

From Ebola to Zika: international emergencies and the securitization of global health

Do Ebola ao Zika: as emergências internacionais e a securitização da saúde global

Del Ébola al Zika: las emergencias internacionales y las medidas de seguridad de la salud global

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The expression “global health”, widely used since the 1990s, originally referred to the awareness that an event anywhere on the planet poses a potential threat to the world population or to the national security of other countries, especially the United States ¹. The recent health crisis involving the Ebola virus outbreak in West Africa consolidated the trend towards securitization of the international response to emergencies. Securitization here refers to the process by which an issue is socially constructed as a security problem.

In September 2014, the United Nations Secretary-General created the first-ever emergency health mission, the *United Nations Mission for Ebola Emergency Response* (UNMEER), with the approval of the Security Council ² and General Assembly ³, classifying the Ebola outbreak as a threat to world peace and security. In charge of the technical component of the response, the World Health Organization (WHO) quickly lost its position as the leading authority and coordinator of international work in the health field, assigned to it in 1946 by the Member States in the United Nations Charter. There is a consensus that the WHO was slow to react to the crisis and suffered from structural limits on its action ^{4,5}. In fact, the organization’s chronic underfinancing binds it in a vicious circle: the lack of confidence decreases the investments that could otherwise provide it with greater efficiency ⁶. But whose purpose is served by the attrition of the WHO?

According to Horton & Das ⁷ (p. 1805) “*Thanks to Ebola, global health security is now a priority, not only for ministers of health but also for heads of state*”, but this heightened security has led to the erosion of multilateralism. The atmosphere in Washington (considered the most influential city for the future of global health) is now deeply hostile to the WHO, thus serving to legitimize various unilateral initiatives by the United States and other players. The global health agenda’s lack of transparency in relation to the populations targeted by its policies calls for a critical analysis of such initiatives, because “*the proposed beneficiaries of interventions are generally lost from view and appear as having little to say or nothing to contribute*” ⁸ (p. 377).

Meanwhile, the securitization of health can turn health issues into threats to existence, thus requiring exceptional measures and technical or administrative procedures that can escape democratic scrutiny, especially due to their urgency, and thus have broad political repercussions ⁹. Securitization can threaten democracy and human rights. While it is true that depicting Ebola as a threat to international security helped increase the material aid to the hardest-hit States, it also symbolically launched a form of global-scale warfare logic under the aegis of the threat-and-defense diad ¹⁰.

In the West, the seven reported Ebola cases (four in the United States and one each in Spain, Italy, and the United Kingdom), with only one

death, had far higher repercussions than the total of 28,639 confirmed, probable, or suspected Ebola cases and the 11,316 deaths reported to WHO¹¹. An infected or suspected patient came to be seen as an enemy, justifying all necessary measures to defend others¹⁰.

The negative effects of securitization include the risk of arousing panic through the mass media, hindering the fight against the epidemic rather than strengthening it, besides stigmatizing health professionals and the population in the hardest-hit areas. In the United States, Spain, and the United Kingdom, health professionals that had worked in West Africa reported abusive restrictions on their rights and discrimination following their repatriation. Australia and Canada refused entry into their territories for individuals coming from West Africa, in blatant disregard for the WHO directive not to restrict individual travel. In Brazil, one individual who requested asylum and was considered a suspected case (not subsequently confirmed) had his identity exposed intensely in the mass media, in flagrant violation of health legislation and refugees' rights. Episodes of discrimination against African migrants have been reported in various countries.

In the case of the Zika virus, securitization has appeared in various ways. Although the international response remains within the sphere of the WHO, such response involves intricate interaction between emergency governance and securitization, the analysis of which is hindered by the gaps in transparency and accountability characterizing the decision-making processes in times of crisis¹².

In February 2016, the association between the Zika virus, neurological disorders, and congenital malformations¹³ has put Brazil at the epicenter of a *Public Health Emergency of International Concern* (PHEIC). WHO declared the emergency based on the *International Health Regulation* (IHR)¹⁴ adopted in 2005 by the World Health Assembly and in force in 196 countries since June 2007. The expanded worldwide circulation of persons and goods has increased the likelihood of spread of diseases and induced the adoption of health barriers that the IHR is intended to control and reduce, besides favoring more proactive surveillance¹⁵.

Previous versions of the IHR aimed to fight specific diseases like cholera or smallpox, while the prevailing version innovated by creating the legal and political figure of the PHEIC. Such an emergency is "an extraordinary event" that poses a public health risk to other States due to the international spread of a disease or injury – regardless of the origin or source, representing or

potentially representing significant harm to human beings – and requiring a coordinated international response¹⁴. More precise than the concept of emerging disease and broader than that of epidemic (limited to the occurrence of harm), a PHEIC is thus not limited to the occurrence of transmissible diseases and can include chemical or nuclear events as well as environmental disasters¹⁶. The characteristics that define a PHEIC are not an event's severity or case-fatality, but its potential international scope.

A PHEIC is declared by the WHO Director-General, independently of consent by member States. The declaration is based on the opinion of an Emergency Committee of independent experts, chosen according to the field of expertise that best corresponds to the specific event under way¹⁴. However, the repeated participation by some experts on diverse committees and a benevolent approach to potential conflicts of interest call for specific studies on the issue.

To date, WHO has declared four PHEICs, whose multiplicity and complexity of causes and characteristics make them difficult to compare. The first was influenza A (H1N1) in April 2009, later recognized as a pandemic (in June that year). There were complaints that WHO had overestimated influenza A (H1N1) in order to benefit the pharmaceutical industry¹⁷. A committee on MERS-CoV (Middle East Respiratory Syndrome Coronavirus) was created in July 2013, but its periodic meetings have reiterated that MERS-CoV is not a PHEIC.

The second declaration, in May 2014, concerning poliovirus, basically involved the expanded risk of spread due to armed conflicts, especially in Syria, whose vaccination services have been severely compromised.

The third PHEIC, involving Ebola, was declared in August 2014. The observation of limits on action by WHO sparked proposals to alter the IHR (2005) in order to give the organization the power to punish States that fail to comply with its recommendations. In fact, each declaration of a PHEIC is accompanied by a set of WHO recommendations, addressed to the general public and different categories of stakeholders, especially to the States and the transportation sector. These guidelines allow coordinating the response to the disease by rationalizing means and measures. It is definitely a "soft law", involving temporary or standing "non-binding recommendations" issued by WHO "with regard to specific public health risks and the appropriate health measures, applied routinely or periodically, and necessary to prevent or reduce the international spread of disease and avoid unnecessary interference with international traffic"¹⁴. Thus, the IHR (2005) does

not specify sanctions against States that fail to comply with such recommendations.

The power to punish non-compliance with the IHR (2005) in order to “give teeth” to the WHO could prevent failure to comply with the recommendations by States that are capable of doing so. A case in point involved the abusive restrictions on rights that occurred during the Ebola crisis. However, this punitive capacity would not resolve the impossibility, experienced by numerous States, of developing their own national response capabilities as provided by the IHR, since there is a vast asymmetry in the States’ level of development. The countries hardest hit by Ebola had not only suffered bloody civil wars, but had also been the victims of structural adjustment policies by the International Monetary Fund (IMF), which played a decisive role in dismantling their local health systems¹⁸. Still, gaps in the enforcement of the IHR (2005) include much more than the Ebola crisis. In November 2014, 64 member States (32.65%) reported to WHO that they had reached the minimum standards for the national response capacity according to the IHR (2005); 81 member States (41.33%) requested an extended deadline to upgrade their response capacities (by 2016); and 48 member States (24.48%) did not report on their response capacity¹⁹.

However, as in the case of Ebola, the fourth PHEIC, pertaining to the Zika virus, shows that efficient surveillance systems may be the best response for the developed countries’ security, but that they are insufficient for the health security of populations in the developing world. Poverty-related diseases constitute the shameful “collateral damage” of global health governance resulting from profound inequalities. However, from the

point of view of the PHEICs, neither the existence of the disease nor its magnitude matters. What does matter is to prevent the disease from leaving the place where it should have stayed. Revealingly, the current PHEIC focuses on an association between the Zika virus and other disorders, rather than on the endemic diseases that plague the developing countries.

In Brazil, the securitization of the response to Zika turned the *Aedes aegypti* mosquito into public health enemy number one. However, although the “war on the mosquito” is necessary as an immediate measure, it cannot hide the fact that the list of health enemies is much longer. Budget cuts in social programs must be suspended immediately, with prioritization of investments in basic sanitation and strengthening of the Brazilian Unified National Health System (SUS). Once the emergency has subsided, only an efficient health system can guarantee continuity of care for persons affected by the crisis. In addition, there is an urgent need to implement a scientific agenda with major investment in research and development²⁰.

Finally, viewing the response to international emergencies only through the limited prism of security would condemn global health to an infinite succession of periods of “war” interspersed with “truces” focused on surveillance systems, rather than confronting the causes of the epidemics, rooted in the social determinants of health. If the immediate responses are not accompanied by structural changes capable of promoting a radical reduction in inequalities, the question remains: who will truly be safe at the end of each “war”?

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