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Health (In)Securities and their Consequences for the EU and Africa: Towards a New Definition of Health Security

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Abstract

Health insecurities know no borders. The reigning World Health Organization (WHO) definition of health security is inadequate on three counts. First, it prioritises interventions to minimize vulnerability to adverse public health events for "national populations". Second, while it includes reference to the "collective health" of populations across borders, it remains unclear whether these should also enjoy minimised vulnerabilities. Third, the definition leaves unresolved who or what is responsible for health security and for whom. This Policy Brief offers a renewed definition of health security that aims to address these gaps.

Context and Importance

While globalisation has been meted out for rhetorical punishment especially recently, the reality of the interconnectedness that is at its core has never been more apparent. Globalisation continues, and not just with regard to the speed of communications, financial transfers, and air travel, but also with regard to the slower-moving connections inherent in climate change, migration and the spread of disease. This momentum holds both upheaval as well as opportunities.

Nowhere might the latter become more apparent than at the United Nations Security Council starting with the new rotation in January 2019. In addition to the Permanent Five (P5), both Germany and South Africa[1] will ascend to non-permanent seats to be held until January 2021. Their participation comes at a pivotal moment for both: for a Germany struggling again with its position as 'too big for Europe, too small for the world', and for a South Africa striving to emerge from the disastrous tenure that was Jacob Zuma's presidency. Key reasons for these two countries' significance for health security lie in their respective regional clout amidst a geopolitical shift. Both Germany and South Africa find themselves as regional political voices if not interventionists; as net recipients of financial and immigration flows; and as headliners against climate change in the energy and water sectors.

Health (in)security, with its challenges and opportunities, is quintessentially tied to the connectivity of globalisation. It lies at the intersection of all of these variables, and links the North and South Atlantic, including Germany and South Africa. Health (in)security does not heed national borders. It follows that any adequate response to it must be conceived and implemented beyond borders – globally. Key reasons include that health security involves communication and financing, incorporates tourist and migrant travel, and is subject to the whims of climate change, all of which have global reach and repercussions.

It is against this backdrop that the reigning World Health Organization (WHO) definition of health security is outdated and inadequate. According to the WHO, global health security refers to "the activities required, both proactive and reactive, to minimize vulnerability to acute public health events that endanger the collective health of national populations, as well as collective health of populations living across geographical regions and international boundaries" (WHO, 2007, p.1). That is primarily because it, as is appropriate for an international organisation constituted by sovereign Member States, depends on the commitment and enforcement of health security measures at the state level. However, this brings with it three limitations: First, it prioritizes interventions to minimize vulnerability to adverse public health events for "national populations." Second, while it includes reference to the "collective health" of populations across borders, it remains unclear whether these should also enjoy minimized vulnerabilities. Third, the definition leaves unresolved who or what is responsible for health security for whom.

[1] Germany was elected with 184 votes, South Africa with 183. New York.

Critical Overview of Policies

Definitional problems result in policy gaps. As a consequence of the WHO definition and the state-centric approaches to health security that dominate the discourse and its operationalization, health security is and remains a primarily vertical enterprise. It is vertical both at the national level and at the international level. On the national levels, this means that health security is implemented via a contract between a national state and its citizens. On the bilateral and multilateral level, the contract is between individual nation states. Non-citizens literally reside outside of such a contract.

The International Health Regulations (IHRs, 2005) illustrate the current vertical state-citizen order inherent in health security. This is further showcased in the Foreign Policy and Global Health Initiative (FPGHI, 2006) of the United Nations, in the Global Health Security Agenda (GHSA) and the Global Health Security Initiative (GHSI), all of which, despite the theoretically horizontal ***global*** in their names, rely on states for their policy decision-making and implementation processes. Furthermore, bilateral programs such as PEPFAR (The U.S. President's Emergency Plan for AIDS Relief), and multilateral funding arms such as those of the Global Fund to Fight AIDS, Tuberculosis and Malaria have focused on responding to select diseases without fully embedding these either in the context of social determinants of health (SDH, WHO) or of an environment of human security (Nef, 1999).

Now that the Millennium Development Goals (MDGs, 2000) have given way to the Sustainable Development Goals (SDGs, 2015), there is a shift on the part of the global policy agenda towards addressing broader insecurities more ***horizontally***. Whereas the health strategies of the 2000s, during the "grand decade of global health" (2000-2010), targeted specific disease interventions, notably for HIV, tuberculosis and malaria, the momentum today is directed towards universal health coverage (UHC). However, the onus remains on individual states to implement these measures.

Yet it remains that (re)emerging infectious diseases (EIDs) do not stop at borders. Furthermore, increasing numbers of people do not stop and borders. Consequently, health security must be reconceived horizontally to take both health insecurities and mobile populations into account. Securing health thus requires state, regional, international and global governance. Insecurity at one level is insecurity at all levels. This presents both challenges and opportunities.

Challenges

Challenges to health security in sub-Saharan Africa (SSA), and between SSA and Europe, can be categorized on the one hand as internal and on the other as external challenges. These are horizontal as opposed to vertical challenges, and demand a horizontal approach in their response. Internal challenges include legal as well as social and structural determinants such as environmental degradation, water scarcity, and the burden of disease, all of which affect health security in various ways. These are exacerbated by external challenges in the form of unconsolidated states on the African Continent; and of over-institutionalized multilateralism on the European Continent. Both sets of challenges converge in efforts to define, create and maintain health security in SSA and between SSA and Europe.

These internal and external challenges are mirrored by two crucial differences between what strategic planning occurs on and between the African and European Continents. This leads to:

i. Sub-Saharan African states that do not have the European luxury of responding in to challenges in separate policy spheres (silos); they almost always have multiple over-lapping crises to address simultaneously. Most European states cannot imagine the ***orders of magnitude*** of these challenges, but the interconnected future is more likely than not to have such in store around the globe.
ii. Institutionalism and multilateralism will find themselves under strain and at times too brittle to conceptualize or operationalize strategic responses to challenges including risks and threats to health security.

Migration impacts both of these key challenges and does so within and across regions. The challenge for health security is greatest when health (in)securities, especially EIDs, intersect with migration ***and*** incomplete or unresolved citizenship status. Adolescents are by legal definition not consistently protected by provisions aimed at either children or full citizen adults. Yet their health status affects them not only as individuals, but also impacts upon their communities, including if and whereto they migrate.

In Eastern and Southern Africa, UNAIDS estimated that 1.3 million adolescents[2] in 2016. UNICEF's estimate for the same year was of 1.48 million young people (20-24) living with HIV in the region. The definitions are at times overlapping and at times exclusive. Among these there are an estimated 610,000 new HIV infections among young people between the ages of 15 to 24, with 260,000 new infections among adolescents between the ages of 15 and 19 (UNICEF). In South America, incidences of malaria, measles, diphtheria and tuberculosis are on the rise, especially at the borders of Venezuela. As an estimated 1.6 million people (Organization of Migration, 2015), many of them young people, migrate into neighbouring countries such as Columbia, Ecuador, Peru, and Brazil, without provisions for access to medical care to contain and treat these diseases, these are likely to spread.

As evidenced, while the WHO definition does not delimit actions to states, it is dependent upon these actors' actions to promote, protect and implement health security. Furthermore, while the definition takes into account "populations living across geographical regions and international boundaries", its focus is first on national populations. Secondly, it does little to explain which populations are to be included outside of national, state-based definitions of populations.

Opportunities

As the cases above illustrate, health security intersects with state responsibility and the necessity of reconceiving citizenship. EIDs threats know no territorial borders. In Africa especially, with its porous borders, a state-based approach to health security amidst increasingly mobile populations is impractical. Expanding the inclusion of whose health security is taken into account, and exercising flexibility vis-à-vis health risks and threats, would render a definition of health security that takes into account both the space of (in)security and its scope. This presents an opportunity.

Since EID health threats do not stop at borders, but citizen rights tend to, health security remains bounded by recognition of legal, legitimate, state citizenship. Non-citizens, or citizens who are unable to actualize such rights are thereby excluded from state-based health security guarantees (see also Šehović, 2014, 2017). The gap posed by this governance accountability problem, GAP (Šehović, 2014, 2017), demands a re-definition of health security that accounts for human rights and responsibilities alongside but beyond the binary of states and classic, territorial citizenship.

A new definition would have to straddle the current state-centric discourse and the sub- and supra-state reality presented by the potential spread of disease, the mobility of populations, and the limitations of full citizenship. Taking this into account and influenced by the idea of global health and thus global health security as "supraterritorial" (Bozorgmehr, 2010) I propose a renewed definition of health security. It states:

> Health security refers to the claim of a safe space for health at the ***population*** level. This claim goes ***beyond*** the state-citizen contract. It relies on state, as well as sub- and supra-state actors to conceive and implement but also to account for health security.

The elements of health security, notably whose health against which threats, are included in such a space vary across time and place. The ***prioritization*** of risks and threats are part of a political process

[2] The agency defines adolescents as persons between the ages of 10 and 19.

active along a spectrum between human and geopolitical security. It does not inherently mean that all individual health guaranteed. Putting such a renewed definition into practice is the next step.

Policy Recommendations

It is important to note that health security serves as a buttress against identifiable and identified risks and threats.

The two strategic options available include:

i. Continuing to allow migrants to cross territorial and political borders, while failing to formally recognize their human and health rights, or to act on any corresponding citizenship responsibilities. This scenario would marginalize significant numbers of people, putting their own, and the health of the populations with which they come into contact, at the mercy of NSA provisions for as long as these might last (Šehović, 2017). It would most certainly further marginalize already vulnerable populations, foremost among them adolescents whose legal protections as minors, stand to run out. This would severely undercut the educational and economic and political potential of the individuals, communities and ultimately states caught up in this policy (compare IJHPM, '***State Support***,' 2017).

ii. A second scenario would be to issue identification documents, at the national or regional level, to document and enable access to state health and educational, among other, services, as well as the collecting of taxes as part and parcel of recognized, reciprocal relationship between rights and responsibilities. Though such a perceived 'opening' of citizenship benefits would risk a (xenophobic) backlash, the gains in bringing marginalized populations into the fold would positively benefit the non-marginalized as well, in terms of better health outcomes, educational attainments, social inclusion, economic opportunity and political participation.

Conclusion

Global health security lies at the intersection of Europe and Africa, between state-based intervention and a new regional, global approach. It has been on the global agenda since the HIV/AIDS epidemic of the 1990s and 2000s, as evidenced by the establishment of the Global Health Security Initiative (GHSI, 2001) and the Global Health Security Agenda (GHSA, 2014). Its prioritization has shifted from HIV, tuberculosis and malaria to focus on universal health coverage. Yet the definition has not kept up with the reality, especially of disease spread, migration, and incomplete citizenship. In order to address health insecurities in theory and in practice, it is time to work towards a new definition of health security that incorporates these three variables.

References

1. Bozorgmehr, Kayvan (2010). "Rethinking the 'global' in global health: a dialectic approach," Globalization and Health, Volume 6, Issue 19, pp. 1-19.
2. Foreign Policy and Global Health Initiative (2007). See https://www.un.org/press/en/2007/sgsm11190.doc.htm (last accessed 10 October 2018).
3. Global Health Security Agenda (2014). Available at: https://www.ghsagenda.org/about (last accessed 10 October 2018)
4. GHSI (2001). Available at: http://www.ghsi.ca/english/index.asp (last accessed 10 October 2018)
5. IHRs (2005). Available at: http://www.who.int/topics/international_health_regulations/en/ (last accessed 10 October 2018)
6. International Organization of Migration (2015). "World Migration Report 2015: Migrants and Cities: New Partnerships to Manage Mobility," Available at: https://www.iom.int/world-migration-report-2015
7. International Organization of Migration (2018). "World Migration Report 2018." Available at: http://www.iom.int/wmr/world-migration-report-2018 (last accessed 10 October 2018).
8. Marten, R. and R.D. Smith (2017). "State Support: A Prerequisite for Global Health Network Effectiveness Comment on "Four Challenges that Global Health Networks Face," ***International Journal of Health Policy Management*** (IJHPM), Vol. 7, Issue 3, pp. 2757-277 (24 July)
9. Millennium Development Goals (MDGs) (2000). Available at: http://www.un.org/millenniumgoals/ (last accessed 10 October 2018)
10. Nef, Jorge (1999). Human Security and Mutual Vulnerability: The Global Political Economy of Development and Underdevelopment," IDRC (1 January).
11. Sustainable Development Goals (SDGs) (2015). Available at: https://sustainabledevelopment.un.org/?menu=1300 (last accessed 10 October 2018).
12. Šehović, Annamarie Bindenagel (2017). "Identifying and Addressing the Governance Accountability Problem (GAP)," Global Public Health (13 September), DOI: 10.1080/17441692.2017.1371203
13. Šehović, Annamarie Bindenagel (2014). "HIV/AIDS and the South African State: The Responsibility to Respond", Ashgate. Global Health (April)
14. UNAIDS (2016). Global AIDS Update. Available at: http://www.unaids.org/sites/default/files/media_asset/global-AIDS-update-2016_en.pdf (last accessed 10 October 2018).
15. UNICEF Annual Report 2016 (2017). Available at: http://www.unaids.org/sites/default/files/media_asset/global-AIDS-update-2016_en.pdf (last accessed 10 October 2018).
16. World Health Organization (WHO) (2007). "The World Health Report 2007: A Safer Future: Global Public Health Security in the 21st Century."

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