GOF BRIEFING ON COVID-19 RESPONSE AND PREPAREDNESS
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Good morning to all of you in New York. It is a great pleasure to be with you today.

I would like to start by giving you an overview of the current COVID-19 global situation and response.

Globally, as of 8:35am CEST, 14 May 2020, there have been 4,218,212 confirmed cases of COVID-19, including 290,242 deaths, reported to WHO.

The most affected regions, in terms of cumulative case count, are Europe and the Americas. Overall, the European region has stabilized, though the Russian Federation continues to have an upward trend. South-East Asia continues to show an upward trend in cases, primarily due to an increasing trend in Bangladesh, India and Nepal. The Eastern Mediterranean region is also seeing an upward trend in cases, primarily driven by case counts in Iran, Pakistan and Saudi Arabia.

Because pathogens know no borders, this is a truly global crisis. We are only as strong as our weakest health system. The failure to manage health challenges at any level is a threat to health security globally.

The COVID-19 pandemic has profoundly affected the path towards universal health coverage. Only a few months ago – at the General Assembly last September – world leaders came together to endorse the Political Declaration on Universal Health Coverage.

At its core, UHC is a political issue and now, more than ever, we need our leaders to ensure universal access to essential health services, without financial hardship. This is essential for successfully combatting the COVID-19 pandemic and mitigating its socioeconomic impact.

COVID-19 has potential to cause three waves of morbidity and mortality: the first is due to the virus itself, the second is due to the inability of health systems to provide ongoing essential health services, and the third is linked to the socioeconomic impact. To reduce the human toll of all of these, fulfilling the commitments made in the *Political Declaration on Universal Health Coverage* is essential.

Universal health coverage and strong health systems, supported by sufficient financial and human resources, are a critical defense against disease outbreaks. However, COVID-19 has dramatically exposed existing vulnerabilities in our health systems—in high- , middle- and low-income countries alike—ranging from reliance on employment-based health insurance and social protection schemes and burdensome medical fees during a time when the economy is constricting and many people are facing financial insecurity, to the limited capacity of health systems to adapt and respond efficiently to a surge of new patients, while maintaining continuity of care. It has highlighted resource gaps such as shortages in the health workforce and medical equipment and supplies, and inadequate investments in infrastructure.

The pandemic has also demonstrated deficiencies in health systems to protect the most vulnerable, irrespective of a nation's wealth. Although the virus does not discriminate, its effects do – often hitting hardest those who can least afford it: the old, the poor, those with chronic disease, or those in poor living conditions. Equitable access to health services, including testing and treatment, has both individual and population health benefits.

Now, more than ever, critical work is needed to extend and strengthen the three main mechanisms of UHC to respond to this and future pandemics:

1. First, governments need to rapidly scale up their investments in core functions (Essential public health functions, or Common Goods for Health): those core public health functions that require collective action and can be funded only by governments or risk large market failures. This includes policy making based on evidence; communication, including risk communication and community outreach to empower individuals and families to better manage their own health; information systems, data analysis, and surveillance; laboratory capacity for testing; regulation for quality products

and healthy behaviours; and subsidies to public health institutes and programmes; these are integral to the commitments all Member States have signed up to in the International Health Regulations.

2. Second, countries need to continue to maintain essential health services and systems during the COVID-19 response such that additional illnesses and deaths do not occur while we are responding to COVID-19. Failing to do so puts additional strain on already overstretched health systems. When health systems are overwhelmed, both direct mortality from an outbreak and indirect mortality from preventable and treatable conditions increase dramatically. When essential health services are not maintained, the burden of morbidity and mortality from preventable health threats may even exceed that of COVID-19.

   This requires strategic expenditure to expand and protect the health workforce to safely carry out the essential services: prevention for communicable diseases, particularly vaccination; services related to reproductive health, including care during pregnancy and childbirth; care of vulnerable populations, such as infants and older adults; provision of medications and supplies for the ongoing management of chronic diseases, including mental health conditions; continuity of critical inpatient therapies; management of emergency health conditions and common acute presentations that require time-sensitive intervention; and auxiliary services, such as basic diagnostic imaging, laboratory services, and blood bank services; while protecting individuals and families from financial hardship. Equitable access is critical to ensure targeted services for those populations most vulnerable and marginalized.

   In order not to lose ground on the significant gains made over the last two decades, countries must sustain health services aimed at specific age groups across the life course. Not sustaining essential sexual, reproductive, maternal, newborn, child and adolescent health services will have a major impact on women's and newborns' health and survival, especially in low- and middle-income countries and in settings of fragility, conflict, and violence. For example, Johns Hopkins University modelling shows the potential impact on child and maternal deaths; over 6 months there would be 1.15 million additional child deaths and 56,700 additional maternal deaths. These deaths

would represent a 44·7% increase in under-5 child deaths per month, and a 38·6% increase in maternal deaths per month, across 118 countries.

A reduction in or cessation of the immunization programme will result in a resurgence of life-threatening infectious diseases like measles, diphtheria, polio, yellow fever and others that are preventable by vaccines that are available now. The magnitude of the impact could be very substantial, the longer and the more widespread the disruption to the immunization progammes. Countries need to make a concerted effort to reach the most at-risk and marginalized populations. Failures to do so will have severe negative effects on nations' health, wealth, and sustainable development.

We see that women, newborns, and children are already being severely affected by the "second" wave of morbidity and mortality: Essential sexual and reproductive health services are being deprioritized or are even more difficult to access with health system disruptions. Without sustained access to contraception, essential pregnancy and newborn care, and safe abortion to the full extent of the law, many millions of women will experience unintended pregnancies, unsafe abortions, and obstetric complications, resulting in an estimated 29,000 additional maternal deaths and 128,000 newborn deaths in the next 12 months.

Alternative approaches to making essential medicines and services available when facility-based services are restricted or stopped should be urgently introduced. For example, telemedicine for key information and delivery of medicines by post, self-care interventions, and task-sharing for outreach workers are all mechanisms that can increase access to essential sexual and reproductive health services when facility-based care is not possible. Making the systems, policy, legal and social modifications needed for such alternative approaches will not only immediately reduce the impact of the "second wave".

These changes will also pave the way for countries to step up their post-COVID UHC strategies.

We see that COVID-19 can negatively affect outcomes in people with noncommunicable diseases through several pathways: higher susceptibility to

infection, higher case fatality among people with NCDs who contract COVID-19; delays in diagnosis of NCDs resulting in more advanced stages of disease; delayed, incomplete, or interrupted therapy (treatment, rehabilitation, palliation) for NCDs; increased behavioural risk factors, and delayed care-seeking for emergencies including heart attack and stroke, diabetic crisis caused by interruption in insulin supply, or a worsened prognosis as a result of a delayed cancer diagnosis. In addition, patients with chronic respiratory diseases face particular challenges in making choices about when to seek care and in receiving accurate diagnosis, as their baseline disease may cause signs and symptoms similar to those of COVID-19.

Countries need to continue to invest in increasing the health workforce at this time of shortage, investing in scaling up training capacity to generate the needed skills of health and social care workers. Countries also need to scale up investments in health system infrastructure, ensuring that all people have access to health clinics with water, electricity, and connectivity. Finally, countries need to invest to ensure that supply chains are not disrupted by the crisis and make sure that access to medicines is maintained. Countries, particularly those with vulnerable health systems, will need external funding support to build their health systems to a level that can ensure access to essential health services, particularly in rural and remote areas.

As part of the COVID-19 response, WHO has issued guidance to Member States on maintaining essential health services during the pandemic, including those related to optimizing service delivery settings and platforms, establishing effective patient flow at all levels, and rapidly re-distributing health workforce capacity.

The COVID-19 shock has underlined the importance of primary health care as the cornerstone of UHC, as called for by the Astana Declaration, which serves as the first point of contact for many during emergencies and outbreaks.

A primary health care approach promotes multisectoral action on the determinants of health and on the key issues that involve all sectors, such as migration, water, sanitation, and hygiene, nutrition, and governance. Going beyond health facilities and workers, PHC is also supported by services that

are integrated and may involve other parties such as schools, religious institutions and cultural advisers.

The UHC-Partnership (WHO, EU, France, Ireland, Japan, Luxembourg, and the UK) is a flexible WHO mechanism that supports national priorities on health systems and health security. In the framework of COVID-19, activities have been quickly reprogrammed in the 115 countries supported by the UHC partnership to support the response, including maintaining health services.

The UHC-Partnership, in addition to reprogramming its ongoing resources, has also benefitted recently from additional earmarked COVID-19 resources from the European Union and Japan to support preparedness in target countries, in particular, the implementation of their National Action Plans for Health Security.

3. And thirdly, countries need to remove as much as possible financial barriers to accessing health services. People should not pay user fees (co-payments) at the point of care for essential services during an outbreak, since the expectation of payment may pose a substantial barrier to seeking and receiving needed care. In settings where informal payments (for example, for medical supplies or to health workers) are common, a mere declaration of free services is likely to be insufficient. Governments should establish reliable mechanisms to ensure no-fee delivery of essential services and communicate this policy clearly to the public. Beyond covering costs related directly to the epidemic, government financial planning should also include compensation for the loss of fee income by health facilities.

   Together we need to advance rapidly to implement these three UHC mechanisms in every country, to provide global health security and resilience.

COVID-19 has reinforced the existing evidence that investments in health have long-term returns, while underinvestment has potential large-scale social and economic implications. The COVID-19 pandemic can be the catalyst for reorienting national priorities toward the achievement of the 2030 Agenda for Sustainable Development, providing the political momentum needed for national health system reform, including public financial management and regulatory systems. These reforms

should include not only increased investment in the health sector but also toward strong multisectoral policies, led by a whole-of-government approach.

COVID-19 has been the ultimate stress test on the integrated framework of our social and economic ecosystems, extending well beyond the health sector. Inequities in access to health information and services, and financial protection are likely to disproportionately affect the poor and other populations facing social exclusion, including women, children, persons with disabilities, migrants, and refugees. These inequities have economic, social, and developmental consequences, and threaten progress toward the SDGs.

WHO's Strategic Preparedness and Response Plan (the SPRP) describes WHO's and countries' immediate actions and requirements to battle COVID19. The Global Humanitarian Response Plan (HRP) launched on 25 March, complements WHO's SPRP, in guiding the COVID-19 response in the most vulnerable countries and populations. The UN Framework builds from the SPRP and from the HRP and is a roadmap for the entire UN system to mobilize action for countries in all sectors following the immediate response. WHO is fully engaged in all five streams of work of the UN Socioeconomic Framework.

Now is the time for countries to apply the three key components of UHC, to update their national health plans in light of COVID-19, and to ensure alignment with WHO's Strategic Preparedness and Response Plan, the UN SG's framework for a socio-economic response to COVID-19, and the UN's Global Humanitarian Response Plan.

At the same time, key global donors need to support countries' efforts toward UHC and also support WHO's unique role and technical expertise to combat COVID-19 and build a stronger, more secure, and more resilient world with health for all.

Thank you for your attention.