ECOSOC's emergency authorization could have permitted it to establish an appropriate structure to (a) establish fact-finding commissions or to host a public portal to track behaviors that are dangerous to global health; (b) recommend to state-parties of the WTO the scope of allowable tariffs or other non-tariff measures to compensate for costs incurred by the actions of non-conforming states or non-state actors; (c) recommend to governments and intergovernmental financial, trade, and monetary bodies that they consider sanctions or withdrawal of benefits from state or non-state actors aggravating a global crisis; (d) establish public lists of states agencies and non-state actors whose actions are undermining the global efforts to contain the health crisis; and (e) refer non-state actors to global, regional, and national judicial, policing, or civil authorities when it perceives that their behavior threatens global standards related to the health emergency.

Based on revised budget estimates, the UN could have authorized an ad-hoc supplemental payment from member states to fund the extraordinary costs of organizing an effective global response to the health crisis.

STEP F: THE PRESIDENTS AND CHAIRS TRACK

The UNSG, the DG, and PGA could have briefed the presidents of ECOSOC, the UNSC, UN Commissions and programs, heads of the BWIs, presidents/chairs of

relevant UN system bodies, and the intergovernmental heads of relevant conference of parties (COPs) on the emergency situation.

These intergovernmental leaders could have been asked to consider the impact of the DG's report on their respective organizational mandates, and to provide the PGA as soon as possible the results of their organizational responses and their recommendations on how any rules or procedures affecting the international market may need to be adapted in response to the health emergency.