Disease diplomacy: international norms and global health security

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In mid-2016, why would a global health scholar, or student, want to read a book about Disease Diplomacy that was written before the great Ebola outbreak which started in December 2013?1 If that Ebola outbreak is indeed the game changer many observers expect(ed) it to be, then this is a book about the past: a textbook for global health’s history classes. However, I think this is an important book that all global health scholars should read. Let me give you three reasons.

First, it is prescient; a lot of what went wrong in the global response to the great Ebola outbreak is or was predicted in this book. Near the end of the book, the authors write: ‘When a number of states cannot meet the IHR [International Health Regulations] core capacity requirements and cannot attract the help they need to do so, the entire ethos of the global health security regime is undermined’ (p. 146). This is, in my opinion, exactly what happened with the great Ebola outbreak. At the beginning of the outbreak – and during the years before the outbreak – the governments of Guinea, Liberia and Sierra Leone did not receive the assistance they needed, and a lot of the ‘assistance’ they received later was focused on containing the epidemic within their borders. Other governments watched the epidemic unfold, and took notice. It should not come as a surprise if the appetite for international cooperation – reporting the outbreaks means taking the risk that other countries will impose harmful measures, including travel bans and economic embargos, while not offering the required support – will later appear to have been severely damaged by the great Ebola outbreak and the slow and inadequate international response.

Second, this story is not yet over. In mid-2016 the great Ebola outbreak has yet to become the game changer it could be. Sure, there have been appeals to revise IHR in light of the lessons learnt from the great Ebola outbreak,2 and the World Health Organization (WHO) went as far as a public apology,3 and commissions and panels have been created to examine the failures. But the crux of the matter, namely that IHR rests on ‘a delicate balance: open reporting in return for a guarantee of no disproportionate travel and trade restrictions’ (p. 145) not including preventive or mitigating assistance, has not been addressed yet.

Third, this book adopts a rather unusual approach to unpacking global health diplomacy. Whereas most global health diplomacy analyses lean heavily on issues of power and enlightened self-interest, this book focuses on norms, and norm compliance. It illustrates acts of governments in relation to IHR that cannot be explained only by power (or lack thereof) or interests (or lack thereof), but are probably the results of norm acceptance, norm internalization and norm compliance. It also challenges the common belief that ‘voluntary cooperation is more likely to happen when it makes sense for all, that is, if it is based on a clear and fair win–win agreement’.4 A potential win–win outcome is no guarantee of cooperation; it may even

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make states more averse to cooperate, if others win without contributing a fair share (the *free rider* syndrome). At times, clear norms that spell out exactly what kind of behaviour counts as *right*, and what kind of behaviour counts as *wrong*, may be equally or more effective. Of course, the creation of international norms may depend more on power and interests than on moral and ethical considerations, but once adopted, norms may well overcome reluctance stemming from unclear or unpredictable benefits and concerns about free rider behavior.

It was common knowledge then (as it is today), that Guinea, Liberia, Sierra Leone, and many other low-income countries, were (and still are, unfortunately) ill equipped to face epidemics like Ebola. The 2007 World Health Report – on ‘global public health security’ – warned that at least ‘57 countries, most of them in sub-Saharan Africa and South-East Asia, are struggling to provide even basic health security to their populations’. This should have triggered article 44 of the IHR, which gives the WHO a mandate to collaborate with States Parties, upon request, to the extent possible, in: (a) the evaluation and assessment of their public health capacities in order to facilitate the effective implementation of these Regulations; (b) the provision or facilitation of technical cooperation and logistical support to States Parties; and (c) the mobilization of financial resources to support developing countries in building, strengthening and maintaining the capacities provided for in Annex 1 [namely to develop, strengthen and maintain the capacity to respond promptly and effectively to public health emergencies of international concern].

So why did this not happen? Perhaps because the IHR do not contain an explicit obligation for wealthier countries to provide the assistance poorer countries need: the WHO has a role to coordinate financial support for poorer countries (to strengthen their capacities to respond to public health emergencies), but if such assistance is not available, there is nothing to coordinate. So the more important question, probably, is why this part of the IHR is so weak; why the IHR indeed captures ‘the quid pro quo of the expanded reporting requirement in return for guarantees of proportionate trade and travel measures’ (p. 72), but not the provision of assistance.

On this question, I felt a bit disappointed by the book. Considering the emphasis on state capacity in Chapter 5, and the abovementioned comment on the ‘entire ethos of the global health security regime’, I would have expected a deeper exploration of why that ethos left so few traces in the IHR. The implicit answer can be found in Chapter 2, which addresses how the 2003 Severe Acute Respiratory Syndrome (SARS) epidemic constituted the *tipping point*, leading to the extensive revision of the IHR. SARS hardly affected low-income countries at all. It spread from China, to Viet Nam and Hong Kong, and further into Indonesia, Singapore, Thailand, the Philippines, Germany, Canada and the USA. For SARS, the problem was not weak capacity, but weak political will to report and to cooperate. Weak capacity was somewhat overlooked.

If the IHR are revised again, in the near future, will weak capacity – and the ways to overcome it, including international financial cooperation – be included? The answer to that question will not be found here, obviously. However, global health scholars who would like to see international financial cooperation included in the next iteration of the IHR can learn a lot from this book. What it takes is ‘a critical mass of states, persuading them to cease being apathetic (or even resistant) to a set of new collective behavioural expectations concerning infectious disease outbreak’ (p. 52), and then, of course, to persuade them that international public financing of health systems is part of the collective behavioural expectations …

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