DRAWING LESSONS ON BETTER GOVERNING FOR EMERGENCIES FOR IMPROVED RESILIENCE AGAINST HEALTH EMERGENCIES

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Summary: The COVID-19 pandemic has taught us that preparedness for and resilience against health emergencies is critical. To improve preparedness for health emergencies, the emergency preparedness and response governance architecture at all levels should be strengthened. It should be based on cross-cutting, whole-of-government, and whole-of-society approaches, moving away from siloed perspectives. Moreover, resilience against health emergencies should be based on universal health coverage and anchored in the International Health Regulations (IHR) 2005 core capacities implementation. Capacities and capabilities that are required to improve health services for national and global health security should also be strengthened.

Keywords: Emergency Response, International Health Regulations (IHR), Preparedness, Resilience, COVID-19

Introduction: COVID-19 has revealed shortcomings in governance mechanisms for health emergencies

The COVID-19 pandemic has revealed serious shortcomings in preparedness and response to health emergencies both at the national and global level. Traditional health governance mechanisms have faced an unprecedented need to interconnect the various complex aspects of society and systems to manage the response.

The WHO estimates that the excess deaths directly and indirectly associated with COVID-19 was at least three million in 2020 alone, which is almost double the reported cumulative deaths from COVID-19 infections. A recent report by the Global Preparedness and Monitoring Board estimated that the cumulative global cost of the COVID-19 pandemic is already in the order of USD 11 trillion; in comparison, investments in preparedness capacities which could have significantly mitigated these costs would have amounted to less than USD 40 billion, or USD 5 per person per year. Baseline analyses conducted by the World Bank Group estimate that COVID-19 pushed an additional 88 million people into extreme poverty in 2020, yet this number could be as large as 115 million people with the largest share disproportionately living in South Asia and Sub-Saharan Africa.
The global community has seen that health is a critical determinant of development and should be placed at the centre of the UN’s Sustainable Development Goals (SDGs).

The Independent Panel on Pandemic Preparedness and Response (IPPR) has found weak links at almost every point in the chain of preparedness and response. Preparation was inconsistent and underfunded; the alert system was too slow and too meek; the WHO was underpowered; the response has exacerbated inequalities; and global political leadership was absent. The IHR Review Committee concluded that the IHR helped make the world better prepared to cope with public health emergencies; however, the core national and local capacities called for in the IHR (2005) are not yet fully operational and are not on a path to timely implementation worldwide.

In this article, we consider lessons that countries and the global health community can learn from the COVID-19 pandemic and how preparedness and response for the next health emergency can be strengthened.

Driving forward using the wisdom of hindsight

Previous emergencies have motivated countries to better prepare for future emergencies. For example, just after the 2009 A(H1N1) pandemic, the global health community, led by WHO, mobilised the Pandemic Influenza Preparedness (PIP) Framework. Together with industry and other partners, the PIP enabled capacity strengthening with the main aims:

- to improve and strengthen the sharing of influenza viruses with human pandemic potential through the WHO Global Influenza Surveillance and Response System (GISRS), and
- to increase the access of developing countries to vaccines and other pandemic response supplies.

Some of these suggested capacities were already evident and used at the start of the COVID-19 pandemic response (see Box 1). Yet, while PIP helped advance capacities to respond to a health emergency in some aspects, other areas of emergency preparedness and response remained lacking. A global mechanism to ensure equitable distribution and access to vaccines within the context of a pandemic was not in place. This gap has contributed to millions of people having no access to COVID-19 vaccines, despite them being developed in record time. Vaccines, the most effective weapon to fight the pandemic, are notably not yet accessible to many low- and middle-income countries in an amount that would prevent the SARS-COV-2 virus from spreading and mutating.

To address this gap in global health governance, the WHO’s strategy was to establish COVAX to close the immunity gap globally, starting with protecting at-risk groups and frontline health care workers, then proceeding with vaccinating other groups. It is important to note that since the COVAX partnership was created when the pandemic had already wreaked havoc around the world its mission, strategy and tools were new to all. Had structures like COVAX been implemented before the pandemic, it is likely that morbidity and mortality could have been reduced. It is estimated, for instance, that the unequal distribution of vaccines has contributed to the over three million lives lost and millions more who are still facing Long-COVID and these numbers continue to grow. If the principles and structures of COVAX were developed further (perhaps also in areas other than vaccines) then humanity could move forward more equitably in terms of recovering from COVID-19, but also in building resilience for future health emergencies.

An opportunity for global shared learning

Throughout the pandemic, countries have experienced various morbidity and mortality rates at different times,
Box 2: The Over-C’s of pandemic governance: capacities and capabilities (IHR and beyond)

1. **Committed**, coherent and accountable leadership employing a whole-of-government and whole-of-society approach, which is accountable and trusted, has dynamic capacities and capabilities to adapt to new challenges;
2. **Command-control-coordination** architecture that is anchored at the community level with clear top-down, bottom-up, and cross-cutting approaches towards responsiveness, planning, actions;
3. **Capitalise** on emergency response funds to aid traditional sustainable health finance;
4. **Communication**, including risk communication and infodemic management;
5. **Community engagement and volunteering**;
6. **Case investigation**, Contact tracing, surveillance, intelligence, early warnings, isolation, quarantine;
7. **Chains** of procurement and supply that are intricately planned, and carefully managed with adequate stockpiles, enhanced local production, and allowing for rapid import and export;
8. **Contemporary tools**, cyber innovation, digital health information and blockchain management and integration;
9. **Countermeasures** including essential packages of health services and goods, research and development, One Health; Antimicrobial resistance; infection prevention and control; social and defence services;
10. **Core services**, emergency workforce and institutional capacities, Chemical, Biological, Radiological, Nuclear, and high yield Explosives (CBRNE) defence, and mass events;
11. Common public goods promoting global health governance and common standards for critical public health information, with global participation, including enhanced investment on research and development;
12. **Cohesiveness** of people, countries, regions and globally, based on solidarity, stability, flexibility, and sharing best practices. 

Reflecting the different data collected, policy decisions, and adherence to local measures. WHO has encouraged countries to learn from each other’s experiences, especially with respect to harmonising health information systems.

The WHO Intra Action Review (IAR) tool has been proposed to countries to assess their response and enable them to pursue corrective measures in real-time. The key purpose of a country IAR is to provide an opportunity for continuous collective learning by bringing together relevant stakeholders to critically and systematically analyse and document best practices and challenges identified in the response so far. IAR tools also allow countries to evaluate whether the governance and coordination structures implemented prior to the pandemic have helped them launch and continue to respond to the COVID-19 pandemic. At the time of writing, six countries have held IARs with WHO and partners in the European Region.

When taking a step back and reflecting on the pandemic through a governance lens, certain capacities and capabilities, coined here as the “Over C’s”, require specific corrective actions (see Box 2).

Building resilience against health emergencies

Throughout the pandemic we have gained new knowledge, technologies, and tools which have led to milestone achievements and critical insight. However, the world remains in the grip of COVID-19 as cases continue to surge, and new challenges continue to surface. The notion of resilience recognises that extreme interruptions can and will happen and therefore core systems must have the capacities for adaptation and recovery (see Sagan et al. in this issue). It proposes to see emergencies as opportunities to improve the system through broader systemic changes and constant change management. The COVID-19 pandemic therefore provides an opportunity to switch from “bouncing back” to “bouncing forward”.

Necessary ingredients for building resilience to respond to health emergencies include the maturity of health systems and emergency preparedness.

1. **Maturity of health systems**

Governance structures based on societal norms and values can help cultivate effective leadership and timely decision-making as they breed trusted, fair, and participatory policies. Universal Health Coverage (UHC) is an example of such policies as it guarantees access for all people and communities to good quality health services, without financial hardship. Countries with UHC are those with matured health systems. In many cases, they have adjusted better to the high demand for health care services throughout the pandemic exhibiting lower case fatality rates. These systems have been able to continue the provision of essential health services, including mental health, throughout the pandemic. Countries with mature health systems also have a capable, agile, and diversified public health workforce and tools. In many cases, they have been able to provide timely and accurate data, share information, activate laboratories, repurpose their services, and deliver a diversified portfolio of activities, including surveillance, contact tracing, and risk communication.
2. Emergency preparedness

In order to combat COVID-19 and be ready for future health emergencies, it is necessary to pursue a multidisciplinary approach accounting for local norms, values, and politics. This multidisciplinary approach must be supported and reflected in policy, laws, and procedures that enable a rapid response to emergencies. They should be strengthened in conjunction with the evolving evidence base, technology, capabilities, and necessary competencies in the public health workforce.

The COVID-19 pandemic revealed that resilience against health emergencies specifically is the first line of defence against emergencies of any kind. Yet to date, many countries, rich and poor alike, have not adequately invested in comprehensive preparedness. In the context of governance, the pandemic revealed weaknesses in both steadfast evidence-based policymaking and subsequently translating policy into practical guidance and implementation. The ability of policymakers to take good quality, timely, evidence-based, and relevant decisions requires an effective architecture of command-control-coordination that is anchored in human rights, ethics, and integrity. Such systems must be transparent, accountable, participatory, and continuously monitored to ensure their effectiveness.

The sum of these components can lead to resilience in the face of health emergencies

Mature health systems and emergency preparedness are both necessary to achieve resilience against health emergencies. They must be jointly secured through good governance, and anchored in societal norms and values, setting them in global and country-wide leadership. Globalisation has unprecedentedly interconnected humanity though the travel of people and the transport of animals and goods, as well as by communication and technology. While this interconnectedness has enabled the rampant spread of the virus, it can also be turned into a strength by having robust multinational collaboration.

To become resilient against health emergencies, the core capacities of both health systems (through the essential public health functions) and health emergency preparedness must be strengthened and included at the centre of national agendas and supported by societal actions and community empowerment (see Rajan et al. in this issue).

Strengthening global resilience against health emergencies

A strengthened global, regional, national and subnational resilience against health emergencies requires the global sharing of data, information, medicines, vaccines, diagnostics, consumables, genetic material, knowledge, research, and technology. The IHR (2005) lays the foundation for global health security requiring State Parties to accelerate implementation, continue reporting annually to the World Health Assembly on their gaps and achievements, and to use the IHR monitoring and evaluation tools to further assess and improve their systems and capacities.

Effective global health governance that puts people at the centre, at all levels of society, could be the platform to enhance resilience. It should be based on interconnected, all-hazards, and ‘One Health’ approaches, aiming to include all people. Only through coordinated, holistic, and equitable governance structures, can the world be resilient and ready for these future hurdles, and ultimately leave no one behind.

References

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