

Global Pandemics and Global Public Health



ABOUT THE INDEPENDENT COMMISSION ON MULTILATERALISM

The Independent Commission on Multilateralism (ICM) is a project of the International Peace Institute (IPI). It asks: How can the UN-based multilateral system be made more “fit for purpose”?

In answering that question, the ICM has analyzed fifteen topics. These include armed conflict, humanitarian engagements, sustainable development, and global public health, among others (see complete list in Annex 2). The goal of the ICM is to make specific recommendations on how the UN and its member states can improve responses to current challenges and opportunities.

The ICM undertook simultaneous tracks of research and consultation for each issue area on its agenda. The Commission initially launched in New York in September 2014, followed by subsequent launches in Vienna, Geneva, and Ottawa. In February 2015, the ICM briefed delegates from the five UN Regional Groups in New York. The Commission also convened meetings with Ambassadorial and Ministerial Boards in New York, Vienna, and Geneva. Global outreach included briefings to officials in Addis Ababa, Berlin, Brasilia, Copenhagen, New Delhi, London, Madrid, Montevideo, and Rome. Civil society and private sector outreach and engagement also constituted an important component of the ICM’s consultative process, including a briefing specifically for civil society in June 2015.

The research process began with a short “issue paper” highlighting core debates and questions on each of the fifteen topics. Each issue paper was discussed at a retreat bringing together thirty to thirty-five member state representatives, UN officials, experts, academics, and representatives from civil society and the private sector. Based on the inputs gathered at the retreats, each issue paper was then revised and expanded into a “discussion paper.” Each of these was uploaded to the ICM website for comment and feedback, revised accordingly, and presented at a public consultation. The public consultations were webcast live on the ICM’s website to allow a broader audience to take part in the discussions.

This paper is one of the fifteen final “policy papers” that emerged from this consultative process. A complete list of events taking place as part of consultations on this specific issue area and of those involved is included in Annex 1. The recommendations from all the policy papers are summarized in the ICM’s September 2016 report “Pulling Together: The Multilateral System and Its Future.”

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Contents

Executive Summary	1
Introduction	3
Mapping the Landscape	4
Epidemics and Pandemics	4
Other Health-Related Challenges	5
The Impact of Other Global Trends	7
Overview of Current Debates	10
Revisiting the WHO's Role and Structure	10
Implementing the International Health Regulations and Other Frameworks	11
Coordinating among Global Health Actors	12
Increasing Preparedness in Response to Recent Outbreaks	13
Conclusions and Recommendations	16
Reaffirm the Centrality of WHO	16
Strengthen Normative Frameworks for Accountability	17
Forge Partnerships and Reinforce Linkages beyond WHO	18
Recall the Primary Responsibility of States	19
Annexes	21
Annex 1: ICM Personnel	21
Annex 2: ICM Policy Papers	24
Annex 3: Participation in Consultations	25

Executive Summary

The global health architecture is increasingly under strain, largely due to recent, ongoing, and potential global health crises. Pandemics and epidemics are occurring at an unprecedented rate in recent years, spurred by globalization, environmental changes, and a crowded world population. The Ebola crisis in particular revealed serious flaws in the capability of the system to prevent and respond to these crises. As the links between health, development, and security challenges become ever clearer, the multilateral system anchored in the United Nations must address these issues with renewed focus.

The World Health Organization (WHO) remains the right organization to set international policies and coordinate action in the area of global public health. That said, the organization's structure and operational capacity need to be strengthened and bolstered by existing and new partnerships, including with regional organizations, nongovernmental organizations (NGOs), and the private sector. These actors are geared toward finding innovative solutions, and establishing stronger relationships with them could enhance the ability of local, national, and global health systems to respond to crises. Such partnerships have worked in the past and have become increasingly prominent because they are often more flexible and result-oriented and attract more resources.

Institutional silos are an impediment to sound and holistic policymaking, smooth implementation, and operational capacity. These silos have effectively created an international system that is insufficiently prepared for an outbreak and reacts too slowly when an outbreak escalates to a global health security threat. Furthermore, the lack of adequate funding for the international health system, including the lack of assessed contributions to WHO, hampers its ability to meet demands. Moreover, as the report of the High-Level Panel on the Global Response to Health Crises highlights, there is a need to improve the operational capacity of WHO and to increase

accountability within and to it.

The multilateral system can play both a normative and a more operative role in helping member states build resilient and robust national health systems, such as through investment in human capital, political commitment, community engagement, technology development, and international solidarity. At the national level, there is a need to implement comprehensive public health policies, as many challenges transcend the health sector. The multilateral system should support the development of these inclusive and inter-sectoral national health policies and systems, as well as assist states in implementing the International Health Regulations. The 2030 Agenda for Sustainable Development in particular provides an opportunity for such a structured and comprehensive approach. More than half of the seventeen Sustainable Development Goals (SDGs) relate to health, either directly or indirectly, including Goal 3 to “ensure healthy lives and promote well-being for all at all ages.”

The paper makes a series of recommendations aimed at the UN system, member states, and other global health actors:

- **Reaffirm the centrality of the WHO:** WHO remains the right organization to make international policies and coordinate action on global public health. However, its accountability mechanisms, operational capacity, and structure need to be adjusted and strengthened, and it requires more assessed contributions. WHO should also work with the secretary-general to follow up on the recommendations of the High-Level Panel on the Global Response to Health Crises.
- **Strengthen normative frameworks for accountability:** The international community needs to reaffirm the normative dimensions of global health mechanisms. A global health

summit and a high-level council on global health crises could contribute toward this end.

- **Forge partnerships and reinforce linkages beyond WHO:** There is a need to establish further synergies and coherence with other recently adopted agendas and frameworks that seek to address challenges that have a direct impact on global health, such as the 2030 Agenda for Sustainable Development, the Paris Agreement on climate change, and the Sendai Framework on Disaster Risk Reduction. The
- **Recall the primary responsibility of states:** Governments and health ministries should ensure their healthcare systems are sustainable, reliable, comprehensive, resilient, and based on inclusive approaches. States should also reaffirm the protection of health professionals and facilities and further explore the role of military forces in health emergencies.

multilateral system should also strengthen partnerships with private sector actors.

Introduction

Public health threats have long posed a challenge for the international community. International health cooperation began in 1851 when government representatives gathered in Paris for the International Sanitary Conference to address the spread of cholera. Since then, the development of basic public health practices and advances in medical technology (e.g., vaccines, antibiotics, and diagnostics) have countered many public health risks. When combined with other factors, such as declining rates of poverty, malnutrition, and child mortality, the average global life expectancy increased from 67 to 71 years between 2000 and 2015.¹

At the same time, dramatic social, political, economic, environmental, and demographic changes are expected to increase the conditions that give rise to pandemics and other public health crises. The world population reached nearly 7.6 billion in mid-2017. It is growing at a rate of 1.1 percent per year and is projected to increase to roughly 8.5 billion by 2030 and 10 billion by 2050.² This trend is taking place against a backdrop of dramatic changes in the way humanity inhabits and interacts with the planet. The planet is becoming more crowded. Urbanization is exploding to the point that more than half of the world's population lives in cities. This,

in combination with the ongoing industrialization of developing countries, is dramatically changing the Earth's biosphere. Demand for food and water is outstripping supply, and the resulting scarcity fuels conflict and violence. Natural disasters are becoming more frequent and more severe.³ All of this has dramatic implications for public health and well-being.

Epidemic and pandemic diseases such as influenza, malaria, polio, Ebola, tuberculosis, HIV/AIDS, and SARS pose additional threats to public health, particularly in developing countries. Developing countries are disproportionately affected by outbreaks of these diseases and the resulting crises, which are often exacerbated by a lack of investment in their health infrastructure and uneven burden sharing for this responsibility between developed and developing countries. It is impossible to respond effectively to health crises without building the capacity of national healthcare systems, which are not only essential to the health of populations, societies, and economies, but also key to preventing their spread across international borders. In light of these continued shortcomings and new challenges, a rethinking of how to strengthen approaches to managing global health is needed more than ever.

1 UN Department of Economics and Social Affairs, "World Population Prospects," 2017, available at https://esa.un.org/unpd/wpp/Publications/Files/WPP2017_KeyFindings.pdf ,

2 UN Department of Economics and Social Affairs, "World Population Prospects," 2017, available at https://esa.un.org/unpd/wpp/Publications/Files/WPP2017_KeyFindings.pdf .

3 Centre for Research on the Epidemiology of Disasters, EM-DAT Database, available at www.emdat.be/database .

Mapping the Landscape

The world faces a wide range of public health challenges, including: (1) communicable diseases, which have the potential to become epidemics or pandemics; (2) other challenges directly related to health, including hunger and malnutrition, noncommunicable diseases, maternal and child mortality, road accidents, substance abuse, mental health issues, suicide, and small arms; and (3) other challenges that have a more indirect effect on public health.

EPIDEMICS AND PANDEMICS

A number of communicable diseases have led to recent, ongoing, or potential epidemics and pandemics:

- **Influenza:** By far the greatest pandemic threat comes from influenza viruses, such as the H5N1 virus outbreak in 2003, the H1N1 epidemic in 2009, and the ongoing H7N9 epidemic in China. Reflecting the scale of this threat, WHO's classification of pandemic phases is based on influenza outbreaks. The Spanish flu pandemic of 1918-1920 was the deadliest influenza outbreak in modern history, killing somewhere between 50 and 100 million people. A particularly deadly and virulent strain of influenza could emerge within the coming decades, either from natural or manmade origins.⁴
- **Ebola:** Beginning in 2013, West Africa experienced the worst outbreak of Ebola in history. This outbreak was not just a health crisis; it evolved into a social, humanitarian, development, and economic crisis. As Ebola spread and its death toll began to double every few weeks, it destabilized whole countries. The epidemic paralyzed the healthcare systems in Guinea, Liberia, and Sierra Leone, leading to preventable deaths from others in need of healthcare. It also deteriorated security, with local police and military using lethal force to quarantine areas and rioting mobs attacking and killing officials. The economic consequences are not yet fully apparent, but expected gross domestic product (GDP) growth rates in the region have been reduced by multiple percentage points, and experts expect the negative economic impact to be in the order of billions of dollars. These spillover effects, the inability of the countries affected to cope, and the international community's late and (according to some) inadequate response show that the world needs to find a way to prevent, anticipate, and respond to such health disasters more quickly and effectively. Another Ebola outbreak in the Democratic Republic of the Congo in 2017 reveals the need for continued vigilance against the virus.
- **Neglected infectious diseases:** One billion people suffer from neglected infectious diseases, mostly in tropical areas. These diseases, such as trachoma, schistosomiasis, and leishmaniasis, historically attract little investment for treatment, prevention, or control and disproportionately affect the poorest and most vulnerable people. Improved drug delivery and better diagnostic tools are required for effective treatment, mapping, and surveillance.⁵
- **Polio:** Despite hopes it would be eradicated in 2017, the persistence of polio in Afghanistan, Nigeria, Pakistan, and Syria starkly demonstrate how zones of instability are more vulnerable to disease. Syria was declared polio-free in 1999 until its reemergence in 2013, following the

⁴ "Bill Gates warns tens of millions could be killed by bio-terrorism," *The Guardian*, February 2017.

⁵ Bill & Melinda Gates Foundation, "Neglected and Infectious Diseases," available at www.gatesfoundation.org/What-We-Do/Global-Health/Neglected-Infectious-Diseases.

onset of civil war. The healthcare infrastructure has since been devastated, and childhood immunizations have fallen from 95 to 60 percent.⁶ Better understanding the linkages between instability and polio is necessary to identify vulnerable regions and more effectively anticipate and respond to outbreaks. Diplomacy, strategic coordination, and advocacy could be important tools to expanding access to healthcare services in vulnerable regions.

- **HIV/AIDS:** While the global number of people dying from AIDS-related causes is steadily decreasing, from 2.3 million in 2005 to 1.6 million in 2012, HIV/AIDS remains a major health crisis in parts of Africa, which accounts for about 70 percent of global deaths from the disease. Moreover, many people living with HIV, particularly in low- and middle-income countries, still do not know their HIV status.⁷
- **Malaria:** In 2015, there were roughly 214 million malaria cases and an estimated 438,000 deaths from malaria. Yet over 6.2 million malaria deaths have been averted between 2000 and 2015, primarily in children under five in sub-Saharan Africa. The global malaria incidence rate has fallen by an estimated 37 percent, and the mortality rate by 58 percent.⁸
- **Tuberculosis:** Tuberculosis (TB) kills over 4,100 people a day and is now the number one infectious killer in the world. Drug-resistant forms of TB represent a significant threat, in particular multidrug-resistant tuberculosis (MDR-TB). An estimated 480,000 people around the world developed MDR-TB in 2014, and its cure rate hovers under 50 percent.⁹ A

recent UN report predicts that 75 million people could lose their lives to MDR-TB in the next 35 years. Yet between 2000 and 2013, TB prevention, diagnosis, and treatment saved an estimated 37 million lives.¹⁰

Antimicrobial resistance further increases the risks posed by a number of these diseases. Common infections are developing resistance to antibiotics at a quickening pace. So-called superbugs already kill 700,000 people each year, a number projected to rise to 50 million by 2050.¹¹ Multi-drug resistant strains of diseases such as tuberculosis, syphilis, and gonorrhea have spread globally, making them extremely difficult to treat. Drug resistance results in part from overuse of antibiotics on humans, on animals, and in agriculture. In the US, for instance, over 70 percent of antibiotics are sold for use in animals and livestock. The first-ever UN high-level meeting on antimicrobial resistance was held in September 2016 to call attention to this emerging crisis and propose a multi-sectoral response.

OTHER HEALTH-RELATED CHALLENGES

A number of other issues related to health require multilateral attention:

- **Hunger and malnutrition:** 793 million people suffer from chronic hunger, according to the UN Food and Agriculture Organization. Approximately 100 million children (one in six) in developing countries are malnourished. More than 3 million children die each year because of poor nutrition, representing 45 percent of deaths in children under five.¹² Malnutrition can also lead to developmental problems in children, compromise the immune system and increase vulnerability to diseases, and impair

6 "Health workers in Syria rush to vaccinate 320,000 children amid sudden polio outbreak," *The Independent*, June 2017.

7 WHO, "10 Facts on the State of Global Health," available at www.who.int/features/factfiles/global_burden/facts/en/index4.html .

8 Ibid; United Nations, *The Millennium Development Goals Report, 2015*, available at www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20%28July%201%29.pdf .

9 WHO, "Tuberculosis," Media Centre website, 2015, available at www.who.int/mediacentre/factsheets/fs104/en/ .

10 United Nations, *The Millennium Development Goals Report, 2015*.

11 The Wellcome Trust and the UK Department of Health, "Tackling Drug-Resistant Infections Globally: Final Report and Recommendations," May 2016.

12 World Food Programme, "Hunger Statistics," available at www.wfp.org/hunger/stats ; Food and Agriculture Organization, "Millennium Development Goal 1: Eradicate Extreme Poverty and Hunger," available at <http://www.fao.org/sustainable-development-goals/mdg/goal-1/en/> .

cognitive development.

- **Noncommunicable diseases:** Noncommunicable diseases, including cardiovascular diseases, cancer, chronic respiratory diseases, and diabetes, present a major challenge for socioeconomic development. Cardiovascular diseases (which include heart disease and strokes) are the leading cause of death in the world, accounting for three in ten deaths globally, followed by lower respiratory infections (e.g., pneumonia) and chronic pulmonary disease (e.g., emphysema).¹³ Almost 10 percent of adults worldwide suffer from diabetes, and the number is on the rise.¹⁴ In many parts of the industrialized world, cancer is steadily gaining on cardiovascular disease as the number one killer; the number of cancer deaths per year tripled in the US between 1950 and 2011.¹⁵
- **Child mortality:** Each year, 6.6 million children under the age of five die. Children born into poverty are almost twice as likely to die before the age of five as those from wealthier families. Most of these children’s lives could be saved if they had access to exclusive breastfeeding, vaccines, medication, clean water, and sanitation.¹⁶ Moreover, every year 15 million babies, representing about 10 percent of all babies, are born preterm (before thirty-seven weeks of pregnancy). Complications attributable to preterm birth cause 1 million deaths each year, more than 75 percent of which could be prevented with cost-effective care.¹⁷
- **Women’s and maternal health:** Women face particular health risks as a result of gender and biological differences. While maternal mortality has fallen by almost 50 percent since 1990, about 300,000 women die every year due to complications related to pregnancy and childbirth.¹⁸ There are wide gaps in maternal mortality between developing and developed countries. The proportion of mothers who do not survive childbirth compared to those who do is fourteen times higher in developing than in developed countries. In addition to maternal health, 35 percent of women worldwide have experienced physical or sexual violence in their lifetime, often from intimate partners.¹⁹ This can pose serious harm, including mental or physical trauma and sexually transmitted diseases.
- **Road accidents:** Nearly 1.3 million people die each year from road accidents. Road accidents are the number-one killer of 15-to-29-year-olds. Road accident injuries are projected to rise as vehicle ownership increases, particularly in developing countries.²⁰
- **Substance abuse:** Worldwide, about 2.5 million alcohol-related deaths occur each year, representing nearly 4 percent of all deaths. Alcohol consumption is the third largest risk factor for disease and disability in the world, the largest risk factor in the Western Pacific and the Americas, and the second largest in Europe.²¹

13 WHO, “The Top Ten Causes of Death,” 2015.

14 NCD Alliance, “Cardiovascular Diseases,” available at <https://ncdalliance.org/cardiovascular-diseases-cvd> .

15 US Center for Disease Control, “Changes in the Leading Cause of Death: Recent Patterns in Heart Disease and Cancer Mortality,” August 2016.

16 UNICEF, “Committing to Child Survival: A Promise Renewed,” 2013, available at www.unicef.org/publications/files/APR_Progress_Report_2013_9_Sept_2013.pdf ; UN, “Sustainable Development Goals,” available at www.un.org/sustainabledevelopment/health/ .

17 March of Dimes, “The Global Problem of Premature Birth,” available at www.marchofdimes.org/mission/the-global-problem-of-premature-birth.aspx .

18 UN, “Sustainable Development Goals.”

19 WHO, “Global Health Observatory Data: Violence Against Women,” available at http://www.who.int/gho/women_and_health/violence/en/ .

20 WHO, “10 Facts on the State of Global Health.”

21 WHO, *Global Status Report on Alcohol and Health*, 2011, available at www.who.int/substance_abuse/publications/global_alcohol_report/msbgsruprofiles.pdf ; National Council on Alcoholism and Drug Dependence, “2.5 Million Alcohol-Related Deaths Worldwide Annually,” April 16, 2011, available at <https://ncadd.org/in-the-news/155-25-million-alcohol-related-deaths-worldwide-annually> .

More than 5 million people die each year due to direct use of tobacco, and 600,000 non-smokers die due to second-hand exposure to smoke.²² In addition, at least 15.3 million people have drug-use disorders, including abuse of psychoactive substances like cocaine, opioids, and methamphetamines.²³

- **Mental health:** Although often overlooked, mental health was recognized at the UN for the first time with its inclusion in the 2030 Sustainable Development Goals. Individuals with severe mental disorders, such as depression, schizophrenia, and bipolar disorders, die on average between ten and twenty years prematurely.²⁴ About 350 million people worldwide are affected by depression, and less than half of them have access to adequate treatment and healthcare.²⁵
- **Suicide:** In the US, more people die from suicide than homicide. In addition to the 30,000 people who die from suicide each year in the US, 750,000 people attempt suicide.²⁶
- **Small arms and other weapons:** The proliferation of small arms continues to cause deaths and injuries, both in and outside the context of conflict. Approximately 60 percent of all violent deaths are committed with firearms, varying from a low of 19 percent in Western and Central Europe to a high of 77 percent in Central America.²⁷ In addition to small arms, the continued threat of nuclear weapons and other weapons of mass destruction by powerful nations pose unparalleled risks to the health of humanity and the planet.
- **Bioterrorism:** The use of anthrax, smallpox, and other biological weapons by non-state armed groups poses a grave threat to international security, as well as the health of millions. Advances in biotechnology and genetic engineering, combined with the availability of information on the Internet for manufacturing biological agents, means “the threat of bioterrorism is more likely to occur now than ever before.”²⁸ The risk has been further heightened by recent reports of attempts by the Islamic State to develop bioweapons and release them into civilian populations. Previous bioterrorism events in the United States, Japan, and Iraq demonstrate the harm posed by the intentional release of these pathogens, which may spread through air, food, or water.

THE IMPACT OF OTHER GLOBAL TRENDS

A number of additional global trends not directly related to health could exacerbate the above health challenges or make them harder to address:

- **Climate change:** A direct relationship exists between climate change and health: climate change affects the “social and environmental determinants of health—clean air, safe drinking water, sufficient food and secure shelter.”²⁹ It is also expanding the geographic range of mosquitos, ticks, and other vectors for harmful diseases, such as malaria, dengue, and West Nile virus. It has been estimated that between 2030 and 2050, climate change will account for approximately 250,000 additional deaths as a result of malnutrition, malaria, diarrhea, and heat stress.³⁰ Climate change has also

22 WHO, “Tobacco,” available at www.who.int/mediacentre/factsheets/fs339/en/ .

23 WHO, “Management of Substance Abuse,” available at www.who.int/substance_abuse/facts/en/ .

24 WHO, “Meeting Report on Excess Mortality in Persons with Severe Mental Disorders,” November 2015.

25 WHO, “Depression,” available at www.who.int/mediacentre/factsheets/fs369/en/ .

26 Kevin Caruso, “More People Die by Suicide than by Homicide,” available at www.suicide.org/more-people-die-by-suicide-than-by-homicide.html .

27 Small Arms Survey, “Non-Conflict Armed Violence,” available at www.smallarmssurvey.org/armed-violence/non-conflict-armed-violence.html .

28 Syra S. Madad, “Bioterrorism: An Emerging Global Health Threat,” *Journal of Bioterrorism and Biodefense* 5, no. 1, August 2014.

29 WHO, “Climate Change and Health,” available at www.who.int/mediacentre/factsheets/fs266/en/ .

30 WHO, “Climate Change and Health,” available at www.who.int/mediacentre/factsheets/fs266/en/ .

contributed to the frequency of natural disasters: there has been a quadrupling in the annual number of disastrous floods and a doubling in the annual number of disastrous storms over the past thirty years.³¹ In addition to causing direct injury and loss of life, these events can lead to famine and other harmful conditions. The Paris Agreement on climate change adopted in December 2015 marks an important step forward, but its success depends on implementation.

- **Resource scarcity and environmental degradation:** Current use of natural resources is unsustainable, with major consequences for human health. According to the UN, the world will need at least 30 percent more water, 45 percent more energy, and 50 percent more food by 2030.³² Lack of clean drinking water “has a direct impact on poverty and food security” while increasing transmission of water-borne diseases, such as cholera, dysentery, and typhoid.³³ In addition, deforestation and desertification can lead to further resource scarcity and threaten food security. Although increasing efforts to combat deforestation in some countries have shown significant effects, 46,000–58,000 square miles of forest are lost each year—the equivalent of thirty-six football fields every minute.³⁴
- **The human-animal interface:** With human incursions into previously uninhabited areas and increased population density in cities and slums, humans and animals have come into closer proximity, creating an array of challenges. Outbreaks of zoonotic diseases have led to major pandemics in recent years, including SARS, H1N1 (swine flu), H5N1 (bird flu), and HIV/AIDS. Industrialized food production, with large numbers of animals confined to close quarters, exacerbates these risks. Around 75 percent of new human pathogens emerge from wild and domestic animals.³⁵
- **Urbanization:** The planet is becoming more crowded, with more than half of the world’s population residing in cities. That number is expected to increase to 66 percent by 2050, with an additional two and a half billion urban dwellers, primarily in Asia and Africa.³⁶ While there is great potential for cities to provide improved access to health services, they are frequently associated with crowding, poor sanitation, and poverty, particularly in developing countries. Slums create an ideal environment for microbes, which may spread via contact, untreated wastewater, and rodent- and insect-borne diseases. Environmental hazards such as pollution are associated with higher rates of asthma and diarrheal illness among the urban poor, who face significant health disparities.³⁷
- **Violent conflict:** Armed conflict, such as the ongoing war in Syria, and other situations of violence and instability continue to pose significant risks to public health and well-being. The relationship between armed conflict and health is established but complex. Despite the obvious but important fact that armed conflict leads to people being killed, injured, disabled, abused, or traumatized, people living in fragile or conflict-affected states have far worse popula-

31 The number of floods increased from 39 in 1980 to 154 in 2011; the number of storms increased from 43 in 1980 to 84 in 2011. UN Office for Disaster Risk Reduction, “Disaster Statistics,” available at www.unisdr.org/we/inform/disaster-statistics.

32 High-Level Panel on Global Sustainability, *Resilient People, Resilient Planet: A Future Worth Choosing*, 2012, available at http://uscib.org/docs/GSPReportOverview_A4%20size.pdf.

33 UN Department of Economic and Social Affairs, “International Decade for Action ‘Water for Life’ 2005–2015,” available at www.un.org/waterforlifedecade/scarcity.shtml.

34 World Wildlife Fund, “Deforestation,” available at <https://www.worldwildlife.org/threats/deforestation>.

35 David M. Morens and Anthony S. Fauci, “Emerging Infectious Diseases: Threats to Human Health and Global Stability,” July 2013, available at <http://journals.plos.org/plospathogens/article?id=10.1371/journal.ppat.1003467>.

36 UN Department of Economics and Social Affairs, “World Urbanization Prospects,” 2014, available at <https://esa.un.org/unpd/wup/Publications/Files/WUP2014-Report.pdf>.

37 Ibid.

tion health indicators than those living in states at comparable levels of development.³⁸ Other ways conflict can adversely affect health include: undermining the delivery of essential services such as healthcare and education;³⁹ impeding access of health professionals to at-risk populations or causing them to flee conflict zones altogether;⁴⁰ leading to shortages of basic supplies and equipment in hospitals and clinics in conflict zones;⁴¹ increasing under-five mortality rates, which are three to five times higher in conflict zones;⁴² decreasing basic childhood immunization in conflict zones and increasing vulnerability to diseases like polio;⁴³ and increasing the incidence of sexual violence and of sexually transmitted diseases and physical and psychological trauma. There is also evidence that improved healthcare services can increase trust in state institutions.⁴⁴ The landmark UN Security Council Resolution 2286 of 2016 condemns attacks on health workers and recognizes the importance of safeguarding access to healthcare during conflict.⁴⁵

- **Globalization, migration, and displacement:** The movement of peoples within and across

borders is occurring at an unprecedented pace in human history, with profound consequences for human health. Intercontinental travel, trade, and tourism enable the rapid proliferation of infectious diseases across time zones. In this globalized era, diseases previously endemic to developing countries, such as tuberculosis, hepatitis, and tropical parasites, require global prevention and control measures.⁴⁶ This phenomenon applies to the spread of ideas as well: the popularity of Western diets and homogenization of cultural trends is leading to a global rise in obesity and cardiovascular disease. Forced displacement is a particular challenge. According to the UN Refugee Agency, a record 65 million people were forcibly displaced by conflict, political persecution, human rights abuses, or natural disasters in 2015.⁴⁷ These refugees, asylum seekers, and internally displaced persons suffer from increased mortality, disability, and psychological distress. In Darfur, for example, 87 percent of civilian deaths between 2003 and 2008 were nonviolent—predominantly internally displaced persons suffering from disease and diarrheal illness.⁴⁸

38 Rohini Jonnalagadda Haar and Leonard S. Rubenstein, "Health in Postconflict and Fragile States," US Institute of Peace, 2012, p. 2.

39 Margaret Kruk, Lynn Freedman, Grace Anglin, and Ronald Waldman, "Rebuilding Health Systems to Improve Health and Promote Statebuilding in Postconflict Countries: A Theoretical Framework and Research Agenda," *Social Science Medicine* 70 (2010).

40 See, for example, International Committee of the Red Cross, "Health Care in Danger – Violent Incidents Affecting the Delivery of Health Care, January 2012 to December 2014," April 2015, available at www.icrc.org/eng/resources/documents/publication/p4237-violent-incident.htm. See also WHO, "Tracking Attacks on Health Workers – Don't Let Them Go Unnoticed," December 2015, available at www.who.int/features/2015/healthworkers-in-emergencies/en/.

41 Olivier Degomme and Debarati Guha-Sapir, "Patterns of Mortality Rates in Darfur Conflict," *The Lancet* 375, no. 9711 (2010).

42 Ronald Waldman, "Infectious Diseases in the Context of War, Civil Strife and Social Dislocation," in *The Social Ecology of Infectious Diseases*, edited by Kenneth H. Mayer and H. F. Pizer (Burlington, MA: Academic Press, 2008).

43 UNICEF and WHO, "Middle East Polio Outbreak Response Review," 2014, p. 6.

44 Kruk et al., "Rebuilding Health Systems to Improve Health and Promote Statebuilding in Postconflict Countries."

45 UN Security Council Resolution 2286 (May 3, 2016), UN Doc. S/RES/2286; see also 32nd International Conference of the Red Cross and Red Crescent, "Resolution 4: Healthcare in Danger: Continuing to Protect the Delivery of Healthcare Together," available at http://rcrcconference.org/wp-content/uploads/sites/3/2015/04/32IC-AR-HCiD-_EN.pdf; International Committee of the Red Cross, "Protecting Healthcare: Key Recommendations, April 2016," available at http://healthcareindanger.org/wp-content/uploads/2016/05/4266_002_ProtectingHealthcare.pdf.

46 Brian Gushulak and Douglas MacPherson. "Globalization of Infectious Diseases: The Impact of Mass Migration." *Clinical Infectious Diseases* 38, no. 12, June 2004.

47 United Nations High Commissioner for Refugees, "Global Trends: Forced Displacement in 2015," available at <https://s3.amazonaws.com/unhcrsharedmedia/2016/2016-06-20-global-trends/2016-06-14-Global-Trends-2015.pdf>.

48 Olivier Degomme and Debarati Guha-Sapir, "Patterns of Mortality Rates in Darfur Conflict," *The Lancet* 375, no. 9711 (2010).

Overview of Current Debates

REVISITING THE WHO'S ROLE AND STRUCTURE

The World Health Organization (WHO) has played a pivotal leadership role in coordinating and managing global public health. Nevertheless, it has struggled at times to remain relevant and keep pace with the rapidly evolving public health landscape. Under its constitution, WHO is mandated to play both a normative and an operational role in public health. Its principal added value has been the technical expertise it provides to national health systems, its policymaking and agenda setting, and its convening via the World Health Assembly. For instance, in response to rising rates of tobacco use worldwide, the World Health Assembly adopted the Framework Convention on Tobacco Control in 2003, a major treaty ratified by all but a handful of states. Other examples of norm setting include its List of Essential Medicines and the Codex Alimentarius, which regulates the safety of the international food trade.

Nonetheless, the organization's operational capabilities have been a subject of serious debate. Its operational capacity has been hindered by inadequate funding and a lack of political will on the part of WHO and its member states to engage collectively in a transparent and accountable manner when a health crisis breaks out. For example, WHO's director-general has exclusive control over whether to declare a public health emergency of international concern under the guidance of an ad hoc Emergency Committee consisting of a panel of experts, whose deliberations are kept confidential. In addition, WHO lacks a clear and consistent policy on transparency, public information, and access to records.

Financially, it remains to be seen how WHO can sustain the resources needed to address an ever-growing list of global health risks. The World Health Assembly slashed assessed contributions (member-state dues) by 20 percent between 2010 and 2015. These financial pressures have led to a greater reliance on voluntary funds: in 2014/2015, almost 80 percent of WHO's budget came from extra-budgetary sources, of which 93 percent was earmarked by donors for specific programs.⁴⁹ This has sometimes led to the organization catering to the preferences of wealthy donors instead of the priorities set by its own leadership. For instance, around 25 percent of WHO's budget goes to the polio eradication campaign, which could leave the organization broke if the campaign succeeds and the funding disappears. While WHO has increasingly diversified its funding pipeline—about half of voluntary contributions came from foundations, NGOs, and other nongovernmental sources in 2014—it will need to push for greater flexibility in how it manages and runs its own budget.

Moreover, operational resources for pandemic control have been stretched by programs targeting noncommunicable diseases, environmental health, and other emerging health challenges. An independent panel of experts from the Harvard Global Health Institute and London School of Hygiene & Tropical Medicine called on WHO to “substantially scale back its expansive range of activities to focus on core functions,” including, at a minimum, infectious disease outbreaks.⁵⁰ A balance will need to be struck between the imperative for WHO to provide strong normative leadership while scaling up its operational capabilities. Decisions over

49 For more, see Chelsea Clinton and Devi Sridhar, *Governing Global Health*, Oxford University Press, New York: 2017.

50 Suerie Moon et al., “Will Ebola change the game?” *The Lancet* 386, no. 10009, November 2015.

how to distribute limited resources between outbreak control programs and other thematic areas, such as noncommunicable diseases, will remain contested.

The organizational structure, in particular the roles and responsibilities of the six regional directors and approximately 150 country offices, has been the subject of much criticism. The subsidiarity inherent in today's model has prevented WHO from maximizing its potential and playing an effective role when a crisis erupts. Rethinking the roles and responsibilities of regional and country directors—and their relationship to headquarters—is necessary to ensure that the system is working as effectively and efficiently as it can.

While there have been attempts to reform the governance of WHO for decades with limited improvement, structural modifications made after the Ebola crisis have led to steps in the right direction. As a sign of progress, WHO formally joined and submitted a report to the International Aid Transparency Initiative for the first time in early 2017 (placing it in the same camp as agencies like the World Bank and UNICEF).⁵¹ Other recent initiatives include the 2015 accountability framework, which introduced compliance measures and launched reviews of programmatic performance in country offices, and an Independent Oversight Committee to monitor the performance of WHO's Health Emergency Programme. In 2015, WHO's Africa Regional Office released a "transformation agenda," which outlined new quality assurance and performance indicators and the creation of sub-regional emergency hubs.⁵² It remains to be seen whether these initiatives will lead to concrete results and usher in a wider organizational transformation.

IMPLEMENTING THE INTERNATIONAL HEALTH REGULATIONS AND OTHER FRAMEWORKS

The current international normative framework to prevent, detect, and respond to major disease

outbreaks is the International Health Regulations (IHR) of 2005, which remain the only universal and comprehensive treaty on health. Backed by WHO technical assistance, the IHR require 193 countries to build their "core public health capacities" to detect, assess, and respond to disease events. They also require countries to notify WHO of outbreaks within their territory that may constitute a public health emergency of international concern.

First adopted in 1969 by the World Health Assembly, the IHR were revised in 2005 to expand the range of potential disease threats. While the inclusive approach of the 2005 IHR has strengthened the world's collective defense against pandemics and represents a significant improvement over its predecessor, criticisms of the treaty remain. For instance, the IHR—although formally legally binding—provide neither enforcement measures nor positive incentives for countries to report disease outbreaks to WHO, aside from "peer pressure." Nevertheless, a WHO Review Committee on the IHR concluded in 2016 that amendments to the text are not required.⁵³

Instead, implementation of the IHR is the key challenge. Only 21 percent of states (42 of 193) had fulfilled their IHR core capacity requirements by June 2012. According to the IHR Review Committee, a strategic plan is required to prioritize implementation of the IHR in all countries, backed by adequate financial resources. Notably, wealthy states have not played their part in providing technical and financial assistance to developing countries to strengthen their internal surveillance capacity and push for universal healthcare. Lack of investment in health system infrastructure and uneven burden sharing for this responsibility undermine the sanctity of the IHR and put all countries at risk.

In 2011 the World Health Assembly adopted the landmark Pandemic Influenza Preparedness (PIP) Framework, which brings together UN member states, the healthcare industry, WHO, and other

51 For progress on reform, see WHO, "Ten Years of Transformation: Making WHO Fit for Purpose in the 21st Century," 2017, p. 20.

52 WHO, "The Transformation Agenda of the World Health Organization Secretariat in the African Region," 2015.

53 WHO, *Report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response*, May 2016.

stakeholders to implement a global approach to influenza preparedness and response. The preparedness network—which includes over 110 national influenza laboratories and national preparedness plans—has effectively strengthened global influenza surveillance. It has also established partnerships with pharmaceutical companies to develop flu vaccines, though this initiative has been accused of failing to provide sufficient quantities of said vaccines (and other benefits) to the developing countries where outbreaks most often emerge.

Debates on global public health are inextricably linked to the Sustainable Development Goals (SDGs) adopted in September 2015. More than half of the seventeen SDGs relate to health, either directly or indirectly, including Goals 1 (no poverty), 2 (zero hunger), 3 (good health and well-being), 6 (clean water and sanitation), 7 (affordable and clean energy), 13 (climate action), 14 (life below water), and 15 (life on land).⁵⁴ Goal 3, in particular, is essential to sustainable development. While significant strides have been made in increasing life expectancy and reducing some of the common killers associated with child and maternal mortality, much more effort is needed to fully eradicate a wide range of diseases and address many persistent and emerging health issues. While the adoption of the 2030 Agenda for Sustainable Development during the seventieth session of the UN General Assembly was a major step in the right direction, implementation and financing remain key challenges.

COORDINATING AMONG GLOBAL HEALTH ACTORS

While the primary responsibility for public health rests with states, links between health, development, and the climate epitomized by the 2030 Agenda for Sustainable Development have put a spotlight on the role that non-state and multilateral actors can play. For example, the High-Level Panel on the Global Response to Health Crises (see below) noted the role of regional organizations, which should take economic and political responsibility for their

member states before, during, and after a crisis.⁵⁵ A recent example of the need for regional platforms and responses comes from the Americas and the spread of the Zika virus. Nonetheless, the primary responsibility rests with member states themselves as the initial responders to an outbreak or crisis.

Foundations, NGOs, businesses, the military, and other non-state actors have become increasingly prominent actors in global health. This has provided both challenges and opportunities for the state-centric multilateral system. Since the early 2000s, the advent of public-private partnerships—including GAVI (the Vaccine Alliance) and the Global Fund to Fight AIDS, Tuberculosis, and Malaria—has enhanced the ability of developing countries to build up their health systems, carry out immunizations, and respond to epidemics. Backed by wealthy philanthropists, these partnerships have become increasingly desirable to donors due to their innovative and results-oriented approach, flexibility, and inclusive governance structures.⁵⁶

Nevertheless, donors redirecting funds to these entities has meant fewer resources for WHO and traditional development agencies, such as the World Bank. Amid this crowded field, WHO will need to adapt by growing its partner base and incorporating more non-state actors into its decision-making structures. The new WHO director-general elected in July 2017 has reaffirmed his belief in the importance of building partnerships, citing this and the goal of universal healthcare among his main priority areas. WHO has already responded with its Framework for Engagement with Non-State Actors, adopted by the World Health Assembly in May 2016. The roles and responsibilities of these diverse players will need to be carefully considered going forward.

The involvement of more actors also comes with the need for greater coordination. Since multidimensional health crises may also impact humanitarian, economic, and security conditions, institutional silos within and between organizations are an impedi-

⁵⁴ See www.un.org/sustainabledevelopment/sustainable-development-goals/.

⁵⁵ High-Level Panel on the Global Response to Health Crises, *Protecting Humanity from Future Health Crises*.

⁵⁶ Chelsea Clinton and Devi Sridhar, *Governing Global Health*, Oxford University Press, New York: 2017.

ment to sound and holistic policymaking and coordinated responses. As such, the report of the High-Level Panel on the Global Response to Health Crises emphasized the need for better methods of reporting on crises throughout the UN system, starting with the UN secretary-general and within WHO itself. It recommended integrating health and humanitarian crisis trigger mechanisms and creating a direct reporting line between the head of WHO and the secretary-general.

It also highlighted the importance of coordinating between multilateral, regional, national, and community responses. The need for such coordination was evident during the response to the Ebola outbreak in West Africa, which relied on both community engagement, which was key to changing social behaviors that contributed to the spread of Ebola on the ground, and high-level political leadership at the UN Security Council, which catalyzed international donors and aid agencies. As one example of such collaboration, WHO member states teamed up with the International Labour Organization in 2016 to address shortfalls in the global health workforce as part of a five-year action plan, alongside the Organization for Economic Cooperation and Development (OECD).

INCREASING PREPAREDNESS IN RESPONSE TO RECENT OUTBREAKS

While the 2005 International Health Regulations (IHR) provide a robust framework for preventing, detecting, and responding to major public health threats, the recent H1N1 influenza, SARS, MERS, and Ebola epidemics in West Africa have exposed huge gaps in the implementation of the IHR and in WHO's ability to respond to emergencies. They have also drawn attention to the larger need to prepare for outbreaks by investing in research and development on emerging and neglected tropical diseases and strengthening health systems in developing countries.

The Ebola epidemic, in particular, has led to a serious review of global health security and preparedness.

Multiple initiatives have been launched, both within and outside of the UN system, to identify and address critical gaps and challenges in effectively responding to future outbreaks (see Boxes 1 and 2). These initiatives have called on WHO to rethink its emergency response programs, including by encouraging member states to implement the IHR core capacities regime, creating a research and development blueprint to accelerate diagnosis and treatment during a crisis, building a global health emergency workforce, and improving coordination. Unlike the HIV/AIDS pandemic, which led to the creation of UNAIDS as a separate entity to mobilize and coordinate global efforts, all the major post-Ebola reviews have concluded that WHO should remain the lead global agency in responding to health emergencies and that its operational emergency response capacities should be significantly strengthened.

In 2015 the UN secretary-general appointed a High-Level Panel on the Global Response to Health Crises to make recommendations for strengthening national and international systems to “prevent and manage future health crises, taking into account lessons learned from the response to the Ebola outbreak.”⁵⁷ In its report, the panel argued that the capacity to respond to health crises is woefully insufficient.⁵⁸ It noted that whenever a pandemic breaks out, the initial panic is invariably followed by complacency and inaction.

In the area of research and development, the panel recommended establishing a \$1 billion fund housed wherever appropriate within the existing structure to develop platforms for big manufacturers to research and develop vaccines and rapid-diagnosis tests for all neglected communicable diseases, not just tropical diseases.

WHO has already taken some action toward this end in the past three years, including establishing a single Health Emergencies Programme with a single workforce and clear line of authority, creating the WHO's Contingency Fund for Emergencies, and

57 High-Level Panel on the Global Response to Health Crises, *Protecting Humanity from Future Health Crises*, January 2016, available at http://www.un.org/News/dh/infocus/HLP/2016-02-05_Final_Report_Global_Response_to_Health_Crises.pdf.

58 Ibid.

setting up the Global Health Emergency Workforce with new standards for humanitarian response. Nevertheless, the contingency fund had only raised \$31 million of its target of \$100 million as of late 2016,⁵⁹ and there was an estimated \$87 million budget shortfall for core emergency programs in 2016/2017.

The multilateral system has also taken action to address other types of health crises. For example, in 2013 the secretary-general established an Intera-gency Task Force on the Prevention and Control of

Noncommunicable Diseases under the leadership of WHO. This task force is intended to support national efforts to implement the commitments included in the 2011 political declaration of the high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases and the 2014 outcome document of the high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of noncommunicable diseases.

Box 1. Major internal and external evaluations of the Ebola response

Within WHO

- Ebola Interim Assessment Panel
 - Final report published in July 2015
- Director-general of WHO’s Advisory Group on Reform of WHO’s Work in Outbreaks and Emergencies with Health and Humanitarian Consequences
 - First report published in November 2015, second and final report published in January 2016
- Review Committee on the Role of the IHR in the Ebola Outbreak and Response
 - Final report submitted to sixty-ninth World Health Assembly in May 2016

Other UN agencies

- UN secretary-general’s High-Level Panel on the Global Response to Health Crises
 - Final report published in February 2016

Outside of UN system

- Independent Panel on the Global Response to Ebola, convened by Harvard Global Health Institute and London School of Hygiene & Tropical Medicine
 - Report published in *The Lancet* in November 2015
- Global Health Risk Framework for the Future, convened by National Academy of Medicine (an independent international group of experts in finance, governance, research and development, health systems, and the social sciences)
 - Report published in January 2016

⁵⁹ WHO, “Financing the WHO Contingency Fund for Emergencies,” available at <http://www.who.int/about/finances-accountability/funding/financing-dialogue/financing-contingency-emergency-fund.pdf>.

Box 2. Initiatives to strengthen global emergency response and preparedness

Within WHO

- Ebola Special Session Resolution and Decision adopted at sixty-eighth World Health Assembly in May 2015
- Launch of WHO Contingency Fund for Emergencies
- WHO Emergency Reform to enhance WHO's capacities in responding to emergencies
- Strengthening of the Global Health Emergency Workforce

Outside of UN system

- Global Health Security Agenda (US-led multi-stakeholder initiative to strengthen member countries' capacities to prevent, detect, and respond to infectious disease threats, both natural and accidental or intentional)
- World Bank's Pandemic Emergency Facility

Conclusions and Recommendations

The aim of the various actors of the multilateral system should be to proactively provide and implement solutions, as well as to encourage adaptive leadership, in order to improve the effectiveness of the multilateral system in reducing the harm caused by epidemics, pandemics, and other threats to global public health.⁶⁰ Since many health issues are transnational and closely related to the three pillars of the UN—peace and security, development, and human rights—they require a multilateral response. Indeed, it is worth recalling that one of the first examples of international cooperation came as a result of states working together to deal with an outbreak of cholera in the mid-nineteenth century. The goal should be to develop and implement policies to be better prepared to cope with these crises and to face the challenges of the future.

The following recommendations call for both widening and deepening the global health infrastructure in its current state. They call for deepening the current system by reaffirming the centrality of WHO and establishing stronger frameworks for accountability and implementation of the International Health Regulations. However, the system must also be widened to include (and formalize) relationships with new partners, such as the private sector, and to establish synergies with “old” partners, such as other UN agencies and national governments, which continue to bear primary responsibility for strengthening health systems.

REAFFIRM THE CENTRALITY OF WHO

Continue Gradual Reform of WHO with a Focus on Transparency and Inclusivity

WHO remains the right organization to make international policies and coordinate action on global public health. However, the organization’s accountability mechanisms, operational capacity, and structure—particularly the question of regional directors—need to be adjusted and strengthened.

To restore legitimacy and public confidence in the organization, WHO should prioritize increasing transparency, where it lags behind its contemporaries. As a first step, it could submit reports to transparency watchdogs, such as Publish What You Fund, which puts out the Aid Transparency Index. In the absence of an open-access policy, there is an opportunity for WHO to systematically release relevant data and information to NGOs and academia on the performance of its programs and operations. Increased transparency needs to be complemented by existing and new partnerships, including with regional organizations and the private sector. The recent endorsement of WHO’s Framework for Engagement with Non-State Actors should be built upon further to increase inclusivity, flexibility, and efficiency.

WHO has demonstrated a good faith willingness to pursue iterative reforms in recent years, such as the 2015 Accountability Framework and the reconfig-

⁶⁰ As conflicts and disasters have a significant impact on public health, the multilateral system should also invest heavily in preventing and mitigating the negative impact of such conflicts and disasters. See also first section of the ICM’s Discussion Paper on Humanitarian Engagements, available at www.icm2016.org/humanitarian-engagements.

uring of the Health Emergencies Program, but it remains to be seen if this momentum can be maintained as international scrutiny wanes following the Ebola crisis.

Increase Assessed Contributions to WHO and UN Agencies Dealing with Health Crises

The lack of assessed contributions to WHO and other UN agencies dealing with humanitarian and health crises hampers their ability to meet their mandate. Assessed contributions (membership dues) are more flexible than voluntary contributions, since they are discretionary monies which can be directed toward priority areas. Voluntary funds, which comprise about 80 percent of WHO's budget, are almost always earmarked and therefore inhibit rapid action when an unexpected outbreak or crisis erupts.

As recommended by the High-Level Panel on the Global Response to Health Crises, due consideration should be given to increasing assessed contributions to WHO by 10 percent. At the seventieth World Health Assembly in May 2017, member states endorsed an increase in WHO's assessed contributions by 3 percent—less than the hoped-for 10 percent increase. WHO must continue fundraising efforts, including for its \$100 million Contingency Fund for Emergencies, which has not yet been fully funded. Member states should give the WHO's newly elected director-general the benefit of their complete support and confidence by granting increased dues (and paying dues in arrears) if progress is commensurate.

Follow Up on the High-Level Panel Report and Other Review Processes

While it was a welcome and timely initiative, follow-up on and implementation of the recommendations of the secretary-general's High-Level Panel on the Global Response to Health Crises is critical. This also applies to other high-level review processes, such as the WHO-sponsored Report of the Ebola Interim Assessment Panel. Follow-up and implementation

require better defining and identifying triggers of health crises, renewing focus on compliance capacity throughout the WHO and UN system, and undertaking accelerated research and development for better detection and treatment of diseases.

Secretary-General Ban Ki-moon's response to the high-level panel, including his report on implementation of its recommendations⁶¹ and setting up of a Global Health Crises Task Force mandated to monitor and guide their implementation, are welcome steps. The task force, which was established for a period of one year beginning July 2016, identified nine priority areas during its tenure, including supporting regional arrangements, securing sustainable financing, and support for national health systems.

The secretary-general, with WHO, should build on the task force's mandate by developing a road map for implementing the recommendations made in the various reviews of the global response to health crises over the past two years. This road map should identify areas that require further review, especially the specific challenges of delivering healthcare in situations of armed conflict. The secretary-general should also formalize the monitoring and implementation process by establishing a standing interagency framework to define strategies and policies to address these challenges.

STRENGTHEN NORMATIVE FRAMEWORKS FOR ACCOUNTABILITY

Engender a “Norms-Based” Approach

In order to ensure a more principled approach to responding to public health challenges, greater emphasis is needed on norms and the “rules of the game.” In this sense, the international community needs to shore up its efforts at reaffirming the normative dimensions of global health mechanisms and the codification and development of international law. Only two major treaties have been negotiated under the auspices of the World Health Assembly: the IHR and the Framework Convention

⁶¹ UN Secretary-General, *Strengthening the global health architecture: implementation of the recommendations of the High-Level Panel on the Global Response to Health Crises*, A/70/824, April 2016.

on Tobacco Control. There is potential for international health law to be further concretized. For instance, the IHR dispute settlement mechanism is rarely if ever used in practice, denying the multilateral system an important arbitration tool in the case of disputes over IHR compliance.

Convene a Global Health Summit by 2020

The secretary-general should convene an inter-ministerial forum for addressing the future of the global health architecture and normative framework. This forum should not be too broad and should focus primarily on financing and accountability. Such a summit would determine what key instruments, structures, and players could help create a stable and sustainable global health architecture. The recent appointment of both a new UN secretary-general and WHO director-general further provides an opportunity for such a gathering to align the multilateral system's vision for global public health.

Create a High-Level Council on Global Health Crises

In addition to voluntary IHR monitoring (e.g., the joint external evaluation tool),⁶² a high-level council could significantly contribute to holding member states and other partners accountable for implementing the IHR. Such a forum, with rotating membership, would complement self-assessments with mandated peer-driven evaluations, akin to the Human Rights Council's universal periodic review process. Such a review could help to name and shame countries lagging in implementation and lead to greater awareness and acceptance of health norms. The reports produced by such a council could go to the World Health Assembly and then to the UN General Assembly. The council could be made up not only of the ministers of health of member states but also their ministers of foreign affairs and finance to ensure a comprehensive and holistic point of view. This high-level council could also be tasked with overseeing a paradigm shift in our understanding of global health as a public collective good, placing people at the center and

ensuring that medical research goes beyond market needs and a profit orientation.

FORGE PARTNERSHIPS AND REINFORCE LINKAGES BEYOND WHO

Establish Synergies with Other Agendas

Apart from drawing upon the various review processes related to global health crises, there is a need to establish further synergies and coherence with other recently adopted agendas and frameworks that seek to address challenges that have a direct impact on global health, such as the 2030 Agenda and SDGs (particularly Goal 3, the standalone goal on health), the Paris Agreement on climate change, and the Sendai Framework on Disaster Risk Reduction. The 2030 Agenda should be a catalyst for the health community and encourage a systemic approach. The implementation of Goal 3 should also encourage greater interaction and accountability between citizens and their governments. Implementation of these agendas and frameworks would go a long way toward improving public health globally, minimizing the outbreak, spread, and impact of epidemics and other disease outbreaks, strengthening the capacity to respond to such outbreaks, and making the biosphere more sustainable.

Institutional silos impede sound and holistic policy-making, implementation of policies, and operational capacity. They have created an international system that is insufficiently prepared and reacts too slowly when an outbreak escalates to a global threat to health security. To improve global health, policies need to be holistic and to take into account the entire health system instead of only a fragment. For example, focusing only on surveillance without adequate operational capacity to respond will not prevent the next epidemic.

In addition, the primacy of politics must be considered. As called for by the High-Level Panel on the Global Response to Health Crises, the UN General Assembly and Economic and Social Council should

62 WHO, "IHR Monitoring and Evaluation Framework: Joint External Evaluation tool," 2016, available at http://www.who.int/ihr/publications/WHO_HSE_GCR_2016_2/en/.

regularly raise global health concerns to ensure they are given enough attention. This may require formalizing the relationship between WHO's director-general and the UN secretary-general during public health emergencies.

Enhance Partnerships with the Private Sector

There is great potential for public-private partnerships in health. The multilateral system should engage in partnerships with private sector actors, including the transportation, airline, tourism, pharmaceutical, and insurance industries, in areas such as financial services, core skills, risk management, fund management, clinical management, logistics, communications, and social mobilization. Establishing stronger relationships with the private sector before a crisis erupts would enhance the multilateral system's ability to respond more effectively to outbreaks and could encourage research and development to respond to people's well-being instead of market demand. A useful case study is the Pandemic Influenza Preparedness (PIP) Framework, which reflected solidarity between multilateral mechanisms and pharmaceutical companies. Public-private partnerships have also included the Global Fund to Fight AIDS, Tuberculosis, and Malaria; Gavi, the Vaccine Alliance; and the Bill & Melinda Gates Foundation.

However, the existing model of public-private partnerships needs to be adjusted. Multilateral agencies should devise an incentive-driven approach to influence the private sector to support global public health. For instance, this could be accomplished by incorporating the private sector into traditionally state-centric norms and instruments, such as SDG 3, via the UN Global Compact for corporate sustainability. Since health is a global public good, other methods could include imposing taxes or another type of levy on international businesses, such as the airline ticket tax, which has supplied over \$1 billion to Unitaid to fight tuberculosis, HIV/AIDS, and malaria. To enforce compliance with public health regulations, WHO should reinforce links with the World Trade Organization to open up the possibility of litigation. Overall, a shift in mindset is needed when it comes to engaging the private sector: its role must be seen as one of partnership,

not of charity.

RECALL THE PRIMARY RESPONSIBILITY OF STATES

Build the Capacity of National Healthcare Systems

The primary responsibility for preparing for epidemics and strengthening health systems rests with states themselves. Governments and health ministries should ensure their healthcare systems are sustainable, reliable, comprehensive, resilient, and based on inclusive approaches. Toward this end, member states should:

- Fully implement the IHR by improving national- and local-level capacity to prevent, detect, and respond early to outbreaks through better infrastructure, training, and sufficient stockpiles of medical supplies;
- Treat human capital as the foundation of healthcare systems by implementing programs for the training and continuous improvement of healthcare professionals that harmoniously integrate healthcare needs;
- Ensure adequate budgets for healthcare, including adequate funding for preventing and responding to health emergencies;
- Develop pharmaceutical and drug policies to improve access to medicine;
- Adopt inter-sectoral approaches to health, such as inclusive dialogue and information exchange between health policymakers and clinicians/practitioners, as well as with other governments' ministries (foreign affairs, trade, interior, security, etc.), to include science and health diplomacy;
- Promote public awareness of health issues to include risk perception, citizen self-responsibility, and sustainability (health and climate linkages);
- Respond to development needs and health emergencies as part of a holistic, two-track

response so that new pandemics do not take the focus away from older health crises that still present development challenges;

- Engage communities in identifying, prioritizing, and implementing health responses and in monitoring and evaluating results to ensure that public health programs respond to people's needs; and
- Develop national influenza preparedness plans and other contingencies in the event of a major pandemic or bioterrorism attack.

Reaffirm Protection of Health Professionals and Facilities

Situations of armed conflict, violence, and insecurity pose special risks for health workers. Existing obligations under international law to protect and respect medical personnel, facilities, and means of transportation must be complied with in all circumstances. The same holds true for medical ethics and principles for delivery of healthcare in situations of armed conflict. States should fully implement Security Council Resolution 2286 (2016), Resolution 4 of the thirty-second International Conference of the Red Cross and Red Crescent (2015), and other

recommendations to protect the delivery of health-care in armed conflicts and other emergencies. For the UN system, this may include holding additional UN Security Council briefings on protection of healthcare in armed conflict, issuing fact-finding investigations, and making referrals to the International Criminal Court.

Further Explore the Role of Military Forces in Health Emergencies

Although rarely recognized, military forces can play a positive role in global health crises, as they did during the Ebola crisis in West Africa. Militaries often have the resources and logistical capacity to quickly respond to emergency needs, especially in developing countries. This can take the form of indirect support, such as security escorts for health-care workers, or more directly in the administration of quarantines and health services. However, caution is in order in situations of armed conflict or in places where the military is not necessarily a trusted institution so as not to compromise the real or perceived neutrality and impartiality of the response to health needs. Further discussion on this topic is required among health and humanitarian leaders to establish appropriate guidelines regarding the military's role in health crises.

Annex 1: ICM Personnel

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Annex 2: ICM Policy Papers

This is one in a series of fifteen issue-specific policy papers that the Independent Commission on Multilateralism (ICM) is publishing over the course of 2016 and 2017. These papers cover in greater detail issue areas addressed in ICM's September 2016 report "Pulling Together: The Multilateral System and Its Future." The fifteen policy papers (not in order of publication) are as follows:

- Armed Conflict: Mediation, Peacebuilding, and Peacekeeping
- Climate Change and the 2030 Agenda for Sustainable Development
- Communication Strategy for the UN Multilateral System
- Engaging, Supporting, and Empowering Global Youth
- Forced Displacement, Refugees, and Migration
- Fragile States and Fragile Cities
- Global Pandemics and Global Public Health
- Humanitarian Engagements
- Impact of New Technologies on Peace, Security, and Development
- Justice and Human Rights
- Social Inclusion, Political Participation, and Effective Governance
- Terrorism and Organized Crime
- The UN, Regional Organizations, Civil Society, and the Private Sector
- Global Pandemics and Global Public Health: Non-proliferation and Disarmament
- Women, Peace, and Security

Annex 3: Participation in Consultations

Retreat: February 8–9, 2016 (Graduate Institute of International and Development Studies, Geneva)

Keynote Speaker

Ilona Kickbusch, *Director of the Global Health Programme and Adjunct Professor, Graduate Institute of International and Development Studies*

Participants

Kjetil Aasland, *Minister Counsellor, Permanent Mission of Norway to the United Nations in Geneva*

Bruce Aylward, *Interim Executive Director, Outbreaks and Health Emergencies Cluster, World Health Organization*

Christoph Benn, *Director, External Relations, Global Fund to Fight AIDS, Tuberculosis and Malaria*

Margaret Chan, *Director-General, World Health Organization*

Els Debuf, *Senior Adviser on Humanitarian Affairs, Independent Commission on Multilateralism*

Katherine DeLand, *Chief of Staff, Ebola Response, World Health Organization*

Ariun Enkhsaikhan, *Development Assistant, International Peace Institute*

María Fernanda Espinosa Garcés, *Permanent Representative, Permanent Mission of Ecuador to the United Nations in Geneva*

Abdullatif Fakhfakh, *Expert in International Organizations, Permanent Mission of the United Arab Emirates to the United Nations in Geneva*

Stefan Germann, *Senior Director, Global Health Partnerships and Innovation, World Vision International; Senior Fellow, Global Health Program, Graduate Institute of International and Development Studies*

Barbara Gibson, *Deputy Secretary-General, Independent Commission on Multilateralism*

Nasra Hassan, *Director, International Relations, Association of Austrian Peacekeepers; Senior Adviser, International Peace Institute*

Nassereddin Heidari, *Minister, Delegation to Conference on Disarmament and Biological and Toxin Weapons Convention Meetings, Permanent Mission of the Islamic Republic of Iran to the United Nations Office and Other International Organizations in Geneva*

David Held, *Professor, Politics and International Relations, Durham University*

Didier Houssin, *President, Review Committee on the Role of the International Health Regulations in the Ebola Outbreak and Response; Chair of the Board, French Agency for Food, Environmental and Occupational Health and Safety*

Anne Marie Huvos, *Head, Pandemic Influenza Preparedness, World Health Organization*

Päivi Kairamo, *Permanent Representative, Permanent Mission of Finland to the United Nations in Geneva*

Walter Kemp, *Vice President and Chief Operating Officer, International Peace Institute*

Nadia Khelef, *Senior Advisor for Global Affairs, Institut Pasteur*

Jimena Leiva Roesch, *Senior Policy Analyst, International Peace Institute*

Joanne Liu, *International President, Médecins Sans Frontières*

Adam Lupel, *Director of Research and Publications, International Peace Institute*

Saja Majali, *Permanent Representative, Permanent Mission of the Hashemite Kingdom of Jordan to the United Nations in Geneva*

Esperanza Martínez, *Head of Health, International Committee of the Red Cross*

Rosemary McCarney, *Permanent Representative, Permanent Mission of Canada to the United Nations and the Conference on Disarmament in Geneva*

Pasi Mustonen, *Counsellor, Permanent Mission of Finland to the United Nations in Geneva*

Omar El Okdah, *Senior Policy Analyst, International Peace Institute*

Zaher Osman, *Hospital Subunit, Health Department, International Committee of the Red Cross*

Guilherme de Aguiar Patriota, *Deputy Permanent Representative, Permanent Mission of Brazil to the United Nations in Geneva*

Véronique Pepin-Hallé, *Adviser, Independent Commission on Multilateralism*

Joy Phumaphi, *Executive Secretary, African Leaders Malaria Alliance; Co-chair, Independent Expert Review Group, World Health Organization*

Hardeep Singh Puri, *Secretary-General, Independent Commission on Multilateralism*

Amr Ramadan, *Permanent Representative, Permanent Mission of the Arab Republic of Egypt to the United Nations in Geneva*

Anette Ringnes, *Research Assistant, International Peace Institute*

Anayansi Rodríguez Camejo, *Permanent Representative, Permanent Mission of Cuba to the United Nations in Geneva*

Belkis Romeu, *Health Attaché, Permanent Mission of Cuba to the United Nations in Geneva*

Kevin Rudd, *Chair, Independent Commission on Multilateralism*

Rodrigo Saad, *Special Assistant to the Secretary-General of the Independent Commission on Multilateralism, International Peace Institute*

Ulrich Seidenberger, *Deputy Permanent Representative, Permanent Mission of Germany to the United Nations in Geneva*

Annie Sparrow, *Assistant Professor of Global Health and Deputy Director of Human Rights, Icahn School of Medicine at Mount Sinai*

Thani Thongphakdi, *Permanent Representative, Permanent Mission of Thailand to the United Nations in Geneva*

Public Consultation: June 6, 2016 (Graduate Institute of International and Development Studies, Geneva)

Discussants

Ilona Kickbusch, *Director of the Global Health Programme and Adjunct Professor, Graduate Institute of International and Development Studies*

María Fernanda Espinosa Garcés, *Permanent Representative, Permanent Mission of Ecuador to the United Nations in Geneva*

Katherine DeLand, *Office of the Executive Director, Outbreaks and Health Emergencies, World Health Organization*

Stefan Germann, *Senior Director, Partnerships, Innovation and Accountability, World Vision International*

Omar El Okdah, *Senior Policy Analyst, International Peace Institute*

Moderator

Barbara Gibson, *Deputy Secretary-General, Independent Commission on Multilateralism*

Research

Omar El Okdah
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Cover Photo: Majaz health center, the main health center supported by the International Committee of the Red Cross in northern Yemen, February 27, 2012. C. Martin-Chico/ICRC.

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