Written evidence submitted by Professor Anthony Costello and UCL colleagues (FRC0001)

Thank you for the opportunity to submit written evidence to the Committee in response to the questions you have sent to me. We have not attempted to address every point comprehensively but have provided brief responses to your questions below based on my views and this of UCL colleagues. I would be pleased to discuss any of these further.

This submission has been developed with input from UCL colleagues including: Professor Di Gibb, Dr Lu Gram, Professor Ilan Kelman, Dr Alexis Palfreyman, Professor Audrey Prost, Professor Max Parmar, Dr Sarah Petts, Dr Ed Fottrell, Sarah Chaytor and Dr Naomi Saville.

1. *What regions or countries in the developing world are best equipped to manage a major outbreak of COVID-19? What regions or countries are most at risk, and why?*

The approach of many African countries seems to have slowed the development of coronavirus. This includes: shutting borders, testing new arrivals, use of quarantine, and contact track and trace. This is supplemented by clear guidelines and briefing documents. Some countries may benefit from prior experience of managing other pandemics (for example Ebola outbreaks in Uganda, HIV, and TB). Whilst some African countries have initiated lockdowns, these are unlikely to be sustained for long given the significant economic hardship, especially for the most vulnerable, and impact on food and essential medicine supply (including for HIV).
Nonetheless the World Health Organization is now forecasting that 250 million people in sub-Saharan Africa will be infected with coronavirus in the next year. Their age profile is much younger than in Europe which may reduce mortality rates, but the prevalence of risk factors such as overcrowding, obesity, hypertension, diabetes has grown sharply among city dwellers in the past decade.
India has potentially the best access to lab testing, hospital intensive care and personal protective equipment, but their health budget has always been one of the lowest in the world in terms of % of GDP (1.3%), access to health care is highly unequal, and the impact of lockdown on the poorest groups eg migrant labourers has been severe (see for example, https://www.epw.in/engage/article/covid-19-crisis-understanding-state-economy-during-and-after-lockdown).

2. *How can UK aid best be targeted in the most fragile and/or conflict-affected states?*

Strengthening health systems to be able to cope with repeated waves of Covid-19 infections is particularly important. This will entail ensuring sufficient ICU beds, CPAP machines, PPE, oxygen and oxygen concentrator supplies and test kits that meet WHO standards, wherever possible, whilst recognising the potential limitations to equipment. Trials of antivirals and anti-inflammatory drugs early in the disease will be important.

Additionally, ensuring the **provision and dissemination of appropriate public information** about coronavirus will be critical. This includes ensuring accurate information is

disseminated in a large number of languages, including key messages about shielding the elderly and the need for local solutions in villages. This is important to mitigate the risk of rumours and misinformation, as well as to support public trust in government.

Support for those who are most vulnerable or most affected by coronavirus is also important. This might include social protection for those who have lost income through lockdown (such as cash transfers, or food aid on a large scale) and fortified blended food rations for all pregnant and lactating women and children from 6 months to 2-5 years.

It will also be important to ensure the **protection of food systems**, including by developing guidelines on how to produce food safely in the context of social distancing in the food production industry, and in manual farming systems.

3. *In your evidence to the Health and Social Care Committee, you said there was a risk "that people will start to turn to the east, rather than the west, for help". Why do you think that may happen, and what should the UK Government be doing to preserve UK influence in the developing world?*

There is an increasing perception amongst many countries in the global south that relationships with high-income western countries are weakening. This is coupled with proactive engagement from China – both long-term as existing infrastructure investment in several countries and, more recently, offering coronavirus loans to those countries involved in its Belt and Road initiative (at reportedly high interest rates, which may have future implications for the sovereignty of countries in the global south).
There is a sense in many low- and middle-income countries countries that investment and loans from China are more visible than UK aid. More recently, this has been compounded by negative perceptions of the UK's own management of the coronavirus epidemic through unfavourable media coverage and speeches by political leaders like President Museveni of Uganda. The UK must consider urgentlyhow best it can build productive working relationships with China and with countries in the global south to sustain influence.

It is also important that the UK continues to exercise 'soft power', in particular through participation in key global agencies and networks. This should include **continuing to contribute to the global, coordinated response to the COVID pandemic** through financial support to WHO (and through them, GAVI and CEPI). The UK could also do more to acknowledge and learn from several countries in tacking COVID in different but equally challenging circumstances (e.g. South Korea, Taiwan, Greece, NZ, Germany and Ghana).

The UK could also use its presidency of COP26 as an opportunity to demonstrate good governance (and acknowledge that COVID-19 is a by-product of human impact on the environment) by considering measures including:

- Adopting recently recommended COVID fiscal recovery packages to accelerate progress on climate change
- Establish a cross-party group to develop a coherent tax and spending strategy to support the UK's commitment to a zero carbon economy, and set the Nationally Determined Contribution well ahead of the COP26

- Setting up independent oversight of the UK's £8bn Export Finance (UKEF) fund to ensure it is not used to support fossil fuel projects or overseas buyers of UK defence and security goods and services, thereby directly undermining DFID activities and human rights

A further point to make is around language in UK Government communications and in particular the use of the term 'developing world', which may be viewed as a condescending phrase. It would be preferable to adopt either WHO regions, or the World Bank's HIC/MIC/LIC categorisation or country names instead.

4. *What has been the impact of the pandemic on the way that Western countries are perceived across the developing world?*

As noted above, the negative perceptions of the UK and US handling of the coronavirus pandemic, in particular, may give rise to doubts about their ability to offer support to LMICs.

5. *What would you expect the practical and reputational impacts to be of the US decision to suspend funding for the World Health Organisation? What if anything should UK be doing to mitigate that?*

On May 15 Dr David Nabarro, former UN Asst Sec Gen and WHO Envoy for Coronavirus, spoke out about the attacks on the World Health Organisation (WHO) by certain member states.
"*We just have a complete fracture in global leadership right now, to the point where the UN Security Council resolution on COVID was not approved because the World Health Organization was mentioned in the resolution. The people of the world actually should be going completely crazy with anger. There should be a petition of 500 million people to the world leaders, saying 'What on earth are you doing, what on earth are you playing at? We have the biggest crisis of all time in many of our livelihoods and you are squabbling. You are squabbling over whether the World Health Organization should be killed or kept alive when the world needs the World Health Organization more than ever because it's the only organization that pulls itself together, it's the only organisation that is supporting countries with PPE [personal protective equipment].*"

Dr Richard Horton, editor of the Lancet, has called the US decision to remove funding from WHO as 'a crime against humanity'.

WHO faces several challenges if the US decision to remove funding remains in place
- Direct and knock-on effects on assessed and voluntary contributions
- Loss of access to US expertise and academic advice
- An imbalance of global influence on WHO from the progressive rise in influence of other blocs eg China.

WHO Contributions
The United States is the largest member state funder of WHO. It's contribution to the 2018/19 biennium budget was $893 million (ie $447 million per year) of which $237 million was their assessed contribution based on their size and economic strengths, whereas $656

million came from voluntary contributions. One quarter of their contribution supports the global polio eradication programme. Figure 1 shows assessed contributions to WHO from major economies and Figure 2 shows the distribution of USA contributions and major programme areas supported.

The US contribution is vital to a UN body that has seen its budget fall steadily in real terms over the past 30 years. Unfortunately the US has suffered a surfeit of 'fake news' which has led to a direct causal relationship between Fox news misinformation and Covid-19 cases and deaths:
file://ad.ucl.ac.uk/home2/sejjlg2/Documents/Shubhangi%20Vasant%20Jadhav%20-%20Komal.pdf

The decision to scapegoat the WHO was largely based on rising US-China tension, and a misinterpretation of WHO politeness to China. WHO had maintained careful diplomacy to ensure international access to the country, which, in practice, they were not granted until February 16 2020.

FIGURE 1

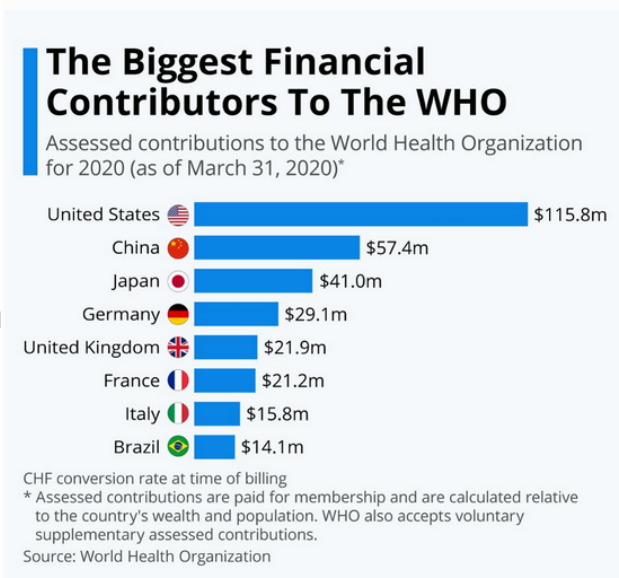
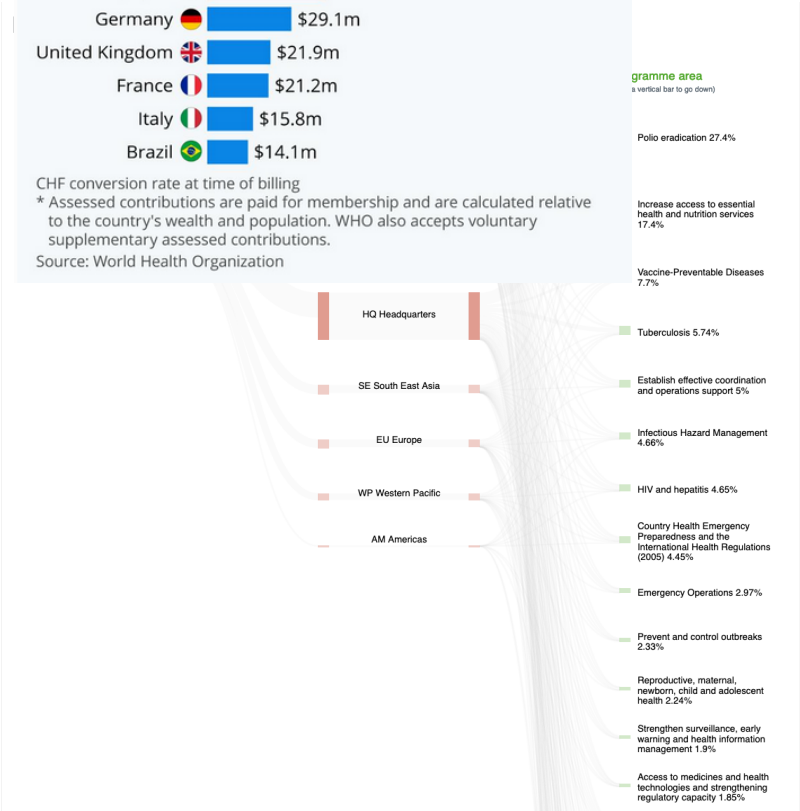


FIGURE 2



WHO struggles with the lack of freestanding monies from, on the one hand, reducing assessed contributions from member states, and on the other, the dominance of tied voluntary contributions. When COVID19 broke, on February 4, Dr Tedros (WHO DG) put out a global call for $675m to support their global response. A month later, on March 4 Professor Costello spoke with Dr Tedros in person and was told that, at that stage, they had received just $1.2m. This was two months into the worst global pandemic for a century. They did receive monies later in March but only about a quarter of what was requested. The organisation may also face threats from cuts in contributions from countries who wish to carry favour with the USA, particularly Australia or Brazil.
Even if US funding to WHO was diverted to other agencies, there are parts of the world where WHO has unique access such as in many states of north, central and west Africa, Yemen and other conflict areas. Failure to support fragile state programmes increases the threats to global security through epidemics, migration and war.

US expertise
WHO has a political and technical function. One of its greatest strengths is to collate expertise and evidence from world leading scientists around the world. The WHO leadership has expressed concern about losing the assistance of US institutions like the National Institutes for Health and the US Centre for Disease Control, as well as the enormous intellectual capital from US universities.

A shift to the East
WHO has much greater soft power than is realised. All member states have an equal voice and vote at the World Health Assembly. WHO guidelines are still the preferred source of health advice and guidelines to most low and middle income countries. If the USA pulls out, Japan and China are the second and third largest contributors to WHO. If Europe's support remains static, WHO will inevitably be forced to look East for funding and technical support. This may not be in the interest of the UK which has a special influence in WHO because of its large voluntary contribution, and the access we provide to our research base and funding in universities and international research centres. Links with DFID and the Department of Health are highly valued and respected at WHO. Dr Tedros appointed Jane Ellison (former MP) to be one of his deputy director generals in 2017 in charge of External Relations & Governance. The Wellcome Trust and the DoH in the UK have been the largest supporters of WHO work on antimicrobial resistance which presents a major security threat to the UK and globally.
For an aggregated view of what people around the world do and believe about the COVID response see https://covid19-survey.org/results.html

What should the UK do?
Now that we are leaving the European Union our relationships with new and emerging economies take on greater importance. The UK should not only retain its generous 0.7% aid budget but also celebrate this fact internationally. Restrictions on DFID travel has meant an absence of UK civil servants in international meetings and fora in recent years. This may be an opportunity cost as friendships and alliances underpin strong international relationships, which can also lead to stronger trade and business deals. Too often we find partners offering much lower funding for international programmes than DFID, while taking much of

the credit. **The UK should be far more proactive in celebrating and promoting its internationalist track record**, its support for multilateral institutions, poorer countries and global goods. DFID has a tremendous track record and the value of the BBC as a source of reliable and balanced news reporting around the world cannot be overestimated.

6. *What risks does the pandemic pose for governance, and what can the UK Government do to support good governance?*

There are dangers in every country around the world of the coronavirus epidemic, and lockdowns in particular, being used for political purposes. **The UK should work to ensure strong global cooperation to support good governance.** This is particularly important in view of global evidence on Covid-19 behaviours and their relationship to key variables including trust in government.

Additionally, the UK can seek to show leadership in good governance, including through transparency and diversity (diversity (of people and disciplines) in the provision of scientific advice and consequent decision-making and appropriate scrutiny of government actions. Clear and accurate public information is also critical; research has shown, for example, a direct causal relationship between Fox news misinformation and Covid-19 cases and deaths.

One small but significant gesture could be the donation of any spare mask CPAP ventilators to the poorest countries. After this wave of the epidemic we may have a surplus and countries like Nepal, Malawi, Nigeria and many others would benefit from a donation.

Most households living in LICs are likely to face significant challenges in adopting COVID prevention measures. Many of these challenges are driven by poverty and economic insecurity and include, for example, communal living and lack of handwashing facilities. These difficulties suggest that government policy advocating handwashing, social distancing, and the shielding of the vulnerable may not be effective at suppressing COVID-19, and lessening its impact, in LICs unless accompanied with substantial support to help households comply. The UK's work on support for water supplies, communications, and shielding and supportive measures for vulnerable groups should be a particular focus.

7. *How serious is the risk that the pandemic may be used to justify human rights abuses and suppression of the rights of vulnerable groups, including women and girls? What can the UK do to mitigate that risk?*

Research has pointed to the risk of significantly increased domestic violence and abuse of women and children is severe.

UCL colleagues working abroad have also provided worrying reports regarding a number of human rights abuses. This include:

- Quazi courts in Muslim family law continuing to perform child marriages whilst ceasing to operate for things deemed as 'personal matters' (e.g. divorce matters, violence complaints, and women's rights to child support in the event of divorce) in many

settings, with significant implication for the vulnerability of women and girls. For further information about child marriage issues in Palestine and elsewhere we would encourage you to reach out to the founder of Musawah - Zainah Anwar zainah@musawah.org

- Problems on the border of India and Nepal, with thousands of Nepalis trapped on the border of India who are not permitted to enter their own country, often for weeks without proper care or support, and facing open-ended quarantine in overcrowded camps where coronavirus is spreading, rather than in isolation. Indian citizens are similarly trapped in Nepal and unable to return home. Other Nepalis citizens are abroad and unable to return to Nepal following border closures. The UK could support the Nepal government to protect the human rights of its citizens by allowing them shelter in their own country including through support for a quarantine system where individuals are really isolated, before returning to their own communities/families instead of making 'covid camps'.
- Amber Peterman and colleagues have also written a review paper on pandemics and violence against women:

https://www.cgdev.org/publication/pandemics-and-violence-against-women-and-children

UCL has the largest and lost prestigious human rights law faculty in the UK. Lawyers can provide invaluable assistance in countries where abuses are infringing local laws but with impunity. The UK could use its academic legal resources to much greater effect for both human and environmental rights abuses.

8. *In your evidence to the Health and Social Care Committee, you mentioned the risk that the pandemic poses to the economies of developing countries. What actions can or should the UK Government take to support developing economies that may be badly damaged by the virus?*

The UK Government should consider both direct COVID-19-related help as well as broader economic support which will be important for mitigating the impacts of coronavirus and supporting recovery. It is important to remember that one size should not fit all in an effective aid response:
https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31089-8/fulltext

In particular, the UK should **increase funding for maternal and child health, nutrition and HIV/TB/Malaria** through the Global Fund and Global Financing Facility: a substantial number of indirect deaths are likely to occur due to hunger caused by disruptions in the cultivation of staple crops and health systems being too overwhelmed with COVID to provide essential health services.

Crucially, the UK (and the global community) should recognise that **interventions must be appropriate to specific national and regional contexts** rather than adopting a 'one size fits all' approach.

Finally, as a global research power, the UK Government could also consider how to **develop coordinated funding for research** in Africa and other countries in the global south on the

spread, treatment and impact of COVID-19 as well as UK-based collaborative anti-viral and vaccine research. Additionally, the UK should continue to invest in research to address critical indirect impacts of COVID-19 – for example to address modern slavery (building on ongoing FO and DFID investments) as a prolonged COVID pandemic has the potential to increase modern slavery and its risks in the UK and globally. It will also be important to ensure that, whilst research is appropriately directed to meet needs, funding decisions are not impacted by politics (as in the case of US funding being cut to research programmes with Chinese involvement).

The UK could consider how existing networks and collaborations, including through research projects, can support more practical actions. For example, the MRC Clinical Trials Unit at UCL has a number of close collaborations with countries in South and East Africa (including Uganda, Zimbabwe, Zambia, Malawi, South Africa, and Kenya etc. The CTU has have also sent out information about COVID-19, including animations being translated into a number of local African languages (via local radio stations). The Covid on the Breadline film (about the unintended consequences of Covid-19 and lockdown) is also an example of a collaboration with African colleagues.

Brazil is a new emerging economy with potentially a large and expanding market for UK trade. Brazil's epidemic is of huge concern, especially in terms of health system capacity and political leadership. So far this seems to have been mitigated somewhat by local-level governance, but it is heading in the direction of the US. The current death rate is likely a huge underestimate if the reports of people dying in queues to access emergency departments are true. The surplus field hospitals built in Rio and Sao Paulo only add a few hundred beds to ease the strain on the public hospitals. One of our research students has written the following:

"We are facing an extremely high rate of under notification, with low testing capacity, and lack of transparency from the government regarding planning and data. Our ministry of health was replaced by a new one on April 16th. The former ministry had strong opinions in favor of social distancing measures, which is opposite to the president's viewpoint. We had open press sessions daily with the former ministry, in which he debriefed strategies and current numbers. After the ministry changed, the press sessions became less frequent, and transparency declined.

Public hospitals are reaching their capacity in several states, and the number of deaths - although rising each day - are not reflecting the real numbers.

- https://www.bbc.com/portuguese/internacional-52383539

Brazil reports testing 0.63 people for each 1 thousand inhabitants as of April 24th. This is one of the lowest testing rates worldwide. From 15 to 21 of March, we had more than 8 thousand patients hospitalized for acute respiratory insufficiency, contrasting with around 1 thousand on the same period of last year.

- https://g1.globo.com/mundo/blog/helio-gurovitz/post/2020/04/28/o-impacto-real-da-covid-19.html (28/04/2020)

In São Paulo, deaths due to COVID-19 are in reality 168% more than the official number attributed to the virus.

- *https://www1.folha.uol.com.br/equilibrioesaude/2020/05/meio-milhao-de-mortes-somem-de-sistema-usado-para-monitorar-covid-19.shtml (14/05/2020)*

- https://transparencia.registrocivil.org.br/especial-covid

The number of deaths from 01/01/2020 to 14/05/2020 due to respiratory insufficiency/pneumonia is 58,869. The number for the same period of last year was 50133. So 8736 more deaths this year (not considering deaths already classified as due to coronavirus).
- https://simulacovid.coronacidades.org/
This is a modelling simulation that municipalities can use to see how many hospital beds and ventilators they have for coronavirus, and then simulate in how many days they will reach their full capacity depending on which non-pharmacological strategies they use.
I am working with this team if there is any interest to know more about this work.

- https://www.terra.com.br/noticias/coronavirus/cidade-do-rio-de-janeiro-tem-98-dos-leitos-de-uti-ocupados,f35647f81fc6abede388f72a4b26fca2x7do2znl.html
98% of ICU beds occupied in Rio de Janeiro state as of April 27th.

9. *In your view, have UK Government departments been effective in coordinating to deliver the £744m aid package that the Government has promised in response to COVID-19?*

We don't have sufficient evidence or insight to answer this question.

But one area that we see as important to emphasise is UK investment in **non-communicable diseases** (diabetes, heart attacks, strokes, hypertension, mental ill-health) prevention and treatment, which are among the strongest risk factors for COVID19.
In terms of regions/countries this is true in both South Asia, the Middle East and sub-Saharan Africa. In rural Bangladesh, a recent UCL partnership study found around 10% diabetes prevalence (75% of people unaware of their status), around 20% hypertension (45% of people unaware), and around 1 in 3 adults overweight or obese (and another ~20% underweight!). The study was in a context of low health literacy, weak health systems and health inequalities where risks are not evenly distributed across wealth centiles. All of these figures come from the DMagic trial and surveys published in the BMJ (https://gh.bmj.com/content/3/6/e000787) and the Lancet (https://www.thelancet.com/journals/landia/article/PIIS2213-8587(19)30001-4/fulltext).

The world has very little **good data** from LICs with which to understand the spread and impact of COVID. Most cases and deaths will occur in the community (as with all diseases) and will remain unrecorded and lacking a cause of death. The lack of basic data makes most LICs very ill-equipped to understand, respond to and evaluate their response to COVID. And it also helps to let governments off the hook as there is less accountability. The UK has some of the best institutions and strongest partnerships to collect data across low income countries. This support and network of expertise is vital to giving countries the skills and data they need and helps to build strong collaborative networks with the IT industry and local trade.

10. *What role should public and private debt relief play in supporting the poorest countries as they grapple with COVID-19?*

The UK should work with other countries to support **a longer, more extensive debt relief initiative for LICs** than the current package agreed by the IMF and G20 until the end of 2020. The UN Conference on Trade and Development and Debt Jubilee Campaign estimates that a $1 trillion debt write-off is necessary to provide fiscal breathing space for LICs to allocate sufficient funds to health and social protection during and after COVID.

May 2020