COVID-19, the UN, and Dispersed Global Health Security

Sophie Harman

The picture is a chaotic one: the threat of the withdrawal of both U.S. funding and membership from the World Health Organization (WHO); a delayed UN Security Council (UNSC) resolution on a major world crisis; and a large number of prominent world leaders ignoring scientific advice, downplaying a looming threat, and shifting away from multilateral cooperation in responding to a crisis. By any measure, this reality has serious consequences for global health security and multilateralism within the UN system. Occurring at the height of a major pandemic, with immediate and long-term consequences for the lives and well-being of people around the world, these issues are downright dangerous. However, while COVID-19 exposes the fault lines in global health politics, it also demonstrates some of the positive gains made in global health security, including a subtle shift away from dependence on the UNSC and WHO. Institutional change and experience from previous global health emergencies have led to a more dispersed and inclusive form of global health security that is more equipped to respond to global political issues during a major pandemic. The response to COVID-19 has shown this shift in four areas: (1) a supported WHO; (2) a civil society and epistemic community of global health research and expertise; (3) obsolescence of the UNSC; and (4) timely inclusion of UN programs.

WHO is at the center of global health security but does not define it. The organization has been beleaguered by politics since the Cold War generated stasis and proxy wars over its membership, controversy surrounding eradication strategies, and obfuscation as to what "health for all" means and requires from member

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states.[1] The last twenty-five years have been a particularly turbulent period for the institution: It has faced constant reform, a funding model that cannot sustain the institution's core functions and mandate, competition from new institutions, a growth in global health security and health emergencies, and reputational damage from the criticism of its handling of various outbreaks, from its work on HIV/AIDS to its response to Ebola from 2014 to 2016.[2] This has generated losses for the institution as the management of some of its core functions and funding have been transferred to other institutions (for example, the Pandemic Emergency Financing Facility; the World Bank; the Global Fund to fight AIDS, Tuberculosis and Malaria; and UNAIDS [Joint United Nations Programme on HIV and AIDS]). There have also been some gains for the organization during this period: the WHO's health emergency capacity was strengthened through a reform of the International Health Regulations (IHR) following the SARS outbreak in 2005, and the WHO Health Emergencies Programme was created in 2016, following the Ebola outbreak from 2014 to 2016, to work with states to assess and fill gaps in their health emergency planning, to strategize for and monitor new threats, and to make response recommendations.[3] Still, despite its apolitical nature and specialized technical agency status, the institution's work has been defined by global politics since its formal creation in 1948.[4]

Criticism of WHO during a pandemic is therefore an inevitable part of global health security. WHO will always be criticized for when and what it calls a Public Health Emergency of International Concern (PHEIC), for how it investigates outbreaks in member state territories, and for any perceived bias toward specific states.[5] COVID-19 is no different. WHO has been criticized for the quiet diplomacy it exercised in how it investigated the source of the outbreak in China, for its inability to recognize Taiwan as a sovereign state and thus the efficacy of the country's early efforts in managing the outbreak, for being too close to China, for the ineffectiveness of the IHR, and for being both too political and too technical.[6] The apex of this critique was President Donald Trump's announcement in May 2020 that he planned to withdraw U.S. funding from WHO on account of the institution succumbing to pressure from China to mislead the world.[7]

What is different with COVID-19 are the consequences of such criticism. The risk of U.S. withdrawal from WHO is hugely significant for the funding and sustainability of its existing programs and the COVID-19 response. However, President Trump's actions did more to delegitimize his own position in global health security than to harm the WHO. His threat galvanized support for the

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institution from other member states and from philanthropists such as Bill Gates, and it was used to publicly highlight the president's failings in his own domestic response to the pandemic. Nonetheless, the threat was a public expression of how the WHO is susceptible to global politics and is the potential site of a proxy war between the United States and China. Instead of taking place in private diplomatic meetings and communiqués, the politics of the move were made clear on public platforms. Defenders of WHO were thus able to point to Trump's public threat and construct a dividing line between success (follow the WHO model) and failure (ignore WHO and go it alone) in the United States. WHO stuck to its usual model of sidestepping the politics and sticking to the science, and allowed its supporters and (inadvertently) President Trump himself to build support for the work it does. Trump may have used his attack on WHO to play to his support base, but WHO used the attack in the same way with its own supporters.

The support base for WHO is a mix of an epistemic community of global health researchers, advocates, UN program staff, and civil society organizations that tend to unify around the right to health and universal health coverage. This epistemic community is a vital part of global health security. No global health outbreak would be deemed a health emergency or pandemic without civil society, activists, the epistemic community, and whistleblowers providing the initial alarm and response. This has been the case from the time of the HIV/AIDS pandemic in the 1980s (where activists, clinicians, and researchers were the ones to initially speak out about the disease); through the Ebola outbreak from 2014 to 2016 (with medics, international nongovernmental organizations, and researchers being the first to sound the alarm); to attempts to eradicate polio (here it was philanthropists, community care workers, and researchers). WHO may follow clear guidelines in calling a PHEIC, but these guidelines are subject to the politics of public opinion and understanding.[8] Civil society and the epistemic community not only elevate a health concern to the level of a threat to global health security but also work as a constant check on how institutions are performing, providing guidance and expertise, and acting as supporters when they are threatened by member state interests. With COVID-19, the epistemic community and civil society attempted to blunt Trump's threat to the WHO (by U.S. experts committing to work with WHO, for example); have constantly monitored domestic and international responses; and have provided expertise or direct assistance to those suffering from the wider consequences of the outbreak. These actors provide an important diffusion of power away from state-centric models. In so doing, they

collectively contribute to determining which health issues are deemed security threats—and how—and shape wider discourse around such threats.

On four occasions between 2000 and 2020, for the first time in its history, the UNSC addressed health-related issues as threats to international peace and security. The four resolutions it produced on those occasions—resolutions 1308 (2000) and 1983 (2011) on HIV/AIDS, and resolutions 2177 (2014) and 2439 (2018) on Ebola—were widely seen to be game changers in disease response.[9] However, when COVID-19 was identified as a global pandemic, and with 8.9 million confirmed cases and 468,484 deaths as of June 2020,[10] no UNSC resolution was forthcoming until July 1, 2020 (UNSC 2532). The lack of early Security Council involvement may not be a bad thing. In contrast to previous health emergencies, the lack of an early UNSC resolution does not appear to have mattered for the global COVID-19 response and seemed unnecessary and even potentially harmful.[11] UNSC resolutions can be helpful for health issues by making them a high-level political priority, mobilizing additional funds, and establishing a commitment to combat the issue.[12] COVID-19 was already a high-level political issue before the passage of resolution 2532. The resolution itself reiterated concerns expressed by the secretary general around worsening conflict and violence, the need for a commitment to cessation of conflict, and the expected commitment to solidarity and cooperation.[13] Two important parts of the resolution are the stark warning that "the unprecedented extent of the COVID-19 pandemic is likely to endanger the maintenance of international peace and security" and point 7, which details the gendered impacts of health emergencies. Instead of providing consensus and collaboration, a move toward greater UNSC involvement in this instance could have exacerbated existing tensions among the permanent five members that would have detracted from gains made from quiet diplomacy. In short, the UNSC resolution is best reserved for health crises of epidemic scale that lack political attention, not for pandemics where the wrong kind of political attention can be problematic.

Finally, various UN programs and specialized agencies have responded rapidly to identify and mitigate the wider impacts of COVID-19—a notable difference from previous health emergencies. In past emergencies, secondary impacts of the crisis have been realized too late, with serious consequences for the UN's wider development goals. These secondary impacts include people not accessing healthcare services for other medical issues they are facing due to the fear of infection, spikes in other health issues such as maternal mortality and mental health

risks, and lack of safe and affordable access to medication. They also refer to the wider political, social, and economic impacts of measures taken to respond to the virus, such as the consequences of home isolation for rates of domestic abuse; the burden of additional childcare on women's economic and political engagement; and the long-term consequences of economic shutdowns on inequality.

Many of the UN programs and specialized agencies have tailored their efforts to respond to COVID-19 and mobilized their own research networks, data analysts, and advocacy networks to raise awareness of the secondary impacts of the virus. High-profile agencies such as UNICEF and UNFPA (United Nations Population Fund) have been pivotal in ensuring and sharing best practices on child protection, domestic abuse, and safeguarding access to safe sexual and reproductive health services.[14] Smaller programs (in terms of funding, scope, and longevity) such as UN Women have taken on active leadership roles in collating, and advocating for, sex-disaggregated data and sharing key sources of information.[15] The difference in the response to COVID-19 from that to previous emergencies such as Ebola or Zika is important: the current work has taken place in partnership with wider civil society and epistemic communities at the *outset* rather than after or toward the end of the outbreak. While attention to such secondary factors is mixed across member states, experts from these programs and specialized agencies have not been ignored or kept out of the room.

A pandemic at the scale of COVID-19 will inevitably expose shortcomings in institutions such as WHO and the wider UN system, lead to member state disagreement, and require critical reflection and change to address the long-term health impacts. COVID-19 had the potential to overwhelm and completely discredit the UN system. It has done neither. Global health security has never just been about the high-profile calls to action from WHO or the UNSC; rather, it involves a diffuse system of governance that rests on the wider UN system, civil society, and the epistemic community of research and advocacy. COVID-19 has exposed the ability of such a diffuse and inclusive model of health security to adapt to and withstand global politics during a pandemic.

NOTES

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[14] For example, see United Nations Population Fund, *Coronavirus Disease (COVID-19) Pandemic: UNFPA Global Response Plan* (New York: UNFPA, revised June 2020), www.unfpa.org/resources/coronavirus-disease-covid-19-pandemic-unfpa-global-response-plan.
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Abstract: The response to COVID-19 demonstrates an inclusive and dispersed form of global health security that is less reliant on the UN Security Council or the World Health Organization (WHO). While WHO remains central to fighting the pandemic, the dispersed global health security addressing the crisis is inclusive of the wider UN system, civil society, and epistemic communities in global health. As part of the special issue on "The United Nations at Seventy-Five: Looking Back to Look Forward," this essay argues that instead of facing crisis or criticism like WHO, this inclusive and dispersed form of global health security provides mechanisms of resilience and support to the UN at the height of global political tensions surrounding COVID-19.

Keywords: COVID-19, UN Security Council, World Health Organization, global health security, global health, pandemic, epistemic community