HOUSE OF LORDS

Select Committee on International Relations and Defence

Uncorrected oral evidence: The World Health Organisation

Friday 17 July 2020

10 am

Watch the meeting

Members present: Baroness Anelay of St Johns (The Chair); Lord Alton of Liverpool; Baroness Blackstone; Baroness Fall; Lord Grocott; Lord Hannay of Chiswick; Baroness Helic; Lord Mendelsohn; Lord Purvis of Tweed; Baroness Rawlings; Lord Reid of Cardowan; Baroness Smith of Newnham.

Evidence Session No. 1 Virtual Proceedings Questions 1 - 11

Witnesses

I: **Dr Brian McCloskey CBE**, Senior Consulting Fellow, Global Health Programme, Chatham House; **Professor Sophie Harman**, Professor of International Politics, Queen Mary, University of London.

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Examination of witnesses

Dr Brian McCloskey CBE and Professor Sophie Harman.

Q1 **The Chair:** Good morning. Welcome to my colleagues and to those who are giving evidence to us today. The meeting of the International Relations and Defence Select Committee this morning sees the launch of our inquiry into the World Health Organisation, its role in co-ordinating global health responses, and its funding and governance.

To our first session I welcome Dr Brian McCloskey CBE, Senior Consulting Fellow, Global Health Programme, Chatham House, and Professor Sophie Harman, Professor of International Politics, Queen Mary, University of London. Thank you for joining us today to share your expertise with us. May I remind you that, as always with select committees, our session is on the record, broadcast and transcribed? May I also remind Members, as usual, to declare any relevant interests?

To assist the operation today, and our broadcasters, I will ensure that I call each Member to ask their question. Having done that, I will call upon our witnesses to give their answers, and I will indicate which witness I would like to go first; I shall try to rotate the going first between the two of you. As usual, I will ask the first question, which will be very broad, and I will then refer to my colleagues to ask further, more detailed questions. At the end of that process, if there is time remaining, which I hope there will be, I will call on Lord Hannay to ask the first supplementary.

The first broad question is from me. Thinking about the structure of the World Health Organisation and the powers at its disposal, are they adequate to deliver its mandate, including of course the response to COVID-19? What are the principal challenges to its effective operation?

Dr Brian McCloskey: Good morning. My starting viewpoint is that a world without the World Health Organisation is a world in danger, because we will not find our way out of this COVID pandemic through a series of disconnected national plans. It needs international co-ordination, so it needs something like the WHO to do it. One of the challenges for the WHO, in a sense, is that it does not really have any powers. It is an advisory body, but it does not have a means to ensure that the member states follow the advice that it gives. It has a legal basis in the International Health Regulations, which we need to talk about, but in a sense it does not have a power to direct member states to do what it advises. That has caused it significant difficulty in the course of this pandemic response.

There is a debate to be had on the structure. The WHO is different from most UN agencies because it has a regional structure. A regional structure is good for local accountability, but we know from emergency response that more layers can cause more confusion in the chain of command. There is a balance to be found for the WHO. For example, having AFRO—the Regional Office for Africa—is a good thing for the WHO, because it allows it to have partnerships with organisations like the Africa

CDC,[1] and it allows the partners to work in a regional context. However, it also slightly complicates the chain of command. There will always be some difficulty. Inevitably, any organisation whose director-general is elected will be subject to a degree of political pressure. The election improves accountability, but it brings in the risk of political interference. That is the same for any organisation with an election process.

Professor Sophie Harman: To add to Dr McCloskey's comments, the WHO does not have compliance powers, so it cannot make states comply with the International Health Regulations. However, it has normative powers through the IHR. For me, the headline is very much that its core health regulation functions are fit for purpose. The first two elements—getting states to detect and report, and to build capacity—work. Only a minority of states do not adhere to the IHR.

We can unpack that a little. I echo Dr McCloskey's comments that the WHO exists to respond to the collective threat of health emergencies and therefore requires a collective endeavour. That is absolutely vital. We cannot have states going it alone, because it will not work, and it will not protect those states' citizens.

Of course, we have seen challenges with COVID-19, and we can unpack those a little. The highlights are the WHO's funding model, the issues of compliance and sustained surveillance, and the whole idea that the IHRs are built around the weakest-link principle—the states with the weakest ability to respond. The problem we have had with COVID-19 is that it is not the states that are low and middle-income countries which the WHO has concentrated but the higher-income countries. Perhaps we can go into that a bit more.

My final point on the WHO's core functions is to reassert that it is a technical agency. Its functional operations are successful, and we see a high level of functional co-operation. It is very effective at drawing on wider epistemic communities in global health—global health researchers, public health advocates and the like.

Q2 **Lord Mendelsohn:** I thank our witnesses very much for coming to help us with this inquiry.

I want to get some broader context for some of our subsequent questions about the particular crisis that we are in. The WHO was set up by the UN as possibly its first institution. It has a very wide mission. When the new Director-General came in he had a variety of priorities, including the health impacts of climate change. I would be very interested in your observations and comments about whether its mission and priorities are fit for purpose, and how effective it is in dealing with and balancing this incredibly broad set of issues in the light of a crisis like the one we are facing now with Covid-19.

Professor Sophie Harman: Undoubtedly, the WHO's mandate has grown since it was founded in 1948. Now the debate is about whether it

[1] The Africa Centres for Disease Control and Prevention

should focus primarily on health emergencies and ignore the rest of the work that it does, and how it balances health emergencies and prevents them from taking over everything else. This is tricky. The institution itself has the right priority in building health systems and universal health coverage, because they are the bedrock of the response to any health emergency and you cannot separate the two. Any calls to do so would be dangerous and defeat the purpose of responding effectively to health emergencies.

Of course, emergencies affect the day-to-day running of the WHO. It has learned from previous emergencies not to let the emergency imperative take over, not to make COVID dominate everything. It is really aware of the distortion effect that it can have on immunisation and vaccine programmes and on high-profile programmes like the one for polio. A vital question for the WHO going forward is how it balances those priorities. Ultimately, it will come down to how it is funded and how member states get behind it to allow it to do that.

To wrap up, the real risk is of a WHO that just deals with health emergencies. That would defeat the absolute objective of the institution.

Dr Brian McCloskey: I certainly agree with the last statement that we do not want to limit the WHO too much, but we need to recognise that the breadth of the work that it does is quite substantial. As public health doctors we always get scared at the breadth of public health work. The three priorities that Dr Tedros brought in—the triple vision challenge: a billion people better protected in health emergency, a billion people covered by universal health coverage, and a billion people with better health—are broad public health challenges that need to be done at a global level. I would very much regret it if we ended up with the WHO doing emergencies, but we lost, for example, the huge work that the WHO has done globally over the decades in tobacco control. To lose that would be a major blow to the health of the globe, in a sense.

However, we have to recognise—this is an issue for every public health institution, from PHE[2] in England to the CDC[3] in Atlanta—that it depends what you count as failure. Failure to control non-communicable diseases like heart disease will have a severe impact, but that impact will be more in the future and possibly less visible. Failing to respond to an outbreak is very visible now, with very severe damage now, and political damage now. So there is always a tendency that the emergency programme will take priority. That is probably right, because there are things that we have to do, but we do not want to lose the rest of the work which the WHO does.

Q3 **Lord Alton of Liverpool:** Professor Harman and Dr McCloskey, thank you for your clear evidence. You said that you would unpack some of the detail for us.

[2] Public Health England
[3] The US Centers for Disease Control and Prevention

You will have seen reports of the trade in pangolins and bushmeat in Nigeria and China's wildlife markets. Is there a case for greater co-ordination between the World Health Organisation and the World Organisation for Animal Health?[4] Does the division between the two bodies make sense given that diseases such as SARS, HIV and COVID-19 may have had their origins in animals?

Dr Brian McCloskey: There is certainly a case for greater co-operation and co-ordination between all three actors—the Food and Agriculture Organisation, as well as the OIE and the WHO. That has been recognised over recent years with the growing focus on the One Health movement, which looks at the origins of disease in the context of both animal health and the environment. That is now built into the Joint External Evaluation, which is the means by which the WHO looks at how well its member states have the capacity to deliver the International Health Regulations. There is a specific section in it now that looks at the relationships, at a national and a local level, between the ministries of health, the ministries of agriculture, the OIE and the WHO. That has been built into the system, because it is important and it is being recognised.

When it comes to merging them, the core work of each organisation is so broad that one organisation would struggle to take on both or all three mandates. They have to be separate so that the OIE can focus on specific animal health issues. However, there needs to be a very strong co-ordination, at WHO level and at national ministry level, between those departments, because we recognise that so many of our diseases come from the animal kingdom that we have to focus on that. It is becoming more important and that co-ordination is absolutely vital for the future.

Professor Sophie Harman: I echo Dr McCloskey's comments. I would tend away from a merger, because those organisations have very specific mandates and work. The only thing I would add is that there should definitely be a greater focus on One Health, particularly with regard to antimicrobial resistance—AMR. Historically, the UK has led the way on that since the 2014 reports and the new 2019 strategy on AMR and One Health, so it also aligns to the UK's global health security objectives. AMR is one of the biggest threats to global health security, so this is not just about pandemic flus. The future in looking at global health will be this focus on One Health.

Q4 **Lord Reid of Cardowan:** Thank you to our guests. Could I put this point to them? COVID-19 is not the first pandemic that we have had to deal with. We have had SARS, Ebola, H1N1—better known to the public as swine flu. What were the main lessons learned by the World Health Organisation as a result of these prior epidemics? To what extent were these lessons, and the consequences and operations arising out of them, effectively implemented? Finally, are the revised International Health Regulations that were agreed in 2005, and the existing protocols for monitoring threats of this nature, adequate for the challenges that are now being thrown up?

[4] The OIE

Professor Sophie Harman: I study a range of global health institutions and I know of no other that gets as much criticism as the WHO and that responds to so much criticism. It adapts all the time, and it has adapted to those previous emergencies.

The lessons learned were very much about the importance of timeliness in identifying the threat and calling public attention to it; non-state reporting mechanisms to try to get around state compliance with the regulations; transparency; strengthening surveillance systems; and building that capacity within low and middle-income countries. You can see this from the revision of the IHR after SARS and the creation of the Health Emergencies Programme after Ebola. Considerable work has been done in low-income countries to build that capacity to detect and report outbreaks.

Of course, the points that you are reflecting on by mentioning this are whether that worked with Covid-19, and whether the IHR work. Again, I come back to my first point: that the majority of states detect and report, and we only hear about the minority that do not. Those are the ones that create all the headlines and concerns. Of course, you need all states to do it for it to be effective, so that is an issue that we need to explore. But the majority do it, and we have seen improvements in that area.

The question is really about one element of the special measures that are implemented: border restrictions and travel. States such as Australia have been very vocal about the WHO on this. This is a problem, an issue of balance, because obviously if the WHO calls this and suggests a ban on travel, there will be a lot of resistance from states and it may impact on their ability or willingness to report because they do not want it to affect trade. The WHO is always having to balance and manage this.

I do not think it is a problem with the IHR specifically but with how states implement and work with the IHR. I would not like to say that the states that follow the guidelines of the WHO have performed well—I do not like the word "perform"—in response to a global crisis, but they have managed it better, and they have put surveillance systems in place—this is constant surveillance; it is not just detecting a case, and that is it. It is the constant tracking and tracing of what has happened. You can see that that is a successful model.

So it is not a problem with the IHR; it is the states. If anything, the problem was that the WHO was focused on strengthening health systems in low-income countries and took for granted that those with strong health systems would just comply.

Dr Brian McCloskey: By and large, I think the lessons from SARS and other outbreaks have been identified, and have very much been learned, but there is obviously still more to do.

One of the principal things identified early on in the SARS outbreak was the need for co-ordination—bringing together the local response to the outbreak and the national ministry response, with the international

community and the WHO to support them. That was put in place by the WHO—you will be talking to one of the key people in that in the next session—and it has survived and developed. The Global Outbreak Alert and Response Network—GOARN—was established as part of that response. It has now grown and expanded, and there are now 200-odd partner organisations ready and willing to help the WHO with outbreak response. That is evolving into developing a regional approach.

A whole network of organisations like CEPI[5] now work together more collaboratively. Setting up virtual groups of clinicians and other experts who can immediately advise countries on the response to outbreak is now very much part of the response to COVID that we are seeing from the WHO. Those things have been learned and have been put in place, and are very effective.

The reporting and sharing of information, as Professor Harman has said, is better. We will have to wait to see what Helen Clark and Ellen Johnson Sirleaf's panel says about that, but the current view of the timeline is that the initial reporting worked well and the WHO got alerted. The WHO has also brought in a much wider network to collect information, using social media and newspapers. That triggered in as well with a tool called ProMED, which put in an alert about the first cases of pneumonia in Wuhan.[6] Those systems have been put place and have been expanded, and they are working.

I was part of the review committee for the International Health Regulations after the west Africa Ebola outbreak. Like many others, we concluded that the problem was not the IHR by themselves but the implementation of the IHR by the member states. We need to talk about how that can be improved, because that is where the weakness sits. We have moved on a lot in the last couple of years. There is now external evaluation of how that is done. However, there is more work to be done in overseeing that properly. I would say that the IHRs are fit for purpose, but the implementation at member state level remains an issue we have to focus on.

Q5 **Lord Grocott:** My question is about transparency. The WHO is often criticised for its lack of transparency, particularly in relation to pandemics. Is that a fair criticism? Is that the case? Could you suggest how transparency might be improved?

May I put one additional related point to both of you but particularly to Professor Harman? Professor Harman has said that most states report well but that there are a few that do not. Is there any common pattern in the numbers, size and characteristics of those who are not doing it as the rest of us would like to see them doing it?

Dr Brian McCloskey: I do not share the view that the WHO has a problem with transparency. I think it has been extremely transparent

[5] The Coalition for Epidemic Preparedness Innovations

[6] The Program for Monitoring Emerging Diseases (ProMED) is a programme of the International Society for Infectious Diseases to identify unusual health events globally

over the years, and throughout this pandemic, by putting on the record where it is, where it has changed its mind and where it has reviewed evidence. I think it has generally been doing well on that front.

We have to recognise that it is working in a very charged political environment, which is always the case in big outbreaks but particularly in this one because of the economic impact and the implications with the US Administration and China, et cetera. In that environment, there must always be some balance between complete transparency and a degree of diplomacy. Working as it did with China, for example, to encourage the collection of information was the right thing to do, but it is now criticised for being not transparent. There is always a balance, and diplomacy has to have its place in this work.

Equally, when you are working on an emerging infection and the science is not at all clear and we are learning day-by-day, there is a tendency for scientists to be reluctant to publish or to say openly what they think until they have had a chance to check and correct it, et cetera. That can sometimes lead to delays in information being shared. Again, we have been working through that. Currently much of the information about Covid has been put in the public domain, even without peer review, which is not always a good idea but it improves transparency.

However, there is a balance between not being certain of the science but having to speak up and give advice at the same time. Again, that applies at the national level as well as at the international level. I would say the WHO is transparent in this, but there are challenges, some of which are justifiable—for example, with regard to diplomacy—but we have to recognise that it works in a very difficult environment. Everybody wants to follow the science, but the problem for the WHO currently is that there is no science to be followed for much of this.

Professor Sophie Harman: I absolutely agree with Dr McCloskey on the issue of the science and following the science, but I would say that the WHO has been hugely transparent, and I reject the idea that it is not transparent. In preparation for this session, I looked at some of the briefings that it has been doing. It has daily briefings and a very public role for the Director-General, more so than we have seen before. There have been 23 member state briefings so far. Minutes of all the technical working groups are available. So, actually, there is a deluge of information and transparency on this.

The transparency question arises when we think about the quiet diplomacy in China. I imagine this is where this question is coming from. Was the WHO transparent enough in its dealings with China? I think it was. There is an element in all forms of diplomacy, as I am sure my esteemed colleagues in this group know, of having to do things quietly in order to have access to those states to investigate what is happening. So there is a little bit of a balance between health diplomacy and transparency in the science.

As I say, I think the WHO has been very transparent. I do not think an accusation of it not being transparent is easily met, but, again, we will see what happens when the Helen Clark and Ellen Johnson Sirleaf review comes out. Of course, the review was put to the WHO at the World Health Assembly and has been assembled quite rapidly.

In response to the question about trends in states that do not report, I have not systematically looked at this, but there is a general trend with states that you would expect. North Korea is an obvious example; it says that it has no cases, which I do not believe for one second.

There is a wider question about whether it is more populist leaders who are resisting reporting. People would say Brazil, and even Tanzania, which now is not reporting cases, which is incredibly worrying. I have not systematically looked at it, but you could say that there are some quite predictable trends within that. Of course, there are always unpredictable trends that do not prove the rule as well.

Q6 **Lord Purvis of Tweed:** My question is about funding. I readily accept that I have a very untrained eye, but I see in the organisation's funding process that, among the different categories of funding, there are: the assessed contributions from member states, which represents only 14% of the WHO's core funding; the specified voluntary contributions; core voluntary contributions; pandemic influenza preparedness funding; and projected funding.

The UK example is really interesting. Of the £630 million that we are donating over this two-year period, £49 million is in core assessed, £294 million is in voluntary, and £287 million is in projected. These are huge sums and it is very positive, but I wonder how resilient the WHO is, given the fact that the vast bulk of its funding comes from voluntary contributions and programme funding contributions. Presumably, each member state or funding organisation can decide its own priorities, which will potentially shape how the WHO operates. Is my concern unwarranted? What are the challenges, given the WHO's funding model?

Professor Sophie Harman: I think your concern is very much warranted. This is the biggest concern for the WHO and it is shared across the global health community. This is a trend that has been going on for 20 years. You see more and more voluntary contributions instead of assessed contributions. On the one hand, the WHO has managed to sustain itself, despite the fact that there has been a reduction in the amount that is going to its core budget for it to be able to set strategic priorities in the way that any major institution would.

Despite this, it has done quite a good job of sustaining its work, but of course this is hugely problematic, because no institution can plan strategically without being able to predict the type of income that it will have. There is also a distortion in health priorities towards big projects such as the Health Emergencies Programme, which quite rightly should be funded, and polio and malaria projects—the interests that states want to have funded.

I am not saying they are not important issues. They are hugely important, but, again, it comes back to the lack of funding for health systems and the very basic idea of the need to strengthen health systems and primary healthcare. That contradicts the wider mandate of the WHO. It is a huge concern and it is amazing that the WHO has been able to sustain itself this long through these measures.

A secondary point to make is about the role of philanthropy in global health governance. We know that the Bill and Melinda Gates Foundation is one of the biggest funders of the WHO, as well as other health institutions. This is very good and it is extra funding, but it comes with wider questions of accountability, transparency and the legitimacy of that organisation when it funds so people who cannot then hold it to account. There are myriad issues to do with the funding of the WHO in that sense.

Dr Brian McCloskey: I absolutely agree that this is a major issue for the WHO, certainly from a personal perspective. I have sat in on what is called the SHOC, the strategic health operations centre in Geneva, where the WHO manages these things, and watched people making almost impossible decisions without knowing whether the WHO would have the funds to deliver what it had to do.

The WHO has a no regrets policy, so it will always commit to doing it and will always overreact, but it still has to have sustainable funding at least so that it can work out how, after an emergency is over, it can start to rebalance the funding back into the core programmes like non-communicable diseases and mental health issues. The lack of that guaranteed sustainable funding at the right level over a long period limits how it can react and respond.

We have to recognise that emergencies scale up and suddenly create a huge demand for extra resources that are not necessary all the time, so we need contingency arrangements. The contingency funding that was brought in after Ebola was a good idea, but it is not yet sufficient and not enough member states are contributing to it. The UK is a major contributor, which is very welcome, but not all member states are putting forward what would be a reasonable view of what they should pay.

The World Bank pandemic fund again seemed a good idea, but it has not worked. It is not constructed well. Essentially, it does not deliver the money to stop a pandemic; it delivers the money only after the problem has arisen. Some of us predicted that after Ebola. We need to look at a different model that allows the WHO to know when it has a major need the money will come in and it will be able to rebalance on the chronic diseases later. We need some form of contingency arrangement, which should not be a voluntary contribution but one which the WHO can assess and rely on and know it will be there when it is needed.

Q7 **Baroness Fall:** I turn our attention to the pressures that the WHO has been under recently from geopolitical tensions, especially the most recent tensions between the United States and China. To what extent do you think the leadership of the WHO, and the WHO as a whole, has handled

this well? What could they be doing differently?

Dr Brian McCloskey: We have to recognise that geopolitical pressure is a reality in any UN agency. An agency cannot exist outside politics. Indeed, it would be naive to think that there was no political pressure or influence on the UK's response to coronavirus. It is a reality with something as big as this, with the economic impact that it has, that there will be political pressure.

In practice, the team at the WHO is quite good at managing this. Many of them have long experience, for example, with the polio eradication programme, where they had very difficult and sensitive political negotiations with Afghanistan, Iraq and Nigeria about getting that programme through. They are quite experienced and good at it. Dr Tedros has had a lot of experience in it, and that shows.

We need to recognise that this is an area where there is a greater role for the member states themselves, rather than the internal organisation in Geneva or the regional offices. Member states should help and support the team in managing that pressure, and making sure that the wrong decisions are not made and that they are accountable when the event is over.

I suggest that it is member states that need to step forward and help the organisation to manage those pressures, because the pressures are inevitable.

Professor Sophie Harman: I absolutely agree that political pressure is inevitable and it is something you just have to manage. Given the extreme situation of a major pandemic, and the withdrawal of its biggest donor, the WHO is handling it quite well. A proxy war was perhaps inevitable on this stage, and it was inevitable that the WHO was going to get dragged into it. It was inevitable, because Trump already had a dispute with China and was concerned about China's influence in the UN, so this was the major institution that fell into his line of vision, so to speak.

I think the Director-General has generally handled it well. The leadership has maintained very clear and transparent communication, as we spoke about before. It has stuck to the evidence and the science and has not got too dragged into it; it has not been having a Twitter war with President Trump, or anything like that. It has also drawn on member state support and the wider UN system.

It comes back to this epistemic community. When we think about the US, it is not just the President. A lot of people in the US are supportive of the WHO and work within the WHO, and have been very vocal, and in doing what he has done the President has subtly created an "us and them" situation. Are you with the WHO, which is following the science and trying to deal with this, or are you with Trump and trying to undermine it, while overseeing a catastrophic response to COVID-19 in his own country? It has been quite subtle. It has not publicly done that, but you can see that

the wider epistemic community around the WHO is trying to create these kinds of divisions.

There have been some missteps. The quiet diplomacy with China was good, praising China may have been a step too far, and the WHO has opened itself up to these accusations of bias. This is a minor issue that became a major issue.

It is also important to keep an eye on these criticisms. They are not just coming from the US, although the tensions between the US and China are quite significant. We need to think about the wider criticisms coming from Australia, which also has disputes with China at the moment, and Germany's criticisms, and the Taiwan debate.

These geopolitical tensions are not just US and China. I am sure the leadership in the WHO is very much keeping an eye on that. I think it is good that it did not pander to Trump and say, "Let's just blame China for this outbreak", because as soon as you do that you are on a path dependency of having to pick sides. That one minor misstep aside, and in trying to keep that neutral position, I think the WHO has managed a very difficult situation quite well.

Q8 **Baroness Smith of Newnham:** Thank you very much for your initial answers. We have already touched on the United States, and the next question concerns a bit more specifically the impact of the withdrawal of United States funding and its intention to withdraw from the WHO. Some of it is clearly financial, but there is the question whether there is a symbolism that could have a wider knock-on effect.

Professor Sophie Harman: The wider ripple effect is a vital question. It will have huge implications for the funding of the WHO and the WHO's budget. The US not only makes voluntarily contributions but contributes a lot to the assessed contributions, which is the core budget of the WHO. That will exacerbate the funding situation that we talked about before. That is big not just for health emergencies but for all the work the WHO does—all the really important work linked to the Sustainable Development Goals.

I would add that the US is also quite a large bilateral funder in global health, so I imagine that the flagship programmes that it runs will continue. That will also require some collaboration with the WHO. This is when the question of what withdrawing actually means comes into play.

I have two concerns in answer to your wider question. The first is the future of global health security. Will this set off a domino effect where other states think, "We've not had a great response to Covid-19, so we'll blame the WHO for this", and lead to further withdrawals from the institution? This will turn the whole idea of global health security on its head. As I said at the start, global health security, like most of the UN, is about collective security in response to a collective threat. If we see states trying to follow national programmes, or withdrawing from these institutions, that will not help anybody, and will exacerbate the threats.

How these arguments start to sink in to create a domino effect is a major concern.

Where this will start to get acutely felt, and one area that we should be very much keeping an eye on, is with the COVID vaccine. We do not want to see vaccine nationalism. This is a debate that is coming out now and it will be hugely important. We have to maintain global health security based on the notion of collective threat, collective security and maintaining work through co-operation with the WHO.

The bigger question is what that means for liberal internationalism. Is this the US really threatening to withdraw from liberal co-operation, being a leader on the world stage and collaborating with the United Nations more broadly? That is the other big danger flag and, as the Committee on International Relations and Defence, I am sure you are acutely aware of that. It is a wider discussion beyond global health, but because of what is happening it is definitely one to be concerned about.

Dr Brian McCloskey: I definitely agree that the loss of funding will be an issue, but to some extent the funding can be replaced if other member states want to step up and do it. It would be ironic if China did that, for example.

There are other issues. One, as Professor Harman has said, is the move away from global health security. The previous Administration in the US was very much the driver for establishing the global health security agenda. It was meant to be a way of bringing countries together to support global health. That was very much supported by the UK in getting started. The current US Administration is withdrawing from that, which is not a good signal for the future.

Another big issue for me is whether the withdrawal of the US will result in CDC Atlanta having to withdraw from the WHO. That would probably have a bigger impact than the loss of funding. As a PHE person, I always saw CDC as a rival, but they are one of the major contributors of expertise to the WHO, to the GOARN, et cetera. If they are disconnected, that will create a big technical gap as well as a financial gap.

That is one area where the UK could look to see if it can help ameliorate that problem. Public Health England is one-tenth the size of CDC, but we have always said that it has the same capability if not the same capacity. There is an opportunity for Public Health England to help to increase the capacity of the WHO to replace some of what it loses from the CDC. I think the UK Government should have that discussion in the light of the US decision.

Q9 **Baroness Blackstone:** How important is the UK's role in supporting and strengthening the WHO? Would the merger of DfID with the FCO have any impact on the UK's ability to support the tackling of global health challenges more widely? I have a supplementary question, but I will come to that later.

Dr Brian McCloskey: The UK has always been a very important supporter of the WHO, in two respects. First, it is a major funder, and has been quite active in producing funding, for example for the contingency fund. Also, it is active as a critical friend. It has not been a bland supporter of the WHO that just gives them more money, but an organisation, a Government, a member state pushing and driving for reform in the WHO where it was needed.

The UK has offered critical advice, been friendly, and not taken the US approach. It has said, "We need to see some improvements made. We need you to do this, this and this, and we will be with you to help you do it". It has also been important, because within the global health security agenda, for example, it has worked with other countries to support the WHO. The UK was one of the countries promoting the development of the tool to evaluate IHR capacity—the Joint External Evaluation—through the GHSA.[7] It worked to move it into the WHO as part of its basic assessment of IHR capacity.

That sort of supportive role by the UK has always been valuable. There is an opportunity now for the UK to step up again to be a much better critical friend and supporter of the WHO.

Professor Sophie Harman: Again, I agree. The UK has a significant role within global health more broadly, so not just within the WHO. In the WHO itself we are one of the biggest contributors to the programme budget. In the last two years, we were the second and third largest contributor to the programme budget. That is pretty significant if you consider these wider debates everyone is having on Chinese influence and that type of thing. We also have leadership within the secretariat and the executive board.

Again, I come back to the UK's strong epistemic global health community: leading health institutions from philanthropy such as the Wellcome Trust to the type of research coming out of universities such as Imperial, UCL, the London School of Hygiene and Tropical Medicine—all those kinds of institutions, which the publications are coming from. The *Lancet* has been leading a lot of the debate and the science on this, and it is based here in the UK.

The UK is broader than just what our Government do. You see the influence on global health around the world. Even people working in ministries of health in low and middle-income countries will often have come from doing post-graduate research in UK institutions. You see a huge influence there.

On the DfID merger, there are two concerns here. Again, the first comes back to the shared understanding about global health security being about strengthening the weakest link in the chain—strengthening health

[7] The Global Health Security Agenda, a group of 69 countries, international organisations and non-government organisations, and private sector companies with the vision of a world safe and secure from global health threats posed by infectious diseases.

systems and surveillance capacities in low and middle-income countries—which DfID has done a lot of work on. That is very important. It is a question of whether the Foreign and Commonwealth Office understands that that is part of global health security and not a need to protect the state in a very nationalist way.

A second concern is maintaining the 0.7% aid commitment and where that goes. Within the development community there is a concern that it will shift away from public health actors to more Ministry of Defence actors—military services and that type of thing. I know that is the Ministry of Defence as well as the FCO, but a general shifting of where that aid allocation is used is a very big concern.

To give an example, the UK has been a leader on sexual and reproductive health. It has huge projects under DfID in Nigeria and Sierra Leone. It is also a world leader in approaches to violence against woman. We know from independent reports that the FCO approach and the DfID approach to issues of violence against women are quite different. The DfID approach has been evaluated to be better; it is the idea that you prioritise violence against women and women's rights as a good in itself. The FCO, on the other hand, has sometimes used it as a way in which to criticise or exert the sanctions against particular states that the UK Government want to criticise or sanction. There is a tension there of great concern.

There is also the classic problem in international relations of a clash of values and interests. Global health is very much part of our values and part of our interest in global health security. The question is whether we will shift back and look towards our interests with the merger between DfID and the FCO. That was a bit of a long-winded answer to that question.

The Chair: Part of your answer means that perhaps I ought to declare a past interest that is relevant to your answer. When I was the Minister at DfID, for an overlapping period of about nine months, I held the post of the Prime Minister's Special Representative in the initiative for preventing violence against women, launched by William Hague, as well as being the champion leading across government on DfID's approach to reducing violence against women and girls. That is a rather convoluted declaration of past relevant interests.

Q10 **Lord Hannay of Chiswick:** Thank you for that very interesting testimony. May I ask two short questions? The first is on the powers of the WHO. If one accepts—perhaps you do not—that giving it really draconian powers like banning travel or instituting a mandatory lockdown in a country are a bridge too far, is there somewhere beyond what it has now, which is very little, which might strengthen its access to information and its ability to ask that? The second question is: if you had three points you wanted the British Government to make to the Johnson Sirleaf and Clark inquiry, what would they be?

Professor Sophie Harman: The draconian powers would definitely be a bridge too far in that they would not be effective. Even if the WHO had the power to shut down borders, there would always be states that would not do it and would try to go around it, as well as the private actors.

The way to strengthen that is through non-state actor reporting. The big issue is compliance. The borders are a sideshow to some of these issues. It is about getting states to comply. Strengthening non-state reporting is really important, and as Dr McCloskey said at the beginning it is about the WHO drawing on different sources, such as supporting whistleblowers, looking at what is happening in media trends, doing social media mapping and that type of thing. It is much more the quiet diplomacy that will be more effective.

As you know, the more sanctions you put in, the more people try to go around them and do not do them. Sanctions are notorious for not working in lots of different forms of international relations, and I think that would be acutely felt here within global health.

The three points to make to the inquiry are, first, that the majority of states report and only the minority do not. Secondly, there is a case for greater funding. Thirdly, we need to ensure that emergencies do not dominate the rest of the WHO's mandate; we cannot have a WHO that becomes hollowed out by the emergency imperative.

Dr Brian McCloskey: Having draconian powers would not be effective or helpful. I do not think the WHO would like to be in that position, because it would upset its neutral position.

We had a long discussion at our review committee about this question. One conclusion we came to was that the most effective power, to some extent, is the naming and shaming approach. If the WHO makes more public where countries do things that they should not do, or do not do the things that they should do, other member states could react to that. Certainly when people take actions beyond the WHO's recommendation on travel and trade, that should be made public. There are options to use the WTO for disputes, but that has never been used. There are some vague ways of doing it, but probably being more public and allowing the member states to react themselves is one way of doing it.

On the three points, one would be encouraging member states to be more active in responding to countries that do not report or do not take the right actions.

Secondly, there is the issue of how we can separate out the travel and trade issues from the public health issues. That has always been one of the problems and why some countries are reluctant to report events; they are concerned that it will result in the declaration of a public health emergency, which will lead to travel and trade restrictions and economic damage. They tend to hang on and not report.

There is a very important recommendation with regard to moving away from the public health emergency of international concern as being the only way in which the WHO can raise the alert internationally about a problem. The previous review committee and others have recommended an alternative international public health alert that would have no implications for travel and trade but would allow the DG to stand up and say, "This problem is becoming difficult, it is escalating, and I think we should now do something about it globally".

Linked to that, one of the criticisms of PHEIC[8] declarations is that, after a PHEIC is declared, nobody knows what is different and what they should do differently. Linked to the international public health alert, we would say that there needs to be a clear statement to the effect: "This means that the UN must do A, B, C. Member state Governments must do D, E, F. Charitable organisations and funders must do ... ".

There needs to be a clear declaration of risk, alongside a clear statement of what people are expected to do, and probably with a report-back mechanism saying, "Member states should do this, and they should report back to the WHO within four weeks they have done it". That gives the WHO greater power, in a sense, to influence what the key players do on this.

Q11 **Lord Alton of Liverpool:** Recalling how the deceased ophthalmologist Li Wenliang was forced to recant by the Communist authorities in China when he and other doctors tried to warn about what was happening in Wuhan, may I ask you about a statement made last week by an escaping Chinese scientist Dr Li-Meng Yan, who accused the WHO of concealment and corruption—her words—and said the Chinese authorities now threaten her life? Is she believable and credible? How and who should investigate her accusations? And how do we tackle China's ban on allowing Taiwan to join the WHO?

Dr Brian McCloskey: I am not sure that I can comment directly on the details, because I do not know them. I think we need to separate out in part what China does about reporting to the WHO and the world about incidents that happen in that country, that we need to know about, from how China decides to manage its population. We may disapprove of how China manages its population; it is an authoritarian state and it does things that we would not find acceptable, but to some extent it is a matter for China to decide how it wants to manage its country, unless we decide that we want to interfere in that as well.

I would also mention the commander of the aircraft carrier in the United States Navy who was sacked from his job for reporting a coronavirus outbreak on his ship. It is not unique to China.

There is an issue about how we can encourage and incentivise member states to do it and find other ways of getting the same information so that we can go back and challenge a member state. With the first cases

[8] Public Health Emergency of International Concern

in Wuhan, for example, as well as the Chinese reporting, information was coming out through the news media, through ProMED, which the WHO picked up on, which allowed it to go back to China to ask for confirmation and verification.

The WHO obviously cannot get involved in internal investigations of what happened in individual doctors' cases in China. It can generally comment on them, criticise, and advocate in support of protecting doctors and medical workers, but there is a limit to what it can do as regards internal investigations of these things.

Professor Sophie Harman: This question points to a really important issue of global health and human rights. This is not limited to China. It happens when you see human rights abuses under lockdown or quarantine measures, and it is about how you balance those factors. We know that when certain forms of lockdown are implemented there is a higher risk of violence. How do you account for that? That is one thing which the WHO has been a bit slow to adapt to. However, it works with its partner organisations such as the UNFPA and UN Women to address some of those issues.

Coming to your very specific point on China, again this is a wider question of China's human rights record. It is not just what is happening with the silencing of whistleblowers in China but what is happening with the Uighur community, and obviously with Hong Kong at the moment—something very much on the UK Government's mind at present. The international community has to think about this more broadly.

I would also stress the importance of the UN General Assembly and the Security Council, as well as the human rights bodies of the UN, in investigating this as part of their work. This might be in the report on the WHO's involvement in the relationship with China in response to COVID-19. The Director-General or the leadership of the WHO coming out and speaking to this would be not helpful at the moment. We need someone independent to look at these issues.

My response is very much that this is a really critical human rights and global health issue, and it is beyond the WHO, although that is not to exempt it from any complicity it has had in this regard.

The Chair: That takes us to the end of the allotted time on this session. On behalf of the Committee, may I thank both Dr McCloskey and Professor Harman for their contributions, which I know have been very helpful indeed?