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DIPLOMATIC PROPHYLAXIS OF PUBLIC HEALTH EMERGENCIES OF INTERNATIONAL CONCERN: WHO, UNSC and the (mis)alignment between states and international organizations in responding to the pandemic of the century[1-2]

Profilaxia Diplomática das Emergências de Saúde Pública de Importância Internacional: OMS, CSNU e o (des)alinhamento entre os Estados e as Organizações Internacionais nas respostas à pandemia do século

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ABSTRACT: A term appropriate to preventive medicine, prophylactic care, imported here for political and diplomatic purposes, can be implemented to avoid a Public Health Emergency of International Concern – the so-called PHEICs. The COVID-19 pandemic is not the first use of this health protocol, which was adopted in 2005, in the International Health Regulations, but it is certainly the biggest usage of the concept in this Century so far. However, the way bodies such as the World Health Organization and the United Nations Security Council deal with this type of situation is not always standardized, which leads to certain questions about the diplomatic capacity to deal with this type of issue, that also involves the typical intersectorality of health matters at the domestic level of States. The UNSC does not always consider a PHEIC to be a security emergency, and when it does, there is apparently a geopolitical bias. In any case, as Martti Koskenniemi emphasizes, the way each institution and legal branch will deal with a crisis, using its own internal logic and history, determines how the contingencies will be handled – including the responses of the private sector, the public sector and, in this case, of International Relations.

Keywords: WHO. Right to Health. International Law. Covid-19. Health Diplomacy.

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RESUMO: Termo próprio à medicina preventiva, os cuidados profiláticos, aqui importados para a seara política e diplomática, podem ser implementados para se evitar uma Emergência de Saúde Pública de Importância Internacional – as denominadas PHEICs. A pandemia do COVID-19 não é a primeira utilização desse protocolo sanitário, surgido em 2005, no Regulamento Sanitário Internacional, mas é certamente a de maior proporção neste século, até o momento. Contudo, a maneira com a qual órgãos como a Organização Mundial da Saúde e o Conselho de Segurança das Nações Unidas lidam com esse tipo de situação nem sempre é padronizada, o que leva a certos questionamentos acerca da capacidade diplomática de lidar com esse tipo de temática, que envolve também a intersetorialidade típica das questões de saúde a nível doméstico dos Estados. O CSNU nem sempre considera uma PHEIC uma emergência securitária, e quando o faz, aparentemente, há um viés geopolítico. De toda forma, como Martti Koskenniemi enfatiza, a forma como cada instituição e ramo legal lidará com uma crise, utilizando-se de suas próprias histórias de formação e lógicas internas, determina a forma como as contingências serão conduzidas – incluindo-se também as respostas do setor privado, do setor público e, nessa hipótese, das Relações Internacionais.

Palavras-chave: OMS. Direito à Saúde. Direito Internacional. Covid-19. Diplomacia da Saúde.

1. INTRODUCTION

In the biggest pandemic of the century so far, the need to increasingly implement preventive health mechanisms in order to avoid the advance of new pandemics and the emergence of other Public Health Emergencies of International Importance (PHEICs) has significantly affected how the operationalization of the health network in international level occurs, demonstrating that the way in which it will relate to domestic health systems from now on can be decisive in saving thousands of lives and requires an expanding diplomatic effort.

For over 150 years, the expression "health diplomacy" has encompassed a series of international strategies regarding disease prevention and containment, since the first Health Conference, in 1851 (until 1938), developing mechanisms to fight diseases such as cholera and yellow fever, through the creation of the first health agency in the League of Nations (1919), until the creation of the United Nations health agency, the World Health Organization (WHO), in 1948, which is largest health structure at the international level until today, with its own constitution.

Under the aegis of the WHO, there was the definition of what health is, the creation of international protocols and health regulations in the political sphere, under the viewpoint of the Principle of Dignity of the Human Person – non-derogable. However, the agency is not the only health body in the world, although it is the main one, and must act in an articulated manner with other bodies of the international system, with governments of different regions of the globe and health systems with different institutional cultures, whether public or not.

Martti Koskenniemi (2007) reminds us that, between technicality and politics, positioned at the center stage of International Relations, each institution, based on its own institutional history and logic, will deal with crises differently. Depending on the logisctics responsible organ, the form of action, in a not too distant analysis, is also predictable. The way a response to a crisis will be prepared is decisive, in any sector, but especially when dealing with lives.

In this sense, one can analyze how prophylaxis – the form of disease prevention, extended here rhetorically to pandemics – is addressed at the international level and what its main gaps are. In order to best proceed with the approach to the theme, it will be adopted bibliographic research and documentary analysis, with substantial study of WHO documents.

2. HEALTH STRUCTURE AT THE INTERNATIONAL LEVEL

The right to health, a human right, included in the list of rights guaranteed to every human being due to their very existence, whether in the Universal Declaration of Human Rights (UN, 1948) whether reaffirmed in numerous other international documents about this subject, such as the Covenant on Social, Economic and Cultural Rights of 1966 (BRASIL, 1992), went through long consolidation processes throughout history, but the Health Conferences, from 1851 to 1938, adding up to a total of 14 conferences, were the first consolidated initiatives to control diseases of endemic potential, focused on combating cholera, yellow fever and bubonic plague (HUBER, 2006).

This historical period was especially important to the identification of the most effective phases of sanitary protocols – such as a better surveillance of continental entry channels, in order to better identify contaminated travelers, focusing on their disinfection, instead of just preventing traffic. In 1897, there was an unprecedented success in the history of health regulations (HUBER, 2006): the 1893 Conference on cholera control reached the minimum number of ratifications required for its entry into force (11 countries in total).

Nevertheless, only with the emergence of the first international organization with universal vocation – the League of Nations, created in 1919, with the Treaty of Versailles, and inspired by Woodrow Wilson's 14 Points, of Kantian inspiration –the first health agency in history would emerge in 1923 as the culmination of all the efforts of the previous century. The main subjects discussed by the new organization, however, would be more related to opioid and alcohol consumption (FIDLER, 2001).

Notwithstanding, the League of Nations, would not persist for too long, mainly due to the discrepancy of opinions of its members about the armed conflicts that would culminate in World War II, that led to the end of the organization. The 1939-1945 conflict, of intercontinental proportions, would cause the emergence of another international organization of universal vocation, much more successful and with better administration of the voting and veto procedure of its main council: the United Nations Organization (HANHIMAKI, 2015, p.52).

Under the institutional arrangement of the UN, in 1948, the World Health Organization would arise, with the validity of its Constitution, bringing to international law the definition of health, beyond simple physical well-being, but also comprising the right to a dignified life, as well as invoking the statement that everebody health is dependent on cooperation between individuals and between States (WHO, 1946).

In this sense, according to the WHO Constitution, the member states undertake the commitment to cooperate with the organization, whose main functions will be to promote improvements in the quality of life, present technical opinions, establish minimum health standards at an international level, conduct research, assist governments to improve their health systems and help them in times of need, especially in cases of emergency, in addition to "stimulate and improve work to eliminate epidemic, endemic and other diseases", under the terms of Article 2 of its Constitution (WHO, 1946).

Regarding this last mentioned function, specifically, it will encourage the emergence of the International Health Regulations of 2005, under which the States must

> prevent, protect, control and provide a public health response against the international spread of disease, in ways that are proportionate and restricted to the risks to public health, and that avoid unnecessary interference with international traffic and trade (ANVISA, 2005).[3]

However, it is not always possible to avoid interference in the international trade of possible traffic limitations, and a Public Health Emergency of International Concern (PHEIC) may be declared, defined by the document as

> an extraordinary event which, under the present Regulation, is determined as: (i) constituting a public health risk to other States due to the international spread of disease and (ii) potentially requiring a coordinated international response (ANVISA, 2005).[4]

It is exactly because of this need to evaluate whether or not it is necessary to impose more restrictive measures on circulation and movement, to impose more effective health and regulatory codes, that there must be a discussion about health diplomacy. With the acceleration of market processes promoted by globalization, the flow of goods and people also accelerates, in a world that is increasingly integrated, and in which the strategies of international alignment are more and more present. Art, culture, news, and, negatively, disease and inequality are shared globally.

Thus, health is growing as an international policy issue, with social, migratory and trade implications, which is why it is necessary to have an inter-institutional dialogue between the specialized agencies of the UN, affected by health issues, and the governments of the States, responsible to implement measures at a domestic level, in their own health systems.

From a Latin American perspective (RIBEIRO; VENTURA, 2019), it becomes even more important that countries of global South-South cooperation create joint international public health strategies, in order to seek joint benefits and create new parameters of action regarding diseases of rapid advance and contagion, such as what is observed at this beginning of the century with SARS-COV-2.

3. THE REAL LIMITS TO HEALTH DIPLOMACY

This is not the first time that international protocols for preventing the advance of contagious diseases have been implemented. It is memorable a well-known disease in the tropics, especially in South America and sub-Saharan Africa – the Yellow Fever –, which was the subject of the first Health Conference in history, in 1951 (VANDERSLOTT; MARKS, 2020), along with bubonic plague and cholera, endemic at the time. The vaccine for yellow fever,

[3] Original excerpt in Portuguese: prevenir, proteger, controlar e dar uma resposta de saúde pública contra a propagação internacional de doenças, de maneiras proporcionais e restritas aos riscos para a saúde pública, e que evitem interferências desnecessárias com o tráfego e o comércio internacionais (ANVISA, 2005)

[4] Original excerpt in Portuguese: um evento extraordinário que, nos termos do presente Regulamento, é determinado como: (i) constituindo um risco para a saúde pública para outros Estados, devido à propagação internacional de doença e (ii) potencialmente exigindo uma resposta internacional coordenada; (ANVISA, 2005).

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nonetheless, would only appear in 1940, being the only one of the three mentioned to still cause significant deaths.

It is not the first time that humanity has been forced to adopt the protocol of social isolation. Since the 15th century, with the bubonic plague (VANDERSLOTT; MARKS, 2020), this strategy to control the advance of diseases is familiar to the most varied societies, affected by its effects, once technological resources at the time were quite scarce. Today, legal or diplomatic incidents related to impeding the movement of humans for health reasons are uncommon and states have developed mechanisms of cooperation over the years.

In January 2020, when announcing a new form of pneumonia similar to SARS (Severe Acute Respiratory Syndrome) and MERS (Middle East Respiratory Syndrome), Tedros Ghebreyesus was fighting against an institutional arrangement of his own organ, the WHO, which still did not offer him enough elements to identify the severity of the new syndrome, and little information was offered by the government of China – where happened the potential origin of the vírus –, having met with Chinese leaders on January 28, 2020 (BROWN; LADWIG, 2020).

There was a delay in the beginning of the international protocols, due to the conflicting information about the incipience of the not yet declared pandemic, considered before a mere outbreak. The formal announcement would come on March 11, 2020, under the alert that the expression pandemic could not be used lightly or carelessly, in the words of Ghebreyesus, and that if used wrongly, it could cause widespread panic, which is why all precautions in the adoption of the term were taken (WHO, 2020).

However, the problems are not summed up to a late announcement of the gravity of the situation. The international society coordination capacity to prevent the further virus spread was, to say the least, incipient (BROWN; LADWIG, 2020). Yet, for some international bodies, such as the WHO, there is no binding force for its recommendations, making it difficult to implement measures that should be mandatory.

It is a fact that an international security situation will hardly be analyzed by any other UN body than the Security Council, due to its well-established institutional mandate. Still, for other issues, such as environment and development, the institutional performance is wider. It is more difficult to delimit which body will take care of each case (KOSKENNIEMI, 2007). The same occurs with health.

Is a pandemic a health problem or a migration problem? It can also be an economic problem. Therefore, COVID-19 can be dealt with, although mostly through WHO protocols, by the dynamics of the International Trade Organization, the International Organization for Migration, the United Nations High Commissioner for Refugees, without the institutional logic of these bodies necessarily converging among themselves.

In this perspective, the more fragmented the dynamics to deal with the same fact and the more different institutional systems and arrangements are directed to manage an intersectional problem, the more difficult will be the effectiveness of the strategy (KOSKENNIEMI, 2007, p.8). One cannot speak of institutional hegemony in a separate organizational order. A mosaic of distinct institutional singularities, apparently incompatible and non-dialogical.

The path an organ will take to handle the problem will also depend on its own institutional history and logic. Returning to questions about the approach of the Security Council on securitization issues, there have only been two health emergencies considered

"securitizable" by the UNSC: HIV/AIDS in 2000 and the first wave of Ebola in 2014, both on the African continent (BURCI, 2014).

The second wave of Ebola in 2018, the Influenza A (Influenza H1N1) in 2009, and Zika/Chikungunya in 2018-2019 have not received the same attention. Neither did the 2020 COVID-19. Once again, the intersectionality of health and economic matters appears in the debates and questions arise about the UNSC as "healthkeeper", in reference to the "peacekeepers" of humanitarian interventions, since there seems to be a geopolitical criterion to establish a pandemic or epidemic as a "threat to international health and security" (BURCI, 2014).

Furthermore, there are the domestic boundaries of the states, which do not necessarily have to comply with the protocols established by the WHO. There is no formal political control at an international level. Also, as Koskenniemi alerts, even when there is a formal procedure of international legislative production, its contextual interpretation by the states in their soverignty, the so-called "ad hocism" (KOSKENNIEMI, 2007, p.9), causes any norm at the international level to be either overly comprehensive or insufficient, and its effectiveness will be calculated on a case-by-case basis.

The way health is operationalized within a state can substantially affect the reality of other countries and the absence of an internationally binding regulatory mechanism – something that is not usually a political agenda – becomes the vocabulary of the times (CHATTU, 2020), exposing the gaps in the system, especially because it is increasingly clear that health problems do not remain confined within political boundaries. The virus does not know them.

4. FINAL CONSIDERATIONS

Considering the evolution of the right to health in the last 150 years, it can be seen that there is considerable progress regarding international integration strategies in the field of health diplomacy, to ensure better sanitary conditions worldwide and to prevent the spread of diseases of fast contamination.

Starting the historical digression of this article in the first Sanitary Conference in 1851, the time course brought new concerns, such as cholera, bubonic plague and yellow fever, the latter still causing victims every year. Subsequently, from the League of Nations to the current United Nations format, the actions of health agencies are the culmination of centuries of academic, medical and social efforts to implement the effectiveness of the right to health.

Nevertheless, it is possible to identify numerous blank spaces in this context, especially regarding the fragmented nature of international organizations, with numerous specialized agencies, each one with their own internal dynamics and vocabularies, acting by their own histories and technicality. There is a geopolitical bias behind the way international crises will be handled, regardless the adopted protocol: of health emergency or not.

This can be seen, for example, in the way the Security Council has dealt differently with different endemic diseases in recent decades, considering only two major epidemics in Africa a threat to international peace and security.

Moreover, governments, the internal administration of countries, and not only at the state level, should also be part of this intersectorality, both in prevention and dissemination of accurate information about events, which did not occur at the beginning of the 2020 pandemic. It has been seen a patchwork international dynamic, difficult to articulate together.

It seems that his lack of dialogue was one of the reasons for the World Health Organization's late declaration – only in March –, of a pandemic disease that had been causing multiple victims since January. The mismatched information from the numerous institutions involved was crucial to the picture that was seen at the end of the year 2020.

Thus, the success of the pandemic strategy, or of any other public health emergency of international importance that may occur, will only be known in the future, but its failures can already be observed, serving as a substrate for new learning and new advances in the area of health diplomacy.

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