Asia-Pacific Review

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/capr20

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To cite this article: Takuma Kayo (2020) Global Solidarity is Necessary to End the COVID-19 Pandemic, Asia-Pacific Review, 27:2, 46-56, DOI: 10.1080/13439006.2020.1841949

To link to this article: https://doi.org/10.1080/13439006.2020.1841949

Published online: 11 Dec 2020.

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Asia-Pacific Review, 2020
Vol. 27, No. 2, 46–56, https://doi.org/10.1080/13439006.2020.1841949

Global Solidarity is Necessary to End the COVID-19 Pandemic

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Historically, the control of epidemics has been closely linked to international cooperation, which has subsequently increased with globalization. The spread of infectious diseases is no longer just a threat to public health, but a global crisis, as it can paralyze the economy, the development, or the defenses of every country worldwide. However, the response structure has not adapted to this feature of modern infectious diseases. Issues with the existing structure have been exposed through COVID-19, such as lack of global solidarity, structural problems, and the lack of a coordinating mechanism for responding to the pandemic as a global crisis, none of which will improve without active commitments from member states. International solidarity is also crucial for maintaining the liberal international order that is now at risk. In addition to other middle powers such as the nations of Europe or Oceanian countries, expectations of Japan have never been higher than now. Japan should make efforts to strengthen preparedness by establishing a regional monitoring system and a cooperative system, utilizing existing frameworks such as the Tripartite Health Ministers Meeting, ASEAN+3, or the Free and Open Indo-Pacific.

Introduction

Since the outbreak of COVID-19, the tension between China and the US has intensified. US President Donald Trump announced that he would halt funding to the World Health Organization (WHO) in April, while criticizing the WHO for being too close to China and for its mismanagement of COVID-19. The US has now formally notified the United Nations (UN) of its withdrawal from the WHO.[1] The Chinese State Councilor and Foreign Minister Wang Yi argued against the action, stating that China had controlled the virus with serious efforts, and criticized the US, saying “some figures insisted on politicizing

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the outbreak and defaming the WHO."[2] Furthermore, some countries including the US, China, and Russia are not participating in the COVAX Facility, which aims to distribute vaccines equally, even though equal access to the vaccine is necessary for the world to return to normal. In sum, the "My Country First" policy and a lack of leadership characterize the response towards this unprecedented global crisis.

Looking back in history, however, the control of epidemics has historically been closely linked to international cooperation. This article explores how international society has responded to COVID-19, examines what response is necessary in order to end the pandemic, and also examines Japan's role in this response.

The history of international health cooperation

The beginning of international health cooperation

Humanity has experienced numerous epidemics such as cholera or the plague, through which the framework for international cooperation has developed. For instance, the epidemic of cholera in 19th century Europe led European society to the convening of the International Sanitary Convention in 1903, which was the first convention for the control of epidemics in human history.[3] The spread of Spanish flu or malaria during the First World War, however, prompted the perception that it was not sufficient to respond to pandemics or epidemics with only a Convention, which turned into the creation of a health organization under the League of Nations.[4]

The US did not join the League of Nations, but was unofficially involved in the League's health work, and this experience made the US attempt to control various infectious diseases during the Second World War, in collaboration with the League of Nations' Health Organization. The US also committed actively to the establishment of the post-war health organization as early as 1943.[5] The US, under then president Franklin Roosevelt, was quite active in establishing functioning organizations in the food, financial, and health fields. In fact, the US convened the Hot Spring Conference in 1943, where the Allied countries agreed to establish the Food and Agriculture Organization (FAO), and convened the Bretton Woods Conference in 1944, where the Allied countries agreed to establish the International Monetary Fund (IMF) and the International Bank for Rehabilitation and Development (IBRD). President Roosevelt and the then Secretary of State Cordell Hull expected that establishing functional organizations under which nation states could cooperate more easily would be the basis for broader cooperation, including in fields in which they would find it difficult to agree.[6]

Such expectations were reflected in the structure of the World Health Organization (WHO). At the International Health Conference, convened in June 1946 for the purpose of drafting the WHO's Constitution, some countries, including the UK and USSR, were reluctant regarding the idea that non-UN member states would join the WHO. The US, on the other hand, insisted that the door to join the WHO should be open to every nation state, which resulted in the name "World" Health Organization, rather than "United Nations" Health Organization. As mentioned above, the US expected that functional cooperation would be the basis for the post-international order and, in this regard, the US believed that the WHO should be an inclusive and universal organization.[7]

US-USSR cooperation under the Cold War

Just after its inception, the WHO engaged in various health activities, despite the Cold War. For example, the US at first gave a cold response towards the smallpox eradication programme proposed by the USSR, but then changed its attitude after the 1960s, in an attempt to regain its international reputation following the Vietnam War. Since then, the WHO's Smallpox Eradication Programme accelerated under the auspices of these two superpowers. The tension between the two countries never disappeared, however. The USSR was displeased with the WHO when the WHO appointed an American as the Director of the Programme, and also when the vaccine supplied by the USSR did not pass the WHO's qualification test. The WHO, however, showed utmost consideration to both of these superpowers, which resulted in their continued cooperation.

The US and USSR also collaborated with each other on the development of the polio vaccine. The inactivated polio vaccine was popular, which was expensive and had to be injected by a doctor. In order to make the vaccine more accessible, the American scientist Albert Sabin developed an oral polio vaccine, which was cheaper and could be orally administered. After the death of the USSR's Premier Joseph Stalin in 1953, both the US and the USSR realized the necessity of collaborating with each other in its development, and a mass clinical trial of the oral vaccine was conducted through collaboration between the US and the USSR. This resulted in the oral polio vaccine being put into practical use.[8] As a result of the two super powers' collaboration, the oral polio vaccine was widely used under the WHO's Polio Eradication Programme, which was launched in 1988.

Unlike the US and China in 2020, the US and the USSR had quite flexible attitudes towards health cooperation. They realized that cooperation was necessary for promoting each country's national interests. In addition, the WHO paid the highest consideration to both countries to ensure that health cooperation was possible even in the shadow of the Cold War. This episode of history contains many suggestions to consider in the reaction towards COVID-19.

Response towards COVID-19

The lack of global solidarity

As mentioned above, the control of epidemics has historically been closely linked to international cooperation, and the importance of cooperation has increased with globalization. This is because the spread of infectious diseases is no longer just a threat to public health, but a global crisis, as it can paralyze the world economy, development, or the defense of each country. In this globalized age, where we are closely connected through travel, trade, and the internet, an infectious disease can spread very quickly, and its impact can be global. The control of infectious diseases then has been redefined as also being a security issue, rather than just a public health issue.

The response structure, however, has not changed to fit this feature of modern infectious diseases. The various problems of the existing structure have been exposed through COVID-19. The first problem is the lack of global solidarity to cope with the pandemic as a global crisis. Looking back at the responses to recent epidemics or pandemics, global solidarity was essential. In the response to Severe Acute Respiratory Syndrome (SARS) in 2003, the US offered help to China, which was the origin of the virus. For the H1N1 influenza in 2009, the US promptly informed the WHO of the outbreak, and the WHO appealed for solidarity, which resulted in a small number of patients, and led to worldwide criticism towards the WHO for its "overreaction."[9]

Regarding the Ebola virus outbreak in 2014, a world summit was convened under the auspices of the then US President Barack Obama, and the UN Security Council agreed to establish the UN Mission for Ebola Emergency Response, which responded to the epidemic in collaboration with the UN Mission in Liberia. The Ebola epidemic was an unprecedented crisis, with a large number of deaths in West Africa. It ended after approximately a year under US leadership, and through global solidarity among various actors including the WHO, the UN, the World Bank, and Doctors Without Borders.[10]

In contrast to the precedents mentioned above, the response to COVID-19 has lacked global solidarity, not to mention US leadership. Instead, US-China tensions have made the matter worse. The issue around the COVID-19 vaccines reflects such a situation. The COVAX Facility, which is co-led by Gavi, the Coalition for Epidemic Preparedness Innovations (CEPI) and the WHO, was established to accelerate the development and manufacture of COVID-19 vaccines, and to guarantee fair and equitable access for every country in the world.[11] All participating countries, regardless of income level, will have equal access to these vaccines once they are developed. The initial aim is to have two billion doses available by the end of 2021, which should be enough to protect high risk and vulnerable people, as well as frontline healthcare workers.[12] As of October 2020, more

than 180 countries have joined the COVAX Facility; however, the US and Russia have not yet joined. Therefore, there is much uncertainty regarding the future of the COVAX Facility.[13]

Such selfish movements would have a bad influence on developing countries' access to vaccines, as they do not have the ability to produce their own vaccines. Actually, the African Union is quite pessimistic about their access to the vaccine, as there is much uncertainty about the prospect of the COVAX Facility, as mentioned above.[14] The competition and access gap among countries would be intensified without global solidarity.[15]

Equal access to vaccines is necessary for ending the pandemic earlier. The Bill & Melinda Gates Foundation asked Northeastern University's Laboratory for the Modeling of Biological + Socio-technical Systems (MOBS) to consider two different scenarios. In one, approximately 50 high-income countries monopolize the first two billion doses of vaccine. In the other, doses are distributed globally, based on each country's population. The MOBS Lab found that in the latter scenario, a vaccine would avert 61% of the deaths, while in the former scenario, where more developed nations hoard the vaccine, almost twice as many people would die, and the disease would continue to spread unchecked for four months across three quarters of the world.[16] Sharing the vaccine equitably would result in fewer deaths, and would result in faster control everywhere.

Structural problems

The second problem that has arisen around COVID-19 is the shortcomings of the International Health Regulations (IHR). The IHR, the origin of which was the International Sanitary Regulation of 1903, provides an overarching legal framework that defines countries' rights and obligations in handling public health events and emergencies that have the potential to cross borders. The IHR has been revised many times, accompanied with various changes in the international environment. The present IHR, which was revised in 2005 after the SARS epidemic, functions as an instrument of international law that is legally-binding for 196 countries, including the 194 WHO Member States. The IHR outlines the criteria to determine whether or not a particular event constitutes a "public health emergency of international concern."[17] The IHR, which dealt only with infectious diseases before the revision in 2005, now includes "public health emergencies of international concern" reflecting the threat of anthrax terrorism that arose in 2001 following the September 11th attack on the World Trade Center. Furthermore, the revision gave the WHO the right to refer to a country for the information the organization gets from various sources, including non-state actors. This revision was made because it has become easier to get accurate information promptly through the spread of the internet.

Despite the above revision, the reality revealed by COVID-19 is that member states have not necessarily upheld their duties as outlined by the IHR. In particular, the delay of the response in the early stages of the pandemic was a serious mistake. A study published in March 2020 suggests that if Chinese authorities had acted just three weeks earlier, the number of global COVID cases could have been reduced by 95%.[18] We are now facing a big challenge of how to improve the duties of the WHO and its member states, as provided in the IHR.

COVID-19 has also revealed the fact that the WHO does not have the compulsory power to come into the country where a pandemic occurs. The WHO has been criticized for praising China's response in January; this action resulted in part from the reality that the WHO lacks compulsory power and depends on the voluntary cooperation of Member States. In 2003, the then Director-General of the WHO criticized China's response to SARS, which subsequently resulted in poor communication with China.[19] That experience may have made the WHO more cautious this time, as it lacks any compulsory power such as coming into the country for investigation without consent. The WHO therefore reacted in a reserved manner with the expectation of achieving better communication with China.

The third problem, which has arisen following COVID-19, is the lack of a coordinating mechanism for responding to the pandemic as a global crisis. As mentioned above, the COVID-19 pandemic today is not only a threat to the public health, but also a global crisis that is having an enormous impact on a wide range of fields. The crisis is, however, too large of a burden for the WHO, which lacks both funding and compulsory power. As we saw in the responses towards Human Immunodeficiency Virus (HIV) or Ebola in 2014, a global coalition that includes Member States, various international organizations and other non-state actors, is indispensable for dealing with a pandemic as a global crisis. More concretely, some coordinating mechanism is necessary under the UN system, so that various actors collaborate efficiently, while keeping the WHO as the key to such a coalition.

Why do we need collaboration?

Each of the three problems described above—lack of global solidarity, structural problems, and the lack of a coordinating mechanism for responding to the pandemic as a global crisis—will never be improved without active commitments from Member States. The Member States make the concrete roadmap for reforming the WHO, and diplomatic negotiations are needed in order to get support for a reform plan. Actually, the G7 health ministers have held consultations about reforming the WHO, which have resulted in the WHO reform plan drafted by Germany and France.[20] They propose that the WHO should be able to access areas where an outbreak has occurred early on; the WHO should have a more

nuanced system to define health emergencies and should be able to assess whether countries are respecting international rules on health emergencies, and are prepared to respond to and report them. The WHO reform is not formally on the agenda of the Executive Board meeting, which will be held in October 2020, but the fight to influence this discussion is ongoing.[21]

There are many other reasons why global solidarity is necessary. One is that COVID-19 is impacting a wide range of fields, which can be dealt with only through global solidarity. As mentioned above, COVID-19 is not only harming public health, but has also shrunk the world economy, increased poverty and social insecurity, and has impacted international order. Furthermore, each challenge cannot be coped with internally by each country, but through global solidarity. International solidarity is also crucial for keeping the liberal international order. China has placed value on health cooperation as a diplomatic tool, and is treating COVID-19 in the same way. If China can develop an effective vaccine and offer it to developing countries at an affordable price, this would allow China to expand its influence. China, on the other hand, does not necessarily value the existing global values such as the rule of law or multilateralism. In this regard, the active commitment of democratic countries such as Japan, the nations of Europe, or Oceanian countries is necessary. Actually, these countries have played important roles since spring 2020, under the rising tensions between China and the US. In April, they set up the Access to COVID-19 Tools (ACT)-Accelerator, as a new, ground-breaking global collaboration project to accelerate the development, production, and equitable access to COVID-19 tests, treatments, and vaccines, in collaboration with the WHO and the Bill & Melinda Gates Foundation.[22] As mentioned above, Germany and France have also taken the initiative in the reform of the WHO. At the 75th UN General Assembly convened in September 2020, the UK Prime Minister Boris Johnson announced a 30% increase in the UK's funding of the WHO, which will make the UK the single largest national donor after the US leaves. He left the impression that the UK is now a key player in global health by announcing its commitment to the COVAX Facility and the WHO reform.[23] If these middle powers could be united to maintain multilateralism and contribute to realizing equal access to the vaccine, the future may be bright. If Joe Biden is elected as the new US President in the November 2020 election, the US would return to the multilateral framework, which is now underpinned by middle powers. The US, especially the Democratic Party, are actually eager to commit to reforming the WHO, even while announcing their withdrawal from it.[24]

The role expected of Japan

As well as those middle powers, expectations for Japan have never been higher than now. Japan, which has maintained a satisfactory relationship with both

China and the US, is expected to persuade both countries to join other global efforts for ending the pandemic. Furthermore, Japan, as one of the members of the COVAX Facility, is expected to play a crucial role in realizing equal access to the vaccine.

In addition, Japan needs to collaborate with neighboring countries for positioning its pandemic preparedness, as part of security. Even before COVID-19, Japan had placed emphasis on health in its Official Development Assistance. Japan, from now on, should not only help its neighboring countries to strengthen their health system and preparedness, but should also strengthen its own preparedness, in collaboration with those countries. More concretely, Japan should make efforts to strengthen preparedness by establishing a regional monitoring system, and a cooperative system on research and development (R&D), utilizing existing frameworks such as the Tripartite Health Ministers Meeting (China, South Korea, and Japan), ASEAN+3, or the Free and Open Indo-Pacific.

In fact, Japan has actively collaborated with ASEAN since the outbreak of COVID-19. On the 7th of April 2020, the Special Video Conference of ASEAN +3 Health Ministers in Enhancing Cooperation on Coronavirus Disease 2019 (COVID-19) Response was convened. The participants reaffirmed their commitment to coordinate the sharing of information on rapid research and development of diagnostics, antiviral medicines, and vaccines. They also aimed to provide assistance in sustaining affected national health systems in the region, in improving the readiness of others, and in using publicly known digital technologies for the efficient exchange of information.[25]

On the 14th of April, the Special ASEAN+3 Summit on COVID-19 was convened, where the leaders adopted a joint statement in which they reaffirmed their commitment for ending the pandemic.[26] At this meeting, then Japanese Prime Minister Abe Shinzo announced the plan of establishing the ASEAN Centre for emerging diseases and public health emergencies as the flagship of Japan-ASEAN cooperation, for the purpose of protecting the people of ASEAN from the threat of infectious diseases and jointly developing the Centre as a hub for countermeasures against infectious diseases in ASEAN for years to come.[27] At the Japan-ASEAN Ministerial Meeting held in September 2020, Japanese Foreign Minister Motegi Toshimitsu expressed his aim to fully support the establishment of the ASEAN Centre for emerging diseases and public health emergencies. Minister Motegi also expressed Japan's support for, and cooperation with, the establishment of the COVID-19 ASEAN Response Fund, which aims to procure medical supplies and develop vaccines. He also announced that Japan had decided to donate US$1 million as its own contribution. In addition, Minister Motegi stated that the ASEAN Outlook on the Indo-Pacific Region (AOIP) and Japan's Free and Open Indo-Pacific (FOIP) vision have much in common, and expressed that he wishes to work together to concretely develop Japan-ASEAN

cooperation regarding the AOIP. He also stated that Japan hopes to steadily advance the development of its quality energy infrastructure and extend its technical assistance.[28]

Collaboration among Japan and its neighboring countries in preparedness would have multiple effects. This collaboration would undoubtedly help to improve the preparedness of Asian countries; collaboration would strengthen Japan’s preparedness, and would secure multilateralism in the region, where the rise of China may be worrying. With the rise of China, which may attempt to extend its influence by supplying a vaccine to neighboring countries,[29] the collaboration between Japan and ASEAN countries would contribute to preserve multilateralism, and make the framework more inclusive in the future.

Conclusion

As history shows, we cannot control pandemics or epidemics without global solidarity. Even with the rising tensions between China and the US, the efforts of the middle powers could pave the way for ending the COVID-19 pandemic. Especially in Asia, collaboration has materialized as the plan for establishing the ASEAN Centre for emerging diseases and public health emergencies. If the related countries succeed in making the Centre more inclusive, including other countries such as China or South Korea, the Centre will probably have an impact not only on regional preparedness, but also on the geopolitical movement. As the US expected in 1946, health cooperation has the capability of smoothing international relations. In order to realize such a possibility, the active commitment of each country is necessary.

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Takuma Kayo is a professor of international politics at the Faculty of Law and Politics, Tokyo Metropolitan University. Her research interest is global health governance's origin, evolution, and challenges, with a focus on its relationship with the changing international political order. In this regard, she has been engaged in several projects, such as a comparative study on G7 countries' contribution to the implementation of the International Health Regulations and health cooperation in Asia. She received an M.A. and Ph.D. from the Graduate School of Arts and Sciences, Advanced Social and International Studies, University of Tokyo. Her major publications are Yasuda Kayo, *Kokusai Seiji no nakano kokusai hoken jigyō [International Health Work in International Politics: From the League of Nations Health Organisation to the WHO and UNICEF]*, Minerva Shobō, 2014; Takuma Kayo, *Jinrui to Yamai: Kokusai Seiji Kara Miru Kansen Sho to Kenko Kakusa [Mankind and Diseases: Infectious Diseases and Health Inequality in International Politics]*, Chuokoron Shinsha, 2020.