HOUSE OF LORDS

Select Committee on International Relations and Defence

Uncorrected oral evidence: The World Health Organisation

Friday 17 July 2020

11 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. 2 Virtual Proceedings Questions 12 - 20

Witnesses

I: Professor Devi Sridhar, Chair, Global Public Health, University of Edinburgh; Professor David Heymann, Professor of Infectious Disease Epidemiology, London School of Hygiene and Tropical Medicine; OB Sisay OBE, Senior COVID-19 Adviser and Country Director for The Gambia, Tony Blair Institute for Global Change

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Examination of witnesses

Professor Devi Sridhar, Professor David Heymann and OB Sisay OBE.

Q12 **The Chair:** I will begin the second session today. In doing so, I am going to welcome as our experts Professor David Heymann, Professor of Infectious Disease Epidemiology, London School of Hygiene and Tropical Medicine; Professor Devi Sridhar, Professor of Global Public Health, University of Edinburgh; and OB Sisay OBE, Senior COVID-19 Adviser, Tony Blair Institute for Global Change. You are all most welcome. I would remind you that the session is on the record, it is broadcast and transcribed. I would remind all Members to declare any relevant interests as they may arise. To assist the broadcasters to be able to operate the system today, on each occasion I will invite by name the Member of the Committee who is to ask the next question to do so, and then I will turn to our panel of three experts in turn and indicate my invitation to respond to that question. As ever, I will ask the first question, which is broad, and then I will refer to my colleagues, who will go into more detail.

My question refers to the structure of the World Health Organisation and the powers that it has at its disposal. Are they adequate to deliver its mandate, including co-ordinating the response to the COVID-19 pandemic? What are the principal challenges to its effective operation? I will go in the order I introduced our experts, and begin with Professor David Heymann.

Professor David Heymann: Thank you very much for inviting me to participate today. The World Health Organisation, as you heard earlier, is an organisation with headquarters in Geneva and six regional offices. There are often tensions between the headquarters and the regional offices. Those tensions can be worked out by the Director-General, who spends more time with those regions, and with the regional directors, than he has in the past, in certain instances. Now, there is intensive work between the Director-General and the regional directors, and things are going smoothly, but let us remember that regional directors are nominated and elected by a regional committee, and it is the same Ministers of Health who in turn elect the Director-General. The Director-General does not have the ability to appoint regional directors. Their appointment is at the whim of the regional committees and regional Ministers of Health. It makes it quite a complex organisation, but it functions quite well, especially with intensive work from the Director-General.

As to whether the WHO should have more power to be able to enforce what it says, I think it does quite a good job now in setting norms and standards, and in using the few tools it has—the resolutions, regulations and treaty powers—to accommodate quite a bit. You heard earlier about the Framework Convention on Tobacco Control, which has had a major impact worldwide. This was initiated by Gro Harlem Brundtland, the Director-General of the World Health Organisation in the 1990s. At the same time the International Health Regulations, international law which cannot be enforced, provide a framework within which countries can

exert peer pressure on each other. Of course, there is also the resolution, an expression of political will, which has accomplished such things as smallpox eradication, polio eradication—almost completed—and many other activities.

Professor Devi Sridhar: The WHO is a member state organisation. That means it can do only what member states delegate it to do. It is composed of a World Health Assembly, where member states come together in an annual meeting to discuss what their priorities are. It is overseen more closely by an executive board made up of representatives, ideally from a technical background but increasingly of a political nature, of the different regions. These actions get delegated to a secretariat which has to deliver on them. As David highlighted, the regional issue adds a layer of complexity.

I want to highlight what it can and cannot do. The first of its three essential roles is a legal role. It is the only institution with any legal ability in this huge landscape of global health. Under the International Health Regulations, China had to notify the WHO. We can talk about the delays, but it notified the WHO on 30 December and the WHO sent a memo to other countries in early January. The next key moment was 30 January when it declared a public health emergency of international concern. There is some fixation on the word pandemic. Pandemic does not mean anything operationally. That was the highest alarm bell and that is where its normative legal powers stopped and responsibility to act transferred to member states.

The second is a technical role. It shares the best and latest information through daily briefings by its technical team. This has been led by science journalists, the director of health emergencies, Dr Mike Ryan, or Dr Maria Van Kerkhove. These people are technically expert and this helped in the sea of misinformation, and in trying to understand what the newest preprints were saying.

The third is a convening role of keeping all countries at the table. The World Health Assembly—this year virtually—brings all countries together to commit to having a vaccine or other products for the global public good. It has been trying to keep the co-operation going in a very fractured and difficult time in international relations.

It has challenges. I will highlight three. The first is in financing. Its budget is extremely limited for what it is asked to do. Its budget is less than for a major hospital on an annual basis. The second is the regional issue, as David highlighted. It could be seen as seven WHOs and there is very limited power over the regions. It has to delegate to those regions and hope that they can deliver on what is needed to be done. The third point is it is not a watchdog or enforcer. It cannot go into countries and say, "You did this wrong" or, "You did that wrong". That is just not its role. It is there to facilitate a forum for countries to come together to try to agree on a good path forward. It has always been seen as a mechanism of peace and solidarity. If countries cannot agree on health, what can they agree on?

OB Sisay: Thank you very much for having me. I should perhaps point out at the start that, aside from being Senior COVID Adviser at the Tony Blair Institute, I am also the Country Director for our team in The Gambia, advising the Government and President there. Beyond that, I fought Ebola in west Africa. I was the Director of the Situation Room at the National Ebola Response Centre of Sierra Leone. I have come up toe to toe with the WHO operationally fighting a virus. I might have a lot of criticisms of the WHO, but my view is very strongly, just to point out, that the WHO is as strong, or as weak, as its member states let it be. There has been a constant conflict as to whether it is to be a normative organisation, as you say, to provide scientific review, promote best practice, and all of this, or it is to be an operational organisation, to put boots on the ground and respond to outbreaks.

As the other speakers have pointed out, the organisational structure of the WHO starts with its treaty, and that weakens it. There is a debate about whether you want to make it stronger. Before SARS, it had some powers to impose travel and trade bans. After SARS, and when the International Health Regulations were revised in 2005, this power was removed. A key power the WHO might need to have to make it more effective is the power to inspect. It does not have that power at the moment. I do not agree that it should be given the power to impose travel and trade bans because, ultimately, these are health issues but there are also underlying political considerations. Over the last many years, the WHO's power has shifted more towards member states than towards the organisation itself.

The issue of regional directors is a very crucial one. During the Ebola outbreak in west Africa we had at least one president who was hiding cases. I watched my country, Sierra Leone, go almost to the edge of total catastrophe, and the WHO seemed to be doing nothing about declaring an International Health Regulation. The WHO could not do that. It had to get the consent of the government, and if the government were unwilling to do this, the WHO could not. There is all this discussion around the WHO and its funding and whether it is doing its job or whether it is not. It is about the member states and the world deciding what they want as the global architecture for public health. If you do not have the WHO, you are going to have to invent it. I will stop there.

Q13 **Baroness Rawlings:** That was very interesting. With 7,000 workers in the WHO, 150 offices, and a remit over when to declare emergencies and make recommendations, does the WHO have the right priorities? How effectively does it deliver its mission, for example, maintaining its day-to-day work in the context of the COVID-19 pandemic? Its advice so far, contrary to what has transpired in this country, is that the most vulnerable are children, adolescents and women, whereas here it has proved that it is men and the elderly. It said, "Test, test, test", which proved right, yet I am afraid to say was disregarded here, and now there is the ambivalent debate on masks.

Professor Devi Sridhar: I will start with the later part of your question and return to the first. A challenge for the WHO has been having its voice

heard in high-income countries. The United States, the UK and other European countries are so used to going it alone and setting their own agenda that some of that core advice the WHO was giving was not listened to early enough. I agree with that comment.

Coming back to the challenges, when Dr Tedros came in as Director-General, his priorities were firmly around universal health coverage—everyone having access to health services at primary healthcare level. The second priority was global health security and ensuring that we would not have a repeat of the 2014 Ebola outbreak. Those were the right priorities at the time. They are the correct priorities right now and are a more sustainable way of looking at this, because it is about systems and financing and how you set up the structures so that people can be healthy in their daily lives. There are other global health institutions which deal with disease programmes, whether it is HIV, TB, malaria or vaccines. In a way, it does not need to be disease specific and can keep a wider mandate. Its agenda is huge. We talk about COVID 19, but it also covers mental health, dementia, road traffic injuries, cancer, TB and polio. It is a huge mandate on a limited budget.

I am afraid for the knock-on effects we are going to see in the world. COVID 19 does not affect children or women as harshly as other groups. However, the knock-on effects are going to be extremely severe on them. What we have learned from previous outbreaks is that when there is disruption to health services, maternal mortality rises, because there is no one in clinics to help women give birth. You see vaccination campaigns halting for measles. We are already seeing polio campaigns being put on hold. We are going to go backwards on many of the agendas we were going forward on, including the child survival revolution, where children were doing better. We saw that on a smaller scale in west Africa in 2014. We call these the uncounted victims of Ebola. We focus on COVID-19 deaths, but no one is looking at the knock-on effects and all the deaths and the morbidity from the outbreak becoming a black hole and consuming all the resources and power. We are already seeing that not only with the WHO but the Gates Foundation, which is turning completely towards COVID-19, the World Bank, which is orienting its work towards COVID-19, and many governments who are orienting their services towards COVID-19. We have seen this in the UK with the NHS becoming the COVID health service and all the knock-on effects here. What is happening in the UK is exactly what is happening in countries across the world. It is good that the WHO is one of the few institutions to be looking more broadly and trying to take a view outside of COVID-19 alone. I will stop there.

OB Sisay: The WHO is asked to be all things to all people. The global public health space is huge. If you look at the reasons that people die globally, you see just how broad a responsibility the WHO has. As regards its capacity to respond to outbreaks, just before the Ebola outbreak in west Africa, the WHO's mandate for its core priority was moved away from pandemics, or epidemics, towards HIV. Mike Ryan had a team of over 200 and that was decimated to fewer than 50. The priorities were

changed. It was caught on the back foot when Ebola came. It has responded far better to COVID than it did to Ebola. There is a lot of talk around the WHO being China-centric or being heavily influenced by China. Dr Tedros had to practically threaten an international emergency incident to be able to see President Jinping. He saw him, and President Jinping insisted that they had to have a joint commission to investigate. It was to include the US, Singapore, Nigeria, Germany, Canada, plus Chinese officials. It did, and it got some data.

It is very difficult to take an organisation that is made up of scientists and ask it to do operational response. There is a key thing we often fail to understand. You can learn how to sequence the DNA of Ebola or COVID at Johns Hopkins medical school, but you cannot learn how to stand up and run command and control operations, which is the other element of an epidemic response. What we find very often is that the medical experts are being asked to do things they are not trained to do. It is one thing to understand surveillance. It is another thing to co-ordinate and command and control a national response across a lot of countries. That requires war-fighting skills, logistics skills and all those sorts of things. If we want the WHO to do well, we have to strengthen it.

The other question we have to answer concerns the current model. The WHO worked really hard after Ebola to bring together international experts to be able to respond. It has responded very well to Ebola in the DRC over the last few years. The question is whether you can bring enough experts to enter enough countries when the disease spread is so multilateral. If it is an outbreak in one country, fine, but now we have it across all countries, or many countries, it is very difficult to be able to do that. I think the WHO has made mistakes and taken missteps, but it has done better than it did before. It keeps learning lessons. Dr Tedros has been doing a very good job of being transparent, doing a press conference practically each day and taking questions. Yes, it could do better, but it is up to the global community to decide what architecture we want—I repeat—and to invest in that capability. I have a lot of criticisms of the WHO, but we must remember that it can only do as much as we will allow it to.

Professor David Heymann: The priorities of the WHO are clearly set by the member states. However, that is not the only input the WHO has from outside its own secretariat. It has many advisory groups. I chair one of the advisory groups at the WHO. It is a group that was set up after the west Africa Ebola outbreaks; a group that advises independently the emergencies programme. We have been meeting now for two hours twice a week for the past three months so that we can provide expert guidance to the emergencies programme on questions that it asks. I must say the questions it asks are very important. It is very concerned that we do not give it anything but evidence-based recommendations. You will hear that a recommendation of the WHO has changed from one time to another, such as advice on mask-wearing. That comes about because there is new evidence to the WHO, either published in medical journals or through some other source, which is used to provide evidence-based replies to

the WHO's questions so that it can produce evidence-based policies. The WHO works through many different ways, but all those ways are contributing externally to what the secretariat does, based on what the member states ask it to do.

Q14 **Lord Alton of Liverpool:** Given everything we have been told about bats and pangolins and trade in bushmeat, is there a case for greater co-ordination between the WHO and the World Organisation for Animal Health? Does the division between two bodies make sense given that diseases such as SARS, HIV and COVID may have had their origins in animals? How do you achieve greater co-ordination when a democratic country such as Taiwan, with a population of 23 million, and with a good story to tell about combating COVID and other diseases, is excluded from membership of the WHO?

OB Sisay: There is already a good degree of co-operation between the WHO and the World Organisation for Animal Health. There is always room for more, but I worry about creating even larger, perhaps unwieldy, organisations. For organisations to be fit for purpose, they have to be efficient and they have to have a clear focus and vision. I would not be in favour of merging those two together. I think we can increase the co-operation between them. As to the issue of Taiwan's participation, that is a political matter which I do not think I am qualified to comment on. I think yes, they could co-operate more, but as for merging them, I am not so sure. It is such a big beast trying to do so many different things. One of the challenges the WHO already has is just how broad its responsibilities are. I am not so sure merging it will allow it, effectively, to be master of all trades.

Professor David Heymann: I will start with Taiwan. Before I do that, I would say that I was 22 years with the World Health Organisation. I started on a secondment from the Centers for Disease Control and Prevention in the US for 12 years. I retired from the CDC and stayed on at the WHO as an executive director. During the SARS outbreak there were great concerns on the part of Taiwan that it was being excluded from the WHO's activities. The Director-General at that time, Gro Harlem Brundtland, spoke with the Chinese ambassador about this issue in Geneva. She told him that she was going to second someone to the Taiwan Centers for Disease Control to be a link between the WHO and Taiwan to resolve this problem, and the Chinese government had no concerns about that. There was someone in Taiwan during the entire outbreak of SARS. That has not happened this time. There are many reasons why it has not. As we have heard, this is a political issue. When Taiwan attempts to enter the World Health Organisation, there are always political discussions at the beginning of the World Health Assembly and those discussions usually end up with Taiwan being excluded again from the WHO. I cannot answer for that. It is the political arm of the WHO working and I mostly work with the technical arm.

It is very important that animal and human health groups work together, including the environmental agencies. There is a tripartite agreement, as you know, between the FAO, the WHO and the World Organisation for

Animal Health—the OIE in Paris. They are working now to add the UN Environment Programme as a fourth partner in that. They need to have a way forward which permits them to work together. Right now, the secretariat is at the WHO. When I was the executive in charge of that, we attempted to put the secretariat in Athens in an office that the government of Greece proposed to provide to the WHO for this purpose. Unfortunately, that office burned down just before the agreement to set up the tripartite with its own secretariat was signed. It has thus remained with the secretariat within the WHO. It is very important for moving ahead on antimicrobial resistance. It is also important in understanding animal-human interactions, especially in wild animal markets. There is an opportunity now for a country to provide support to the WHO, the FAO, the OIE and the UN Environment Programme by proposing an independent secretariat, which would permit them to have an identity and to move further ahead.

Finally, I would say a word about this animal-human interface, because, as you know, there is a WHO planning team of two persons now in China. One is a veterinarian from the secretariat at the WHO and the other is a medical epidemiologist from the London School of Hygiene and Tropical Medicine. They are working together in China as a pre-team to establish the ground for a full team to come in and investigate the animal-human interface, and work with the Chinese government in the long term. At the end of the SARS outbreak, the Chinese government had identified already that animal handlers were at greater risk of coronavirus infection, but, unfortunately, after that outbreak those studies were not continued as, the funding dried up. That cannot happen this time.

Professor Devi Sridhar: The animal-human nexus is incredibly important. There are 1.7 million viruses circulating in the animal kingdom, and, at any point, one of those could spill over and become a pandemic-like event. There are several barriers to that occurring. You first need a pathogen to move into a host—a bat or a pangolin—and then move into a human. At that point, it needs to sustain human-to-human transmission, and it needs to have certain characteristics to do that. Unfortunately, SARS-CoV-2 has many of the characteristics that make it incredibly infectious, including pre-symptomatic or asymptomatic transmission, and the fact that it is usually a mild illness in a lot of individuals, but it is not as mild as flu, and so you cannot just let it go through a population because of the mortality and morbidity associated with the virus.

What can we do to stop these transmission events? We are not going to stop the viruses in the animal kingdom. All we can do is try to stop and block them at that point of jumping when it might spill over. The OIE has a very important role to play in that, in partnership with the WHO. To take a step back, what does the WHO do in this space? The WHO's Health Emergencies Programme is dealing with thousands of signals or events occurring every month in the world. Of those, it has to decide which of the few hundred it wants to investigate, and of those, maybe 30 will get site visits. Of those, perhaps one to two become events which will need a

response. It is very hard to assess out of all those thousands of signals which ones are going to develop into a sustained outbreak or a pandemic. At the beginning, it is very difficult to discern what is happening. What could work, and David was referring to this, is some kind of tripartite or partnership arrangement which has very clear objectives around reducing these spill-over events and identifying processes such as deforestation, wet markets, increased frequency of contact between humans and animals, and urbanisation. All these processes are the reason we are having more and more spill-over events occurring as time goes on. It is about trying to understand how we can deal with this environmentally, in a proactive way rather than reactively, to prevent these spill-over events.

One thing I would say, having looked at the AMR partnership in detail with Dame Sally Davies two years ago, is that we do not want competition and territorialism between agencies. In the United Nations when you try to get agencies to work together, often you end up getting a lot of blockages and the setting up of parallel structures, without dealing with the core issues. How you set up the governance, the financing and the mandate are incredibly important, to ensure that it is effective and that you do not just create another body that competes with all the other bodies for money and authority.

Q15 **Lord Reid of Cardowan:** All our witnesses have referred to precedents for the present pandemic: Ebola, SARS, MERS, H1N1—better known as swine flu. What were the main lessons learned from those precedents? To what extent were the lessons learned effectively implemented? To what extent are the International Health Regulations, as revised in 2005, adequate for the threats and challenges that we now seem to face?

Professor David Heymann: I will start with some of the lessons. The lessons began back in the late 1990s when there were major outbreaks of both pneumonic plague in India and Ebola in DRC. At that time, I was working in the field and at the WHO in Geneva. I had worked with Ebola in Africa from the beginning of my career in 1976. The lesson from the 1990s was that the WHO was not able to communicate with member states as was expected. There were new technologies coming online such as the internet which eventually led to the WHO revising the International Health Regulations in 1995. That was a slow process which began with setting up a means by which the WHO could help member states by bringing in partners when they needed them through the Global Outbreak Alert and Response Network, as Brian McCloskey said earlier. It also included some new ways of working, taking information from sources other than the countries, through the internet and various other sources. The WHO all of a sudden became very powerful in information.

By the time the SARS coronavirus outbreak occurred in 2003, the WHO had at its disposal many different sources of information. It knew about the outbreaks in China in November 2002, but China refused to report them several times when the director-general went to it. It did not report until 3 April, I believe it was, when the Director-General accused China publicly of not reporting. The day after it reported it, Madam Wu Yi, the vice-premier, was on a plane up to Geneva to apologise to the WHO. It

opened up its communications with the WHO and became a close partner, and established the China CDC, and many public health capacities.

The SARS outbreak also gave Member States an opportunity to see how the WHO could potentially operate, not just how it was operating, because it had all these new and different core communication methods in place. A resolution during the SARS outbreak finalised the revision of the International Health Regulations. Instead of trying to stop disease at borders, they require countries to develop core capacities in public health which permit them to detect and respond when and where disease occurs. If there is a global emergency such as now, there is the safety net of the public health emergency of international concern and a global response. The IHR are now all about countries strengthening their capacities. The lesson has been that countries can do the best job in dealing with this. We need now for the development agencies, and others, to provide unspecified funding, matched by country funding and country commitment, to develop the capacities they need to detect and respond where and when disease occurs. We have learned many lessons. We are moving forward with those lessons being implemented in many ways, including through the Global Outbreak Alert and Response Network, and the revised International Health Regulations.

Professor Devi Sridhar: I would say the first key mistake that was made in the past, and that we have learned from, is about speed, and the speed of response. If we look at the 2014 Ebola outbreak, it took months for the WHO to even convene an emergency committee. In contrast, here we saw a very fast response. By 12 January, the WHO had managed to get the sequencing out of China. By 16 January, there were test kits and guidance for a blueprint for what a test kit could look like so countries across the world could start producing them. We saw that with South Korea. By the third week of January, it was starting to contact diagnostic manufacturers and asking them to make test kits.

The second mistake concerns overreaction. In the past, there has always been this fear of overreacting and scaring the world, I guess off the back of swine flu and previous flu pandemics. Here it has been the opposite. I think that the WHO, if anything, could be accused of scaremongering from the start. It was saying to take this extremely seriously and prepare and that this was not something to joke about. Even in early February, Dr Tedros in his briefings to African Ministers was talking about clinical outcomes and what that meant as regards acute respiratory distress and multi-organ failure.

A third mistake was around communication and messaging. In the past, the WHO was seen as not a secretive organisation, but it was quite hard to track what was happening. The daily briefings and communication and messaging have been quite open here. Where there was confusion, for example, around asymptomatic transmission, the next day the WHO has immediately held a press conference to clarify what was being said, and to answer any questions, to get in front of it.

A problem with the IHR going forward is around enforcement. You cannot force countries to comply. Was China too late notifying the WHO? When exactly did it know in December that it had a problem? That remains to be investigated, but there is not much the WHO can do to point a finger to say "You were too slow" at this point. It is not an enforcer.

The second point is that WHO guidance in the IHR has been oriented around poor countries. David talked about core capacities. The ideas in our minds working in global health were around rural Guinea, rural Haiti, plague—it was very much orientated towards that. There were two ramifications from that kind of orientation. The first is that travel restrictions are not generally recommended, because you do not want to cut off a place which needs help. We did not want to cut off west Africa and say, "No one is going to help you". Looking back here, China did not need the help of the world. It could have dealt with this outbreak largely on its own. It had enough staff and enough PPE, so could some travel restrictions at that point have made a difference? There is a big question in my mind over the role of travel restrictions, and whether we need to re-look at that as regards disease spread—exporting infection, not importing infection.

The next one is around the US and UK. If we look at all the indicators of core capacities and pandemic preparedness which align with the IHR, the US and UK usually come in first and second place. Places such as Vietnam, Thailand, Senegal and Ghana are really far down the list. If we look at the response to COVID so far, it does not align with that. The US and the UK have done remarkably—I will be frank here—badly considering their resources and capacity. If I compare it to our teams' work in Haiti and rural India, there you really have a tough job to deal with COVID. We perhaps need to re-look at core capacities and preparedness and re-make our indices to be more reflective for the next pandemic.

OB Sisay: If you do not share your riches with the poor, the poor will share their poverty with you. During the Ebola outbreak, we were pointing out that global disease resilience starts in the weakest places. We are only as strong as the weakest link in the chain. The WHO needs to do three things. It needs to detect an outbreak and contain it. That means it has to have more robust inspection powers. As the other witnesses have said, and they are far more expert in public health than I am, the idea of travel and trade bans is a double-edged sword and something that member states themselves did not want the WHO to have the power to do. That does not mean the WHO has to be without any teeth. Are we going to make it like the WTO, which has certain powers to enforce? I would argue that it needs to be more like the IAEA, which would mean it had the power to inspect.

Secondly, the WHO has to get countries to work together when an outbreak cannot be contained. We are perhaps seeing the world learning the wrong lessons from COVID when we look at the way countries are dealing with vaccines and at what one of my colleagues called the "wild

west of vaccine development". The WHO is the technical expert in deciding the allocation criteria for any new vaccines, but it is terrified of doing it because it is such a political hot potato. The countries that are funding the most want to take priority in how that vaccine is allocated. Those countries have to accept that some amount has to be exported to other countries. You cannot build walls for disease security. The WHO has to provide a safety net that is better than it is now. This goes back to what my more expert colleagues have been talking about, which is developing capacities in these weak and poor countries.

We have to take a second look at how we provide disease security and how we fund it. We have insurance for natural catastrophes and insurance for terrorism, but we do not have insurance for disease outbreaks. As Professor Sridhar said, the word pandemic does not mean anything. It starts with one case. The first response determines whether that one case becomes an outbreak, an outbreak becomes an epidemic, and an epidemic becomes a pandemic. If the first response to Ebola in west Africa had been well resourced and robust enough, we would not have had the number of needless deaths. When we fail to prepare, people, property and profits are lost unnecessarily. We have to look at the funding of the WHO, its powers and its work in supporting health system capacity in a lot of these poorer countries, because it is in all our interests.

The Chair: Thank you very much indeed. I am going to turn now to Baroness Helic. I am keenly aware that we have gone through four questions, but we have five remaining, so I know we are a little pressed for time.

Q16 **Baroness Helic:** Thank you to all our experts and colleagues. I want to ask about the WHO's apparent lack of transparency, particularly in relation to the handling of pandemics. In your view, is that the case? If so, how can we address it or how can it be best improved?

Professor Devi Sridhar: Transparency from Geneva has been better than I have seen it in previous outbreaks. I have been happy with that. I think there is a problem with regional transparency. It is very hard to know what is happening at the regional level as regards priorities, operations and budgets. If there is a push for transparency, it should be at the regional level. I think those in Geneva would also welcome full transparency across the system, and therefore full trust from publics about what the WHO is doing with all our public moneys.

OB Sisay: I agree with that. This Director-General has been very transparent. As I pointed out earlier, he has been holding press conferences practically every day. They are very transparent about what they know about the virus. A key aspect to understand is that we are only learning as we go along because it is a new virus. The key thing has to be, "We tell you what we know; we tell you what we don't know; we tell you what we think", and we never confuse the three. I think the WHO has been pretty much following that path. I agree with Professor Sridhar that at the regional level there needs to be more transparency. Again,

every organisation could be less bureaucratic and every organisation could be more transparent. Yes, the WHO could be more transparent, but it has been much more transparent than it was before.

Professor David Heymann: Rather than just agreeing with the others, I will give an example of how transparency was established at the WHO, at the request of member countries. The WHO has a network for the sharing of influenza viruses, both seasonal and pandemic viruses, that goes back 75 years. In 2007, there was an issue where one country had been sharing viruses and needed to get a vaccine that was prepared from one of the viruses it provided to the WHO through this surveillance network. It provided the virus freely, but when it wanted to get a vaccine made from this virus, it could not get it. The WHO provides the viruses to manufacturers at no cost and they produce the vaccines. There was a lack of transparency in where viruses were going when they got to the WHO. Through an intergovernmental process, governments decided that there needed to be more transparency. Now there is a free system that shows when a virus comes into the WHO which industry might take it to make vaccines. The WHO is a member state organisation and its transparency is clear. When it is asked to be more transparent, it solves that problem by becoming more transparent.

Q17 **Lord Purvis of Tweed:** I am not sure if the panel would have heard the question that I asked the previous panel as regards funding, and the slightly complex funding mechanism of the WHO. It is a combination of assessed contributions, voluntary contributions, core voluntary contributions, the pandemic influenza preparedness funding and projected funding within this two-year period. My question to the previous panel was: what challenges to resilience does that provide? May I also ask a question from a different perspective? The assessed contributions are only 14% of the WHO funding, but, because they are based on member states' GDP contributions to the UN, could it be that, because the WHO has a lot of funding from discretionary and voluntary contributions, the reduction in member states' GDPs that is likely to be seen because of the economic impacts could mean that the WHO is protected as far as its funding is concerned, if this is a major focus? Am I being too optimistic about potential funding for the WHO going forward?

OB Sisay: I think you are being optimistic when we step back and look at the WHO. Somebody pointed out a statistic to me the other day that the WHO's budget is lower than that of the New York Police Department. It has less money than the NYPD or as, another expert pointed out, a major hospital. Some time back in the mid-1990s, the WHO's funding was 50:50, so 50% from member states and 50% from non-state sources. Now it is something like 80:20 and only 20% comes from member states' budgets and 80% is non-state. There is a significant implication of this, because non-state actors fund programmes they like. In effect, they are directing, or buying, programmes for the WHO. That is quite dangerous because they run according to their own priorities. If the WHO has stronger core funding, it can decide for itself where all that funding is going to go. We need to take a look at it. Again, I go back to my point

that these are all political questions wrapped up in a health conundrum. We have to decide as a world what we want to fund and what is more important. We spend more on arms and all sorts of other things and we do not spend enough on health security. I am hoping that COVID concentrates minds on this. The WHO needs to be funded better. It needs to be funded specifically for its outbreak response capabilities. This 80%:20% funding has to be reviewed.

Professor David Heymann: I will try to talk a little bit about the GDP, as I understand it, and I am sure Devi can complement what I say. As I understand the formula for contributions, it was developed immediately after World War II and based on the GDPs of countries at that time. That formula of course put the greatest contribution in the hands of the United States. There have been attempts to change that formula. I believe it has been changed one time to decrease what the US is giving. If you look at the formula, it is still pretty much based on the GDP after World War II. However, many GDPs have changed since then, and many industrialised countries have a higher GDP than reflects their budgeting.

As far as the extra budget is concerned, it is a real dilemma for the WHO. Just as one example, countries right now want to see polio eradicated. The UK is one of the major donors to that, along with the United States, the Bill & Melinda Gates Foundation, Rotary International and others. That is distorting the budget of the WHO, because the WHO is being asked to do the implementation of this activity by its member countries. As a result of that, of the $21 billion so far spent on polio eradication, a good proportion has gone through the WHO. This has distorted its budget but has not permitted the WHO any flexibility for its other activities. Those are some of the observations I have: a GDP formula which I believe was developed after the world wars and continues to be disproportionate. At the same time, there is extra budgetary funding based on what countries want to see done, which creates a distortion to the budget.

Professor Devi Sridhar: I guess I would also say that it is an optimistic view, because, as you have noted, over 80% of the budget is discretionary, and that comes largely from the United States, the United Kingdom and the Gates Foundation. These are the top three donors in general in global health. Two questions follow. The first is whether donors will have that money, especially that discretionary pot, going forward. The second is: if they do, will they choose to spend it at the WHO? There are a lot of institutions you can spend your international money at. It is referred to in international relations as forum shopping. You choose the forum where you get the outcome you would like to have delivered. Here I would point to the Global Fund, GAVI and the World Bank, especially the Global Fund and GAVI. They were set up, first, because of what some saw as the failure of the United Nations to deliver on what they wanted to have, which was performance-based financing for specific objectives, and to pursue specific agendas which would be better pursued in some kind of multilateral forum, but outside the UN system.

To give you an example of that challenge, in the same week that the WHO asked for £150 million to combat Zika virus and received less than £20 million, the Global Fund had its replenishment conference and got £13 billion. The issue was not the money on the table but where donors wanted to spend their money.

To add to that, what has been interesting to see with the shifting world order is that the BRICS countries—primarily China, India and Brazil—are not paying into the WHO in the discretionary budget. They pay their assessed contributions. It is revised from time to time, but the real increase is pretty much flat over time given inflation. The real question is whether these new powers are going to want to contribute to the WHO or are they setting up their own ways to establish what they want to achieve in global health, whether it is bilaterally or regionally? China has a very strong bilateral programme. India is very involved regionally. It is more strategic how they engage, and that is quite a difficult position for the WHO to be in. How does the Director-General or leader run an organisation where there is such little control over the priorities of what is implemented? An analogy is going out for dinner with a bunch of friends and everyone orders what they want, but if you ask who is going to pay for it, the person who is going to pay for it will choose what everybody is going to eat.

The Chair: We are going to try and squeeze in the remaining three questions.

Q18 **Baroness Fall:** How is the WHO managing to navigate very difficult geopolitical tensions, especially between America and China? How is it doing? How could it navigate this more effectively?

Professor David Heymann: Despite the geopolitical tensions that are occurring, the technical arm of the WHO, as you have heard from many different witnesses, is working as it should work. It is providing information to countries in real time. It is providing recommendations that countries can evaluate and use if they wish, as they combat this outbreak of COVID-19. The WHO has always worked despite geopolitical tensions. Smallpox eradication was accomplished during the Cold War when the United States and the USSR together endorsed a resolution that called for the eradication of smallpox and worked side by side in the field supporting countries. I myself worked in that programme in India side by side with people from the then USSR. Technically we worked together seamlessly with the Indian government and were able to stop smallpox in India. The WHO has a way of working at the top which is clearly political, but at its technical levels it is a technical way of working, whether it is giving guidance or working in the field as advisers.

Professor Devi Sridhar: I really feel for the WHO because it is like it is the child of two warring parents and you do not want to choose which parent you like more, and so try to stay silent and let it play out. A lot of the critique of the WHO has been over its praising of China in January. All I can say, having looked at it carefully, is that that was the cost of getting the co-operation and getting the sequencing and information. We did not

want to have a repeat of SARS, where there was a delay in the sharing of information. We needed speed. Speed meant getting that sequencing out, and getting the test kits and materials out, so that African countries especially, which have very limited diagnostic capacity, could build their kits and be ready for any incoming infections. If the cost of that was praising China, so be it.

I would read the February China mission report as a joint report. No, it does not talk about human rights breaches during the COVID-19 response, but it was a joint mission with the Chinese government, and so you would not expect it to include that. You have to read it as a particular kind of document. Going forward, I would say on an optimistic note that scientific collaboration has been very robust. I have been very impressed by the way the WHO has managed to bring scientists from across the world together, including from China, the United States, Europe and Africa, to try to move forward the science, which is ultimately going to be the best way out of this current pandemic.

OB Sisay: The WHO has done a good job of trying to manage the political tensions that it finds itself in. When we hear about the WHO being accused of being too China-centric, I would point out a few things. The WHO's technical COVID lead is American. The WHO's head of case management is American. The WHO's head of labs is American. In its scientific endeavours, as Devi said, it brings together scientists from all across the world. In west Africa, post Ebola, it brought together an international expert team that did a good job in DR Congo. We should avoid trying to drag this organisation into political battles. It is the politics that is debilitating this organisation, and the less we expose it to that, the better.

Q19 **Baroness Smith of Newnham:** I was going to start my question referring back to OB Sisay's initial answer, where he said that if the WHO did not exist, we would have to invent it. I was going to ask, if the United States is leaving the WHO, whether it needs to consider reinventing a WHO. From what you have just said about needing to get away from politics, does the departure of the United States mean there will be less politics in the WHO, or that the WHO will be weakened by the departure of the US and the ending of its financial commitments?

Professor Devi Sridhar: The first thing to say is that it might be that the US does not leave the WHO, because legally it has to give a one-year notice period and it must honour its financial commitments during that period. At least for that buffer period, the current status and programming would remain. It depends on what happens in the November elections. The Democratic candidate, Joe Biden, has said that the US will be part of the WHO. He made that very clearly part of his electoral mission. I think there is still uncertainty over how the next year will play out.

If the US pulled out fully, it would hurt US interests, and I wonder whether congressional committees and the checks and balances within the US system would mean that it did not leave the institution. I guess I

am more hopeful. I think this was a symbolic and political moment of trying to shift blame and that it will not substantively change the work of the WHO or its engagement over the next year or two.

OB Sisay: It would be a terrible thing if the US was to leave. I believe that other countries might be able to step up to make up for the funding gap. However, the US carries quite a lot of expertise and influence, so it would be a terrible thing if it was to leave. There is an argument on your point that the politics might be reduced a little, and it could get on and do things a lot quicker and a lot better, but no, the world would be poorer for not having the US, purely in the sense of disease security. We are learning the wrong lessons from COVID. It should be bringing us closer together, not driving us apart. Allowing politics to slice and dice us is a terrible thing.

Professor David Heymann: I will not add much and just say, yes, there would be a great gap left by the US, but I know that other countries could fill that gap. I know the UK has very many skills to do that. We are not yet sure the US will leave, and hopefully it will not. The US provides support through collaborating laboratories in the United States itself. It provides support by secondments to the secretariat in Geneva and in the regional offices and it provides extra budgetary funding in the countries. It also provides experts to many of the advisory groups throughout the WHO. Some of that will possibly continue because much of it is academic and not from government institutions, but the NIH[1] and CDC, the two government institutions, provide much support, and they will be missed if they leave.

The Chair: We have been allocated an extra couple of minutes for the last question to be asked by Baroness Blackstone.

Q20 **Baroness Blackstone:** My question is about the UK and how important a role it can play in the WHO. Can it help to strengthen it? Will the FCO-DfID merger make any difference and have an impact on the UK's ability to support the tackling of global health challenges more generally?

OB Sisay: The UK is one of the most significant actors in the WHO. It gives quite a lot of money and it provides quite a lot of technical support. I would like to see that enhanced even further. If the US is to leave a gap, I would like to see the UK, and the European Union perhaps, expand in a co-ordinated way to fill that space quite strongly. The UK's commitment to international development has to be reinforced, not reduced. We are talking about 0.7% of GDP, which is a tiny amount of money compared to the capacity of a country such as the UK. The UK should be stepping up and taking more of a leadership role, especially now with Brexit. We have to step up and do more in our own right, and stop being what I would call reticent about moving forward.

I do not know the technical implications of DfID being absorbed into the FCO. I hope that those who control our foreign policy understand the

[1] The US National Institutes of Health

importance of the UK's soft power influences through the British Council and the WHO, and that they should be enhanced, not reduced. Somebody was talking about GDP and funding. Post COVID, I am worried that when we start to make cuts to pay for things, we will start to misplace value and only want to put money into things that bring profits. Health comes before wealth.

Professor David Heymann: Even if the US does not leave the WHO, the UK could be playing a much greater role, not so much financially but technically within the organisation. As an example, when the SARS outbreak began, there were only five people working in the outbreak response area of the WHO. Within 48 hours, the UK had seconded four medial epidemiologists to work in the WHO. Those experts co-ordinated various networks moving forward in the outbreak. One of those people is now in an international organisation and three are back in the UK contributing greatly to the global activities of the United Kingdom. The United Kingdom has much to offer. Countries prefer collaboration with the United Kingdom to collaboration with the country I come from—the US—because it is a much different type of collaboration. It is a collaboration which in many ways listens to what is going on and provides support where it is asked to provide support. The UK could play a much greater role than it is now. Hopefully in the future it will play that role through many different ways.

Professor Devi Sridhar: The UK plays a hugely important role. Just in this current COVID crisis within the WHO, it has donated almost £110 million towards the global response. It has one of the leading vaccine candidates and has committed to try to share that with the world if it is successful. This is a real opportunity to bolster the UK's leadership in soft power and influence in the world. China is trying to use the current absence of American collaboration to pursue a very bilateral agenda, but there is space for the emergence of leadership. We are seeing Germany, France and the UK trying to commit to a global world order which is collaborative and united. The UK has the advantage of DfID and its relationships with Commonwealth countries. It has a fantastic reputation. Instead of seeing the loss of US leadership as—just that—a loss, it would be great to see it also as an opportunity where the UK can play a big role and demonstrate the values, ethics and solidarity that emerged from World War II and which were why, ultimately, the WHO was created.

The Chair: I very much want to thank all our experts today. We wanted to compress a huge amount of information into a short time and your expertise has enabled us to do just that, to assist us in this first ever inquiry by this Committee into the work of the World Health Organisation. Thank you very much indeed.