STG Resilience Papers

Resilience: Health Security Beyond Borders

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Summary

There is a **vital need to rethink human centric health resilience beyond borders.** Inequities are being perpetuated and accentuated in the development and distribution of COVID-19 vaccines. Inequalities – economic and health related – within and between countries are again increasing. Although complex, necessary policy change for building a resilient human and health security centric global health system demands:

- A new definition of global health security;[1]
- A new perspective and policy paradigm pivoting from individual public health to global health security; based on:
- First and foremost, equitable access to vaccines, diagnostics and therapeutics to infectious as well as chronic diseases – also anticipating the next pandemic;
- Second, comprehensive and coordinated national and regional universal health care and health care coverage.

The EU, and regional blocs such as the AU in Africa, have key roles to play in rethinking and enacting a renewed global health security for the 21st Century.

1. Introduction

The cascading epidemic outbreaks of the past decades – among them HIV, Ebola, H1N1, Zika, SARS, MERS-CoV, and now SARS-Cov-2 – illustrate the borderless spread of pandemic disease. While life-saving, vaccines are no perfect "silver bullet": it will always be impossible to inoculate or medicate – continuously – the entire world's population. **Ultimately, the only sustainable solution to global**

* *The views expressed here are those of the author and do not necessarily reflect those of her institution.*

1 Šehović, A. B. (2019). Towards a new definition of health security: A three-part rationale for the twenty-first century. *Global public health*, 15(1), 1-12.

(pandemic) health threats is global health security nurtured by resilience at the individual but also at the systemic levels.

Global health security (GHS) has no uncontested definition. Despite ample pandemic warnings (HIV, H1N1, SARS, MERS-CoV, Ebola, Zika), the world remains woefully unprepared for an adequate pandemic response. This state of affairs highlights the vital need for rethinking human centric health resilience beyond borders. Resilience in turn is predicated on pandemic preparedness and pandemic response at both the *individual* (global public health) and *population* (state based health security) levels.

The first section of this policy brief lays out the particular challenges to health resilience exposed by the spread of COVID-19. The second part discusses the inequities being perpetuated and accentuated in the development and distribution of COVID-19 vaccines. The third section discusses ways to address these global inequities and its related complexities. The paper concludes with some ingredients needed for building a resilient human and health security centric global health system.

2. Challenges

The 'grand decade of global health' (2000-2010) introduced a host of vertical (top-down) health interventions to address and eradicated particular, notable infectious, diseases: HIV (AIDS), tuberculosis and malaria. The verdict at the end of the decade indicated that eradication is (nearly) impossible. This focus also left non-communicable diseases (NCDs), maternal health, mental health, and even (re)emerging (infectious) diseases largely in the lurch. Furthermore, this vertical medicalized policy approach neglected horizontal responses based on local, regional and global networks and knowledge, while the successful response of some affected communities to HIV and AIDS, and the 2014-2015 Ebola outbreak in West Africa showcase how community-led interventions – including door-to-door contact tracing (TB and Ebola) and family-centered care (HIV) built trust, enabling follow-up care (TB) and vaccination (Ebola).[2]

As these examples illustrate, there is an important definitional divergence global health security as operationalized on the one hand in the global North, whose primary focus equates health security with state security and whose secondary focus hones in on individual safety, and on the other hand in the global South, where the health security perspective derives from a human security approach that incorporates social and political determinants of health and emphasizing community-based health

[2] Villagers in a number of the affected countries identified transmission chains and implemented isolation of the sick to interrupt the spread of disease.

security. The consequence of these different paradigms is a stymied human-centric approach where an integrated health, social and economic global health security is necessary to build resilience in global health. Building resilience as part of global health security means: a) identifying and drawing on existing strengths in vertical and horizontal health care – integrating disease-specific programs with chronic care and mental health; b) integrating preventive care with pandemic preparedness at the individual (regular check-ups, routine vaccination, screening) with preparedness at the systems level (networking surveillance structures at the supranational and regional levels; fostering knowledge and technical exchange at the academic and scientific but also policy levels); c) fostering a public and policy understanding of the difference between safety and security, of individual and population health and health security (health security literacy – built on health literacy).

a. Lack of global health coordination

With the 'grand decade' long past, the *a priori* importance once attached to health nearly disappeared from the international agenda. As a result, two things happened to international health financing, with profound implications for pandemic preparedness and resilience: contributions to global public health fell, while those contributions that did flow, were increasingly "earmarked", their use pre-determined by donors (states and non-state actors such as philanthropies). Consequently, contributions to priority diseases overshadowed "flexible" contributions, for instance to core capacities such as epidemiological and infectious disease expertise at the World Health Organization (WHO). This shift curtailed WHO's expertise and exposed it to political interference by the largest donor(s). The Centres for Disease Control - in the U.S. (Atlanta, Georgia), in Europe (Stockholm) – and despite the founding of the Africa CDC in Johannesburg (2015) – were side-lined to national health agencies, too many of which were not linked to the National Health Focal Points (NFPs) mandated by the International Health Regulations (IHR, 2005). Effective global health (security) commitment and coordination was undermined and continues to be sorely lacking.

The WHO serves as the central coordinating agency for global public health. It collects and collates information on health risks and vulnerabilities. It also issues guidelines towards which states can orient their health policies. The WHO does not issue, direct, and enforce global health policy; nor does any other international organizational body. However, there are two glaring problems with this arrangement:

1. **The WHO has no authority with which to implement or intervene to enable or enforce its guidelines. This has been amply evident in the response to COVID-19 – despite the fact that the IHR is a treaty obligation.**

2. WHO-directed global health coordination is a vertical construct which assumes global guidelines can or should be suitable for state-level or local political, economic, and social conditions. Any strength of the WHO's recommendations rests on the acceptance and integration of its leadership, which has been sorely tested: technically, in terms of NFP performance, reliable surveillance (versus the Johns Hopkins platform); and translation into coherent policies. The WHO has been caught between its global guidelines, but its waning and compromised authority has resulted in too many competing authorities and too many directives to create a necessary global approach to health security. As one case in point: 73 new 'harmonization initiatives'[3] have been launched in an attempt to secure agreement on global health coordination: an oxymoron. The recent push on the part of EU Council President Michel for an international pandemic preparedness treaty – despite the existence of the IHR – is another case in point.

b. Lack of regional global health coordination

Further, the crises of the WHO's curtailed powers has implications at the regional level, e.g. within the European Union (EU) as well. On the global level, the EU participates in the Global Health Security Agenda, which while raising relevant concerns has no action mechanism. On the regional level, the EU Commission articulates 'principles' and offers guidance to Member States on health policies, but it does not and cannot issue – and thus coordinate – binding legal policies. The emergent gaps of this approach include, in the post-2007 financial crisis era, Spain's revoking much health care access for new migrants, and the systemic discrepancy between commitments to health and health spending and actual disbursements.[4] Fundamentally, global health coordination is *State* health coordination. The challenge is to formulate and coordinate health responses to build resilient local, regional and global health security that is human-centric and resilient at the level of the individual and the system level – state, regional and global.

In order to do this, **five critical policy issues** must be taken into account:

First, local outbreaks can and do rapidly spread to become epidemics and even pandemics. Notwithstanding the current lockdown, with increasingly mobile populations, this trend is set to increase. Knowledge and information collected at the global level has the potential to both inform local preparedness and to mobilize in turn global and local resources in a joint response. The response itself

[3] Holzschreiter, A., T. Bahr and L. Pantzerhielm (2016). Emerging Governance Architectures in Global Health: Do Metagovernance Norms Explain Inter-Organisational Convergence? *Politics and Governance* 4 (3).

[4] See the overview of EU participative action on global health.

has the highest chance of proving successful when it includes local, national, international and global entry – and exist – points.

Second, responding to a health risk or threat is a fundamentally political act. "The fundamental lesson, unsurprising to anyone familiar with the history of social engineering and foreign aid in Africa, is that AIDS effects are driven ultimately by institutional and political interests."[5] National as well as international political leaders must be on board.

Third, extant responses to health crises exhibit a disconnect between State, non-state and global institutional responsibilities, on the one hand, and between the prioritization of national health security and global health security, on the other. **Resilience can only be built with and at the intersections of individual, local, regional and global health security approaches and systems**.

Fourth, each disease outbreak is different, and its required response is as well. There are varied epidemiology, infection, morbidity, and mortality rates and requiring diverse control measures. This means that each outbreak obliges governments to be flexible and respond differently to each pandemic.

The **fifth** and final critical insight is that disease outbreak, including epidemic and pandemic anticipation and response, depends on and in turn creates health security.

> *Global health security depends on many factors—robust disease surveillance systems, reliable health information, prevention, diagnostic, and treatment services, financing, and strong political commitment. But without skilled health professionals, who should be valued and protected everywhere, to act as the first line of defence of individual health security, other efforts will be in vain.*[6]

It means that at every governance level -- local, national, regional, international, and global -- individual health is a constitutive part of global health security. As recent WHO, but also G7, G20, EU, AU, US and other state and non-state actors have pledged, health security is not merely 'nice to have', but a 'must have', in an increasingly interconnected world because it is only a matter of time before the next pandemic challenges individual and population health.[7]

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5 De Waal, A. (2006). *AIDS and Power: Why there is no political crisis – yet*. (Cape Town: Zed Books): p. 123.

6 'No health workforce, no global health security,' (2016), *The Lancet*, Vol. 387, No. 10033, (21 May), p. 2063.

7 Moon, S. et al., (2015). Will Ebola change the game? Ten essential reforms before the next pandemic, The report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola Health Policy, *The Lancet*, (November 22).

3. Paradigm Shift: Reconceiving Health Security and Resilience Beyond Borders

Resilient global health security must prioritize the protection of the health of persons and societies worldwide, including equitable access to medicines, vaccines, and health care, as well as reductions in collective vulnerabilities to global public health events that have the potential to spread across borders.[8] Anywhere health inequities exist, human and health-related civil rights, notably the aspirational "right to health," defined by the 1948 Constitution of the WHO as the "highest attainable level of health", suffer, most notably among the marginalized. Currently, such inequities are accentuated by borders, with dire consequences for health security and health resilience. This is because health risks and threats do not stop at borders – neither within nor beyond the EU.

Since emerging infectious disease health threats such as COVID-19 do not stop at borders, but citizen rights tend to, health security is bounded and thereby constrained by state recognition (or not) 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.[9] These include underage migrants as well as non-nationals with work contracts but not permanent residency status from the US to Mexico, from within the EU to southern Africa. Such (non-)provisions limit not only health care access but also educational opportunities, which in turn negatively affect the socio-economic determinants critical for building resilience. The gap posed by this governance accountability problem, GAP[10], demands a re-definition of health security that incorporates a human security centric perspective into a renewed health security paradigm. This is all the more imperative today because – as COVID-19 and its variants continues to illustrate – pandemic diseases know no borders and make no distinctions between citizens and non-citizens.[11] Such a paradigm would extend the reach of global health security to include both the individual level of health safety and security and the system (state) level of security necessary to establish, nurture and sustain resilient global health security. Thus elements of health security and resilience can thus be prioritized across space and time. This is being done – for instance through the ACT-A (Access to COVID-19 Tool Accelerator) and COVAX to provide vaccines, diagnostics and therapeutics, as well as to support health systems strengthening to countries mainly in the global South - but can be done better – by, for instance: a) strengthening the WHO and the implementation of the

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8 Cáceres, S. B. (2011). Global health security in an era of global health threats. *Emerging Infectious Diseases*, 17 (10), 1962-1963.

9 Šehović, A. B. (2020). Towards a new definition of health security: A three-part rationale for the twenty-first century. *Global Public Health*, 15(1), 1-12.

10 Šehović, A. B. (2018). Identifying and addressing the governance accountability problem. *Global Public Health* 13 (10), 1388-1398.

11 Bozorgmehr, Kayvan (2010). Rethinking the 'global' in global health: a dialectic approach, *Globalization and Health* 6 (19), 1-19.

International Health Regulations (IHR, 2005) to ensure the capacity of national health systems to cooperate in surveillance and response to disease threats; b) facilitating the creation of and access to individual-level (universal) health coverage at the state and regional level; c) guaranteeing universal health care and health coverage regardless of legal status.

4. Opportunities:

a) *Shorter Term: Vaccine Access*

Vaccines have been a major success story of modern medicine. WHO estimates that at least 10 million deaths were prevented between 2010 and 2015 as a result of the Global Vaccine Action Plan, (a framework instituted in 2012, for delivering universal access to vaccines) with millions of lives protected from the suffering and disability associated with diseases such as pneumonia, small pox, measles, diarrhoea, whooping cough and polio (WHO, 2017).

Since late 2020, 13 COVID-19 vaccines have been authorised for use in different parts of the world, based on different typologies (inactivated or weakened virus vaccines, protein-based vaccines, viral vector vaccines, RNA and DNA vaccines). The rapid development of COVID-19 vaccines, a miracle in itself, seemed to provide a panacea for global health security in the face of COVID-19. Yet many problematic issues regarding local, regional and global access to ensure individual and population health security and resilience remain.

On the one hand, while all COVID-19 vaccines are reported to be effective at preventing the onset of serious disease, efficacy rates for particularly mild and moderate forms of the disease vary by vaccine type (for example Astra Zeneca or for Pfizer[12]). It also remains unclear as to whether these vaccines only provide personal protection – safety – to the inoculated — or whether they interrupt transmission, thereby providing some protection to the community – security.[13]

On the other hand, as have prior pandemics, the COVID-19 pandemic and the attendant battle for access to vaccines has once again illustrated the interlinkages between global health, global health security and global inequities. While global health denotes to the health of individuals around the world, global health security refers to when health risk (reduction) is achieved at the population level across the globe. The traditional emphasis on *individual* (global public) health and imbalanced global priorities reflecting differentiated inequities neglects social determinants, including

[12] Olliaro, P. (2021). What does 95% COVID-19 vaccine efficacy really mean?, *The Lancet,* 17 February 2021, and Paul-Ehrlich-Institut (2021). *Safety and efficacy of the COVID-19 Vaccine AstraZeneca*. Retrieved 18 February 2021.

[13] Brüssow, H. (2020). Efforts towards a COVID-19 vaccine. *Environmental Microbiology*, 22 (10), 4071-4084.

geographies, socio-economic status, gender, legal recognition (citizenship status), and related health (care) provisions for achieving good *population* health. Vaccine inequities intensify these existing inequities, stymieing not only individual health, but also the health security of all people around the world.

b) Longer-Term: Universal Health Coverage

A key linchpin in successful pandemic response depends upon the recognition, protection and implementation of health rights for all individuals regardless of their legal status. However, in the current global governance, it remains the responsibility of states to bestow health rights recognition, protection and implementation. Universal health coverage can be a link between individual health security to successful global health security and resilience.

Universal health coverage offers one way to bridge the gap between human and state security. It is a financial instrument whose purpose is to bridge the gap between enabling access to health care and protecting those accessing health from associated financial ruin. "Universal, equitable access to health care with financial protection" "is indispensable for achievement of individual health security and, therefore, collective health and human security."[14] UHC is a critical component to enhancing resilience because is addresses inequities in coverage, while facilitating care access.

5. Policy Recommendations

COVID-19 is not the first, nor will it be the last global pandemic. Drawing the right lessons is critical to identify concepts and approaches to support global health security and to build health resilience. Overall, successful policy depends upon coherence, applicability and implementation at the individual, local, State, international and global levels. In order to rethink and remake global health security that is sustainable and resilient at the individual and systemic levels nationally, regionally, internationally and globally, this brief offers the following policy recommendations. These are directed foremost at the EU, with its normative power, economic and financial weight complex sovereign solidarity, as well as at the AU and regional entities committed to global health security:

[14] Heyman, et al (2015). Global Health Security: the wider lessons from the west African Ebola virus disease epidemic. *The Lancet*, 385: 1884-901.

a. Systemically build resilience:

1. **Support and implement the global health security protocols** in full compliance with the IHR and incorporate Equity Matrix (Ismail et al., 2021).[15]
2. **Strengthen the independence and flexible financing and operability of the WHO and the network of CDCs** by increasing non-earmarked financing and supporting the institutions core functions in epidemiology and infectious disease prevention and control, including adhering to their advice.
3. **Advocate for, collate lessons learned from and implement nationally and regionally tailored universal health coverage**, building on the experiences of the EU, and Colombia (with regard to Venezuelan migrants), South Africa (pertaining to Zimbabwean migrants), and also the Southern African Development Community's (SADC) pilot project(s) in allowing cross-border health care access and health coverage.

b. Technically foster health security:

4. **Endorse and facilitate knowledge exchange** in academic and scientific as well as policy communities. Reciprocal knowledge exchange (instead of transactional one-way knowledge transfer) would promote vertical and horizontal lessons of behavioural and social adaptation (hygiene measures and separating infectious from chronic disease cases in (acute) care settings), as well as intellectual and technological exchange such as genomic sequencing and patent / license waivers.

   The COVID-19 pandemic has shown that even the best resourced countries, cushioned by strong health systems can still respond in deeply inadequate ways to public health emergencies. Lessons can be learnt from low-income and middle-income countries that have used public health strategies like integrated programming (SRH, HIV and TB care), health literacy, contact tracing, door to door health care and the value of community health workers in localising the public health response (see for example, Ebola in West Africa and HIV in South Africa).
5. **Reinforce and strengthen the WHO, the International Health Regulations and their National Health Focal Points, the networks of the Global Health Security Agenda and the CDCs**. This

[15] Shainoor J Ismail , Matthew C Tunis, Linlu Zhao, Caroline Quach. Navigating inequities: a roadmap out of the pandemic. *BMJ Global Health* 6, 21 January 2021. See also the Platform for a Framework Convention on Global Health (FCGH).

entails refraining from establishing and cementing separate parallel structures – as in the 'grand decade' – for COVID-19, for "One Health", for "pandemic preparedness".

6. Conclusion

The COVID-19 pandemic public health crisis is fast becoming an economic, social and a human rights crisis all at once. Only a commitment to global health security, guided by new perspectives integrating individual and global human and health security, and girded by an operational plan including provisions for prevention, and accountably implemented measures, can rise to the challenge of nurturing and inculcating resilience for pandemic control. This commitment is necessary because vaccination campaigns and medication will always remain limited with view to the world's population at large. This commitment should be guided by three maxims:

1. **Elevate human security within a global health security paradigm.**
2. **Apply this paradigm shift to strengthening the scientific and policy institutions, notably the CDCs and the WHO – by reducing earmarked and increasing flexible financing and rebuilding core epidemiological and infectious disease prevention and control capacity.**
3. **Develop and apply universal health coverage nationally and regionally.**

COVID-19 is but one in a long line of pandemic threats. Building resilience in global heath security is crucial to preparing for and addressing the next.