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The Post-Pandemic World and the Foreign Policy Imperatives

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Abstract

Considering the destructive and disruptive potential of pathogens, this research identifies new lessons and policy imperatives in the governance of future scenarios of pandemics. Although foreign policy players and other critical stakeholders are beginning to recognise the values of global health in foreign policy thinking and decision-making, there are still major gaps in pandemic response, particularly as the COVID-19 pandemic has revealed. To plug the observed gaps, this paper calls attention to three political / foreign policy priorities. First, critical actors must enhance their preparedness for future pandemics by building massive health infrastructure, supersizing the health corps, and investing in programmes that will aid their capacity to predict a health emergency before it occurs. Second, foreign policy professionals must prioritize humanity over high politics in global pandemic response. Third, foreign policy actors must place adequate focus on migration health going into the future.

Keywords: COVID-19, Foreign Policy, Global Epidemiology, Global Health Governance, WHO.

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Introduction

Due to recurring outbreaks of catastrophic infectious diseases, pandemics and bioterrorism have emerged as direct threats to national and global security going into the future (Oshewolo & Nwozor, 2020; Gagnon & Labonte, 2013; Evans, 2010; Chan, Store & Kouchner, 2008; Fidler & Drager, 2006). As would be expected, this situation has elevated health/pandemic response as a major foreign policy issue. Again, the transnational nature of health risks in today's globalised world points to the need for collective action and shared responsibility. Countries have become core actors that must reorient their health and foreign policies in ways that align their national interests with the diplomatic, epidemiological and ethical realities of a globalised world (Heisbourg, 2020; Oshewolo & Nwozor, 2020; Drager & Fidler, 2007). Health – being a common concern – could therefore motivate or create incentives for deeper collaboration between nations and institutions (Chan *et al.*, 2008).

The outbreak of COVID-19 in November 2019 in Wuhan, China and its telling impact on global epidemiology have again confirmed the disruptive potential of pathogens and the need for collective action among states. However, the magnitude of the problem and the inefficiency of mass containment measures have exposed the unpreparedness of the world for pandemic challenges. The worldwide spread of the disease and the fatalities were alarming. The pandemic stretched healthcare systems across the world to their limit – strong and weak healthcare systems alike. Although foreign policy players and other critical stakeholders are beginning to recognise the values of global health in foreign policy thinking, there are still major gaps in pandemic response as the COVID-19 pandemic has revealed. This paper therefore calls attention to the political and foreign policy priorities in dealing with future global health emergencies or pandemics.

In terms of structure, this paper is divided into seven sections. While this section represents the introductory piece, section two examines the theoretical connection between foreign policy and global health. Sections three and four cover the history of global pandemics and the outbreak of COVID-19 and its impact on the globalising processes, respectively. The fifth section examines the containment of COVID-19 and the challenges. While section six explores the foreign policy priorities in dealing with global health emergencies, section seven is the conclusion.

Foreign Policy and Global Health: The Theoretical Connection and Gaps

Foreign policy has an overarching impact on the affairs of nation-states. A major stream of thinking in the literature is to explain foreign policy as the continuation of a state's domestic politics in the international arena. This exercise is defined and

redefined by national interest. The national interest of a country embodies those priorities that determine and influence its survival – internally and externally (Saliu & Oshewolo, 2018; Oshewolo, 2019). These priorities could cover military and security, economic wellbeing and wealth, and political and ideological objectives, among others. With the increasing socialisation of states particularly at the global level and the mounting globalisation of diseases, national priorities now include global health concerns. The growing number of global initiatives aimed at combating global health emergencies provides some evidence (Oshewolo & Nwozor, 2020; Watt, Gomez & McKee, 2014; Gagnon & Labonte, 2013; Feldbaum, Lee & Michaud, 2010; Lee, Ingram, Lock & McInnes, 2007). When we talk about foreign policy, the focus here is on actors such as political heads and other accredited state officials whose traditional responsibility is to design policies and frameworks that will protect from external threats (Heisbourg, 2020), and the different multilateral frameworks that afford states the opportunity for collective action.

Authors have attempted to rationalise and justify the connection between foreign policy and global health. The write-up by Labonte & Gagnon (2010) interrogates the rationales for the foreign policy and global health nexus. First, on account of the experiences from the previous pandemics and catastrophic diseases, health concern has become a major threat to security. As far as epidemics/pandemics could cause a major disruption to social and economic life as well as to national and international infrastructures, they constitute security concerns (Oshewolo & Nwozor, 2020; Kotalik, 2006). The securitization of global health could therefore help address many security concerns at the national, regional and global levels (Evans, 2010; Peterson, 2002). Second, the recognition of health as a foreign policy priority could be a major determinant of development. Third, considering the altruistic and humanitarian angle to global health (preventing and combating epidemics and other health catastrophes), it has been categorised as a global public good – the slight imperfections associated with such categorization notwithstanding. Fourth, the connection between global health and international trade is beginning to gain traction. Fifth, health has become a foreign policy concern because it is a fundamental right of every human being. The continuing emphasis on global health diplomacy is therefore a product of moral/ethical reasoning (Labonte & Gagnon, 2010).

The increasing connection between foreign policy and pandemic response notwithstanding, the governance of global pandemics has revealed some gaps. As Oshewolo & Nwozor (2020), Monaco (2020), and Chan *et al* (2008) would want us to accept, foreign policy-makers and actors give serious attention to public health only in times of emergencies and crisis. Similarly, Katz & Singer (2007) observe that global health significantly shapes foreign policy or global response when it poses a far-reaching threat to international, regional and national security or affects global

economic welfare. This implies that in relation to other foreign policy priorities or preferences, public health ranks poorly in the absence of crisis. There are two deductions that could be made here. First, while the consensus is that foreign policy has a major role to play in mitigating global pandemics, its role in practical terms has been reactionary than proactive. This fire-fighting approach has proven to be very costly as late responses often lead to considerable morbidity and mortality, and the disruption of major globalising processes. Second, a major explanatory category is the lack of political will on the part of states and foreign policy actors. More worrisome is the fact that at the end of every pandemic crisis, humanity appears to push the possibility of another outbreak out of its 'collective consciousness' (Garrett, 2019).

While the connection between the foreign policy community and global health has been affirmed, one could say that there have been limited 'intra-marital' conversations between the two. Global experiences have suggested that there have been limited conversations or agreements around what could be the best international standards/practices to aid global preparation and guide efforts in the face of global pandemics (Oshewolo & Nwozor, 2020). For example, the International Health Regulations (IHR) – a set of rules agreed to by 194 countries – were last updated in 2005 following the 2003 outbreak of the Severe Acute Respiratory Syndrome (SARS) (National Academies Press, 2017). Between 2005 and now, there have been a couple of major disease outbreaks with new epidemiological lessons. We strongly feel that the introduction of new changes to reflect new global concerns is long overdue.

Although the World Health Organisation (WHO) had envisioned the last revision of the IHR in the 1990s, the SARS pandemic exposed the necessity of a paradigm shift from halting catastrophic infectious diseases at national borders to discovering and containing them at their source (National Academies Press, 2017; Murphy, 2020; Monaco, 2020). The above calls attention to migration health. While migration and population mobility present many opportunities and challenges which have moderately received the attention of policy-makers, their psychological and health dimensions have been under-investigated (Wickramage, Simpson & Abbasi, 2019; Labonte & Gagnon, 2010). Although 'international mobility is central to the globalisation of infectious and chronic diseases', the foreign policy-migration health nexus has not enjoyed the adequate attention it deserves from policy-makers at the national, regional and global levels (MacPherson, Gushulak, & MacDonald 2007, p. 201).

Finally, in extreme cases, global health could represent a foreign policy tool whose utility lies in serving the material interests of states, particularly in great power competition. In this case, global health interventions and actions could support ulterior foreign policy objectives (Feldbaum *et al*, 2010; Fidler, 2005). Therefore,

another area of concern is whether international politics – power game – should take precedent over health concerns or not. To be sure, response to health emergencies or epidemics falls within the purview of humanitarian action. Nevertheless, practical realities have suggested that high politics could impinge on humanitarian objectives (Murphy, 2020; Thieren, 2007). At the heart of this problem is the poor intellectual articulation of why states incorporate global health into their foreign policy agendas or what interest states ought to pursue when they engage on global health issues (Feldbaum et'al, 2010). This problem will be further interrogated later in the paper.

Global Epidemics/Pandemics: A Brief Historical Review

A major defining element of population mobility – or the spread of humans across the world – has been the spread of infectious diseases. Historical events have revealed that disease outbreaks are a regular feature of human history, albeit not every outbreak reaches pandemic level (one with greater coverage and range or wide geographical spread) (LePan, 2020). During 430-426 BC in Athens, Black Death became the famous plague. Although it was difficult to ascertain what the disease actually was, the devastation in its wake was such that even vultures stayed away from the corpses of those killed. More so, the Antonine plague that erupted at the height of Roman power – between 165 and 180 AD – killed about 5 million people. While the great plague of London during the seventeenth century killed about 70,000 people, the 1894 plague killed about 100,000 people in China and Hong Kong (Day, McKay, Ishman & Chung, 2004).

The twentieth century witnessed some very devastating pandemics. The 1918 Spanish flu recorded about 450,000 deaths in the United States and more than 50 million worldwide. There were also the 1957 Asian flu and 1968 Hong Kong flu that killed about one million people each. The Human Immunodeficiency Virus (HIV) and acquired immunodeficiency syndrome (AIDS) which began towards the end of the twentieth century and still currently ravaging the world has killed more than 25 million people (Scanlon & McMahon, 2011; Kotalik, 2006; LePan, 2020; Oshewolo & Nwozor, 2020). The severe acute respiratory syndrome (SARS) was the first plague of the twenty-first century. SARS was first discovered in China's southern province of Guangdong in late 2002. By the time the WHO declared an end to the disease on May 18 2004, the virus had killed approximately 800 people. Again, there was the outbreak of swine flu (H1N1) virus in 2009. By August 2010 when the WHO proclaimed an end to the disease, the number of worldwide fatalities had risen to about 280,000. The Ebola virus killed about 11,000 between 2014 and 2016, while the middle east respiratory syndrome (MERS) epidemic that began in 2015 has killed about 850 people (LePan, 2020; Sengupta & Wang, 2014; Tew, Lu, Tolomiczenko & Gellatly, 2008; Shantz, 2010).

We could learn a few lessons from the history of global diseases. First, the rapidly disappearing national boundaries has been a key factor in the globalisation of diseases. Day et'al (2004, p. 798) observe that "individual economies are no longer isolated from each other by barriers to cross-border trade and investment – by distance, time zones, and language – and by national differences in government regulation, culture, and business systems". Second, the inability of global networks of leaders to respond promptly to modern diseases and significantly scale down the fatality rate has been blamed on poor public health policies and practices (Oshewolo & Nwozor, 2020; Heisbourg, 2020). As correctly argued by Shantz (2010, p. 4), the global dominance of the neo-liberal ideals has occasioned a misplacement of global priorities by neo-liberal governments. These governments often "prioritize business security above health and social security", thereby validating the thinking that capitalism could make the people sick. Third, the recurrence of infectious diseases worldwide is not biologically and bio-medically indecipherable. A disease will likely occur again when it "undergoes a major change, a so-called antigenic shift, and this will make the whole population of the world, even those who acquired immunity from annual outbreaks, highly susceptible" (Kotalik 2006, p. 70). Explaining further, Schwirian (2006, pp. 243-244) notes that:

> A number of the old viruses have mutated and have returned with the forces of entirely new diseases. Second, new infections have spread from the natural and animal world to humans as formerly isolated ecosystems have increasingly been disrupted by human economic invasion and settlement expansion. Third, the migrations of people from rural areas to cities worldwide have resulted in fractures of fragile city ecosystems such that many have become potential victims to microbes accompanying city-bound migrants.

From the foregoing, it is clear that humanity is always confronted with the possibility of major epidemics.

Table 1: *Globalisation of diseases, major timelines and fatalities*

Disease	Period	Fatalities	Disease	Period	Fatalities
Plague of Athens	430-426 BC	75,000+	Antonine plague	165-180 AD	5M
Plague of Justinian	541-542 AD	30-50M	Japanese epidemic	735-737 AD	1M
Black death	1347-1351	100M+	Italian plague	1629-1631	1M
Great plague of London	1665	70,000+	Cholera pandemic	1817-1923	1M+
Third plague	1885	12M	Yellow fever	Late 1800s	100,000+
Russian flu	1889-1890	1M	Spanish flu	1918-1919	50M+
Asian flu	1957-1958	1.1M	Hong Kong flu	1968-1970	1M
HIV/AIDS	1981-present	25M+	Swine flu	2009-2010	200,000+
SARS	2002-2003	750+	Ebola	2014-2016	11,000+
MERS	2015-present	800+	COVID-19	2019-present	

Source: LePan, 2020 (expanded by the authors)

COVID-19: Spread, Fatalities, and the Plummeting of Globalising Processes

COVID-19 broke out in Wuhan – the capital of China's Hubei province – in November 2019 (Campbell & Doshi 2020; Murphy 2020). While coronaviruses are not entirely new, the most recent outbreak has not been previously identified in humans. The government officials in the province where the virus erupted initially understated the problem and later tried to hide from public knowledge the severity of the disease. As a matter of fact, this cover-up theory became somewhat validated when the government began a crackdown on whistleblowers. The doctor, Li Wenliang, who attempted to publicise the virus was targeted by the police and later died of the disease (Peckham, 2020; Heisbourg, 2020). Since the discovery of the first case in November 2019, the virus has now spread to more than 190 countries of the world. The worldwide COVID-19 confirmed cases have risen to 704 million. While about 7 million have died from the infection, about 675 million have so far recovered. With the figures of over 111,820,000 and 1,219,487, the United States has the highest number of confirmed cases and fatalities respectively (Worldometer, 2024). The irreparable mental damages to the families of those killed by the virus notwithstanding, the significantly higher number of worldwide recoveries gives reason for hope and optimism going into the future.

As COVID-19 rattled the world – spreading across boundaries and nationalities – the key processes that motorise globalisation caved in. The plummeting of the globalising processes was not entirely surprising considering the devastating nature of the pandemic and the need for stringent worldwide containment measures. To begin with, migration and population mobility – a medium through which the virus travelled around the world – was almost halted. Most countries adopted very stringent measures ranging from total to partial lockdowns. For instance, President Donald Trump banned the entry into the United States of all foreign nationals who had travelled to high-risk countries 14 days before their arrival. Although citizens and permanent residents were exempted, they must enter through an international airport with enhanced screening capabilities. Non-essential travel from Canada and Mexico was also restricted. Some countries totally shut down all ports of entry – land, air and sea – to curb the disease. Several other countries imposed partial lockdowns allowing only citizens and permanent residents – including their immediate family members, a few other countries, and foreigners with medical confirmation that they had not tested positive for the virus (Aljazeera, 2020; Salcedo & Cherelus, 2020; BBC News, 2020). As a result of the massive scale down of international travel, major terminals around the world were left almost empty. This situation confirms the thinking in the literature that dangerous health-related issues could present a danger to many globalising processes and could alter and disrupt the trans-border flow of people and goods (Oshewolo & Nwozor, 2020; Gagnon & Labonte, 2013; Watt *et al*, 2014).

Again, COVID-19 disrupted several sporting events and activities. The Tokyo Olympics – originally billed to take place in 2020 – was rescheduled. As announced by the International Olympic Committee, the rescheduling was to allow governments, health authorities, and the organisers to address the disruptions caused by the disease (Ingle, 2020). Major football leagues with massive followership worldwide – such as the English Premier League, Spanish La Liga, Italian Serie A, German Bundesliga, and French Ligue 1 and several other leagues – were suspended. The list of COVID-19 cases in football got longer. A few of the cases include Daniele Rugani, Blaise Matuidi, and Paulo Dybala (Juventus), Ezequiel Garay and Eliaquim Mangala (Valencia), Callum Hudson-Odoi (Chelsea), Mikel Arteta (Arsenal), and Marouane Fellaini (Shandong Luneng) (Wilson, 2020). This crisis negatively affected the financial fortunes of these clubs, and some even negotiated with the staff for wage cuts. The Union of European Football Associations (UEFA) also suspended Euro 2020 play-offs. Other decisions taken include the suspension of the qualifiers for Women's Euro 2021, cancellation of the under-17 and Women's under-19 European championships, and postponement of Women's under-17 and Men's under-19 European championships. UEFA Champions and Europa Leagues were also postponed (Slavin, 2020).

Furthermore, with coronavirus-induced worldwide shutdowns (travel restrictions, company and factory shutdowns all over the world, suspension of sporting activities and events, local economic lockdowns as a result of local enforcement of 'shelter-in-place' or 'stay-at-home' orders), the global economy contracted (Oshewolo & Nwozor, 2020; Elliot, 2020; Horowitz, 2020a; Milanovic, 2020). An infection that was initially localised ended up wrecking the global economy. There were widespread economic uncertainties and shocks (Yergin, 2020; Jaffe, 2020).

The Containment of COVID-19 and the Challenges

At first, China failed to share up-to-date data about the pandemic and stonewalled international health authorities and supports. The implication is that other members of the global system were caught unprepared by the time the virus began to travel across borders. The valuable preventive and management measures that could have been put in place if China had acted transparently were lost (Campbell & Doshi, 2020; Murphy, 2020; Oshewolo & Nwozor, 2020). These were China's initial costly mistakes.

The inadequacy of health infrastructure required to combat and contain the pandemic exposed the unpreparedness of countries. As the cases ballooned daily, health facilities and professionals became overwhelmed. There were shortages of health workers and important medical items such as respirators, ventilators, and test-

kits, among others. Medical scientists also struggled to develop vaccines. For instance, Italy (one of the epicenters of the pandemic) had its health system overloaded. The situation got to a head in March 2020 when medical staff were forced to make extraordinary decisions about who may live or die and refraining from attending to the very old, thereby leaving them to die (Horowitz, 2020b). In Spain, there were very disturbing reports and images of coughing patients lying on the ground because most of the medical facilities were operating at 'maximum capacity'. Non-medical facilities were also converted into makeshift hospitals (Hodge, 2020).

Western countries really got overwhelmed in their mass-containment efforts. The United States – world's most prominent superpower – faltered pathetically in its response to the pandemic. This explains why the country has the highest number of COVID-19 infections and fatalities. President Donald Trump who initially downplayed the problem was later confronted with its stark reality. The White House, Department of Homeland Security, and Centre for Disease Control and Prevention (CDC) made mistakes which undermined public confidence in Trump's containment efforts (Oshewolo & Nwozor, 2020; Peckham, 2020; Campbell & Doshi, 2020).

Managing Global Health/Pandemics: The Foreign Policy Imperatives

There is the need to rethink the connection between foreign policy and global health – fundamentally in terms what role foreign policy should play in pandemic and health emergency response. Global health possesses security, material and human/moral values (Oshewolo & Nwozor, 2020; Labonte & Gagnon, 2010; Katz & Singer, 2007; Kotalik, 2006), which are also the major domains of foreign policy. Global decision-makers and foreign policy professionals must understand that foreign policy values are not in conflict with global health values, and so global health issues must feature prominently in foreign policy thinking. As a matter of fact, if the world is going to develop the capacity to predict and effectively combat future pandemics and other health emergencies, it must begin with foreign policy thinking. The foreign policy priorities that this paper gives attention to are tridimensional.

First, lessons from COVID-19 have revealed that getting ready before a pandemic/health emergency is central to its containment. The dominantly bizarre practice by foreign policy professionals and governments is to adopt fire-fighting and reactionary measures in times of health emergencies. In the absence of crisis, they look the other way. These actors have failed to learn important lessons from the history of global pandemics (Oshewolo & Nwozor, 2020). As table 1 revealed, there is always the possibility of a pandemic and "we have been living with this potential for generations" (Mukherjea, 2010, p. 127). This ever-present possibility stresses the need for pandemic preparedness. Pandemics do not unfold on schedules and the next

episode or outbreak may just be around the corner. While the world is still combating the coronavirus, the learning process must begin immediately to understand what comprehensive measures to be put in place before another major outbreak. How can nations invest heavily on national defense and prepare well in advance for wars but unable to prevent the dangers posed by a disease? For instance, the United States commits close to $1 trillion to national security and defense annually – the biggest in the world by far – but the most ravaged by COVID-19 (Oshewolo & Nwozor, 2020; Murphy, 2020). A national security and defense programme that pays little attention to health could be a recipe for disaster.

An area where preparation is required is the size of health infrastructure and staff. From what we have observed, pandemics will overload healthcare systems for an indeterminate period. Even in strong healthcare systems, the number of people requiring medical attention may exceed the size of health facilities and professionals. For instance, as a result of the shortage of medical staff in the United States, the country offered visas to foreign health professionals to help combat COVID-19. In the coming years, political heads must invest heavily in building massive health infrastructure and corps. There is also the need for governments and intergovernmental organisations to invest in programmes that will enhance their capacity to predict a health emergency before it actually occurs. This will enhance their preparedness in the event of an actual pandemic (Oshewolo & Nwozor, 2020). Murphy (2020) explains that the United States was a global leader in this regard. According to him, the country had a Predict programme which President Trump unfortunately suspended in October 2019. The objective of the Predict programme was to identify dangerous animal viruses that may infect humans in the future and lead to a pandemic. Before it was shutdown, the research and surveillance programme had collected well over 100,000 biological samples from animals and detected over 1,000 new viruses, including a new kind of Ebola. Several scientists from African and Asian countries had also benefitted from Predict training workshops (Murphy, 2020; McNeil Jr., 2019). Supporting a programme of this nature is more apposite now than ever.

Second, political heads and foreign policy players must prioritize humanity over high politics in the face of global health emergencies. The reason for this admonition is that responses to pandemics or plagues could 'become tangled in the morass of national and international politics'. Even when external actors are ready to assist, a lot still "depends on the willingness of national and local political regimes" to accept international intervention (Schwirian, 2006, p. 242). Whether it is rational or not, nations must never allow high politics or power game to encumber humanitarian intervention that pandemics require.

The coronavirus may have exposed states' penchant for the pursuit of ulterior objectives in certain extreme circumstances, including dealing with pandemics. How do we explain China's initial denial until the virus became full blown? What was China trying to hide, and to what end? Why did China stonewall international health professionals initially? Again, how do we explain the blame (power) game involving China and the United States? Chinese officials maintained that the virus in fact originated elsewhere – in a thinly veiled dig at the United States – and President Trump retaliated by calling COVID-19 the 'Chinese' virus (Heisbourg, 2020). In addressing a challenge of this magnitude, power game or international ambition must take the back seat.

Third, foreign policy players and professionals must place adequate focus on migration health. International travel or population movements have always created opportunities for the international spread of infectious diseases. There are historical accounts of explorers, wanderers, and other categories of travelers who aided the introduction of pathogens and vectors into susceptible populations; and accounts of war-related population movements that led to epidemiological outbreaks (Soto, 2009). In terms of infectious disease epidemiology therefore, the association between the introduction of disease and migration has long been recognised (Gushulak & MacPherson, 2004). COVID-19 has further confirmed that diseases transported by travelers could have a significant impact on global epidemiology. Yet, international discourse has not given sufficient attention to this reality. International discourses have been dominated by migrants transiting "through 'irregular' means – outside the laws and regulations that govern migration – and those who overstay their visas", while the health of migrants/travelers and their family members has been on the fringes (Wickramage, Simpson, & Abbasi, 2019, p. 1). National governments, foreign policy players, and relevant international organisations must incorporate migration health into global policy-making.

The rapid spread of COVID-19 around the world has clearly strengthened the case for imposing timely and tight restrictions on local and international movements during a major community disease outbreak. However, these restrictions should not assume a misguided racist dimension whereby a particular 'foreign' group is demonized and tagged as carriers and discriminated against on the basis of that (Somin, 2020). Again, although epidemic-induced restrictions on movements are necessary, they must be sufficiently explained and justified. In light of this, Jones (2019) rightly argues that there must be a moral justification for such restrictions. A major argument against mobility restrictions is that they are morally wrong. But, Somin (2020) observes, quite intelligently, that there are circumstances in which arguments against restrictions may not apply or are overridden by other considerations. An exemption could be a great danger – such as a deadly disease – that can only be

prevented by limiting migration. According to him, saving lives is a major moral imperative.

Conclusion

This article has been able to call attention to major foreign policy gaps in COVID-19 health emergency response and how they could be plugged going forward. The foreign policy priorities explored here include the increasing importance of adequate pandemic preparedness – in terms of building massive health infrastructure and corps, humanity over high politics in dealing with pandemics, and the focus on migration health.

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