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COVID-19 and U.S. International Pandemic Preparedness, Prevention, and Response

Testimony before the Senate Foreign Relations Committee

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Dear Chairman Risch, Ranking Member Menendez, and distinguished Senators,

Thank you for inviting me to testify before you today. This hearing comes as the COVID-19 pandemic is proving what public health experts have warned for years: no country in the world is adequately prepared for a lethal pandemic. Many countries today are failing to contain the virus, whether through poor management, weak systems, late action, or all of the above. There is an aphorism that one must never waste a crisis. So even as we work to defeat the current pandemic, we must begin learning from the failures to contain it, and prepare ourselves to be more ready the next time around. We are fortunate that COVID, while highly transmissible, has a lethality far lower than past threats like SARS-1, Ebola, or the Spanish flu. A comparably transmissible virus with a much higher lethality is plausible, and over time even probable. So we must use this moment to marshal the political will to be ready for that.

Being ready for the next pandemic must be a global effort: US readiness at home will be compromised if there are vulnerabilities overseas. As COVID is teaching us, a lethal pathogen will take advantage of any weakness in the world's defenses. The Pandemic All Hazards Preparedness Act, which was reauthorized a year ago, focuses on domestic pandemic readiness but is nearly silent on international aspects. This is a moment to rectify that, for our global and our domestic efforts must be well aligned. We must understand that our investments in global cooperation are not purely altruistic; the also keep *us* safe. And we must connect those efforts directly into our domestic efforts.

The Global Outlook

In an earlier hearing of this Committee, Chairman Risch asked a group of administration witnesses to identify the "fire department" for global health emergencies. While none acknowledged it, the world already has such an institution: the Health Emergencies Programme of the World Health Organization, guided by the WHO's mandate under the International Health Regulations to "prevent, protect against, control and provide a public health response to the international spread of disease." While WHO is not a perfect institution, it has improved dramatically since its failings during the 2014 Ebola outbreak, and has largely served the world well during the present pandemic. US involvement with WHO is a critical pillar of American and global pandemic preparedness. Withdrawing the United States from the WHO will weaken both the WHO and the United States, and put at risk the health of millions around the world and here at home.

There have been assertions by the administration, and by some in Congress, that WHO's performance on COVID has been a repeat of mistakes it made during the West Africa Ebola outbreak, and that the US is therefore justified in abandoning the organization as hopeless. This mis-diagnoses both what went wrong in 2014, and what constrained the organization during the early phase of this pandemic.

There is no question that the organization badly mishandled the Ebola outbreak in 2014 during the critical May-August period when the outbreak accelerated across West Africa. The WHO country offices were slow to take the risk seriously, WHO HQ in Geneva was slow to sound the global alarm, and the organization lacked the operational wherewithal to mount a rapid and effective response. The independent panel tasked with evaluating WHO's response to that outbreak concluded that the organization did not "currently possess the capacity or organizational culture to deliver a full emergency public health response."[1] And this glaring gap in the global readiness for complex outbreaks allowed a virus that had never previously produced more than 425 cases in any single outbreak to infect 28,616 people and kill 11,310. It forced the US and other nations to deploy massive civilian and military operations to contain the outbreak, at a cost of billions of dollars.

At the time, I served at USAID as the director of foreign disaster assistance, and my team served as the backbone coordinating the US response in West Africa. Following the outbreak, I was closely involved in US deliberations over what to do with WHO. The interagency debated a range of options, up to and including the creation of a new, separate agency responsible for health emergencies. But we concluded ultimately that that was neither feasible nor advisable, and that the best approach was to press for a fundamental overhaul of WHO's role in health emergencies.

We also recognized, as did other prominent WHO member states, that part of the responsibility for the failure rested with us. WHO is a member state-based organization, and its policies and priorities are not determined in a vacuum: they reflect the guidance and direction that the WHO secretariat receives from WHO members. And for too long, member states had pushed WHO leaders to prioritize non-emergency missions while ignoring the erosion of the organization's emergency response capacity.

So rather than abandon the organization, the US set out to strengthen it. We worked with WHO leadership to develop a plan for a major organizational overhaul; I and a CDC representative sat on the advisory group that helped design the proposed reforms. We also mobilized diplomatic efforts to build support among member states for the emergency reform package, which was passed by the WHO's governing body in May 2016 with broad support. We provided targeted funding to help kickstart the reform process, tied to rigorous accountability requirements to ensure that the organization followed through on reform implementation. And since 2016 I have had had a unique vantage point on the implementation of these reforms from another perspective, as a member of the independent oversight board that monitors WHO's Health Emergencies Programme and reports back to the member states on the organization's implementation of the post-Ebola reforms.

These reforms have had a real impact. There is perhaps no clearer contrast between the WHO of 2014 and the WHO of today than the organization's handling of the extremely complex Ebola outbreak that finally concluded last week in Eastern Congo. An agency that had been unable, in 2014, to mobilize a rapid or robust operational Ebola response in three stable and peaceful countries was able, by 2018, to mount a massive field operation in one of the most complex conflict zones on earth. And furthermore,

[1] https://www.who.int/csr/resources/publications/ebola/report-by-panel.pdf?ua=1

WHO did this without anything like the kind of massive US and UK personnel deployments that had rolled out in West Africa. In fact, WHO received far less technical support and cooperation from CDC and USAID than it customarily would, due to the State Department's fears about security risks to US personnel. WHO meanwhile deployed more than 700 personnel, at significant risk, and lost staff to armed violence. Over the course of the outbreak, WHO and the Congolese government partnered to build an operation that vaccinated more than 300,000 people and at its high-water mark was tracing and monitoring more contacts (in a war zone!) than most US states are today.[2]

And that in turn is a useful backdrop to understanding WHO's performance during the ongoing COVID pandemic. The organization today remains far from perfect but has made huge strides since its nadir in 2014. And while the Trump administration has criticized the WHO for supposed failures on COVID-19, the main charges do not hold up to scrutiny – and certainly do not justify withdrawing from the institution.

The administration has made three main accusations: that the WHO is uniquely close and credulous toward China; that it was late to warn the world about the dangers of the virus, particularly its potential for human-to-human transmission; and that it opposed President Trump's imposition of a travel ban on China. Collectively, the administration has suggested that different behavior from WHO on these fronts would have spared the US and the world from the catastrophe that this virus has wrought.

These accusations are false.

With respect to WHO's supposed closeness to China, it is certainly true that WHO is highly deferential toward member states – but this is not unique to China. Like any multilateral, member-state based organization, WHO is loath to criticize its members in public. This is by design; WHO's members (the US included) have traditionally steered it to be highly deferential toward member state prerogatives. WHO also avoided criticizing shortcomings by the Congolese government, or the governments of West Africa, during Ebola outbreaks there; all of those members states have far less global power than China.

This kind of deference is formally enshrined in the International Health Regulations, the binding treaty negotiated by WHO member states that guides WHO's authorities in major outbreaks. The IHRs make explicitly clear that WHO has virtually no authority to second-guess outbreak reporting by a member state, and can only investigate new outbreaks with the state's cooperation and consent. Furthermore, the IHRs grant WHO no authority to sanction or punish states for inaccurate, late, or incomplete reporting. Again, it is important to emphasize that this situation was created by the choices of the member states that negotiated and adopted the IHRs. As for the notion that China has outsized influence in the WHO, US citizens occupy two senior leadership positions in the organization while only one is occupied by a Chinese national.

The idea that WHO was unjustifiably late in warning the world about COVID-19 also ignores the evidence. China confirmed the outbreak to WHO on December 31 2019. Within days, WHO had released an extensive set of resources and technical guidance on the virus, and on January 12 (unprecedentedly fast compared to previous outbreaks) WHO shared the virus' genetic sequence with the world, with

[2] https://www.who.int/news-room/detail/25-06-2020-10th-ebola-outbreak-in-the-democratic-republic-of-the-congo-declared-over-vigilance-against-flare-ups-and-support-for-survivors-must-continue

detailed guidance for diagnostic testing released on January 13.[3] With respect to human-to-human transmission, WHO stated in a press conference on January 14 that human-to-human spread was a possibility (albeit yet unproven).[4] WHO subsequently confirmed human-to-human spread was occurring on January 22, a day after WHO staff returned from the first trip that the Chinese government had permitted them to make to Wuhan. Another day later, on January 23, Director General Tedros convened the WHO Emergency Committee (and advisory body composed of outside experts, including a senior US CDC official) to review emerging information from China and advise on declaration of a public health emergency of international concern. The PHEIC is the highest level of alert that WHO is authorized to sound under the IHRs.

The emergency committee was split at that time on declaring a PHEIC; there were fewer than 600 cases officially reported. Nonetheless the WHO's summary of the committee deliberations provided a picture of the virus that was deeply alarming: a novel respiratory coronavirus that was spreading uncontained in the community; had a severity rate of 25% and a preliminary fatality rate of 4%; and had a reproduction number of up to 2.5[5], making it significantly more transmissible than seasonal flu. In the infectious disease world, this is a highly worrying collection of characteristics. A week later, after China had begun shutting down Wuhan and other major cities, the Emergency Committee reconvened and advised declaring a PHEIC, which Director General Tedros did. At the time, fewer than 100 cases had been detected outside China, and only 5 in the United States.

With respect to on the travel ban controversy, WHO's posture was grounded in the widely held view in public health literature that travel bans are a highly disruptive measure that provides limited real protection against the spread of a respiratory virus. Most research on travel bans has found that in a large and open country like the United States, such bans can at best modestly delay the acceleration of an outbreak by a few weeks. They cannot shield a country from the eventual arrival of a virus, as is now obvious. There was good reason to therefore be wary of such bans, for fear that they foster a false sense of complacency that deters emphasis on true readiness for the arrival of the outbreak – which indeed is precisely what happened here. And in fact WHO did not actively oppose such bans; it sent a circular notice to member states on February 6 noting that such bans could be justified if they were used to allow time for countries to implement sustained preparedness and response measures.

Put together then, these accusations have little merit and there is no reason to believe that different behavior from WHO would have produced a different readiness posture by the US Government. The failure of the US to be ready for the pandemic now battering our country is not result of listening to WHO, but rather a result of not listening. China was slow to release information on the virus; but WHO had no authority under the IHRs to compel different behavior. Once WHO verified updated and more accurate information it relayed that evidence to the world, at a time when there was still a sufficient window for preparedness. And it noted that travel bans, if implemented, should be used to buy time for domestic preparedness, advice that the US ignored.

The US withdrawal from WHO is absurd on the merits and will be tragic in its consequences. WHO is a crucial reporting hub for every country in the world, and there are numerous USG secondees working

[3] https://www.who.int/news-room/detail/29-06-2020-covidtimeline
[4] https://twitter.com/UNGeneva/status/1217146107957932032
[5] https://www.who.int/news-room/detail/23-01-2020-statement-on-the-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov)

for the organization. Membership provides access to important policy and research bodies; walking away from WHO leaves the US less informed in COVID-19 and future pandemics. The US has also invested heavily over the years in WHO's ability to lead the fight against infectious diseases so that we don't need to carry that burden alone. Global polio, for example, is close to full eradication due to WHO's US-backed vaccination efforts. Withdrawing from WHO will leave the US isolated in global health efforts and unilaterally surrender US influence.

Instead of withdrawing, the United States should focus its efforts on continuing to advance WHO reform. While great progress has been made, much more is needed. The United States' ability to promote those reforms will evaporate with our departure from the institution. The US should focus as well on the bigger weakness that this pandemic has revealed: glaring shortcomings in the International Health Regulations. If we want to see greater country transparency and accountability in outbreaks, the IHRs' tepid handling of those dimensions is the place to start. We should also explore updating the PHEIC mechanism, whose binary structure undermines its usefulness as a true alarm bell for health emergencies. A far better approach would be to rethink the PHEIC as an escalating scale of pandemic risks, with different global and national readiness triggers tied to gradations of risk. These kinds of reforms would make the US and world meaningfully safer in future emergencies; by leaving WHO, we lose the ability to accomplish this.

Organizing the US Government

As the US focuses on adapting the international system to the lesson of COVID-19, we must also rethink how the US Government itself works to advance global pandemic readiness. I am very heartened to see a flurry of proposals to bolster US government focus, operations, and financing toward this critically important objective. We must seize this moment to begin building a stronger US and global architecture for health security, just as we did after 9-11 for counter-terror cooperation (although hopefully with greater regard for human rights and civil liberties).

And so I welcome and commend the spirit of the proposals that have emerged – the Risch/Murphy/Cardin bill and the Menendez bill in the Senate; the Connolly bill in the House; and elements of the emerging proposals being formulated by the administration. However, I have real concerns about the design of some of these proposals. Global health security and pandemic preparedness are whole-of-government functions that must be effectively organized within the US government and well aligned with our multilateral partners, particularly the WHO. I do not believe that modeling the new initiatives on PEPFAR, as some of these proposals envision, is the best approach. While PEPFAR's robust budget and long-term political commitment are both characteristics we want to emulate here, other aspects of that initiative are poorly suited to pandemic preparedness. I will outline several elements that I believe USG-focused reforms must incorporate.

First, it is important to establish a clear division of labor across the interagency, building on each agency's comparative advantages.

This was not enough of a focus during PEPFAR's inception, and that lay the groundwork for years of interagency friction that continues to plague the USAID-CDC relationship. Due to initial ambiguity over the division of tasks and expertise, each agency built parallel capacities and programs in different

countries. Even now it is not uncommon for CDC to lead program areas in one country that USAID leads next door, and vice versa.

In developing the Ebola response in West Africa, my team at USAID and our counterparts at CDC instead sought to explicitly avoid this kind of ambiguity. We defined each agency's roles clearly at the outset, based on our respective comparative advantages – and then OMB developed budget proposals that reflected that pre-arranged division of labor. This led to a much smoother partnership, because we each obtained the resources we needed and had little reason to compete with the other agency for turf. I would urge that as Congress considers how best to authorize a new USG initiative, it establishes up front the respective roles of CDC, USAID, State, and other USG institutions (I was encouraged to see this reflected in the Menendez bill). This will reduce the potential for interagency friction and the need for a heavy coordination infrastructure.

Second, the coordinator role at the State Department should accordingly be a lighter structure modeled on the Counter-ISIL envoy, rather than the heavy and directive model of the PEPFAR Coordinator.

The PEPFAR Coordinator role centers expansive authority over program priorities, evaluation, and most importantly budgetary oversight at the State Department. This centering of interagency authority at State was arguably necessary for two reasons; the Coordinator's role in refereeing the aforementioned interagency turf battles, and to give the Coordinator leverage for interagency coordination. Repeating that model for pandemic readiness would have real downsides. It would prompt resistance from USAID and CDC, who are skeptical of the need for an added budgetary and program layer for initiatives that in many cases they have been investing in for years. And it would put a huge amount of program control in a Department that, outside of the PEPFAR office, has a weak institutional track record on global health.

While PEPFAR has worked well overall, the State Department has struggled with other global health efforts over the years. The Obama-era "Global Health Initiative" launched in 2009 was an earlier attempt by the State Department to improve interagency coherence across the US government's global health programs. But, as my CGD colleagues wrote at the time, it was "plagued by infighting, leadership questions, and general confusion since its launch" and was quietly shuttered in 2012.[6] A few years later, during the Ebola outbreak, the State Department performed some tasks extremely well – such as organizing medevac services and providing Embassy-level support to outbreak response in the affected countries. But Main State in Washington struggled with interagency coordination, because the issue had no clear institutional home in the department. Eventually the Secretary recalled retired ambassadors to manage an ad-hoc Ebola Coordination Unit to manage State's contributions and represent in interagency deliberations. It is quite a leap to go from this track record to overseeing and leading the full range of programmatic, strategic, diplomatic, and budgetary functions envisioned in some of these proposals, and in the reported State Department vision.

A lighter approach modeled on the Counter-ISIL envoy would have a higher chance of success. The Counter-ISIL envoy role has numerous parallels to what is needed for pandemics. It emerged from a recognition that protecting the US homeland from ISIL would depend on both a well-aligned US interagency response, and a major global diplomatic mobilization. The US Special Envoy role was established in the State Department and tasked with building a coalition of allies – a classic State

[6] https://www.cgdev.org/blog/failure-launch-post-mortem-ghi-10

Department function. The Envoy's office also co-led the US interagency planning, in close partnership with the National Security Council at the White House. This produced an effective and expansive coordination model, that gave government departments and agencies appropriate space to manage their operations while ensuring alignment and mutual visibility. Like the counter-ISIL campaign, a pandemic readiness initiative must mobilize a surge in global diplomatic outreach alongside agency-level programs and operations. The same kind of decentralized alignment – rather than concentrated bureaucratic power – is what the US government needs for its global pandemic readiness efforts. Lastly, there is simply no substitute for White House leadership. A signature US pandemic initiative needs visible Presidential backing and White House coordination in order to deliver on the ambitious scale that this challenge requires.

Third, as many of the proposals have acknowledged, any new US initiative must be robustly resourced. The pandemic has stripped trillions of dollars from global economic productivity, and cost trillions more in emergency economic stimulus and safety net spending. Investing on a PEPFAR-like scale – which is to say several billion dollars a year – to build the capacity to prevent a recurrence of this kind of catastrophe is an extremely good return on investment.

Whatever the bureaucratic shape of this initiative, its priorities are clear. It must build a global partnership that advances the world's ability rapidly detect and contain future pandemic threats. This means investing in surveillance, diagnostics, and early warning – building the same capacities for infectious disease risks that we have built for hurricanes, droughts, and tsunamis. It means creating clearer triggers for global and country-level preparedness, so that we never again see the kind of inconsistent patchwork of country response that we have seen on COVID-19. It means investing in the readiness and resilience of medical and public health systems in weak and low-income countries, so that those states can contain disease threats that might reach us here. It means reinforcing critical supply chains of PPE and drugs. It means collaborating toward development of innovative diagnostics, vaccines, and therapeutics as global public goods.

Conclusion

All of these priorities will cost money, and all will require multilateral cooperation. To state it plainly, it is impossible to envision the US advancing this kind of agenda without the full engagement of the World Health Organization. And it is hard to envision the rest of the world collaborating with us in this effort if they perceive it as an alternative – rather than a complement – to the WHO.

Finally, it is painful to say this but it must be candidly said: the US' credibility to lead a global coalition on pandemic preparedness will also fall short unless and until we also get serious about containing our domestic outbreak. Our credibility globally starts with our competence at home, yet we are presently a prime example of how *not* to handle this pandemic. To rectify this, and to be able to credibly reassert our global health leadership, we must start taking the advice we have long provided to other countries: depoliticizing public health, following the evidence, communicating risk effectively, building public trust, and deploying competent management structures. And as we engage with the world going forward, we must show a degree of humility, in recognition that even a country as nominally well-prepared as the United States can falter when it departs from sound public health principles.