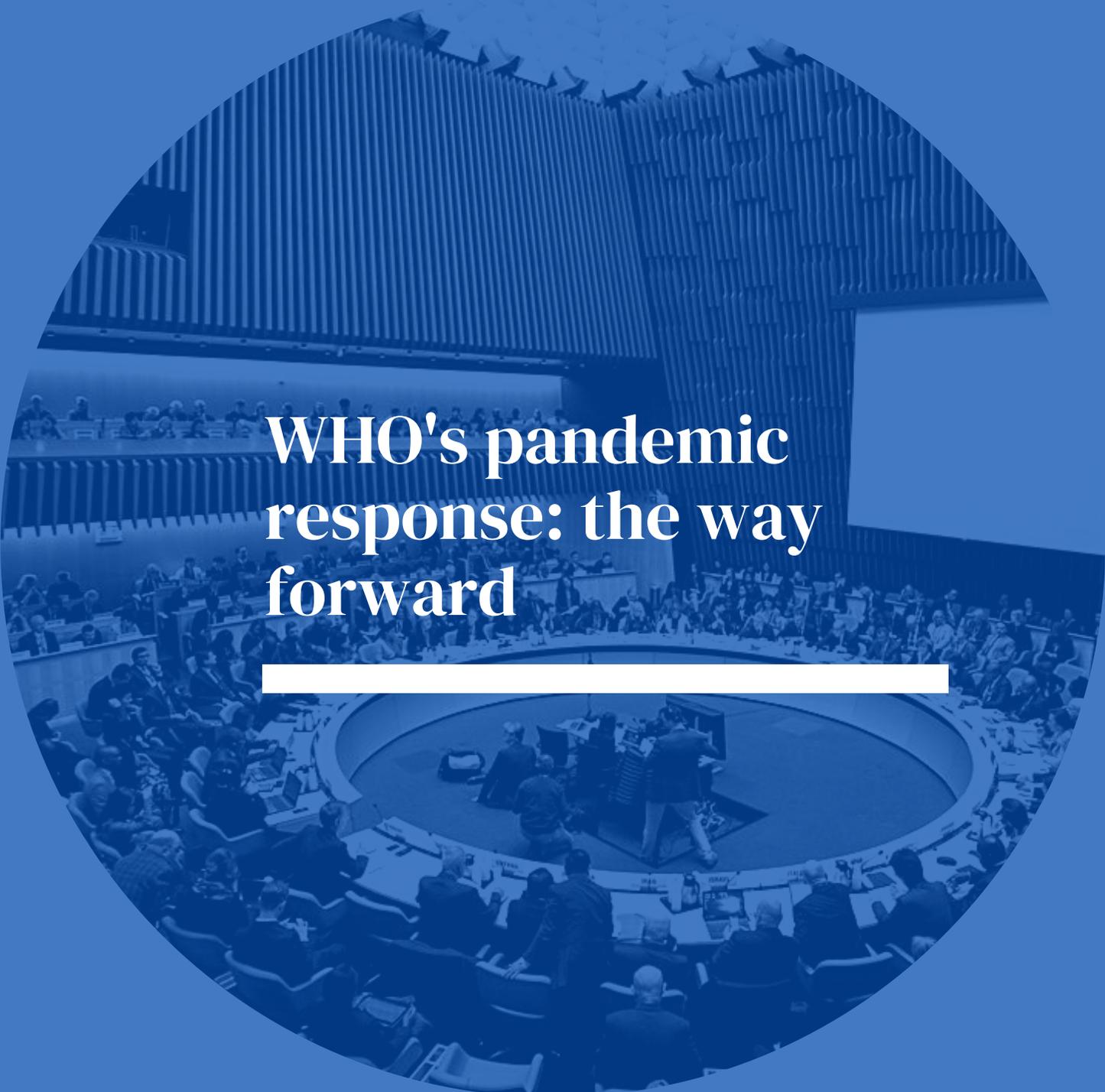


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SOWD REPORT

STATE OF WORLD HEALTH SECURITY & DIPLOMACY



WHO's pandemic response: the way forward



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About the World Health Organization¹

Founded in 1948 as a United Nations Agency, the World Health Organization (WHO) operates globally to promote health, expand universal health coverage, and respond to emergencies. Specifically, the WHO's Triple Billion Target aims to ensure a billion more people have universal health coverage, a billion more people are protected from emergencies, and a further billion more people are provided with better health and well-being by 2023. To achieve their first target of universal health coverage, the WHO focuses on primary health care at a national level to improve access to quality essential services. This covers workforce training, policy development support, and efforts toward sustainable financing within the health sector. As the second focus of the Triple Billion Target, WHO responds to health emergencies by adopting a coordinating leadership role in emergency preparation and preparation. This includes risk identification, mitigation, response, and support through the delivery of essential health services. In all policies and settings, WHO also prioritizes health and well-being as the third target by addressing social determinants and promoting an intersectoral approach.

It is crucial to understand the source of the WHO's funding as it reveals their financial dependence and implications toward their policies. WHO has two main sources of fundings: Assessed contributions (AC) and Voluntary Contributions (VC)². Assessed contributions as countries' membership fees come from a percentage of each country's GDP, as approved by member states every two years at the World Health Assembly. It only makes up 20% of the budget with the majority coming from voluntary contributions. In addition to the WHO's Member States, the voluntary contributions come from other UN or intergovernmental organizations, philanthropic foundations, etc.

¹ World Health Organization. (n.d.). *Frequently asked questions*. World Health Organization. Retrieved December 12, 2022, from <https://www.who.int/about/frequently-asked-questions>

² World Health Organization. (n.d.). *How WHO is funded*. World Health Organization. Retrieved December 12, 2022, from <https://www.who.int/about/funding>

WHO's Strategy Framework³

In 2019, the WHO announced their 13th General Programme of Work (GPW13) strategic priorities and shifts, which aims to place countries at the center of their work. This ensures that support from the WHO is relevant, flexible, effective and translates into measurable impacts. Through the GPW13, WHO is challenged to be a country-focused and impact-oriented organization. This means all efforts done by the WHO are directed towards three main goals⁴: focus on measurable impacts that improve people's health, prioritizing their work at national level to drive public health impact and direct resource allocations towards these targets, and aligning and building synergies to deliver work at all levels. Simply put, the goal of the GPW13 is to make a measurable impact in the health of billions of people. The strategic framework to guide WHO's work at national level and the framework to implement the Thirteenth General Programme of Work (GPW13) is called the Country Cooperation Strategy (CCS).

The CCS serves as both a process and an instrument for the WHO⁵. It informs and supports WHO's programme budget and operational planning, but also serves as a strategic process and instrument. The CCS contributes towards WHO's work in six unique ways. First, CCS development facilitates dialogue and strengthens partnership based on the country's national health and development plans. This includes priorities that are beyond the GPW13 outcomes and impacts. Second, the CCS situation analysis provides a strategic rationale and context for WHO's work at national level. Third, CCS outlines WHO's role and contribution to the UN system. It is more detailed than the United National Sustainable Development Cooperation Framework (UNSDCF) and thus, the CCS can influence development of the UNSDCF and serve as a policy accelerator for

³ Country cooperation strategy guide 2020: implementing the Thirteenth General Programme of Work for driving impact in every country. Geneva: World Health Organization; 2020. Licence: CC BY-NC-SA 3.0 IGO.

⁴ World Health Organization. (n.d.). *Who country cooperation*. World Health Organization. Retrieved February 7, 2022, from <https://www.who.int/countries/country-strategy-and-support>

⁵ As a process, CCS development provides a national level platform to conduct dialogues on a country's health needs and goals, drawing attention towards WHO's GPW and their work at global and national level. As an instrument, CCS serves as a "strategic vision towards public health impacts and outcomes", by reinforcing the works of the GPW13 while contributing to its internal and external assessment. CCS also serves as a political instrument to promote national ownership and a mechanism to ensure strategic coherence, and thus a tool to mobilize resources. As an instrument, it also highlights WHO's visibility while ensuring their transparency in the use of international aid.

the UN, specifically for health. The CCS serves as WHO's framework for country engagement and provides direct input. Fourth, CCS promotes national ownership in achieving health-related sustainable development goals. Fifth, CCS evaluation extends beyond measuring WHO outcomes and impact. It also assesses a country's progress in terms of its joint priorities with the WHO and the targets they set themselves. Sixth, CSS promotes the visibility and accountability of WHO operation by ensuring the WHO's transparency.

The CCS comprises six stages. The first is to analyze the country's context, health and health equity situations, national health and development agenda, and partnership environment. The CCS should reflect each country's specific priorities that are linked to the GPW13 and aligned with the UNSCDF time frame. The first stage is estimated to take around 1 month. The second stage is to conduct dialogue. This is necessary to guide the outcome of the analysis stage and is usually done through high-level discussions. The main objective of this dialogue is to engage key stakeholders such that there is an agreement on the strategic priorities for WHO's collaboration with the country in the medium term. Each strategic priority would be the joint responsibility of the country's government and WHO and should adopt the SMART framework (specific, measurable, achievable, realistic and time-bound). This process should account for the type of support that exists and is needed in the country based on its capacity, health system maturity and stability. The outcome of this stage is an agreed country impact/results framework.

The third stage is to draft the CCS by the core working group from previous stages and should not exceed 30 - 40 pages. It should be "evidence based, concise, visually appealing and ... focused on implementation and results". The fourth stage is to launch the CCS. The aim is to reach a wide range of audience and raise awareness of the CCS and what it can accomplish. The fifth stage is to implement the CCS. The first step in implementing this is to ensure that the operational plans are aligned with the CCS, through some rounds of review and adjustment. The next step is to review and/or redescribe resources at national level to achieve target identities in the CCS. Fundamentally, the CCS should be used to generate strategic partnership for health. It should serve as an advocacy and planning tool to create strategic partnership and allocate required resources. The sixth and final stage is to monitor and evaluate the CCS implementation. Although this falls under the responsibility of the WHO Country Office, monitoring should be a joint collaboration between the government

and WHO to encourage ownership. Progress should be reviewed at least once a year and should be done whenever the country undergoes significant changes like new government, new UNSCDF, changes in health situation and risks, etc.

WHO's Pandemic Strategy⁶

In response to the recent COVID-19 pandemic, the WHO's strategy has been centered around “control[ing] transmission of the virus, sav[ing] lives, and protect[ing] the vulnerable”. The WHO's response can be divided into ten main pillars, where seven pillars focus on the technical and operational aspects and are underpinned by three cross-cutting pillars, namely coordination & planning, operational support & logistics, and accelerated research & development. Across all levels of organizations, this structure forms the bases of the WHO Incident Management Support Team (IMST).

The pillar of coordination encourages national public health mechanisms to engage relevant ministries like health, education, and tourism to implement coordinated management of preparedness and response. Under the pillar of operational support, the COVID-19 supply chain systems (CSCS) provide countries with essential supplies by identifying demand, forecasting, certification, market scanning, sourcing, allocation, and delivery of essential supplies. The third pillar of research focuses on vaccination. The WHO believes that availability, accessibility and deployment of vaccines are the highest health, social, economic, and political properties and be done through the establishment of the COVAX Facility of the ACT Accelerator in 2020⁷.

The seven technical pillars include:

1. Risk communication and community engagement
2. Surveillance, rapid response teams, and case investigations
3. Points of entry, international travel and airport, and mass gatherings

⁶ 2019 Novel Coronavirus (2019-nCoV): Strategic Preparedness and Response Plan. Geneva: World Health Organization, 4 February 2020.

⁷ COVID-19 Strategic Preparedness and Response Plan. Geneva: World Health Organization, 2021. License: CC BY-NC-SA 3.0 IGO.

4. Laboratories and diagnostics
5. Infection prevention control (IPC) and protection of the health workforce
6. Case management, clinical operation, and therapeutics
7. Maintaining essential health services and systems

A brief description of each pillar is given below.

The first pillar of risk communication and engagement acknowledges the importance of communicating and engaging the public on preparedness and response activities for COVID-19. Communities should be involved in addressing the demand-side barriers of utilizing health services, informing measures to mitigate the socioeconomic impact, and co-designing solutions. This need for collaboration with the communities is evident in the third pillar. The third pillar on points of entry argues that efforts and resources there should focus on supporting surveillance and risk communication efforts. The WHO and their partners will continue to collaborate with the tourism industry at national level like aviation, maritime, event organizers, and borders to develop guidance and measures to mitigate the risk of transmission in mass gathering.

Until vaccines are widely and equitably available, the pillar of surveillance is key in suppressing transmission. It focuses on rapid detection of imported cases, comprehensive contact tracing, and case identification. Decisions to alter public health and social measures should be primarily driven by a situational assessment on the intensity of transmission and capacity of the health system, while considering the impacts on general welfare of society. Coordinating together with the pillar of surveillance, the pillar of laboratories and diagnostics acknowledges the key role that testing plays. It is critical to detect and investigate cases so that public health efforts can isolate the infected and break the chain of transmission as fast as possible. Under this pillar, the WHO urges countries to prepare laboratory capacity for large-scale testing and if not possible, to leverage Global Influenza Surveillance and Response System. Similarly, the pillar of infection prevention and control (IPC) aims to review practices to prepare treatments of patients infected with COVID-10 and prevent its transmission to the health workforce. The pillar of case management also emphasizes the importance of saving the lives of those at risk and ensuring quality of life in all patients. The final pillar of maintaining essential health service acknowledges that public health measures has led to

some disruptions to the supply chains, shortages of PPE, reduced staffing, and challenges to the health sector budgets and governance. Efforts to strengthen essential health services need to resolve demand- and supply-side barriers to access the service and be supported with continued efforts to strengthen the capacity of the systems' governance, health, information systems, etc.

WHO's Support to COVID-19 Preparedness for and Response⁸

One of WHO's key functions lies in their capacity to prepare for and respond to health emergencies. Their support to the pandemic response was built upon experiences that were adjusted to account for shifts in global landscapes and evolving country context.

One of the first steps undertaken by each WHO country offices was to “activate their business continuity plans”. It ensures that each office has the capacity to manage risk and respond to emergencies effectively and timely. 93% of the 149 country offices reported having a business continuity plan prior to the pandemic and 94% of the offices revised their plan to adjust to the COVID-19 pandemic context. The remaining offices developed new plans after the declaration of the PHEIC. In addition to preparedness, the WHO understood the urgent nature of the pandemic and responded quickly, as seen by their speed in activating an Incident Management Support Team (IMST). 49% of all WHO country offices reported activating a COVID-19 IMST between the declaration of PHEIC and the characterization of pandemic on 11 March 2020. The activation of the business continuity plan and IMST are part of the initial actions in the WHO Emergency Response Framework (ERF).

This was shortly followed by WHO country offices' support to individual countries. Around 76% of all offices initiated support for the development of the national response strategy between January and February 2020. Approximately 83% of offices initiated support for logistics, supply chain and procurement between January and March 2020. 79% of the offices began capacity building or training relevant national and partner staff in technical areas.

⁸ WHO presence in countries, territories and areas: 2021 report. Geneva: World Health Organization; 2021. License: CC BY-NC-SA 3.0 IGO

WHO attributes their support to Member States to their internal and external enabling factors. Their internal factors include the ability to repurpose staff, leverage WHO's role and capacity in leadership on the ground, and partners' trust in the WHO. 23% of all country offices acknowledge that their speed in mobilizing funds aided their work in meeting the ERF performance standards. Some external enabling factors include existing mechanisms to cooperate and coordinate between government, UN, non governmental organization, etc., the existence of IMST, the availability of data, laboratories, and the commitment of national authorities.

Yet, despite these factors, there exists challenges, whether it be at global, national or organizational level. At the global level, around 15% reported delays in the global supply chain and insufficient collaboration with international stakeholders. At the national level, 32% of offices struggled with restricted access to data. 31% reported difficulties in collaboration between national agencies as they were affected by national lockdowns, limitations in the national health system capacity and a limited understanding of WHO's role. At the organization level, 26% of offices argue that they experienced limited availability of staff and the skills required. 22% argue that they experienced a lack or delays in funds and 9% cited the existence of difficult working conditions like working remotely and staff burnout.

WHO Pandemic Response Analysis

Angela Merkel, Chancellor of Germany remarked in February 2021, "The COVID-19 pandemic once again reminds us: Global crises require global solutions." The need for urgent collaboration that encourages equity is echoed by António Costa, the Prime Minister of Portugal who noted, "Universal and affordable access to vaccines is essential if we are to resume our lives in full"⁹. In the past two year, the WHO Europe has deployed \$90 million in critical supplies, trained over 42,000 healthcare workers, supporting 2.3 million people through organizations engaged by the

⁹ May, C. (2021, February 23). *18 inspiring quotes from world leaders in support of the 'Recovery Plan for the World'*. Global Citizen. Retrieved December 27, 2021, from <https://www.globalcitizen.org/en/content/recovery-plan-world-leaders-inspiring-quotes/>

WHO¹⁰. Yet, despite its “mammoth efforts” and garnering praises from countries, the WHO is not immune from criticism. This section analyzes the WHO’s pandemic response chronologically, delving into the issue, the reason, and possible solution.

WHO’s Preliminary Response: PHEIC Declaration Issues

In May 2020, the former US President Trump accused the WHO of protecting China who he alleged misled the world about the COVID-19 virus. He then announced his plan to terminate the US relationship with the WHO and halt their funding. Although it can be seen as Trump’s attempt to shift blame¹¹, it also reveals shortcomings in the WHO’s organizational structure. Because of the sources of their funding, WHO is arguably subject to the inclination of the countries that fund their efforts. Essentially, it is beholden to member states to fund the organization. This has several crucial implications. First, the WHO’s financial dependence means offending a member state can lead to defunding. This is seen in the criticism by many that WHO acted too slowly in the beginning of the pandemic and “allow[ed] China to dictate the parameters of their [investigation] mission”. On January 14, 2020, the “mission-driven WHO [] tweeted” that preliminary investigations by the Chinese authorities found no evidence of human-to-human transmission in Wuhan, China. On February 26, the WHO Director-General- Dr. Tedros Adhanom Ghebreyesus, said that one of the biggest challenges the WHO faces is that “many affected countries are still not sharing data with the WHO”¹².

One could then argue that granting the WHO the right to investigate and collect data would resolve this issue. Yet, in reality, the WHO has been granted these rights since 2005 under the International Health Regulations (IHR), the prominent international agreement on infectious

¹⁰ World Health Organization. (n.d.). *Two years of COVID-19: What it takes to run an emergency response across 53 countries*. World Health Organization. Retrieved February 2, 2022, from <https://www.who.int/europe/news/item/21-01-2022-two-years-of-covid-19-what-it-takes-to-run-an-emergency-response-across-53-countries>

¹¹ Ravelo, J. L. (2020, May 18). *Battered with criticism, what's next for who? - devex*. Inside Development: World Health Organization. Retrieved December 20, 2021, from <https://www.devex.com/news/battered-with-criticism-what-s-next-for-who-97257>

¹² Cheng, M. (2020, November 11). *Recordings reveal who's analysis of pandemic in private*. AP NEWS. Retrieved February 7, 2022, from <https://apnews.com/article/who-recordings-reveal-analysis-pandemic-1faf92adb0f02d7b028bd25199dd242>

diseases. Under IHR, the WHO is granted the authority to challenge governments in how they exercise sovereignty within the public health sector. First, WHO is authorized to collect disease-event information from non-governmental sources, seek verification, and share such information with other countries. Second, the IHR authorizes the WHO Director-General to declare a public health emergency of international concern (PHEIC), regardless of the source country's objection. Third, the WHO can reinforce requirement for trade or travel measure justifications. Fourth, the WHO as a "leading guardian" is authorized to monitor human rights outcomes of disease-control measures. The WHO's success depends on their ability to deploy "scientific, medical and public health capacities to help countries prevent, protect against, and respond to disease events. David P. Fidler, a senior fellow for global health and cybersecurity at the Council on Foreign Council, argues that ideally, deployment would not generate "political problems" as the aim is on pandemic outbreak response that hinges on science, medicine, and public health¹³.

Yet, following the adoption of IHR in 2005, it was evident that global health would involve "heightened political interest from country and non-country actors, policy and governance innovation, and [low] unprecedented levels of funding". For example, the Great Recession had put WHO and its member states in a financial crisis. As a result, WHO had cut their budget for outbreak preparedness and response and member states show little to no concern to strengthen this, even amidst recommendations to do so following the H1N1 pandemic. Another historical controversy surrounding the WHO that gives context for their pandemic response took place during the Ebola outbreak in the Democratic Republic of Congo at the end of 2018. The emergency committee established under the IHR struggled and repeatedly decided that the worsening outbreak was not a PHEIC. Director-General Tedros eventually declared a PHEIC but only did so after the outbreak escalated. This showed resistance to declare a PHEIC and can be attributed to criticism they received in 2009, claiming they were causing "undue public fear"¹⁴ when declaring the H1N1 virus outbreak in 2009 a PHEIC.

¹³ Fidler, D. P. (2020, April 10). *The World Health Organization and Pandemic Politics: Think Global Health*. Council on Foreign Relations. Retrieved December 20, 2021, from <https://www.thinkglobalhealth.org/article/world-health-organization-and-pandemic-politics>

¹⁴ Barna, M. (2020, April 1). *WHO process for declaring health emergencies scrutinized: COVID-19 response shows limitations*. The Nation's Health. Retrieved February 20, 2022, from <https://www.thenationshealth.org/content/50/2/1.3>

Another issue with the PHEIC declaration lies in its timeline. Many argue that the declaration should have been earlier, as WHO was alerted of the virus on December 31, 2019 but only declared a PHEIC on January 30, 2020. The reason was that WHO experts had gathered a week earlier, but failed to agree whether it qualified as a PHEIC, as there were fewer than 100 cases and no deaths outside of China¹⁵. However, a one-week lag in declaring a PHEIC was not the biggest issue during the beginning of the pandemic, the actual issue lies in the fact that many countries did not take action until the word “pandemic” was used on March 11¹⁶. This analysis argues that the PHEIC declaration is too binary and creates much room for miscommunication. WHO can benefit from a system of declaration based on incremental stages, e.g. Stage 1: Alert, where there is evidence of epidemic but a lack of evidence of its transmission makes it unqualified to declare a PHEIC. Along with each stage, the WHO can prepare and communicate to its member states of the actions that the country should prepare or take in each stage.

WHO’s Communication: Handling of Infodemic

Tina D. Purnat et. al. points out that the COVID-19 pandemic is the first to occur in a “highly digitalized society of the 21st century”¹⁷. It reaps both the benefits and cost of a digital information ecosystem that continuously grows. Because of this, an infodemic defined by an overabundance of information that includes those that are false¹⁸, becomes a critical issue. It leads to distrust of health authorities and erodes public health response. The WHO has been hailed for their efforts in communication and handling of the infodemic. In collaboration with research partners, the WHO established the WHO Information Network for Epidemics (EPI-WIN). It analyzes weekly digital

¹⁵ *WHO's pandemic response: From criticism to Nobel? The Economic Times. (n.d.). Retrieved December 20, 2021, from <https://economictimes.indiatimes.com/news/international/world-news/whos-pandemic-response-from-criticism-to-nobel/articleshow/81443977.cms?from=mdr>*

¹⁶ Maxmen, A. (2021, January 23). *Why did the world's Pandemic warning system fail when Covid hit?* Nature News. Retrieved December 7, 2021, from <https://www.nature.com/articles/d41586-021-00162-4>

¹⁷ Purnat TD, Vacca P, Burzo S, Zecchin T, Wright A, Briand S, Nguyen T. WHO Digital Intelligence Analysis for Tracking Narratives and Information Voids in the COVID-19 Infodemic. *Stud Health Technol Inform.* 2021 May 27;281:989-993. doi: 10.3233/SHTI210326. PMID: 34042821.

¹⁸ World Health Organization. (n.d.). *Infodemic.* World Health Organization. Retrieved January 17, 2022, from https://www.who.int/health-topics/infodemic#tab=tab_1

media data and aims to identify and categorize main concerns posted in online conversation. It allows the WHO to respond towards misinformation or common myth, and serves as a source of “real-time information to flow from a trusted source to people at risk”¹⁹. In addition to their EPI-WIN platform, the WHO was also praised for hosting numerous press conferences and international meetings of global experts and leaders, while continuously providing updates through social media.

Yet, the WHO has also received criticisms for their mixed messages, which were more prominent on the topic of wearing facemasks. In the beginning, WHO announced that facemasks may create false sense of security and individuals wearing them will touch their face more, thus discouraging the use of facemasks. They changed their stance several times. In April 6, they argued that generalized use of facemask would only be beneficial if accompanied by other protective measures like social distancing. It was only on June 5 that the WHO recommended wearing facemasks in high-density areas. The WHO also faced criticism for not encouraging border closures or discouraging air travel in the beginning of the pandemic. WHO Director-General Tedros argues that they are of limited utility and are potentially harmful. It discourages countries from sharing data about the virus²⁰.

This emphasis on data sharing and analytics to inform public health response is a stance that the WHO has taken throughout the pandemic. Director-General Tedros said, “[] The world needs a significant leap forward in data analysis to help leaders make informed public health decisions. This requires harnessing the potential of advanced technologies such as artificial intelligence, combining diverse data sources, and collaborating across multiple decisions.”²¹ He concluded, “Better data and

¹⁹ *EPI-WIN: Information Network for Epidemics (WHO)*. READY Initiative. (n.d.). Retrieved February 7, 2022, from <https://www.ready-initiative.org/portfolio-item/fight-misinformation-with-epi-win-who-information-network-for-epidemics/>

²⁰ France 24. (2021, December 1). *Who warns against Omicron Travel bans as nations shut borders*. France 24. Retrieved February 7, 2022, from <https://www.france24.com/en/live-news/20211201-who-warns-against-omicron-travel-bans-as-nations-shut-borders>

²¹ Cornish, L. (2021, July 21). *Interactive: Who's funding the COVID-19 response ... - devex*. Funding Trends: COVID-19. Retrieved February 27, 2022, from <https://www.devex.com/news/interactive-who-s-funding-the-covid-19-response-and-what-are-the-priorities-96833>

better analytics will lead to better decisions.” This stance is seen in their global collaborations with public and private sector organization, international networks, and academia and culminated in the WHO Hub for Pandemic and Epidemic Intelligence. It serves as a global platform with shared and networked access to multi-sectoral data. It encourages innovation in data analytics and practices to predict, detect, and prepare for health-related threats. It also aims to scale the innovation for forecasting and warning capacities of the WHO and its member states, while simultaneously promoting wider access to data and information. Jen Spahn, German Minister of Health echoed this need for early risk identification and remarked, “We need to strengthen the global early warning surveillance system with improved collection of health-related data and inter-disciplinary risk analysis”.

Yet, the effectiveness of innovation and data analytics to inform public response is limited by the extent to which countries share their data. On December 20, WHO Director-General Tedros commented that China “must be more forthcoming with data and information related to the origin of the SARS-CoV-2 coronavirus”. Currently, there exists a lack of rules and regulation under the 2005 International Health Regulation (IHR) to compel countries to be transparent and share accurate data. A possible solution is to devise a regulation under IHR that makes it obligatory for countries to do so and thus, allow both global and national public health response to be as informed as possible. A regulation to empower WHO to dispatch their personnel to investigate possible outbreaks and publish their findings without government approval may also be included. This is echoed by WHO Director-General Tedros, who remarked that there had been “many failures” during the COVID-19 pandemic due to a lack of rules. He said, “we need to continue until we know the origins, we need to push harder because we should learn from what happened this time in order to [do] better in the future”.

WHO’s Focus on Equity: Equitable Access to COVID-19 Vaccines

As written in the WHO’s website, “equitable access to safe and effective vaccines is critical to ending the COVID-19 pandemic ... but it’s not vaccines that will stop the pandemic, it’s vaccination. We must ensure fair and equitable access to vaccines, and ensure every country receives them and can roll them out to protect their people, starting with the most vulnerable”. Despite this emphasis on

equity, WHO Director-General Tedros points out at the recent International Forum on Vaccine Cooperation that, “there remains a shocking imbalance in the global distribution of vaccines”²². Because of this, WHO has been working to “support low- and middle-income countries to strengthen their capacity to roll out vaccines effectively and efficiently”.

This effort to achieve equity is evident and goes beyond vaccinations. For example, the WHO has provided protective gear, tests, and items required by low- and middle-income nations. Another example is the establishment of the COVAX as the vaccines pillar of the Access to COVID-19 (ACT) Accelerator. This initiative is co-led by Gavi, the Coalition for Epidemic Preparedness Innovations (CEPI) and WHO. It aims to specifically distribute two billion doses in 2021 and vaccinate health workers and the most vulnerable 20% of the population in 92 poorest participating countries. Through the COVAX initiative, the WHO has appealed to leaders of leading nations and encouraged them to donate and assist low- and middle-income countries and have had large success in doing so. For example, the Philippines received over 3.2 million doses of vaccines as a donation from the US government through the COVAX facility on July 16, 2021²³. Sri Lanka also received over 1.4 million doses from the Japanese government via the COVAX facility²⁴. WHO has also appealed to leaders of the Group of 20 (G20) for funding of \$23.4 billion to provide COVID-19 vaccines, tests, and medicines to low- and middle-income countries in October 18, 2021²⁵.

However, the main controversy surrounding vaccines has been whether waiving intellectual rights would be more beneficial or harmful. The International Panel for Pandemic Preparedness and

²² World Health Organization. (2021, August 20). *Lower-income countries and indigenous populations receive who assistance amid the ongoing threat of covid-19*. World Health Organization. Retrieved February 27, 2022, from <https://www.who.int/news-room/feature-stories/detail/lower-income-countries-and-indigenous-populations-receive-who-assistance-amid-the-ongoing-threat-of-covid-19>

²³ Orbina, J. R. (2021, July 16). *Philippines receives over 3.2m vaccines donated by the US government through the COVAX facility*. World Health Organization. Retrieved December 27, 2021, from <https://www.who.int/philippines/news/detail/16-07-2021-philippines-receives-over-3.2m-vaccines-donated-by-the-us-government-through-the-covax-facility>

²⁴ Unicef. (2021, July 31). *Sri Lanka receives a large consignment of AstraZeneca vaccines from Japan via the COVAX facility*. UNICEF. Retrieved January 27, 2022, from <https://www.unicef.org/rosa/press-releases/sri-lanka-receives-large-consignment-astrazeneca-vaccines-japan-covax-facility>

²⁵ Wires, N. (2021, October 28). *Who calls on rich countries to fund \$23 billion plan to 'end' covid-19 pandemic*. France 24. Retrieved February 7, 2022, from <https://www.france24.com/en/health/20211028-who-calls-on-rich-countries-to-fund-23-billion-plan-to-end-covid-19-pandemic>

Response issued their report on May 12, 2021 that proposed the following recommendations. First, they argue that the WHO and the World Trade Organization (WTO) should convene government and pharmaceutical companies to devise an agreement on “voluntary licensing and technology transfers” to boost vaccine production. If that fails within three months, the intellectual property rights around vaccines should then be immediately waived under the WTO’s Agreement on Trade-Related Aspects of Intellectual Property Rights.

This view and solution argues that there is a mismatch between pandemic crisis response and existing policies in intellectual property protection. Currently, there exists a tradeoff in patent law, where inventions are encouraged in the long run but this is paired with slow diffusion of such invention. Under US patent law, there is a period of 20 years where nobody else can produce or sell the patented invention without the permission of the patent holder. This temporary exclusive right or monopoly benefits the patent holder by ridding the market from competition, allowing them to charge higher prices to the customer. Additionally, patent law provides “a decentralized system for encouraging innovation”, as argued by Brink Lindsey²⁶. Through the patent law, there is no need for the government to inform the pharmaceutical industry what drugs are demanded. The patent law creates the motivation for development by offering temporary monopoly rights.

However, this protection of property rights does not guarantee enough consumer demand for the new drug such that the endeavor is profitable. Lindsey argues that in a pandemic, the government knows what to incentivize, “the creation of vaccines to prevent the spread of a specific virus and other drugs to treat the virus”. The government could further motivate and quicken the process by guaranteeing that the government would buy a large, predetermined quantity that guarantees a good return to the first pharmaceutical firm to develop effective vaccines and drugs. It is important to keep in mind that establishing a waiver for the COVID-19 vaccines and treatment would set a precedent that the government would employ more direct means to encourage creation during emergencies.

²⁶ Lindsey, B. (2021, June 2). *Why intellectual property and pandemics don't mix*. Brookings. Retrieved January 8, 2022, from <https://www.brookings.edu/blog/up-front/2021/06/03/why-intellectual-property-and-pandemics-dont-mix/>

However, this view is not universal. The International Federation of Pharmaceutical Manufacturers and Associations argue that waivers do not address the actual challenge in the production and distribution of COVID-19 vaccines: “elimination of trade barriers, addressing bottlenecks in supply chains and scarcity of raw materials and ingredients in the supply chain, and a willingness by rich countries to start sharing doses with poor countries”²⁷. Critics question whether low- and middle-income countries have the capacity, infrastructure and technology to manufacture these drugs even if they were granted the “recipe” of the treatments. They argue that a waiver would risk diverting raw materials and supplies away from established supply chains to less efficient ones. An alternative they proposed is to scale up production by “building more factories directly under Pfizer, Moderna, AstraZeneca, and Johnson & Johnson”, enabling production and distribution of vaccines for low-income countries without disrupting the patents. However, a potential issue is distance - if production is far away from where they would need to be distributed, there is supply chain and storage issues.

James Love, the director of Knowledge Ecology International reconciles these two views and argue that a patent waiver is a “valuable first step, [but] not a panacea”²⁸. It would allow third-party manufacturers to produce and sell the patented products, while freeing up resources that would have been spent figuring out how the manufacturing is done. Additionally, the waiver encourages financially third parties to enter the industry and invest in the production and distribution of vaccines. This brief supports this idea - the waiver of vaccines incentivizes third parties and governments in low- and middle-income countries to invest in building infrastructure and human capital that would quicken the process and reduce their reliance on other countries.

²⁷ Iacobucci, G. (2021, May 10). *Covid-19: How will a waiver on vaccine patents affect global supply?* The BMJ. Retrieved January 15, 2022, from <https://www.bmj.com/content/373/bmj.n1182>

²⁸ Garde, D., Branswell, H., & Says, C. O. (2021, May 6). *Waiver of patent rights on covid-19 vaccines, in near term, may be more symbolic than substantive.* STAT. Retrieved December 8, 2022, from <https://www.statnews.com/2021/05/06/waiver-of-patent-rights-on-covid-19-vaccines-in-near-term-may-be-more-symbolic-than-substantive/>

Key Recommendations

- A system of declaration based on incremental stages, that is less binary than current PHEIC declaration
 - May include stages where there is evidence of an epidemic but there is a lack of evidence in its transmission
- Devise a regulation to make it obligatory for countries to share data, thus enabling global and national public health response to be as informed
- Devise a regulation that empowers the WHO to dispatch personnel without government approval
- Support waiver of intellectual property rights during a pandemic
 - Strengthen collaboration between government, private, and public sector

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