Editorial

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Editors' Introduction: The Politics of Infectious Disease

Duncan McLean

Senior Researcher, Unité de Recherche sur les Enjeux et Pratiques Humanitaires (UREPH), Médecins Sans Frontières – Switzerland; duncan.mclean@geneva.msf.org

Michaël Neuman

Director of Studies, Centre de Réflexion sur l'Action et les Savoirs Humanitaires (CRASH), Médecins Sans Frontières – France; michael.neuman@paris.msf.org

The 1577 Oxford trial of Rowland Jenks for the dissemination of 'Popish' books was not unusual for the period. Large crowds attended the proceedings and the bookbinder was duly condemned – comparatively lightly given the context of religious fervour and persecution – with his ears being either removed or nailed to the local pillory depending on the source. While Jenks survived the ordeal, many of the trial attendees were less fortunate. With deaths from 'jail fever' vastly outweighing those succumbing to corporal punishment, filthy prison conditions inevitably overflowed into packed courtrooms. In this case several hundred people died from 'Jenks' curse' with the culprit now assumed to be the body louse, a key vector for the transmission of typhus (Martin, 2015: 144–5).

This curious anecdote, well-known among medical historians and certainly obscured by legend, provides an apt illustration of the intersection between infectious disease and the surrounding political environment, particularly when subsequent developments are considered. The dominant medical paradigm of the day deemed that *miasma*, essentially foul odours, was responsible for the propagation of illness. While this resulted in the ostentatious display of various aromatic herbs, garlic and so on, improved ventilation – be it in courtrooms, prisons or poor urban dwellings – was largely ignored. Compounding the problem was the subsequent establishment of property taxes based on the number of windows in a structure, notably in England and France. Over the course of the eighteenth and nineteenth centuries bricked-up windows became a common sight, facilitating the spread, not only of typhus, but other diseases of proximity such as tuberculosis and typhoid (Hays, 2009: 162–8).

History is littered with such examples of infectious disease impacted by politics, often to the detriment of those most exposed. To take but a few cases, it is impossible to grasp the rationales used during the Atlantic Slave Trade without tracing the corresponding voyages and reproductive habits of the female *Aedes aegypti*, the mosquito responsible for transmitting yellow fever and for which Africans were conveniently considered immune (Watts, 1999: 228–9); nor is it possible to understand the role of colonial medicine in the 'Scramble for Africa' without decrypting later boasts such as that from the French Governor of Morocco who intended to 'cure the diseases that for so long have corrupted this people' (Rieff, 2002: 63). In pure geopolitical terms, nineteenth century sanitary debates between contagionists and anti-contagionists often took on nationalistic tones, pseudo-scientific interpretations of quarantine regulations conveniently hinging on perceived benefits (or lack thereof) from free trade and eventual access to the Suez Canal (Chakrabarti, 2014: 85–6).

Contemporary examples are likewise not hard to come by. The portrayal of migrants, irrespective of their status, as harbingers of disease recalls not only the coffin ships of the Irish famine but the xenophobia and restrictive border controls that the arrival of the 'unwashed masses' ostensibly justified. The sudden appearance of cholera in post-earthquake Haiti might have its origins in the sanitary negligence of United Nations peacekeepers, but the subsequent abdication of responsibility was entirely political (Katz, 2016). While the murder of polio vaccinators in Pakistan is cloaked in anti-Western conspiracy theories, there is also a broader scepticism that questions the priorities of international donors, not to mention a clear political

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failure on the part of the State, that should not be glossed over (Khan and Constable, 2019).

It was with this rich and often tragic historical background in mind that the *Journal of Humanitarian Affairs* published a call for papers in January 2021 on the politics of infectious disease. The collective experience of COVID-19 has certainly sharpened the mind, notably around why some individuals and communities have proved more vulnerable than others. Indeed, during the early stages of the pandemic noble aspirations that 'we are all in this together' emerged, essentially that the disease knew no politics or borders (United Nations, 2020). Unsurprisingly, reality has proven more complicated, with both risk and mortality unevenly distributed, as ever much like the wielding of wealth and power.

As we have seen over the past two years, however much scientific and data-based rationales are pushed to the fore, public health approaches also reflect the domestic priorities and biases of those who designed them. Strategies to deal with infectious diseases are likewise susceptible to political interests. Again, the varying national health plans and related discourse around the COVID-19 pandemic are a case in point. There are multiple examples, a few of which have been briefly mentioned, that provide similar illustrations. And as concerns this journal, the humanitarian sector faces its own challenges when navigating the global health environment and responding to outbreaks of infectious disease.

The first contribution to this issue is a research article by Myfanwy James *et al.* that digs through the debates surrounding Ebola vaccine trials in the eastern Democratic Republic of Congo. The focus is on the introduction of a second experimental vaccine and the related ethical dilemmas of doing so in an epidemic context. The authors clearly place the medical response in its historical and political context, exposing and exacerbating 'a profound sense of distrust in the central government and foreign intervention, which was linked to the region's history of political marginalisation as well as contemporary political upheaval and violence'. The anthropological rather than classic bioethical approach is particularly revelatory, treating the study subjects as 'interlocutors in ongoing global ethics debates, not mere objects of ethical responsibility'. And the conclusions are instructive, emphasising the need to recognise the basis of 'local popular critiques', especially relevant given current debates and controversies linked to COVID-19 vaccination.

This is followed by a field report from the same area and period. Natalie Roberts offers a perspective very much based on Médecins Sans Frontières' (MSF) experience. Building on perceptions within and outside the organisation that MSF's Ebola intervention in West Africa 'had been an overwhelming success', she is harshly critical of the results achieved in North Kivu. Much like the previous article, she points to 'political, social and economic grievances' that crystallised around a response where the population suffered from 'long-standing health needs, the cancellation of the elections, and coercive practices of the armed forces and police'. However, this is hardly helped by MSF's own contradictions in adopting the World Health Organization's approach of 'go big and go fast' and attempting to maintain relevance to an increasingly controversial response strategy, all the while struggling to preserve a degree of independent action that held no interest to local power brokers.

A second field report by Ximena Di Lollo *et al.* returns to the COVID-19 theme, highlighting the challenges of designing an emergency intervention for a particularly vulnerable and, at least early in the first wave of the pandemic, forgotten population. Care home residents reportedly accounted for up to half of all COVID-19-related deaths in Spain over the first half of 2020. In describing MSF's activities pre-existing factors come to the fore, a precarious situation exacerbated by the pandemic. In this regard, the authors point to a fragmented system combined with 'years of neglect, privatization, and underinvestment' that led to care home residents 'falling through the cracks'. The report concludes with recommendations aimed at ensuring that 'the most at risk are not left behind'.

These accounts from the field describing underlying structural and political constraints when responding to disease outbreaks contrast with a roundtable interview conducted by Elba Rahmouni. The interviewees discuss the political, scientific and operational challenges in a relatively successful HIV project managed by MSF and the Ministry of Health in Ndhiwa, Kenya. In describing the implementation of innovative strategies and care models at the local level, the broad evolution of the HIV pandemic is charted: from early stigmatisation to multibillion-dollar funding to current ambitions of elimination. In pushing treatment as a means of prevention, large question marks are nevertheless highlighted, notably the sustainability and replicability of the project.

Both the DRC Ebola vaccine trial and Ndhiwa 'treatment cascade' strategy were interrupted by restrictions imposed as a result of COVID-19. Lachlan McIver *et al.* contribute an editorial that decries a more nefarious side, an increase in illness and death as a direct consequence of 'policies and political decisions made in relation to the COVID-19 pandemic'. More specifically the authors point to a range of neglected tropical and non-communicable diseases where indicators of excess mortality are already emerging. They conclude

with a plea to address 'health problems that have been overlooked and amplified' during the current crisis, and warn of the likelihood of a repetition as new infectious diseases emerge.

Stepping back from the politics of infectious disease, a research synthesis and book review are included in this issue. Aditya Sarkar *et al.* provide an overview of longstanding work on the *political marketplace framework* (PMF) and mass starvation, aimed at improving humanitarian analysis, early warning and response. The PMF highlights the role of transactional politics over formal rules and institutions in forms that are 'monetized and coercive, often overtly violent'. By referencing multiple case studies where mass starvation has emerged as a key humanitarian consequence, the authors point to PMF as 'one tool among several' for understanding politics and organised violence. At the very least, applying this analytical framework 'can help improve humanitarian information and early warning systems, as well as programme decision-making, while helping humanitarians think more carefully about the constant trade-offs they are forced to make'.

In a final contribution Jeffrey Flynn reviews two books, *Humanitarian Photography: A History* (2015) and *The Biafran War and Postcolonial Humanitarianism: Spectacles of Suffering* (2017). While his commentary on ethical questions over the use of images is particularly salient today, almost as striking are his observations on how the challenge of framing human suffering 'has been debated ever since the pain of others could be captured on camera'. The pitfalls of humanitarian imagery are thus noted, as are the risks of simplifying complex situations in paternalistic images of innocent victims. More recent attempts at reconciling such contradictions are given a mildly hopeful conclusion, that the broad spectrum of humanitarian photography has provided a painful but necessary 'record of our inhumanity'.

In this issue, both the special section on the politics of infectious disease, and the other contributions, highlight and return to concerns that have long plagued humanitarianism. For example, all the contributions give insight into the need to understand the political context in which humanitarianism operates, whether to deliver medical care, to prevent aid being co-opted, or to ensure the dignity of aid recipients used by agencies in their fundraising and communications. This issue is an important and timely reminder that politics matter in any humanitarian response, not least when dealing with infectious disease.

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