The Multilateral System and COVID-19: What are we doing and where are we going?

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Analysis

The Multilateral System and COVID-19: What are we doing and where are we going?

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KEY MESSAGES

- **International institutions have been created to manage pandemics and other health-related challenges, but in the era of COVID-19 mixed results have been observed**
- **Examining actions by the World Health Organization, the World Bank, Gavi the vaccine alliance, and the Global Fund to Fight AIDS, TB, and Malaria finds that these institutions have used the approaches and authorities given to them by member states.**
- **The patchwork of results and strategies reflects, on the whole, reasonable performance by these institutions, and at the same time reveals limitations in their mandates that reflect the unwillingness of some member states to fully collaborate.**
- **Addressing these deficits in collaboration is essential to resolving global collective action challenges, including COVID-19, climate change, non-communicable diseases, and many others.**

Contributors and sources
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Standfirst

*The COVID pandemic has raised questions about the performance of international institutions. The mixed patchwork of achievements and mis-steps points mainly to limited agreement and low solidarity among the powerful nations that dominate the governance of these institutions, argue **Jesse Bump** and colleagues.*

The ongoing pandemic and its thus-far unchecked devastation have raised legitimate questions about the performance of the main international institutions for health cooperation. As the pandemic continues, worsening in many parts of the world, there are many reasons to believe that better performance is possible, and this sentiment is mirrored by popular opinion: about 60% of people in a 14-country survey say that greater international cooperation would reduce the number of COVID cases.[1] But what exactly are international agencies doing and how could they do it better?

International collaboration on infectious diseases was formalized in the mid 1800s to limit transmission, share information, establish standards, and coordinate activities—the same things nations need in the ongoing COVID-19 pandemic. These long-term imperatives have been met with an evolving set of international institutions. The most central of these is the World Health Organization (WHO), established in 1948 as the United Nations' specialized agency for health. As of the 1990s the World Bank also has played a crucial role, in recognition of the importance of health to economic and development progress. Other international entities have been established to deal with specific diseases or issue areas, including for example Gavi, the Vaccine Alliance (2000) and Global Fund to Fight AIDS, Tuberculosis, and Malaria (2002). In this article we briefly review a major action by each of these agencies to reveal strengths to build on and weaknesses to address.

The World Health Organization

WHO has been under special scrutiny as the lead health agency within the United Nations system and the only one with a legal mandate over international public health matters such as the spread of SARS-CoV-2 across border.[2,3] One of WHO's most crucial responsibilities is to notify its member states about the emergence and spread of infectious diseases. In this

connection, there has been criticism that WHO reacted too slowly at the beginning of the COVID-19 outbreak in Wuhan, China.[4 5] In due course, the results of detailed analyses of WHO's response will be available. However, in the meantime the brief timeline of some key actions and decisions is as follows.

On 31 December 2019, WHO's Country Office in the People's Republic of China picked up a media statement by the Wuhan Municipal Health Commission from their website on cases of 'viral pneumonia' in Wuhan. After seeking more information on 1 January 2020, WHO notified Global Outbreak Alert and Response Network (GOARN) partners on the 2 January. (GOARN includes major public health institutes and laboratories around the world and other key organizations such as NGOs.) Chinese officials formally reported the information on the cluster of cases viral pneumonia of unknown cause on 3 January. WHO alerted the global community to this situation via Twitter on 4 January and provided detailed information to all countries through the IHR communication system the following day, advising them to take appropriate precautions. A period of intense activity followed during which WHO convened teleconferences of global expert networks, provided guidance, monitored and evaluated the developing crisis, and published their assessments of risk and public health advice, before the Director-General (DG) convened an Emergency Committee (EC) under the IHR on 22 January 2020. The EC met again on 30 January, this time advising the DG that the outbreak now met the criteria for a public health emergency of international concern (PHEIC), the WHO's highest level of alarm. The DG accepted this advice and immediately declared a PHEIC. He went on to characterize the spread of COVID-19 as a pandemic on 11 March 2020.[6]

In the many reviews that are already taking place and will come in the future, it is right to revisit the IHR, in particular the issues concerning the declaration of a PHEIC and the announcement of a pandemic, to determine if they are fit for purpose, and if not what improvements need to be made.[7] However, important as they are, the IHR are only rules by which WHO and member states are expected to operate. Other issues are far more influential on WHO's performance and international cooperation in health. For example, chronic underfunding and a lack of authority over sovereign countries mean that WHO is not as well positioned as it should be to detect and respond to emerging threats. It is

required to accept national data as delivered under the IHR, with little or no power to verify or prepare alternative estimates, even if they appear unreliable. Recommendations made in the global interest, can carry little sway with countries that often assess their own risks and take the actions they consider necessary from a national perspective. These shortcomings in WHO's capacities and capabilities are restrictions clearly placed on it by member states, some of which have been reluctant to place health above other political and economic goals. [8]

The World Bank

The World Bank's most direct engagement with global infectious disease control is its Pandemic Emergency Financing Facility, supported by issuing "Pandemic Bonds." This scheme was announced in May of 2016 at a G7 meeting in Japan, reflecting a broad consensus that international financing had been too slow to materialize in the 2014 Ebola virus disease outbreak in West Africa. Pandemic bonds could have mobilized financing three months faster than had happened then, the Bank argued, noting that Ebola cases had increased by a factor of ten during the delay.[9] When the first pandemic bonds were sold in 2017 coronaviruses were mentioned specifically, along with five other viruses deemed most likely to cause a pandemic. The bond offering was oversubscribed by 200%, and would, the Bank claimed, "channel surge funding to developing countries facing the risk of a pandemic" and "potentially save millions of lives."[10]

With the arrival of the COVID-19 pandemic in 2020, these claims faced an empirical test. As the pandemic built in January and February many investors believed the bonds would pay out, but as time passed more details of their design became apparent.[11] The bonds were issued in two tranches, one of which was not eligible for payout until three months after the beginning of any outbreak, meaning that prompt action would be impossible. Both tranches had thresholds for mortality and spread, along with a requirement for exponential growth rate of cases in low-income countries, meaning that no payout could occur in advance of the documentation of rapid transmission. By mid-April there had been more than 12,000 cases and 600 deaths in Africa, and the three month delay condition had been satisfied, but the bonds did not pay out because the exponential growth of cases had not been documented.[12] Later in the same month, cases were expanding rapidly enough to trigger a

payoff, but even then eligible countries had to file requests and the per country allocation was capped at a maximum of $15M. In total, about $195M was made available. Too little, too late concluded many analysts.[13] Plans for future pandemic bonds were quietly abandoned.[14 15]

Gavi, the Vaccine Alliance

Gavi was established in 2000 as a public-private partnership for increasing vaccine access in low-income countries. It does this by fundraising, negotiating discounts through pooled procurement, and market shaping via advance market commitment, among other efforts. [16] With the COVID-19 pandemic, the expectation of a vaccine suggested a clear role for Gavi, which leads COVAX together with the Coalition for Epidemic Preparedness Innovations (CEPI) and WHO as one of three pillars in the Access to COVID-19 Tools Accelerator launched by WHO and partners in April 2020.[17] COVAX is a collaborative mechanism for speeding development, production, and equitable access to COVID vaccines.[18] Although COVAX membership is optional, thus far 189 countries have joined, including China, all members of the EU, and 92 low-income countries.[19 20] With an overwhelming majority of the world's countries, the COVAX facility can cross-subsidize vaccines for low-income countries and speed development efforts using advanced payments from high-income members. In our view, this is an effective and appropriate demonstration of voluntary, humanitarian solidarity.

The Global Fund

As the fight against HIV/AIDS became a global priority in the late 1990s there was broad appreciation for the importance of combatting infectious diseases accompanied by many discussions of how to raise and manage unprecedented sums of money. There was some uncertainty over which diseases should be included and what organization would be in charge of the funds.[21] From these debates the Global Fund to Fight AIDS, TB, and Malaria was established in 2002 as a public-private partnership to handle the fiscal responsibilities of raising, allocating, and disbursing money related to programs targeting its three titular diseases and their consequences. Since then the Global Fund has disbursed more than $45B and calculates that it has saved some 38 million lives, figures that demonstrate its prominence as a leading funder in global health. [22]As a point of comparison, the money

disbursed to countries by the Global Fund since inception is far greater than the entire WHO budget, including both assessed and voluntary contributions over the same period. [23]

With the arrival of COVID-19 the Global Fund has sought to support eligible countries by allowing them to divert up to 5% of existing grants and allocating an additional $665M for ad hoc requests to "reinforce the response to COVID-19, mitigate the impact of the pandemic on HIV, TB and malaria programs, and make urgent improvements in health and community systems."[24] The approximately $1B made available this way dwarfs the maximum pandemic bond payout for coronavirus of $195.83M.[25] However, COVID-19 reopens many questions about how global health initiatives are financed and delivered, including whether the Global Fund should be constrained to three diseases and how it should relate to WHO.

Concluding Observations

We interpret the performance of the four international institutions as well aligned with their original designs. WHO served as a rapid clearinghouse for the information member states provided and promptly announced its judgements on the severity and likely course of the outbreak. The World Bank engaged private capital markets in an attempt to smooth pandemic financing. Gavi co-organized a global mechanism for developing, purchasing, deploying, and equitably distributing COVID-19 vaccines. The Global Fund quickly made available about $1B for eligible countries.

But in each case, the constrained mandates of these institutions limited the effectiveness of the overall response, and raises serious questions about the governance of global health. The inability to verify national data or advance its own estimates is just one of the many crucial dimensions in which WHO is prevented from maintaining the primacy of technical competence over the self-interested obfuscations of some member states. The World Bank's market orientation suggested a possible solution to rapid financing, but in the end the instrument served investors better than it did the ostensible beneficiaries. As a partnership, Gavi cannot compel participation in its schemes and accordingly cannot fully redistribute to ensure the most equitable access. The United States, one of the world's

richest countries, simply declined to participate because the Trump administration did not want to support WHO and preferred to negotiate on its own.[26] The Global Fund is limited to three diseases chosen by non-transparent means and without provision for expansion, leaving one of the largest sources of financing in a position of uncertain relevance to the COVID-19 pandemic.

All of these issues are created by member states and by other actors that comprise the governance boards of the four institutions. And they stem from a common reluctance to cooperate—the nations do so partially but not fully. In a pandemic, this is inadequate and the cost is expressed in lives and livelihoods. More than 10,000 people are dying daily and the world economy is forecast to lose as much as $22 trillion in 2020 alone. The imperative of seeking collaborative and collective solutions—solidarity—has never been more obvious, or more urgent, for COVID-19, climate change, non-communicable diseases and the many other critical challenges facing humanity.

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