Written evidence submitted by Professor Sophie Harman (Queen Mary University of London)

This submission is based on Harman's 15 years of research experience in global health security, governance, and outbreak response. The evidence presented suggests the UK was well positioned within the governing institutions of global health security to respond to pandemic influenza. However a combination of complacency, focus on external rather than internal threats and capabilities, failure to fully integrate biosecurity within wider security structures, and a narrow understanding of the wider security impacts of pandemics undermined sufficient preparedness and response to COVID-19.

The first three points relate to the UK's position within the current structures of global health governance and wider commitments to global health security. The final three points reflect an assessment of the three key UK strategies relevant to biosecurity, pandemic preparedness, and COVID-19: 2015 National Security Strategy and Strategic Defence and Security Review, 2018 Biological Security Strategy, and 2018 National Security Capability Review.

1. The UK has a prominent role in shaping global health security and pandemic preparedness.
    - 1.1 The UK is one of the largest contributors to the World Health Organisation's (WHO) programme budget, has clear leadership presence within the WHO's Secretariat and global health security teams.[i] The UK is a key donor to health-related programmes within the World Bank, GAVI, Global Fund to Fight AIDS, Tuberculosis and Malaria, and associated UN programmes (e.g. UNAIDS, UNFPA, UNICEF).[ii]
    - 1.2 The UK's membership of the Permanent Five within the UN Security Council and the G7 places it at the centre of determining global health security threats and offers additional diplomatic pathways to collective security outside of the health-specific institutions.
    - 1.3 The UK is at the forefront of investment in new forms of global health security governance such as the Coalition for Epidemic Preparedness Innovations (CEPI).[iii]
    - 1.4 The UK has a strong epistemic community of global health security experts: inclusive of scientists, epidemiologists, policy experts, publishers, and clinicians, often with previous experience of health emergency response. This epistemic community works in transnational partnerships to advance discovery and innovation in response to new outbreaks and international development health priorities.
    - 1.5 The UK exports global health security expertise and knowledge throughout the world by education and training through world-class institutions such as LSHTM, UCL, Imperial, Kings College London (KCL), and the University of Oxford, and deployment of health emergency and specialist teams.
    - 1.6 Prior to its merger with the Foreign and Common Wealth Office (FCO), the Department for International Development (DfID) has been a committed actor in strengthening low income country resilience to health emergencies through supporting health system strengthening and the development of surveillance systems for outbreak detection.[iv]
    - 1.7 The Global Health Security Index ranked the UK 2nd (behind the US, 1st) in pandemic preparedness and response capacities. This can be explained by the

international commitment to global norms and expertise outlined above, and the provision of universal health coverage to UK citizens through the NHS.[v]

1.8 There has been a proliferation of actors in global health governance with specific growth in the area of health security. While funding and attention is welcome, overlap, repetition, and division among actors can be an issue. This can potentially confuse clarity over pandemic preparedness and response; and allow states to be selective in the guidance, rankings, and diplomacy they seek to pursue.[vi]

2. The UK government has not made full use of its leadership position in global health security in the domestic response to COVID-19.

2.1 The expertise and positioning of the UK at the forefront of global health governance and security suggests an advantage in responding to COVID-19.

2.2 High rankings through international indicators such as Global Health Security Index can give way to complacency. The Index exists to encourage states to strengthen outbreak surveillance and response: however it can create a sense of false complacency among higher ranking states such as the UK. The main finding of the 2019 report is most states need to do better and are totally unprepared for a major outbreak. Rankings where no state is prepared for a pandemic, means that even the highest ranked have gaps and weaknesses in their preparedness strategies.[vii]

2.3 The UK government was selective in following WHO guidance and clear principles of health emergency response. Whereas the UK government's early response to COVID-19 clearly followed the IHR2005 guidelines on travel and trade restrictions; the government did not take timely and/or sufficient action on four clear principles of public health, emphasised by the WHO and partners: test; trace; protection of frontline workers; and, isolate or quarantine.[viii]

2.4 No evidence of leadership on securing a UN Security Council Resolution, prior to the 1st July,[ix] by which time the severe health, social, economic, and diplomatic effects of COVID-19 were evident.

2.5 There is a risk that the UK's domestic response to COVID-19 undermines the state's legitimacy in wider global health security.

3. The focus of UK biosecurity has been towards external threats rather than strengthening comprehensive domestic capability

3.1 Global health security rests on the strength of the weakest health system and therefore much focus, finance, and health diplomacy has been allocated to the development of health systems and pandemic preparedness and surveillance in predominantly low and middle income countries.[x] The UK has had a key role in this work as a bilateral partner through the work of DfID, and its multilateral work with global health institutions.

3.2 The UK's approach to pandemic preparedness has been to position the referent object of global health security threat as other states' health systems, preparedness and/or timely reporting rather than weaknesses in domestic capability. Lessons learned from previous outbreaks, e.g. Ebola, is notable within the UK government strategies but only in reference to the UK's work abroad, not its domestic preparedness plans.[xi]

3.3 Since the UK published the National Security Capability Review in 2018, the government has either not had time, inclination, or been distracted by general

elections and/or the dominance of Brexit on UK foreign and domestic policy to focus on global health security.

4. Pandemic influenza is identified as a threat to the security of the UK within key strategies but lacked investment, specificity, and external evaluation
   - 4.1 The 2015 National Security Strategy and Strategic Defence and Security Review and 2018 Biological Security Strategy are clear in understanding the nature and risk of the threat of pandemic influenza and identified public health 'particularly pandemic influenza, emerging infectious diseases, growing AMR threatens lives and causes disruption to public services and economy.'
   - 4.2 The Tier 1 threat has not been accompanied by sufficient investment. Funding for AMR and the UK Vaccines Network is clearly earmarked, but there is little commitment to surveillance strengthening, service provision, commodities, mitigating against wider impacts, and capacity in domestic health emergency response.
   - 4.3 Strategies on security, defence, and biosecurity emphasise the strengths of the UK position, and flag the economic opportunities of such a position, with little acknowledgment of the gaps or weaknesses.
   - 4.4 Where gaps or weaknesses exist they focus on standard issues of cross-government working and 'fusion doctrine,' strengthening partnerships with the private sector and academia, and a multi-sectoral 'all hazards approach.' These gaps miss the need for external evaluation, an all-government approach that is inclusive of local authorities, or expertise beyond the biomedical sciences in pandemic response.

5. Global health security is not fully integrated into thinking about defence and security in the UK.
   - 5.1 The National Security Capability Review pays minimal attention to issues of global health security with reference to co-operating with the EU on 'shared threats,' the threat of 'health issues' to economic security, and the example of UK Emergency Medical Teams in the 2014/16 Ebola response. There is no systematic analysis, expansion on the 2015 report, future updates or projections on the nature of the threat and necessary response mechanisms, or future training requirements.[xii]
   - 5.2 Global health security has minimal integration with related issues e.g. cyber security, intelligence, and only passing reference to wider UK capabilities such as the military within the 2015 National Security Strategy and Strategic Defence and Security Review. In turn, key security and defence actors such as the military and intelligence services have minimal inclusion in the 2018 Biological Security Strategy.
   - 5.3 A distinct Biological Security Strategy is welcome, but exacerbates the separation between health security and wider UK security priorities. Lack of integration between 'traditional' threats – intelligence, conflict, peace – and 'new' security threats such as pandemics, runs the risk of health emergencies falling between the cracks of two governance systems or a privileging of specific threats, issues, and actors over others.[xiii]

6. Biosecurity planning failed to account for how pandemics exacerbate wider insecurity and inequality.

6.1 All three strategy documents acknowledge the impact of pandemics on the economic security of the UK. However none consider the wider impacts on the care sector; social welfare; inequalities such as racial and gender inequality; or political impacts. This is despite previous health emergencies demonstrating the impact on gender inequality (e.g. Ebola, HIV/AIDS and Zika),[xiv] racial inequality (HIV/AIDS and Zika),[xv] and politics (HIV/AIDS).[xvi] As a consequence, there was no: strategy in place to deal with threats to women's security from an increase in domestic violence during quarantine periods (despite previous evidence of this from Ebola); consideration of the health and social drivers of infection and susceptibility to COVID-19 for specific ethnic and/or socio-economic groups; planning for the wider impact on a number of welfare issues from housing to child protection.

6.2 Local authorities and the Ministry for Housing, Communities and Local Government are exempt from listed partner agencies in pandemic preparedness and response. This is a significant oversight given local authority responsibility for social care, organising local community communication and response, and liaison between Directors of Public Health with central health authorities. Previous health emergency responses have shown the vital role of social mobilisation, local authority, and community responses in the organisation and delivery of social care, specific communication, and pandemic response initiatives such as contact tracing.[xvii]

About the author

Professor Sophie Harman (QMUL) has over 15 years of research and teaching expertise in global health politics. She has led research projects and published extensively on global health governance, African health systems, health emergencies, global health financing, and women, gender, and global health, most notably the books Global Health Governance, The World Bank and HIV/AIDS, and The Global Politics of Health Reform in Africa. She founded the British International Studies Association (BISA) working group on global health, was a Board Member of the International Studies Association (ISA) global health section and was Chair of the Section's Book Prize (2016- 2019), is a Visiting Professor at HEARD, University of KwaZulu-Natal, and has received several awards for her pioneering work (e.g. PSA Joni Lovenduski Award for Outstanding Professional Achievement for a mid-career Scholar, the Philip Leverhulme Award). She has worked as a consultant to UNDP and WHO. Her current work on COVID19 is as advisor to a CIHR grant on gender and COVID19; a collaborative project with the Fawcett Society, Women's Budget Group and LSE on the gendered impacts of the outbreak on women; and the Mile End Institute Global Health Security series. In addition she has given oral evidence on COVID-19 and the WHO to the House of Lords International Relations and Defence Committee and written evidence on the gendered impact of pandemics to the Women and Equalities Committee.

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rewarded with silver in the most recent Teaching Excellence Framework. Queen Mary has a proud and distinctive history built on four historic institutions stretching back to 1785 and beyond. Common to each of these institutions – the London Hospital Medical College, St Bartholomew's Medical College, Westfield College and Queen Mary College – was the vision to provide hope and opportunity for the less privileged or otherwise under-represented. Today, Queen Mary University of London remains true to that belief in opening the doors of opportunity for anyone with the potential to succeed and helping to build a future we can all be proud of.

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[ii] DfID. 2019. *Statistics on International Development: Final UK Aid Spend 2018* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/857904/Statistics-on-International-Development-final-aid-spend-2018d.pdf p44 (accessed August 2020)

[iii] CEPI. 2020. 'UK boosts support for CEPI to spur COVID-19 vaccine development' https://cepi.net/news_cepi/uk-boosts-support-for-cepi-to-spur-covid-19-vaccine-development/ 26th March 2020, (accessed August 2020).

[iv] DfID. 2020. 'Development Tracker: Aid by Sector, Health' https://devtracker.dfid.gov.uk/sector/2/projects (accessed August 2020); DfID. 2019. *Department for International Development Single Departmental Plan https://www.gov.uk/government/*publications/department-for-international-development-single-departmental-plan/department-for-international-development-single-departmental-plan--2 (accessed August 2020)

[v] Global Health Security Index. 2019. 'Index' https://www.ghsindex.org/ (accessed August 2020)

[vi] Sophie Harman. 2012. *Global Health Governance.* Abingdon: Routledge; Simon Rushton and Jeremy Youde. 2017. *Routledge Handbook of Global Health Security* Abingdon: Routledge

[vii] Global Health Security Index. 2019. 'Findings and Recommendations' https://www.ghsindex.org/ (accessed August 2020)

[viii] Richard Horton. 2020. 'COVID-19 and the NHS – 'a national scandal' *The Lancet* 395 (10229): 1022.

[ix] United Nations Security Council. 2020. Resolution 2532 (2020). https://undocs.org/en/S/RES/2532 (2000) (accessed July 2020); Sophie Harman (2020). 'COVID-19, the UN, and dispersed global health security' *Ethics and International Affairs* (forthcoming)

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[xi] *National Security Strategy and Strategic Defence and Security Review 2015* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/555607/2015_Strategic_Defence_and_Security_Review.pdf (accessed August 2020); *Biological Security Strategy, 2018* https://www.gov.uk/government/publications/biological-security-strategy (accessed August 2020).

[xii] Cabinet Office. 2018. *National Security Capability Review (NSCR)*

https://www.gov.uk/government/publications/national-security-capability-review-nscr (accessed August 2020).

[xiii] See for example case of Ebola, Sophie Harman and Clare Wenham. 2018. 'Governing Ebola: between global health and medical humanitarianism' *Globalizations* 15(3): 362-376.

[xiv] Ginette Azcona et al. 2020. *Spotlight on gender, COVID-19 and the SDGs: will the pandemic derail hard-won progress on gender equality?* UN Women https://www.unwomen.org/en/digital-library/publications/2020/07/spotlight-on-gender-covid-19-and-the-sdgs (accessed August 2020).

[xv] Ana Cristina González Vélez & Simone G. Diniz. 2016. 'Inequality, Zika epidemics, and the lack of reproductive rights in Latin America,' *Reproductive Health Matters*, 24:48, 57-61, DOI: 10.1016/j.rhm.2016.11.008

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