ESIL Reflections
Editorial Board: Federico Casolari, Patrycja Grzebyk, Ellen Hey, Guy Sinclair and Ramses Wessel (editor-in-chief)

26 February 2021 Volume 9, Issue 6

The Security Council and COVID-19: Towards a Medicalization of International Peace and Security

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Introduction

The global dimension of the COVID-19 pandemic, and the impossibility of any state to singlehandedly cope with its impact, have raised the question of what role international institutions can play in devising effective responses. The United Nations Security Council (SC) certainly does not escape the reach of this question. In light of the threat posed by COVID-19, shouldn't one of the most powerful international bodies take some sort of action? Yet given its mandate under Article 24 of the Charter of the United Nations (UN Charter), notably the maintenance of international peace and security, when and how do problems posed by the cross-border spread of a disease fall within the SC's purview? And to what extent can the SC's actions lead to an effective response to what is, first and foremost, a global health matter?

On July 1, 2020, the SC approved Resolution 2532.[1] While the resolution underscored the potential danger posed by the pandemic to the maintenance of international peace and security, it did not lead

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[1] United Nations Security Council Resolution 2532 (2020), S/RES/2532.

to the adoption of extraordinary measures under Chapter VII of the UN Charter. Nevertheless, a demand for a general ceasefire was approved, calling upon parties to armed conflicts to engage in a humanitarian pause for at least 90 days (with some exceptions).[2] The resolution's wording states the ongoing pandemic "is likely to endanger the maintenance of peace and security", pointing towards a stronger linkage to Chapter VI of the UN Charter than to Chapter VII.[3] After the period expired, it remained unclear what the consequences of its disregard ought to have been, beyond repeated calls by the SC to respect it.[4] Informative chronologies[5] show how certain ceasefires, such as the 2020 Nagorno-Karabakh agreement between Azerbaijan and Armenia[6] and the agreement in Libya, were negotiated after the resolution. However, others failed to fully materialise, such as in the case of Colombia. Moreover, after the 90-day period, UN officials have pleaded for a renewal of the SC's call for a ceasefire.[7]

The SC's COVID-19 Resolution is embedded in a decades-long process of addressing global health problems through the logic of international peace and security. This process is known as 'the securitization of global health'. Following the analysis by Ilja Pavone, this contribution provides an overview of how SC resolutions preceding COVID-19 shed light on different instances of when and how certain health problems are considered to be actual or potential threats to international peace and security. The following lines also argue that the securitization of global health should not be understood as a linear process. This Reflection concludes by arguing that devising the best responses to specific threats posed by disease outbreaks inevitably requires medical and public health input. Without it, the logic of international peace and security risks amounting to "fighting a fire blindfolded".[8]

International Peace and Security vs Global Health: Synergies and Tensions

The core goals of the maintenance of international peace and security for the purposes of the UN Charter have been interpreted as the prevention not only of military conflict but also of the underlying

[2] Ibid, para. 2.
[3] See especially Articles 33 and 34 of the UN Charter.
[4] https://news.un.org/en/story/2020/09/1072972.
[5] See the "Covid-19 ceasefire tracker", hosted by the University of Edinburgh: https://pax.peaceagreements.org/static/covid19ceasefires/
[6] See the official English translation in http://en.kremlin.ru/events/president/news/64384
[7] Statement by UN Deputy Secretary-General, Amina Mohammed, 'Deputy UN Chief pushes Security Council on global ceasefire, to fight "common enemy"', UN News, 3 November 2020 https://news.un.org/en/story/2020/11/1076792
[8] Expression used by the WHO Director-General on 16 March 2020, https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---16-march-2020

issues likely to cause it.[9] The SC's role as the organ with the primary responsibility in this area may, at times, require the imposition of sanctions or even the use of force, as envisaged in Chapter VII of the UN Charter. A core legal basis is Article 24 (1) UN Charter, which endows the SC with 'primary responsibility' in "the maintenance of international peace and security".[10] The ensuing question is how the scope of this primary mandate is interpreted in certain circumstances.[11] Through its determinations under Article 39 of the UN Charter, the SC may deem a specific situation to be a threat to international peace and security. Moreover, on the basis of Articles 41 and 42 of the UN Charter, it may also legally mandate the adoption of measures. Doctrinal discussions abound regarding the limits to these legal powers.[12]

The use of terminology by the SC in the exercise of its legal mandate has not been fully consistent over the course of time.[13] Nevertheless, the field of 'international peace and security' within the United Nations in general, and the SC in particular, has gradually evolved towards the incorporation of the more multidimensional concept of human security. Its emergence is characterized by the incorporation of non-military factors as preconditions for international peace and security, including issues of social and economic development, including public health.[14] The concept of human security was arguably one of the main catalysts for the expansion of the SC's activities in global health fields such as the HIV/AIDS pandemic.

In turn, the normative goals of global health find their legal basis in multiple legal instruments, including those based on human rights approaches. The Constitution of the World Health Organization (WHO) is a key example, by enshrining in its preamble the "enjoyment of the highest attainable standard of health" as a fundamental right. Here, 'health' is understood as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity". This normative goal is meant

[9] Rüdiger Wolfrum, 'Chapter I. Purposes and Principles, Article 1', in Bruno Simma et al (eds.), *The Charter of the United Nations: A Commentary, Vol. I*, 3rd edition (OUP, 2012), paras. 9-10.
[10] Anne Peters, 'The Security Council, Functions and Powers, Article 24', in Simma et al (n. 9), 764.
[11] Erin Pobjie, 'COVID-19 and the Scope of the UN Security Council's Mandate to Address Non-Traditional Threats to International Peace and Security' (2020), *MPIL Research Paper Series*, No. 2020-41, 6-9.
[12] Michael Wood, 'United Nations, Security Council', in Rüdiger Wolfrum (ed.), *Max Planck Encyclopedia of Public International Law* (OUP, 2007), paras. 25-26.
[13] Michael Wood, 'The Interpretation of Security Council Resolutions' (1998), 2 *Max Planck Yearbook of United Nations Law* 73-95, 82.
[14] Stephen MacFarlane and Yuen Foong Khong, *Human Security and the UN. A Critical History* (Indiana University Press, 2006), 141, 226.

to inform institutional policies, programmes and practices at the international and national levels.[15] The central role played by medical and public health expertise in finding the best means to achieve these goals is hereby known as 'medicalization'.[16]

By following the broader concept of human security, the normative goals of global health can converge with those of the maintenance of international peace and security. Both areas have overlapped in the past, mainly in communicable disease control. The logic of international security has also been applied to the main instrument designed to tackle the cross-border spread of disease, the WHO's International Health Regulations.[17] However, security is not explicitly listed amongst this legal instrument's objectives and purposes.[18]

While certainly not the only actor at the international level to foster the process of global health securitization,[19] the SC can play and has played a central role in it.[20] Yet its trajectory is highly dependent on the shifting political goals of its members, particularly the veto-holding 'permanent five'. Therefore, coherence and consistency in its resolutions should not be taken for granted. That being said, there are visible recurring themes in how the SC has framed disease outbreaks as falling within its mandate. The SC´s global health securitization logic can be divided into two strands: 1) 'diseases within security', consisting of outbreaks emerging amidst pre-existing contexts of armed conflict or general instability; and, 2) 'securitized diseases', occurring when disease outbreaks are considered in and of themselves to be a threat to international peace and security due to their inherent destabilising effects.

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[15] Lawrence O. Gostin and Benjamin Mason Meier, 'The Origins of Human Rights in Global Health', in Benjamin Mason Meier and Lawrence O. Gostin (eds*.), Human Rights in Global Health. Rights-Based Governance for a Globalizing World* (OUP, 2018) 24, 38-39.

[16] Labelled as 'healthification' by Clare Wenham, 'The oversecuritization of global health: changing the terms of the debate' (2019), 95 *International Affairs* 1093-1110.

[17] The WHO's framing of the International Health Regulations as an issue of "global health security" is visible already in World Health Assembly Resolution WHA54.14, 21 May 2001, https://apps.who.int/iris/bitstream/handle/10665/78789/ea54r14.pdf?sequence=1&isAllowed=y

[18] See Article 2, International Health Regulations (2005).

[19] Steven J Hoffman, 'The evolution, etiology and eventualities of the global health security regime' (2010), 25 *Health Policy and Planning* 510-522.

[20] Ilja Pavone, 'Ebola and Securitization of Health: UN Security Council Resolution 2177/2014 and Its Limits', in Leonie Vierck, Pedro Villarreal, Katarina Weilert (eds.), *The Governance of Disease Outbreaks. International Health Law: Lessons from the Ebola Crisis and Beyond* (Nomos, 2017), 325-326.

HIV/AIDS: The SC's First Foray into Global Health

The SC's global health securitization logic in disease outbreaks has been present since Resolution 1308 (2000),[21] the first focused on an ongoing pandemic. The resolution's preamble merely hinted at the strand of a 'securitized disease' in a hypothetical manner, since it considered that the HIV/AIDS pandemic poses a potential risk to stability and security "if unchecked". By contrast, the resolution more clearly referred to a 'disease within security', since its preamble underscored the link between the pandemic and "conditions of violence and instability". The operative paragraphs emphasized the danger posed by the disease to the operations of international peacekeeping personnel.[22] The resolution "encouraged" Member States to increase international cooperation.[23] Beyond issues of actual correlation, the following years did witness an increased funding by major powers for initiatives to tackle the HIV/AIDS pandemic.[24] However, no extraordinary measures to address the spread of disease were approved.

More than one decade later, SC Resolution 1983 (2011) once again focused on HIV/AIDS. Here, the preamble explicitly referred to the close link between the HIV/AIDS pandemic on one hand and conditions of armed conflict and instability on the other, thus falling more in the strand of 'diseases within security'. The resolution stressed the need to "curb the impact of the HIV epidemic in conflict and post-conflict situations". Notably, the resolution's operative part now pointed towards UN peacekeeping operations as "important contributors to an integrated response to HIV and AIDS".[25] The phrasing points to how fulfilling the normative goals of international peace and security was considered to be a contributing factor for tackling the effects of the HIV/AIDS pandemic.

Lastly, both SC resolutions on HIV/AIDS, the only ones so far, made multiple references to UNAIDS, a United Nations Programme directly instituted to steer the international response to the pandemic.[26] Reports issued by the programme's personnel were taken as a factual trigger for the debates leading to the SC's resolutions. This showed the potential of promoting an inter-institutional linkage between the SC and other UN bodies capable of providing medical and public health input.

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[21] United Nations Security Council, Resolution 1308 (2000), S/RES/1308.
[22] Ibid, paras. 1 and 2.
[23] Ibid., para. 4.
[24] Michael Selgelid, Christian Enemark, 'Infectious Diseases, Security and Ethics: The Case of HIV/AIDS' (2008), 22 *Bioethics*, 457-465, 458.
[25] United Nations Security Council, Resolution 1983 (2011), S/RES/1983, para. 4.
[26] Established by the United Nations Economic and Social Council (ECOSOC) through Resolution 1994/24, 26 July 1994.

The Ebola Crises: Deepening the Securitization of Global Health

The strand of a 'securitized disease' was at stake in the SC's actions during the 2014-2016 West African Ebola crisis. The inability of national authorities from Guinea, Liberia and Sierra Leone to stem or mitigate the spread of the Ebola virus, as well as the WHO's delayed response in declaring it a public health emergency of international concern, led to the collapse of the already fragile healthcare systems in these three countries. The situation risked destabilising the region, since the magnitude of the Ebola outbreak was viewed as a potential source of civil unrest and severely deteriorating national institutions, including those related to security.[27] The SC's response was Resolution 2177 (2014), in which the Ebola outbreak itself was declared to be a threat to international peace and security – although no specific actions under Chapter VII of the UN Charter were undertaken.

The extent of the West African Ebola crisis fostered the deployment of international personnel to aid in the response. Although foreign security forces did not implement coercive public health measures, such as *cordons sanitaires,* directly upon the population, they nevertheless provided logistical and coordination assistance to domestic actors doing so.[28] This raised the legal question of whether the participation of security forces meant they could no longer be considered as "health measures", since these are defined in Article 1 of the WHO's International Health Regulations as 'not includ[ing]…security measures'.

Conversely, the strand of 'diseases within security' was once again at stake in the more recent Ebola outbreak in the Democratic Republic of the Congo (DRC). A longstanding armed conflict in the country has led to effective control over certain parts of its territory, namely in the east, being highly contested between state authorities and non-state actors. In fact, the United Nations Organization Mission in in the DRC (MONUC) was first deployed to the country's territory in the year 1999 to undertake peacekeeping operations.[29] In summer 2018, a new Ebola outbreak was identified in the eastern province of North Kivu, precisely at the core of the armed conflict. Medical personnel, including from

[27] Robert Frau, 'Combining the WHO's International Health Regulations (2005) with the UN Security Council's Powers: Does it Make Sense for Health Governance?', in Vierck, Villarreal and Weilert (n. 20), 341-342.
[28] Adam Kamradt-Scott, Sophie Harman, Clare Wenham, Frank Smith, *Saving Lives: The civil-military response to the 2014 Ebola outbreak in West Africa* (University of Sydney, 2015), 13-17, https://ses.library.usyd.edu.au/handle/2123/15949
[29] United Nations Security Council, Resolution 1279(1999), S/RES/1279, para. 4.

international institutions such as the WHO, was in need of security assistance when joining the Ebola response in the country.[30]

The SC took action on the matter by incorporating the medical and public health activities related to the Ebola outbreak in the DRC in Resolution 2463 (2019). On this occasion, the spread of the virus was an event embedded in a pre-existing threat to international peace and security. The same resolution also extended the mandate of the Mission of the United Nations Stabilization Mission in the DRC (MONUSCO), MONUC's successor.[31] Chapter VII measures were included in the form of an arms embargo against non-state actors. As MONUSCO overtook the operational control of humanitarian activities in the northeast region of the DRC, Ebola containment efforts, including by the WHO, were subsumed in the broader peacekeeping operations.

It is not clear to what extent the actions taken by the SC to tackle the recent Ebola outbreak in the DRC could be replicated in other settings, even those involving the same virus. Not all Ebola outbreaks after the 2014-2016 West African debacle have prompted action by the SC.[32] This shows how securitizing an outbreak is contingent upon other factors, including how severe a disease may be, or whether it is present in a conflict or post-conflict setting.[33] Accurately determining whether and when a disease outbreak warrants specific action by the SC requires input related to the nature of a pathogen as well as the best means to tackle it. The most effective tools lie in the fields of medicine and public health.

Precisely on the last point, an open question regarding the SC's COVID-19 resolution is how previous instances of both 'diseases within security' and 'securitized diseases' could shed light on how to devise tools for current and future similar events. Delving deeper into the multiple epidemiological distinctions between HIV/AIDS, Ebola and COVID-19 can provide insights on some of the best practices, which could help adjust the SC's actions to diverse settings. In the COVID-19 resolution, the rationale employed by the SC in calling for a global ceasefire falls more in the remit of a 'disease within security', since an emphasis was placed on pre-existing situations of armed conflict or humanitarian crises.[34]

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[30] Jennifer Nuzzo and Thomas Inglesby, 'Ramping Up the Response to Ebola' (2018), 379 *New England Journal of Medicine* 2490-2491.
[31] United Nations Security Council, Resolution 2463(2019), S/RES/2453, para. 21.
[32] World Health Organization, Ebola virus disease (10 February 2020), https://www.who.int/news-room/fact-sheets/detail/ebola-virus-disease
[33] Robert Frau, 'Combining the WHO's International Health Regulations (2005) with the UN Security Council's Powers: Does it Make Sense for Health Governance?' in Vierck, Villarreal and Weilert (n. 20), 348.
[34] United Nations Security Council Resolution 2532 (2020), paras. 4-5.

The COVID-19 Pandemic and the Need for a Medicalization of Security

There have been instances of synergies between, on one hand, the maintenance of international peace and security and, on the other hand, global health. Nevertheless, there are also risks inherent in the overreliance on the global health securitization logic. For starters, the overlap between issues of international peace and security and those of global health do not result in a fully balanced relation. In light of the SC's core mandate, a rationale of international peace and security must take precedence in its actions. The risks of overshadowing the global health dimension through its securitization was the subject of analysis in the years following SC Resolution 1308 (2000) on HIV/AIDS.[35] As highlighted elsewhere, overly resorting to the logic of security to tackle disease outbreaks can blur the underlying health dimension, thus being counterproductive.[36]

Despite the unbalanced relationship, securitization should not necessarily lead to fully obscuring the normative goals of global health. Even if actions are mainly striving towards the maintenance of peace and security, medical and public health expertise can and has played a key role in this endeavour. For instance, the use of foreign military personnel in 2014 during the Ebola crisis was aimed at assisting with the logistical coordination of public health measures by domestic military and police forces. One of the main objectives was to keep the virus from spreading across borders. The proper implementation of these interventions has an inevitable medical and public health dimension, which in turn is informed by the rights-based approach of global health.[37]

The SC resolution on COVID-19 of July 2020 focused on how the pandemic exacerbates pre-existing situations of armed conflict or humanitarian crises. This reasoning falls in line with the strand of 'diseases within security'. But so far, it is unclear whether deeming COVID-19 itself as a threat to international peace and security, under the strand of 'securitized diseases', would bring any major benefits. The multidimensional magnitude of the ongoing pandemic far exceeds the remit of international peace and security. Actions taken exclusively on the basis of this logic will fall short of the comprehensive solutions needed to face the crisis.

[35] Stefan Elbe, 'Should HIV/AIDS Be Securitized? The Ethical Dilemmas of Linking HIV/AIDS and Security' (2006), 50 *International Studies Quarterly* 119-144, 129.
[36] Wenham (n. 16), 1109-1110.
[37] Brigit Toebes, 'States' Resilience to Future Health Emergencies: Connecting the Dots between Core Obligations and Core Capacities' (2020), 9 *ESIL Reflections*, https://esil-sedi.eu/esil-reflection-states-resilience-to-future-health-emergencies-connecting-the-dots-between-core-obligations-and-core-capacities/

If the SC were to address the COVID-19 crisis in the future, the argument could be made for incorporating the normative insights from global health. Any novel tools in the form of legally binding measures under Chapter VII need to be conducive to the effective containment of COVID-19. Thus far, there is no clear indication on what exactly the SC can do against COVID-19 as a whole. In order to solve this puzzle, input from the medical and public health communities is required to identify the best possible responses at the international level. Otherwise, if they do not have any basis in the normative premises of global health, binding measures by the SC to tackle pandemics risk being myopic.

Resorting to the international institution with the core mandate in the area of health, the WHO, would seem like an obvious step for drawing specialized input. But much like the SC´s deliberations, the WHO´s own assessments are not always isolated from tending towards the political will of its Member States. For example, during the 2014-2016 West African Ebola crisis, the WHO's statements on the severity of the outbreak were deferent towards the reluctance of the national governments of Guinea and Sierra Leone towards sounding the global alarm.[38] Similarly, as is often the case in international institutions, geopolitical tensions may lead to blocking effective cross-fertilization. Controversies related to the accusation by the government of the United States, one of the "permanent five" veto-holding members, against China, another veto-holder, and against the WHO, clearly spilled over to the debates on COVID-19 within the SC.[39] Such an adverse political background may easily undermine any possibilities of inter-institutional cooperation.

In sum, caution against the mystification of the SC's powers *vis-à-vis* COVID-19 should be exercised. Ultimately, its actions can be effective only in so far as the Council members can accurately grasp both the nature and scope of the dire health threat posed by the global spread of a communicable disease, as well as the most appropriate responses. Without insights from the area of medicine and public health, this can hardly occur. In such a setting, the SC runs the risk of doing more harm than good through its future resolutions.

Cite as: Pedro Villarreal, 'The Security Council and COVID-19: Towards a Medicalization of International Peace and Security', ESIL Reflections 9:6 (2021).

[38] Adam Kamradt-Scott, 'WHO's to blame? The World Health Organization and the 2014 Ebola outbreak in West Africa' (2016), 37 *Third World Quarterly* 401-418, 408-409.
[39] Pobjie (n. 11)2.