

To my grandmothers,

Necla and Hacer



GLOBAL HEALTH GOVERNANCE, SOVEREIGNTY AND SECURITY:
CONSTRUCTING THE CASE OF EBOLA

A Master's Thesis

by
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Ankara
June 2016

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CONSTRUCTING THE CASE OF EBOLA

The Graduate School of Economics and Social Sciences
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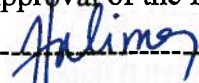
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ABSTRACT

GLOBAL HEALTH GOVERNANCE, SOVEREIGNTY AND SECURITY: CONSTRUCTING THE CASE OF EBOLA

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The 2014-2015 Ebola Crisis in Western Africa was the most severe outbreak of Ebola in recorded history. The individual governments of the affected countries were ill-equipped in controlling and mitigating Ebola. The prominent global actor, the World Health Organization (WHO), responsible for the global health provision immediately declared Ebola outbreak as public health emergency of international concern (PHEIC). Such frame was also utilized by the United Nations Security Council (UNSC) as the members of the Council declared Ebola outbreak a security threat to international peace and security. Such use of a security framework regenerated debates regarding the efficacy and comprehensiveness of the global health governance. To understand how and why a security discourse informed the ways in which the global efforts were mobilized throughout the Ebola Crisis, this

research attempts to elicit a historical overview of the processes through which the global health governance were reformed since the end of the Cold War. The main argument is that since the years of the gradual reformation of the global health governance regime, a security discourse permeated the institutional discourses and apparatuses of the WHO. Such occurrence was a result of the expanding security agendas of the leading Western powers which found purchase at the WHO headquarters. Challenging the prioritization of the national security agendas over human security, this research offers a theoretical resistance point through re-reading Realism in International Relations to argue the case for the prioritization of the human security over the national security.

Keywords: Ebola, Global Health Governance, Realism, Security, Sovereignty

ÖZET

KÜRESEL SAĞLIK YÖNETİMİ, EGEMENLİK VE GÜVENLİK: EBOLA VAKASI

DAĞÇINAR, Sarp Şamil

Yüksek Lisans, Uluslararası İlişkiler Bölümü

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2014-2015 yılları arasında Batı Afrika’da ortaya çıkan Ebola krizi son yıllarda kaydedilen en ağır Ebola salgınlarından biri oldu. Salgından etkilenen ülkelerin hükümetleri, hastalıkla başa çıkmak ve hastalığı kontrol altına almak için gerekli altyapıya sahip değildiler. Küresel sağlık yönetiminden sorumlu olan aktör, Dünya Sağlık Örgütü, Ebola salgınını uluslararası ölçekte bir kamu sağlık sorunu olarak adletti. Benzer bir yol izleyen Birleşmiş Milletler Güvenlik Konseyi, Ebola salgınının uluslararası barışa ve güvenliğe bir tehdit oluşturduğunu açıkladı. Güvenlik söyleminin bu şekilde kullanımı, küresel sağlık yönetiminin kapsamı ve yeterliliğiyle alakalı olan tartışmaları tekrar gün yüzüne çıkardı. Güvenlik söyleminin Ebola krizine yönelik olarak oluşturulan küresel politikaları nasıl ve neden etkilediğini anlayabilmek için, bu araştırma Soğuk Savaş’tan bu yana küresel sağlık

yönetiminin tarihsel oluşumunu inceler. Ana sav, küresel sağlık yönetiminin reform yıllarının ilk günlerinden bu yana bir güvenlik söyleminin etkisi altında kaldığını iddia eder. Güvenlik söyleminin bu denli kullanımı, lider güçlerin güvenlik ajandalarının genişlemesi ve yeni güvenlik söyleminin Dünya Sağlık Örgütü bürokrasisinde kabul görmüş olmasından dolayıdır. Ulusal güvenlik söyleminin birey güvenliğinin önüne geçmesini eleştirerek, bu araştırma Uluslararası İlişkiler’de Realizm’in tekrar okuması üzerinden, birey güvenliğinin öne çıkması için teorik bağlamda bir karşı çıkış önerir.

Anahtar kelimeler: Ebola, Egemenlik, Güvenlik, Küresel Sağlık Yönetimi, Realizm

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TABLE OF CONTENTS

ABSTRACT.....	i
ÖZET.....	iii
ACKNOWLEDGEMENTS.....	v
TABLE OF CONTENTS.....	vii
LIST OF ABBREVIATIONS.....	ix
 CHAPTER I - INTRODUCTION.....	 1
1.1 Framing: The Object(s) of Analysis and Research Question.....	3
1.1.1 The Starting Point: Where to Intervene in the Debate.....	5
1.1.2 How to Conceptualize Health.....	7
1.1.3 The Case Study: Ebola Crisis in 2014-15.....	10
1.2 Theoretical and Methodological Stance: Do You See What I See?.....	11
1.3 Structure of the Research: The Chapters.....	16
 CHAPTER II - GLOBAL HEALTH GOVERNANCE: THE ANALYTICAL MAKING OF THE GLOBAL HEALTH SECURITY.....	 19
2.1 Introduction.....	19
2.2 Health Gone Global: Different Levels of Analysis.....	21
2.2.1 A Brief Historical Overview of Internationalization of the Health.....	21
2.2.2 Analytical Approaches: Global Health to Global Health Security.....	23
2.3 National Security and Global Health.....	27
2.3.1 Changing Political Leverage: National Health Strategies to Global Health Security.....	27
2.4 From National to International and Global Security.....	30
2.5 Securitization Theory and Health.....	34
2.5.1 The Intersection of Security and Health.....	34
2.5.2 Securitization Theory.....	35
2.5.3 Securitization Theory and Health: A Hybrid Approach.....	38
2.6 Conclusion.....	39
 CHAPTER III - GLOBAL HEALTH SECURITY: A GENEALOGICAL INQUIRY (1992-2013).....	 41
3.1 Global Health Security Narrative: A Process or Isolated Acts.....	41
3.2 Global Health Security: The Construction of the Regime.....	44

3.2.1 The Introduction of the Emerging Infectious Disease Narrative (1992-1995).....	45
3.2.2 The Great Leap Forward: The WHO Behind the Wheel (1996-2000).....	54
3.2.3 The IHR Revision Process: Who Is Part of the Cure? Who Is Part of the Disease? (2001-2005).....	58
3.2.4 Before Ebola, After the IHR: Sovereignty's Changing Nature.....	68
3.3 Conclusion.....	70
CHAPTER IV - GLOBAL HEALTH SECURITY AND BIOPOLITICS: THE CASE OF EBOLA.....	72
4.1 Introduction.....	72
4.2 Ebola Virus Disease: The Lineages Between the Present and the Past.....	76
4.2.1 On the WHO Statement on the First Meeting of the IHR Emergency Committee on the 2014 Ebola Outbreak in West Africa - August 8, 2014.....	78
4.2.2 On the Identical Letters Dated 17 September 2014 From the Secretary-General to the UN to the President of the General Assembly and the President of the Security Council	83
4.2.3 On the United Nations Security Council Resolution 2177	85
4.2.4 Global Health Security Narrative: National Security to Biopolitics.....	86
4.3 Global Biopolitics.....	91
4.4 Conclusion.....	100
CHAPTER V - HUMAN SECURITY MUST BE DEFENDED: WILFUL REALISM.....	102
5.1 State, Security and Sovereignty.....	104
5.1.1 Human or National Security?.....	104
5.1.2 Wilful Realism: Understanding the Essence of Sovereign Power.....	106
5.1.3 The Prominence of the Human Security: Hobbes' Referent Object.....	108
5.1.4 Wilful Realism and Hobbes' Individual: What Do They Have to Offer Regarding the Global Health Security.....	110
5.2 Conclusion.....	114
CHAPTER VI - CONCLUSION.....	116
6. 1 The Thematic Focus: What Has Been Argued?.....	116
6.2 The Future of Global Health Governance: Still Security?.....	119
BIBLIOGRAPHY.....	121

LIST OF ABBREVIATIONS

CBRN	Chemical, Biological, Radiological and Nuclear Agents
CDC	Centers for Disease Control and Prevention
CIA	Central Intelligence Agency
EID	Emerging Infectious Diseases
EVD	Ebola Virus Disease
GOARN	Global Outbreak Alert and Response
GPHIN	Global Public Health Intelligence Network
IHR	International Health Regulations
IOM	United States Institute of Medicine
MSF	Médecins Sans Frontières
PHEIC	Public Health Emergency of International Concern
UN	United Nations
UNMEER	United Nations Mission for Ebola Emergency Response
UNSC	United Nations Security Council
WHA	World Health Assembly
WHO	World Health Organization

GLOBAL HEALTH GOVERNANCE, SOVEREIGNTY AND SECURITY: CONSTRUCTING THE CASE OF EBOLA

CHAPTER I INTRODUCTION

[...] when making sense of issues of health/disease, one should go beyond the immediate effects on individual bodies and the impact on mortality levels, life expectancy, productivity or GDP. Rather, one needs to consider the impact of disease upon the ways in which communities and societies are organized.

(Nunes, 2014: 1)

The United Nations Security Council (UNSC) convened in New York City on September 18, 2014 to discuss the plausibility of prospective actions to be taken in response to the Ebola crisis (Kim, 2014). Resolution 2177 passed unanimously, while the leading bureaucrats of the United Nations called for collaborative action in this emphatic fight against the epidemic (“Ebola Outbreak a Threat to World Peace,” 2014). The same day, another event unfolded in a remote village in Guinea as the inanimate bodies of eight civil servants, who had been murdered, were discovered by the Guinean authorities. The local residents of the village did not welcome the arrival of the officials who had come to the area with the very intention of relieving the locals of the fear caused by the disseminated disinformation gripping the region about Ebola (Callimachi, 2014). The delegation had been stoned to death because the locals feared that the outsiders might actually have brought the Ebola virus to the town (Gostin and Friedman, 2014: 1323).

These events are representations of subjects of interest discussed throughout this research. In other words, these incidents manage to summarize, albeit quite crudely, the inner dynamics of the policy-making processes at the macro level and

their repercussions in various micro and meso socio-political settings which are intrinsic to the debates surrounding contemporary global health governance. The events occurred on the same day about the very same issue, yet the reactions were considerably different from each other. On the one hand, an alarming re-emergence of an infectious disease caught the attention of the bureaucrats working at the prominent international organization that is responsible for overseeing the international security. On the other hand, the incident at the Guinean village is representative of real-life repercussions of global health policies, epitomizing the extent to which the sets of policies prescribed at the macro level resonate with the micro level of socio-political reality.

Both occurrences, representing different levels of socio-political reality, are subjects of inquiry that have been striking academics and policy-circles. Depending on their research questions and the objects of studies, researchers often approach issues from different perspectives that generally inform the processes through which research is designed, the data set are located and methodological approach is deployed. In essence, the way that an issue is studied in any discipline is immensely affected by how the issue at stake is framed by the researcher. In case of an acute crisis, such as the Ebola outbreak, perhaps the question of framing becomes more important because how an issue is framed seems to determine the way in which the problem is mitigated. In other words, the way a problem is addressed by policy-makers, bureaucrats and academics essentially impels and informs the course of policy-making, action and research. In some cases such as the Ebola crisis, where the issue at stake is actually a matter of life and death, the actors are required to make quick decisions with regard to the course of action. Often the time-span of the framing interval seems to be outweighed by the severity of the issue itself because

sometimes the question becomes, “As poor people get sick and die in great numbers, should the tragedies be considered humanitarian, developmental, or security?” (Chen, 2004: 5). Yet, the case of Ebola did not really precipitate any discussion as stated by Chen (2004) regarding the conceptualization of an action plan, as the global health governance regime already had been operational long before the 2014 Ebola outbreak. The current governance rationale and apparatuses of global health governance had been in the making since the early-1990s, since its inception in 1992 with the publication of the U.S. Institute of Medicine’s (IOM) *Emerging Infections: Microbial Threats to Health in the United States* (Weir and Mykhalovskiy, 2010: 38; Weir, 2015: 19). Thus, the prominence of the security framework among other possible frames appears to already have been designated with the inception of the new global health agenda with the lobbying efforts of the public health practitioners and policy circles in the United States in 1992.

Struck by the humanitarian cataclysm induced by the Ebola outbreak and its relationship with the different aspects of the socio-political reality, ranging from the United Nations (UN) policy-circles to national policies, from the efforts of non-governmental organizations to the Ebola-struck villages, this research aims at understanding the processes through which such a catastrophe occurred in the first place given the already present establishment of a global health security regime. Moved by such a puzzle, the next section briefly introduces the *problematique* of this research project.

1.1 Framing: The Object(s) of Analysis and Research Question

The process that led to the formation of the research question has been quite arduous as it has been the case with almost every research project. While the starting point of

this research has been the contemporary catastrophe in Western Africa which, was induced by Ebola, a research project aimed at understanding the processes through which such a catastrophe occurred in the first place requires an intricate analytical endeavor. Even though a clear research question is formulated that encompasses the sub-questions that has been answered throughout this research, I believe introducing the initial inquiries benefit the reader as these sub-questions are inextricably linked to the main question that this research attempts to answer.

The sub-questions can be outlined as follows: What does it mean to use a security discourse? What happens when an epidemic is framed as a security threat? What is the difference between using a humanitarian discourse and a security one? Whose security is at stake when the issue is framed as such? Is the security discourse the most viable option for elaborative action? What may be the unanticipated ethical repercussions, if any, of associating the issue of health with security? Distilling the themes of these sub-questions, the main research question is formed as follows: How and why did the contemporary global health governance regime liaise with the security rhetoric which culminated during the 2014-2015 Ebola outbreak? What this research pursues does not aspire to provide a definitive answer to the question above. Rather, the intention is to underscore the importance of understanding the effects of discursive frameworks on real life practices (Aradau *et al.*, 2015: 6). Elaborating on such an undertaking, this study approaches the Ebola crisis as a case study with the intention of comprehending the real-life deployment of the global health security narrative.

1.1.1 The Starting Point: Where to Intervene in the Debate

Even though there is a plethora of research on the phenomenon of global health governance, an article stands out amongst the others with its emphasis on the ethical repercussions of the utilization of a global health security narrative. Elbe's (2006) treatment of HIV/AIDS in congruence with the real-life effects of the global health security narrative is methodologically, analytically and normatively quite informing as an entry point to the literature. Acknowledging the benefits of linking the pandemic of HIV/AIDS to security, Elbe (2006) underscores two normative setbacks. He argues that the security frame "could push national and international responses to the disease away from civil society toward state institutions" which have the power to undermine civil liberties (Elbe, 2006: 120). Such a move could produce a "threat-defense logic" which may make the "efforts not a function of altruism" but a function of national interest by allowing the donor states to channel more funds for their military spending (Elbe, 2006: 120). Elbe's normative concerns are reflected in the case of Ebola as well. A similar reservation has been noted by McInnes (2008: 286) as he argues that the health agenda until now "has been dominated by national security concerns, and particularly those of the West, such that the WHO's (World Health Organization) term global health security is in danger of meaning the national security of Western states from health risks rather than the promotion of well-being globally."

With this background, this thesis particularly examines the extent to which the global health governance that had been developing since 1992 had an effect on the policy-prescriptions of the WHO and the UN regarding the mitigation of the recent Ebola outbreak. The main argument is that the global health governance

tremendously affected the ways in which the Ebola outbreak was perceived by the policy-makers at the WHO and the UN headquarters. Elaborating on this theme, this paper asserts that global health governance has affected the international reception of the Ebola outbreak in at least three ways. The first one is that since the inception of global health governance in the early-1990s, the regime was infused with a security narrative which was aggravated with the frequent cases of emerging infectious diseases such as avian influenza, swine influenza and already existing pandemics such as HIV/AIDS in the 2000s. In addition to these concerns, the ascending fear of the intentional release of chemical, biological, radiological and nuclear agents (CBRN) after the 2001 anthrax attacks at several US governmental institutions, intensified the juxtaposition of global health with security. Such imposition generally had been sponsored by a North-Atlantic alliance, led by the United States. The initial security language was essentially integrated within the UN system through the lobbying efforts of some American public health officials and policy-makers (Weir, 2015). What was deemed as a national security concern amongst the policy-circles in the United States and Canada essentially informed the ways in which the WHO's institutional reformation and its mandate were reshaped. In relation to this, the second point propounds that the institutional apparatuses that had been designed with the WHO's reformation appear to embed a certain degree of Western-centrism which raises doubts over whose security the global health security regime is really overseeing. The third point introduces a discussion on global biopolitics to demonstrate how the strategies of the WHO and the UN carry out an embedded biopolitical approach that is implicitly attached to securitization efforts.

This study is an attempt to outline the reasons upon which the global health governance has liaised with the security rhetoric. This section answers the questions

of how and why the contemporary global health governance liaised with the security rhetoric. The initial assertion is that since the first attempts of the reformation of the global health governance in 1992, a security narrative had been deployed and infused into the apparatuses of the WHO's global surveillance regime. The research engages with the processes through which such an undertaking took place and analyzes the effects of the global health security narrative on the case of 2014-2015 Ebola outbreak. The last section of Chapter IV approaches the global health security narrative through a Foucauldian perspective. The argument is that the real life repercussions of the global health security narrative have increasingly embedded an implicit rationale of biopolitics.

1.1.2 How to Conceptualize Health?

Global health is still a contested term as to what it really encompasses. The concept has been under scrutinized with multiple assigned meanings in the literature. Consequently, the way the terms 'global' and 'health' are conceptualized by academics and policy-makers appear to have a tremendous effect on formation of the policy prescriptions regarding an issue. Benatar and Upshur (2013: 13) outline at least six possible connotations of global health. These are global health (i) as an attempt at measuring the health condition of the entire human population, (ii) with an activist agenda aimed at overseeing the health of all, (iii) as the provision of the health of the people who suffer from disease, and (iv) as an environmentalist approach to "sustain a healthy planet" (Benatar and Upshur, 2013: 13). The remaining conceptualizations of (v) global governance of health and (vi) global social justice regarding health constitute the foci of this research project. The former has been intertwined with a security narrative since its reformation in the 1990s (Price-Smith, 2002) whereas the latter has been discussed by appeals to different

philosophical precepts ranging from the works of Foucault (Elbe, 2005; 2006; 2010) to Rawls (Daniels, 2012). The emphasis of this research is in line with the former conceptualization that centers on the delineation of the processes through which a security narrative is infused into the reformation of the new global health governance. The main aim is to demonstrate how the global health governance regime had been imbued with a security narrative and what repercussions such action had on the global reception of Ebola, which sets the tone for the first three chapters. The last chapter engages with the global justice theme from a theoretical point of view. Problematizing the theoretical conceptualizations of the nexus of sovereignty-state-security transcribed within the global health security debate, the final chapter attempts to establish a theoretical resistance point in favor of the composition of a more humanitarian narrative on the global governance of health. A detailed explication of the subsequent chapters are included at the end of the Introduction.

Firstly, to comprehend the present situation of global health governance and how it has been dominated by a narrative of security, understanding the history of the formation of the current regime is vitally important. The initial intellectual ethos that led to the reformation of the current global health governance regime stemmed from the concerns of some public health officials and policy-makers in the United States (Price-Smith, 2002: 122-123). There had been a global health governance regime prior to its gradual reformation in the 1990s, labeled as “the classical regime,” which can be conceptualized as an earlier form of global health governance between 1851 and 1951 that obliged states to “notify each other about outbreaks of specified infectious diseases” and “limit disease-prevention measures that restricted international trade and travel” (Fidler, 2005: 327-328). Yet, the classical regime declined between the years of 1951 and 1981 as a result of its constricted scope, its

unresponsiveness to the changes in the socio-political reality, the lack of political attention given to the international monitoring of infectious diseases, and the lack of compliance with the regulatory frameworks such as International Health Regulations (Fidler, 2005: 334-335).¹ However, although all these reasons had an effect on the marginalization of the classical regime, the lack of political attention had been decisive in the demise of the classical regime. Such negligence regarding the establishment of a functioning surveillance system of infectious diseases appeared to be a result of the changing nature of political landscape. As Fidler (2005: 335) notes:

Improvements made against infectious diseases by countries owed little, if anything, to the classical regime because the improvements involved changes *within* States, such as strides made in providing clean water and sanitation services, and widespread application of new medical technologies, such as vaccines. In short, the political interest [that] developed countries had in the classical regime prior to World War II dissipated [Emphasis in original].

The political attention regarding the international control and monitoring of infectious diseases gained momentum during the 1980s. Public health officials and the policy-makers from the purported developed states of the Northern Hemisphere led by the United States started to draw more attention to the control of the infectious diseases. The stimuli that led to the allocation of more attention surrounding the concept of infectious diseases was induced by the effects of the accelerating pace of the connection between different spatial and temporal units in the contemporary world, precisely in the aftermath of the Cold War. The increased sense of globalism during the 1990s had tremendously affected the ways in which the distinct political units conceptualized the formerly domestic issues of health. The increase in the velocity and pace of connection revived a certain “sense of vulnerability in the minds of many Western policy-makers [as] even if their countries have comparatively sound public health infrastructures, it is still possible to import such diseases

¹ For an expansive analysis regarding the rise and fall of the classical regime, see Fidler (2005).

inadvertently from distant places where such an infrastructure is not present” (Elbe, 2010: 30-31).

In relation to the increased sense of globalism, the first chapter provides an outline of different conceptualizations of health drawn from literature. The aim is to familiarize the reader with various analytical conceptualizations of the relationship between health and security and to utilize these intellectual frameworks in the subsequent chapters. Informed by these different narratives, Chapter III analyzes the processes through which the new security narrative originated in the United States regarding the future of global health governance was exported to the agendas of the WHO and the UN. The argument is that the utilization of the security framework appeared to be liaised with the reformation of the global health governance regime from the beginning. The securitization theory (Buzan, Wæver and de Wilde, 1998), which is discussed in Chapter II in detail, is used to demonstrate how a security narrative was deployed, with what means it was operationalized and how such narrative found proponents at the WHO and the UN. Chapter III analyzes the methods that the public health officials and policy-makers used when they were establishing the global health security regime. The argument here is that the methods are not just the tools that academics utilize to understand a phenomenon but they also are “developed and deployed as part of security practices themselves” (Aradau *et al.*, 2015: 5).

1.1.3 The Case Study: Ebola Crisis in 2014-15

Drawing on the insights from the first two chapters, Chapter IV discusses the Ebola outbreak which has been the most recent instance that regenerated fierce debates regarding the efficacy of the global health security regime. The recent Ebola incident was probed with the security lenses since the first news of the spread of the outbreak

(Gostin and Friedman, 2014: 1324; UNSC Resolution 2177, 2014: 5). This was the second time that the UN adopted a security discourse vis-à-vis an infectious disease since the initiation of the prolonged campaign against HIV/AIDS (UNSC Resolution 1308, 2000; later updated with UNSC Resolution 1983, 2011). Since the use of the security discourse have been immensely helpful in drawing global attention to the case of HIV/AIDS in Africa (Elbe, 2005; Elbe, 2006: 135), a similar approach has been tailored for the mitigation of the Ebola crisis by the UN. Yet, the global health security regime already was operational before the UNSC meeting regarding Ebola in 2014, such as the WHO's surveillance apparatuses. Thus, the deployment of a security narrative to the case of Ebola was not an isolated occurrence that was solely initiated by the UN. The case of Ebola was indeed an empirical site upon which the effects of the global health security regime, which had been in the making since 1992, might be observed. Therefore, the case of Ebola (Chapter IV) will be the focal point where the history of the global health security regime constituted the present practices.

Each section draws upon the literature multiple disciplines and benefits from different methodologies. Rather than extensively discussing the toolbox of this research in each chapter, the thesis' theoretical grounding and methodology in relation to the data collection processes are introduced here to elicit a clearer and more robust flow of argumentation in the subsequent chapters.

1.2 Theoretical and Methodological Stance: Do You See What I See?

An important aspect of doing research is to disclose one's stance toward a subject. Such manifestation is comprised of a researcher's theoretical and methodological mindset. Often, the ways in which a researcher approaches to a subject generates controversies among the scholars with regard to the rigorousness and validity of the

theoretical and framework. The discipline of International Relations is no exception to debates about the philosophy of science and scholars continue to debate the credentials of research.² For the purposes of this research, what matters is to ensure that the toolbox that has been used throughout this study is adequately addressed, clearly conceptualized and sufficiently elaborated on. Such an undertaking appears to matter because it displays the lenses that are worn throughout this research enabling readers to see what has been intended to be conveyed.

Returning to the research question with this background, a clear identification of the lexicon is necessary to address the research's theoretical and methodological stance. The research question, as addressed above is: How and why did the contemporary global health governance liaise with the security which culminated during the 2014-2015 Ebola outbreak ?

The term security may connote different meanings depending on the researcher's intellectual mindset. Thus, such terminology necessitates robust conceptualization. Theoretically, this research particularly draws upon literature from the contemporary Security Studies in International Relations that study "linguistic origins of the socio-political world" (Mutlu and Salter, 2013: 113). Such studies have varying ways of approaching a security issue. The method changes in accordance with the conceptualization of the security phenomenon. Thus, there often seems to be the problem of "conceptualization of security; as speech act, discourse, field of professionals, *dispositif*, or practice," all of which are "supplemented by methodological questions"(Aradau *et al.*, 2015: 1-2). Since the research question is directed at understanding a process through which a security value has been imposed

² See Jackson (2011: 188-212) for a discussion on the recent philosophical dispositions in International Relations. For a discussion of different positions, see Hansen (2006: 1-13) and King, Keohane and Verba (1994: 3-33).

on an infectious disease and comprehending what repercussions such a move entails, this research conceptualizes security as a speech act. Speech act theory as conceptualized in International Relations aims at understanding how “utterances of speech” attribute “a security value” to a phenomenon (Mutlu and Salter, 2013; 114).

The classical conceptualization of the speech-act theory in International Relations was substantiated by Buzan, Wæver and de Wilde (1998). Building on the insights of the speech-act theory, Buzan, Wæver and de Wilde (1998: 26) argue that “the process of securitization is what in language theory is called a speech act. It [security] is not interesting as a sign referring to something more real; it is the utterance itself that is the act. By saying the words, something is done (like betting, giving a promise, naming a ship).” The main argument is that adding a security value to an issue transcends the very phenomenon that is intended to be securitized to a different level of political reality where extraordinary measures may take place (Buzan, Wæver and de Wilde, 1998: 26). Hence, a security framework denotes that a socio-political phenomenon is deemed as a ‘security’ issue through the utterances of the political elite that has the power to change perceptions, issue new enactments and plan the course of action. In other words, this research focuses on the processes through which certain perceptions germane to a phenomenon are framed (Mutlu and Salter, 2013; Shepherd, 2013; Aradau *et al.*, 2015).

Methodologically, discourse analysis proves to be quite beneficial in understanding such processes through which discourses are formed, changed, updated and adopted. The execution includes the analysis of utterances comprising the security framework through discourse analysis. Such method is used to analyze “spoken, sign-based [...] semiotic markers” (Mutlu and Salter, 2013: 113) that attribute meaning upon the socio-political reality. Van Dijk (2001: 353) outlines the

particular characteristics that Critical Discourse Analysis (CDA) features. He argues that a proper CDA concentrates on “the ways discourse structures enact, confirm, legitimate, reproduce, or challenges relations of *power* and *dominance* in society” (Emphasis in the original, Van Dijk, 2001: 353). This research is designed to understand the extent to which a security framework has an effect on the formation of the perceptions with regard to Ebola. Such an undertaking elicits several methodological controversies. Even though the theoretical framework may be quite fruitful in its contribution to one's understanding of a phenomenon, applying these abstractions to empirical cases raises several questions.³ Aradau *et al.* (2015: 9) elaborate on such statement as they underscore that 'method' in question:

does not refer to a tool that will bridge theory and empirical processes - representation and reality - sustaining the credibility, scientificity, objectivity, and seriousness of knowledge. Instead it questions how to problematize security practices and processes, how to interfere and intervene in security knowledge by analyzing the processes and conditions through which insecurities are made politically significant.

Through discourse analysis, the aim is to understand the changes and continuities in security discourses toward Ebola. Yet, what would be the data? Where is one to begin the analysis? What constitutes a discourse? Such questions relate to the question of suitability. In other words, as “discourse analysis takes textual, visual, or other semiotic data as its primary data;” the data consists of “personal correspondence, publications, newsletters, newspapers, magazines, memos, transcripts, policy documents, visual symbols” (Mutlu and Salter, 2013: 115; Neumann, 2008). Thus, the question of fit is an essentially important aspect of conducting discourse analysis. Which documents are relevant? How should the documents be conceptualized? Answering these questions, Neumann (2008: 67)

³ For instance, "How should an analysis of securitization be completed? How does one locate and analyze particular practices as 'security'? How does a security field relate to a field of surveillance? How can we analyze the relation between security and risk?" (Aradau, Huysmans, Neal and Voelkner, 2015:1).

states that there are “canonical texts or monuments” that act as “anchor points” that are often regarded as referential texts by other academics.

As discussed above, there are three instances when an infectious disease was framed as a security issue and thus became politicized (UNSC Resolution 1308, 2000; later updated with UNSC Resolution 1983, 2011; UNSC Resolution 2177: 2014). These documents set the international agenda concerning the campaign against HIV/AIDS and Ebola, respectively. These documents are the monumental documents through which the course of the future actions are determined. Through analyzing these resolutions by conducting discourse analysis, this research reveals the changing nature of the UN's security agenda. Understanding how and why global health governance liaises with a security narrative, the documents (World Health Assembly Resolutions, the UN Resolutions, the speeches of prominent policy-makers) are methodologically subject to discourse analysis where this research attempts to map changes and continuities in the UN's responses regarding infectious diseases. The WHO's decision making body, World Health Assembly (WHA), also has been an active regulatory body of global health governance. In relation to the UN agenda, this research also focuses on the role of the WHO and how the WHO's agenda since its reformation in early-1990s started to embody a security narrative.

In essence, this research uses discursive approaches to understand a process which seems to be initiated through the use of similar strategies.⁴ Thus, the motive is to understand the nature of processes and effects of discursive frameworks in the

⁴ Elaborating on this irony, Aradau *et al.* (2015: 5-6) note that, “There is neither a real methodological distinction nor a practical one, since there is extensive circulation between the practitioners and methodologies of ‘academic’ methods and those of security methods. If we are to study methods as practices, what is important is not the type of actor, their objects of concern or even their political aims, but the workings, effects and implications of the practices themselves.”

formation of security practices. To accomplish this task, this research subjects the World Health Assembly resolutions, the UN resolutions and policy-documents, and the national policy documents to discourse analysis to understand how and why the global health security narrative emerged in the 1990s and what repercussions the emergence of a global health security narrative have on the reception of the recent Ebola outbreak. The related policy-documents are examined in detail in order to demonstrate the changes and continuities in the global health security narrative between the years of 1992 to 2015. The UN and WHA resolutions are available in the digital archives of these organizations.

1.3 Structure of the Research: The Chapters

The main motivation of this research is to understand how the global health governance regime has come to be dominated by a security narrative. Such comprehension will allow this study to make a case against the unethical repercussions of the utilization of the security narrative. In accordance with this assertion, the first chapter discusses where International Relations and health intersect. In particular, this section surveys the International Relations literature and presents different conceptualizations of health. When the issue in question is health, there seems to be at least five different competing frameworks; evidence-based medicine (EBM), human rights, economism, development and security frames respectively (McInnes and Lee, 2012: 18-19). Generally, where the International Relations and Public Health literature intersect seems to be in the areas of security, human rights and development.

Chapter II features a brief outline of the latter two conceptualizations, and mainly focuses on different conceptualizations of health security. Introducing

different analytical frameworks of health security, this section discusses the instances of where, when and why the national security frameworks have become the prominent conceptualization of health security by assessing whether Jain's (1991, quoted in McInnes and Lee, 2012: 22) assertion of “self-interest has been the primary driver” for mobilizing international action is accurate or not. Before presenting a genealogy of the formation of the global health security regime in Chapter III, Chapter II also offers a brief discussion of securitization theory (Buzan, Wæver and de Wilde, 1998) and global biopolitics (Elbe, 2005).

Chapter III analyzes the processes through which the security framework has become the dominant narrative in the formation of the global health governance. Building on the studies conducted by Weir and Mykhalovskiy (2010), and Weir (2015), this chapter provides a genealogy of the global health security regime by particularly focusing on the years between 1992-2013. Starting with the Institute of Medicine's *Emerging Infections: Microbial Threats to Health in the United States* (Lederberg *et al.*, 1992), the chapter conducts discourse analysis by focusing on WHA resolutions, UNSC resolutions, the speeches of the prominent policy-makers and in an attempt to map how the national security narrative, which originated in the US, was integrated within the agendas of the UN and WHO.

Chapter IV applies the insights developed in Chapter II and Chapter III to the case of Ebola between the years of 2013-2015. The outlines how the global health security regime operated in relation to an actual case. Particularly, this section discusses how Ebola became a global issue. The subject of inquiry specifically addresses the actions taken by the UNSC and the WHO. The chapter extends the discourse analysis conducted in the previous section to cover the WHA resolutions, UN Resolution 2177 (2014), and related policy documents to understand how the

sovereign states of Western Africa have become subjects of international action. This section reexamines the idea of global biopolitics and how such an understanding intertwined with the logic of global health security. This section also offers a dialogue on global biopolitics/sovereignty/security. By defending the case for state sovereignty, this section attempts to understand whether the sovereignty of the donor states challenges the sovereignty of the recipient countries.

Chapter V problematizes the theoretical conceptualizations of the nexus of sovereignty-state-security transcribed within the global health security debate. This chapter attempts to establish a theoretical resistance point in favor of the composition of a more humanitarian approach on the global governance of health. Engaging with Realism in International Relations, this chapter argues that a normative resistance first should occur at a theoretical level. This chapter particularly draws on literature from the Realist School in International Relations. Building on Williams' (2005:5) conceptualization of 'wilful realism,' this part of the study engages with a Hobbesian understanding of the purpose of a state as a normative answer to a Foucauldian critique of global biopolitics.

CHAPTER II

GLOBAL HEALTH GOVERNANCE: THE ANALYTICAL MAKING OF THE GLOBAL HEALTH SECURITY

2.1 Introduction

Conceptualizing health with the words ‘global’ and ‘security’ is not something particular to contemporary politics. Several examples of such juxtaposition date back to the nineteenth century, to the international sanitary conferences where the European powers attempted to address the spread of cholera, yellow fever and plague as obstacles to international trade (Fidler, 2005). Back then, there also was an increased sense of global consciousness which necessitated an international response to the control of diseases.

The contemporary story on the formation of the global health security regime in the aftermath of the Cold War is indeed not entirely different from the nineteenth century experience. After decades of inept belief in triumph against infectious diseases, the aftermath of Cold War witnessed an emerging concern regarding the re-emergence of these diseases. Such change appeared to occur due to (i) an increased sense of globalism which makes it possible for a microbe to travel from one geopolitical space to another in a short amount of time induced by the increased commercialization of aviation, (ii) the changing nature of the security agenda so as to address newer threats such as environment and health (McInnes, 2008). In accordance with these changes, there had been several attempts at conceptualizing health in relation to different themes and different levels of application.

This chapter surveys the plethora of research conducted on different conceptualizations of health in the International Relations and Public Health

literature. The discussion is structured around the development of two different, yet related, analytical frameworks utilized by academics and policy-makers in post-Cold War years. The first analytical framework relates to the geo-politics of health. In the first part of this chapter, the aim is to elucidate how health is conceptualized in relation to the object(s) of analysis (i) individual health, (ii) public health, (iii) international health, and (iv) global health. The main narrative, in the first section of this chapter, ponders that even though these four conceptualizations are still available in the literature, the political *loci* in the gradual years in the aftermath of the Cold War leaned toward the prioritization of the global health image (Lee, 2003; McInnes and Lee 2012; McInnes 2016). Such inclination resembles the motivations of the European powers in their attempts at the formation of an international health regime during late nineteenth and early twentieth centuries. A brief discussion of the internationalization of the health in early twentieth century is included to allow readers to compare the motivations of the states regarding the establishment of a global health governance regime between then and now.

The second section starts with the assertion that even though the accelerating nature of the pace and velocity of the international interactions amongst different geo-political spaces inherently affected the ways in which infectious diseases are perceived, it was rather a familiar sentiment germane to international politics that actually elicited the formation of the global health narrative: National security. Commencing with the publication of the United States Institute of Medicine's *Emerging Infections: Microbial Threats to Health in the United States* in 1992 (Lederberg et al., 1992; Weir, 2015), the public health concerns of the some public health officials in the United States metamorphosed into a national security narrative that had a tremendous effect on the formation of the global health narrative. Yet,

since the beginning of this endeavor, the narrative had been infused with the language of security which inherently made the global health narrative arguably synonymous with global health security.

The final section introduces securitization theory (Buzan, Wæver and de Wilde, 1998) by particularly conceptualizing it for the purposes of this research. The theory is discussed in relation to the formation of global health security narrative. This discussion also is a prelude to the genealogy of the formation of global health security between the years of 1992 and 2013 discussed in Chapter III. The main concern is to understand how a security narrative informed the reformation processes of the institutional apparatuses of global health governance. The literature review is both aimed at understanding the expansion of the scope of the security concerns of the triumphant power in the aftermath of the Cold War, and is designed to demonstrate the different conceptualizations of health in an era of an increased sense of globalism.

2.2 Health Gone Global: Different Levels of Analysis

2.2.1 A Brief Historical Overview of Internationalization of Health

Perceiving health as a global phenomenon is not really particular to contemporary politics. There are two important points to make here. The first remark is that there had been historical attempts at governing health/disease through international cooperation. Since its inaugural congregation in Paris in 1851, there were 11 international sanitary conferences held between 1851 and 1903 (Birn, 2009: 52). These conferences generally were convened to address health problems, especially the mitigation of infectious diseases, on European soil. However, that these meetings occurred was indicative of the growing concern regarding the lurking infectious

diseases and the recognition of the inadequacy of the deployment of unilateral actions regarding the mitigation of the infectious diseases such as cholera, plague and yellow fever. The second point is that the development of an international agenda regarding the governance of the infectious diseases had been narrow in scope confined to a limited number of diseases that were perceived as a threat to expanding European trade and commerce (Fidler, 2005). In other words, the gradual attempts to establish an international health governance regime appeared to be subject to Eurocentrism.

An expansive survey of the gradual formation of the notion of international health exceeds the boundaries of this research. Yet, for the purposes of this research, it is worth noting that the attempts to establish an international regime regarding the provision of infectious diseases in the nineteenth century, were infused with the security concerns of the leading European states. Fidler (2005: 329) notes that the congregation of the international sanitary conferences and the formation of the international health organizations, such as the Pan American Sanitary Bureaus (1902) and Office International d'Hygiène Publique (1907), were aimed at addressing the containment of infectious diseases “across borders through international trade and travel.”

The International Sanitary Conference that congregated in 1893 features a sentence in the preamble's statement justifying the reasons for the international cooperation regarding the containment of infectious diseases. The statement asserts that states “decided to establish common measures for protecting public health during cholera epidemics without uselessly obstructing commercial transactions and passenger traffic” (International Sanitary Convention, 1893 quoted in Fidler, 2005: 329). The European signatory states to the international sanitary conventions also

were concerned with the possible spread of what was called ‘Asiatic diseases’ to European soil (Fidler, 2005: 331). Elaborating on the existence of such concerns, Fidler (2005: 331) notes that “a driving motivation behind international cooperation in the late nineteenth and early twentieth century was to protect Europe and North America from the importation and spread of ‘Asiatic diseases.’

The motivation for the attempts at establishing international control over the containment of diseases is worth noting here as after two world wars and the Cold War, the 1990s witnessed similar state-centric motivations in the call for the reformation of the global health regime. As McInnes (2015: 9) argues in relation to perceiving health as a global problem in the aftermath of the Cold War, “health issues are not identified as national security risk by reference to an explicit set of criteria but rather have arisen in an ad hoc manner and been agreed to intersubjectively by key national and international actors.” The historical development of the global health security regime will be discussed in Chapter III. The next section surveys the different analytical approaches used to conceptualize health and how the concept of global health prevailed amongst other frameworks.

2.2.2 Analytical Approaches: Global Health to Global Health Security

There are generally four ways in which the health has been conceptualized in relation to the population. These are individual health, public health, international health and global health, respectively.⁵ Individual health is narrowly defined as “the absence of disease” (Benatar and Upshur, 2011: 13) whereas a broader definition supplemented in the Declaration of Alma Ata⁶ and WHO Constitution⁷ states that individual health

⁵ The typology is summarized in Benatar and Upshur (2011) where the authors survey the contemporary understandings of global health.

⁶ The Declaration of Alma-Ata is the document that was published after the International Conference on Primary Health Care in Alma-Ata, USSR in September 1978. To access the entire document, visit http://www.who.int/publications/almaata_declaration_en.pdf.

is “the a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity” (Tejada de Rivero, 2003 quoted in Benatar and Upshur, 2011: 13). Public health also has a narrow and a broad definition. A narrow definition conceptualizes public health within the boundaries of medicine with the emphasis on “statistics, epidemiology and measurable proximal risk factors” (Benatar and Upshur, 2011: 13).

The broader definition extends the emphasis to the socio-economic sphere within which the diseases occur. International health focuses on comparative health care systems in countries specifically concentrating on “the provision health-care assistance [...] by personnel or organizations from one area or nation to another” (Benatar and Upshur, 2011: 14; Birn *et al.*, 2009: 5-6; Birn, 2009). Global health centers on the changing nature of temporality and spatiality in contemporary life with the increase in the velocity and intensity of cross-border motion. The proponents of the global health agenda acknowledge “the lack of geographic or social barriers to the spread of infectious diseases” (Benatar and Upshur, 2011: 14).

These four delineations of health in the literature permeated into the International Relations literature when scholars started to conceptualize the relationship between these formerly distinct disciplines. Yet, the Public Health literature and International Relations discipline in the post-Cold War era generally intersected with each other on the problems relating to the international and global health. Even though human health and security (Ogata and Cels, 2003; Curley and Thomas, 2004) are still widely discussed by the scholars of International Relations and cognate disciplines, the traditional state centrism peculiar to the International Relations discipline has dominated the way the health is conceptualized. For

⁷ Visit <http://www.who.int/trade/glossary/story046/en/> to access the entire constitution.

instance, as Stuckler and McKee (2008: 96) note, there have been at least five ways of studying global health: (i) Global health as foreign policy, (ii) global health as charity, (iii) global health as investment, (iv) global health as public Health and (v) global health as security. Even though there has been a proliferation of studies that address the effects of globalization on health and diseases (Huynen *et al.*, 2005: 3-5; Kawachi and Wamala, 2007: 19-20; Cockerham and Cockerham, 2010), the main entry point of health issues to the discipline of International Relations has been the traditional study phenomenon of security (Elbe, 2005; 2006; 2009; Nunes, 2014; McInnes, 2015).

As discussed above, the relationship between health and security was not new, where the traditional linkages of the two seem to be restricted to "the manner in which disease may affect military capacity and especially military operations and the impact of conflict on health and health care" (McInnes, 2015: 7). Yet, the changing nature of global politics in the aftermath of the Cold War conceived shifts in the conceptions of health as basic human right - as was decreed in the WHO Constitution in 1946 - to health as security (McInnes, 2008: 276). Before the 1990s, the health policies were nationally restricted with the exception of aid that was merely part of a hearts and minds strategy of the developed countries. For instance, during the Vietnam War, the United States war effort included developmental aid for Vietnamese in an attempt to legitimize the operations. Yet, in general, there did not exist an "obvious health issue 'out there' for International Relations to explain, there was no requirement for any significant engagement. In this context, a rational assessment was to leave health largely outside of International Relations, and the practices of foreign and security policy" (McInnes and Lee, 2012: 26). This tendency started to change during the mid-1990s because of the reasons (McInnes, 2008: 276-

277; 2015: 7-8) outlined as the broadened security agenda that was formed during the 1990s and the increasing importance given to the infectious diseases in the agendas of national policy-circles.

The broadened security agenda changed the emphasis given to health in international policy circles and International Relations as a discipline. There were two occurrences shaping the future of the *nouveau* coalescence of health and international relations in the mid-1990s. The first reason was the amplification of the already existing diametrically exclusive relationship between health and disease by the International Relations lexicon. Health and disease have often been conceptualized together, basically - one being the absence of the other.

As outlined above, even though almost all definitions regarding health seem contentious, the idea of health is more or less defined as the absence of disease. Exporting the health/disease conundrum to the public, international and global health only witnessed an extension of the initial *modus operandi* - of being healthy and being ill - to the broader populace. The almost mutually exclusive relationship between health and disease was magnified with the new agenda promulgated by the UNSC. The reasons to that, it seems, are embedded within the ontological problems of International Relations as a discipline (Walker, 1993: 6) and a policy area and are furthered by the existence of border politics (being the sharp distinction between national/international) - which have been the main object of study of International Relations - with its built-in logic of us and them.

The discussion, thus far, has outlined the initial reasons why global health is generally conceptualized in relation to global health security. To restate what has been discussed, the main reason behind this shift was the changing security agenda in

the aftermath of the Cold War while the politicians mainly from the United States and Canada started to narrate on the possibility of a new emerging threat: infectious diseases. The emphasis on diseases also reveals another change in the conceptualization of health by the policy-makers and by scholars of International Relations. The increased risk perception induced by the existence of emerging and re-emerging infectious diseases aggravated the attempts by the policy-makers and academics to conceptualize the diseases as security risks. Rather than emphasizing the prominence of health, the narrative conceptualized the lack of health as a security threat to the survival of the state. Notwithstanding, both circles - policy-makers and academics - had been part of the changing perception regarding the conceptualization of health. With this background, the emphasis started to shift toward disease.

2.3 National Security and Global Health

2.3.1 Changing Political Leverage: National Health Strategies to Global Health Security

The narrative of deadly diseases ravaging societies was not unfamiliar, as "our imagination is filled with nightmare scenarios of devastation and political turmoil following from the disease" (Nunes, 2014: 8). Nunes elaborates on this theme by reminding the readers of the Black Death in fourteenth century Europe and the 1918 Spanish Influenza. Both examples as Nunes (2014: 8) underscores are representative of a "typical plot" of a "virus emerging [...] in some exotic location" spreading to the population distorting the "business as usual politics."⁸ The imaginary power of the disease was the main catalyst for the emerging agenda of Global Health Security in the mid-1990s. This was so as the "disease is [...] enveloped in fear: it is to be

⁸ Note that the representative cases in this section are restricted to Europe. I acknowledge possible critiques toward such representation on the grounds of being Euro-centric. Such critique seems quite sound as the development of the Global Health Security itself appears to be suffering from and is a representative case of North/South gap.

approached as a threat to the existence not only of individuals but also of society as a whole” (Nunes, 2014: 8).

The fear-security-politics nexus was indeed the main entry point where health was essentially made part of International Relations. To put it differently, “health is political because it is a matter of security” (Nunes, 2014: 8). This seems like a novel way of conceptualizing health - through its other side of disease. Interestingly, perhaps representing an instance where a more expansive genealogy would be more rewarding - such tendency - being quite Euro-centric - actually started prior to the twentieth century. For instance, as the volume of commercial activities increased between Europe and the rest of the world, the concern among the European policy-makers regarding the possibility of the arrival of an infectious disease to European soil grew. Disease was regarded as “an exogenous threat which had to be dealt with by means of international cooperation and the introduction of internationally agreed health regulations” (McInnes, 2008: 275). As McInnes (2008: 275) asserts, this had been representative of the “origins of international cooperation on public health” which was grounded on European security concerns regarding the ‘external threats.’

The logic of externalizing a disease became the way in which health security is conceptualized in International Relations. This theme was supplemented by growing concern regarding three significant health issues: the spread of infectious disease, the HIV/AIDS pandemic and bioterrorism. The narrative of the spread of infectious diseases has been affected by the increase coverage of the purported disease outbreaks by media outlets. These mediums of information have an effect on shaping “public perceptions of risk and views” regarding an issue of infectious disease (McInnes and Lee, 2012: 10). Such coverage could magnify the reality by

distorting the facts about an infectious disease. Such a narrative “tends to privilege acute and severe infectious disease outbreaks over disease which do not behave in this manner [...] prioritizing the global over the local” with an emphasis on the treatment of the disease rather than the preventive measures (McInnes and Lee, 2012: 36-39). This narrative inherently creates an inside/outside conundrum where the disease is externalized. This dichotomy results in an understanding “where infectious disease outbreaks are seen as threats emanating from outside western countries or over there in the developing world” (McInnes and Lee, 2012: 40).

Interestingly, that seems to be the *modus operandi* of the policy-makers that started to shape the perceptions regarding infectious diseases in the early-1990s. In 1992, the United States Institute of Medicine published a manuscript titled *Emerging Infections: Microbial Threats to Health in the United States* (Lederberg *et al.*, 1992; Weir, 2015). This publication developed a new acronym for emerging infectious diseases, EID, that was defined as “clinically distinct conditions whose incidence in humans has increased” (Lederberg *et al.*, 1992: 34 quoted in Weir, 2015: 19). The concept of EID started to find itself a more prominent spot on the agenda of American policy-makers which culminated in a duo effort by the U.S. and Canada to “persuade WHO to act on global surveillance of EID” (Weir, 2015: 19). The first official document to the joint effort was promulgated with the Lac Tremblant Declaration in 1994, which advocated for a new apparatus to be installed as an “early warning system” which should be tasked with defining “existing patterns of diseases” and identification of “new disease that represent a threat to global public health” (Lac Tremblant Declaration, 1994: 5, quoted in Weir, 2015: 19). Then the director of Division of Communicable Disease at WHO, Dr. Giorgio Torrigiani

found the U.S.-Canadian effort convincing as two ad hoc meetings were held by the WHO in 1994 and 1995, respectively.

These ad hoc meetings resulted in the approval of WHA Resolution 48.13, *Communicable Disease Prevention and Control: New, Emerging and Re-emerging Infectious Diseases* by the World Health Assembly (Weir, 2015: 20). A national policy item that first started to attract politicians in the United States and then in Canada was legislated by the international organization that governs global health. In other words, the resolution “translates EID,” which was a concept developed by U.S. Institute of Medicine “into the normative discourse of international public health endorsed by the WHO's highest political and legislative body” - World Health Assembly (Weir, 2015: 20).

National security concerns of the United States and Canada appeared to be exported to the WHO's agenda that started to reshape the future of the governance of infectious diseases. This brings forth the notion of the politics of conceptualizing health as security. Before probing into the question of politics, it seems essential to outline the ways in which health and security have been conceptualized in the International Relations literature.

2.4 From National to International and Global Security

As discussed above, the concerns about the spread of infectious diseases started to enlarge the national security conceptions of some states such the United States and Canada. This expansion of the U.S. national security agenda was still state-centric in its focus. For instance, in 1999, the Central Intelligence Agency (CIA) “identified a number of risks to U.S. security arising from infectious disease, risks exacerbated by

rapid globalization and the increased worldwide movement of goods and people” (McInnes, 2015: 8). The CIA was quite ambitious in initiating efforts to mitigate this threat “arguing that infectious disease also posed a risk to international stability and even economic growth” (CIA, 2000 quoted in McInnes, 2015: 8). Another example as introduced in the introductory remarks of this chapter features the UNSC. In Resolution 1308, the UNSC warned “that the HIV/AIDS pandemic, if unchecked, may pose a risk to stability and security” (McInnes, 2015: 8). Interestingly, the infectious disease narrative is not really corroborated with factual evidence but rather “have arisen in an ad hoc manner and been agreed to intersubjectively by key national and international actors” (McInnes, 2015: 9). Such agenda is interesting as it embodies a rationale that “working toward a condition of security is socially beneficial - that ‘more security’ is always better” (Elbe, 2006: 129). But whose security is in question? The initial developments regarding the policies aimed at mitigating the purported effects of infectious diseases seem to be mere reflections of national interest of a few states which were afraid of distortions in international political economy, further migration, imperilment of peace-keeping and military operations from diseases such as HIV/AIDS (McInnes, 2015: 9). The fear focalized around the threats that these possible outcomes would pose to international stability and internal security of the states.

In 2007, WHO (2007: 1) published *World Health Report* in which it defined global public security as follows:

Public health security is defined as the activities required, both proactive and reactive, to minimize vulnerability to acute public health events that endanger the collective health the collective health of national populations. Global public health security widens this definition to include acute public health events that endanger the collective of populations living across geographical regions and international boundaries ... [it] embraces a wide range of complex and daunting issues, from the international stage to the individual household,

including the health consequences of human behavior, weather-related events and infectious diseases, and natural catastrophes and man-made disasters.

Compared to the previous discourses employed during the early-1990s with the WHO's initial engagement with health security, and then in the early-2000s with the UNSC's involvement in efforts to mitigate HIV/AIDS, the 2007 WHO report seems to be bolder in its claims and more ambitious in its efforts. Both the encompassment and the intensity of the WHO governance appears to be increased, at least discursively. There have been studies that tried to understand the politics behind such agendas.

McInnes (2008: 286) criticized the changing agenda of the institutions that govern the health issues in the international arena arguing that "the agenda to date [...] has been dominated by national security concerns, and particularly those of the West, such that the WHO's term 'global health security' is in danger of meaning the national security of Western states from health risks rather than the promotion of wellbeing globally." Narrating on such post-colonial critique Weir (2015: 26) states that the global health security agenda has often been another reflection of North-South that reiterated the divide. Elbe (2005) furthers the argument by drawing insights from Foucault's concept of biopower. Addressing the UNSC meeting in 2000 that deemed HIV/AIDS as a security threat to international peace and security, Elbe (2005: 404) argues that conceptualizing HIV/AIDS as a security problem "turns international security into a site for the global dissemination of a biopolitical economy of power that first emerged in eighteenth century of Europe around the government of life." In other words, what Elbe (2005: 406) argues is that "man's biological existence" itself becomes the object of newly deployed governance efforts where the formerly unregulated spheres in the lives of individuals and the population

as a whole is now subject to more intervention. Such interventions inherently included the health of populations as the well-being of the populations meant the well-being of the state. Elbe extrapolated Foucault's critique of the twentieth century liberalism to global health security regime, as he (2005: 407) argues that "the unfolding of securitization of AIDS follows [...] a net-like deployment of biopower" where the traditional top-down structure of the power is reformed in a way where "a plethora of actors ranging from [...] the United States [to] international organizations such as the World Health Organization, the United Nations, the European Union, ASEAN and the African Union" became sources of the surveillance apparatus. Yet, utilizing the security framework in order to prioritize importance given to the infectious diseases is not necessarily always a harmful thing. For instance, Singer (2002: 158) claims that juxtaposing HIV/AIDS with security "strengthens the call for serious action against the menace of AIDS. It is not just a matter of altruism, but simple cold self-interest." Even though the national agendas of the predominantly Western states had an effect on the use of the security discourse in the fight against the HIV/AIDS, this helped boosting the profile of the disease by making it a part of high politics.

On the contrary, labeling infectious diseases as security threats based on the perceptions of few states may have detrimental consequences. For instance, Peterson (2002: 80) argues that even though national interest rhetoric is effective in raising awareness, raising funds and eventually boosting the efforts in the fight against and infectious disease, such line of policy-making may have serious consequences. Conceptualizing an infectious disease in accordance with the interests of a limited number of actors may mean that any infectious disease would be given importance to if that disease would pose a threat to the security of the few agenda setters (Peterson,

2002: 80). Nevertheless, the literature focuses on the hows and whys of security discourse by analyzing the politics of using the security framework. Yet, what does it really mean to use a security discourse? How an actor puts a security value on an object. The next section introduces the securitization theory that was developed by Buzan, Wæver and de Wilde (1998).

2.5 Securitization Theory and Health

2.5.1 The Intersection of Security and Health

What this brief literature survey yields is that (i) it is conceptually possible, and generally arbitrary, to juxtapose a health issue with another concept such as environment, human rights, governance, justice and security. From an International Relations perspective, (ii) the ascendancy of health issues to the agendas of states and international organizations had generally occurred via an imposition of a security tag. Such rapport (iii) instantly located the global health security debate, and the issues that relate to it such as HIV/AIDS, avian flu, swine flu and Ebola, in the middle of the enduring security debate in International Relations.⁹ As McInnes (2015: 7) notes even though “the link between security and health is not new” as health/disease had been conceptualized in relation to its effects on militaries, or the other way around as, the effects of conflict on health/disease; the security agenda expanded to cover other issues that are traditionally left outside the boundaries of the security. He quite competently summarizes the changing ethos as:

This was a period when security audiences had been sensitized to the idea of new risks following the ‘bonfire of certainties’ at the end of the Cold War. The attempt to construct health as a security issue (to ‘securitize’ it) therefore fell on more fertile ground than might previously have been the case. Beyond ‘real world’ concerns, however, were political considerations, with some within the public health community recognizing that the security label was a

⁹ See Williams (2008) for an introductory survey of different approaches in Security Studies.

potentially effective means of elevating global health issues on the national and global stage.

(McInnes, 2015: 7)

Concurring with McInnes' analysis on the expanding security agenda and the utilization of the security narrative with the aim of drawing more attention to an issue, this research particularly draws on literature from the securitization theory that had been deployed as an analytic tool to comprehend the changing nature of security after the Cold War.

Even though an expansive survey of the different positions in the debates surrounding the securitization theory regarding myriad philosophical, definitional, conceptual and empirical approaches exceeds the boundaries of this research, a brief discussion of securitization theory seems essential as the next section (Chapter III) benefits from the insights that have been developed under securitization theory.

2.5.2 Securitization Theory

Securitization theory as laid out by Buzan, Wæver and de Wilde (1998) bringing the insights from of the speech-act theory that was first introduced by Austin (1962) and Searle (1969). Speech-act theory in a nut-shell asserts that "language often conveys more than the literal meaning of the words" (Elbe, 2006:124). To put it differently, words also are mediums of action that have a performative value (Buzan, Wæver and de Wilde, 1998). Building on speech-act theory, Buzan, Wæver and de Wilde (1998: 26) argue that:

the process of securitization is what in language theory is called a speech act. It [security] is not interesting as a sign referring to something more real; it is the utterance itself that is the act. By saying the words, something is done (like betting, giving a promise, naming a ship).

Security as conceptualized by Buzan, Wæver and de Wilde (1998: 203-204) is not something 'out there' but rather is "a quality actors inject into issues by securitizing

them” through a performative speech-act. Since Buzan, Wæver and de Wilde (1998: 211) assert that the security discourse is deployed by someone for some purpose, the very agent is now the bearer of the responsibility of the utterances that load an issue with a security value as “it is a *choice* to phrase things in security (or desecurity) terms, not an objective feature of the issue or the relationship itself.” As summarized by Elbe (2006: 125), a securitization move is comprised of four constituent parts that are:

- i) *securitizing actors* are "actors who securitize issues by declaring something - a referent object - existentially threatened" (Buzan, Wæver and de Wilde, 1998: 36)
- ii) *referent objects* are "things that are seen to be existentially threatened and that have a legitimate claim to survival" (Buzan, Wæver and de Wilde, 1998: 36).
- iii) the claim that the referent objects are *existentially threatened* (war, infectious disease).
- iv) the ability of the securitizing actors to deploy *emergency measures* (Buzan, Wæver and de Wilde, 1998: 26).

With regard to the four constituent parts, securitization is the speech-act that has been uttered by an actor that loads an issue with a security value in claiming that the issue is posing an existential threat to the survival of the referent object. Since its first reception by the academics in the 1990s, securitization theory has generated fierce debates about its assumptions and applications (McSweeney, 1996; Balzacq, 2005; 2010; Stritzel, 2007; McDonald, 2008; Buzan and Wæver, 2009; Ciută, 2009).

Rather than involving the theoretical debate surrounding the securitization theory, this research aligns itself with the piece by McInnes and Rushton (2012) that resonates with the purposes of this paper. The article asserts that securitization theory had been quite useful in understanding how issues that “generally fall well outside traditional notions of what constitute security ... acquired a security tag.” (McInnes and Rushton, 2012: 116). McInnes and Rushton (2012) feature a discussion of

securitization theory in relation to its application to the case of HIV/AIDS. Concurring with Stritzel's (2007: 359) deployment of "two centers of gravity" in securitization theory that profess "two rather autonomous readings of securitization and are based on two separate meta-theoretical convictions", McInnes and Rushton (2012: 119) align themselves with the 'externalist' approach at the expense of the 'internalist' one. The latter as purported by Stritzel (2007: 359) is inclined toward a "more poststructural/postmodern" theoretical mindset and "concentrates on the performative and self-referential nature of the speech act" (McInnes and Rushton, 2012: 118). The former, on the other hand, "leans more heavily towards social constructivism rather than post-structuralism and focuses more on the *process* of securitization in which the speech act forms the move which initiates the securitization process, leading to an emphasis on the intersubjective rather than the performative aspects of securitization" (McInnes and Rushton, 2012: 119).

In the externalist conceptualizations of securitization, the "speech act is the beginning of the process of securitization: persuading the audience to accept that the issue is an existential threat is the key to the success of securitization" (McInnes and Rushton, 2012: 119). Building on this argument, McInnes and Rushton (2012: 117) argue that securitization occurs at multiple levels ranging from domestic, international and global levels with multiple actors and audiences. They also assert that "securitization is not a binary condition" but rather a continuum "with different audience members placed at variety of positions along this continuum." (McInnes and Rushton, 2012: 117). This externalist reading of securitization with emphasis on multi-level securitization and securitization as a continuum appear to be suitable for application to the analysis laid out in Chapter III. This rather nuanced take on the

conceptualization and application of securitization theory appears to be more rewarding than the rather static concentration on the performativity of the speech act.

Regarding securitization as a continuum rather than a binary condition is more applicable to the case of global health security as the formation of the contemporary regime had dispersed into almost twenty years of political discussion. As such, securitization as continuum allows more room for a researcher to apply the analytical insights of securitization to the analysis of longer periods rather than individual events. Secondly, regarding securitization as a continuous process allows one to combine different methodological techniques to the analysis of an issue. Chapter III, for instance, tracks changes and continuities in the utterances of the different actors ranging from US public health officials to the WHO and the UN Resolutions. A genealogical inquiry (Weir, 2015) is deployed to outline the relationship between the US national security narrative and the formation of the global health security regime. The genealogical inquiry through discourse analysis also aims at locating when and how the use of security language changed the way global health governance is structured and how the security narrative has continued to dominate the global health governance regime. The conceptualization of securitization as a process with multiple actors and levels allow this theoretical framework to be used in combination with other analytical methods, which enriches analysis.

2.5.3 Securitization Theory and Health: A Hybrid Approach

There have been a number of studies that deployed the insights that are developed within the framework of securitization theory. Scholars have studied the securitization of infectious diseases (Davies, 2008; Elbe, 2010), avian influenza (Curley and Herington, 2011), SARS and avian influenza (Wishnick, 2010),

HIV/AIDS (Elbe, 2005, 2006; McInnes and Rushton, 2012), and Ebola (Burci 2014). Especially the case of HIV/AIDS has been an empirical site upon which the insights of the securitization theory has been deployed in relation to the changing nature of global health security (Elbe, 2006: 126):

Arguments have shifted from humanitarian and public health ones to officials in international organizations, governments, and non-governmental organizations (*securitizing actors*) increasingly arguing that beyond these humanitarian considerations, the survival of communities, states, and militaries (*referent objects*) is now being undermined (*existentially threatened*), unless drastic measures (*emergency measures*) are undertaken by national and international actors to better address the global pandemic.

Even though the securitization theory has been quite useful in understanding how a health issue has become loaded with a security connotation, this research follows a more hybrid approach. Concurring with Nunes' (2015) argumentation that "focusing merely on speech-act is not enough" in comprehending the decades long formation of the global health security regime, Chapter III also conducts discourse analysis by particularly utilizing intertextuality - "the connection of texts and meanings through reference to other texts" (Mutlu and Salter, 2013: 114). The combination of these approaches are discussed in the next chapter.

2.6 Conclusion

Through surveying the literature and examining the changing nature of perceptions regarding health and disease, this chapter outlined the ways in which health and international relations correlated with each other. In general, the changing security perceptions in the aftermath of the Cold War made a few states to focus on plausible threats to the well-being of the nations. Such rationale is filled with the national interest rhetoric and permeated the international governance regimes of the United Nations and World Health Organization. Many critiques of such a move argued that this has been a quite state-centric and limited way of engaging with the infectious

diseases whereas others argued that the security framework essentially helped politicians to raise the profile of health politics.

Since its inception in the 1990s, global health governance has been infused with a narrative of security. In other words, while the conceptualization of health had become more global in the post-Cold War years, so did the exportation of the security concerns of the few agenda-setters. This chapter outlined the different analytical tools that have been used in the conceptualization of health and discussed why the security narrative became intertwined with global health. Building on these analytical frameworks, Chapter III relates these discursive conceptualizations to their historical trajectories by focusing on key documents, speeches and publications of key actors between the years of 1992-2013.

Chapter III

GLOBAL HEALTH SECURITY: A GENEALOGICAL INQUIRY (1992-2013)

Today [...] biopolitical impulses can also be found resonating beyond the borders of Europe through practices such as the securitization of HIV/AIDS. The latter, after all, marks nothing other than a powerful international intervention targeted directly at the level of population. With the arrival of HIV/AIDS on the international security agenda, security is no longer confined to defending sovereignty, territorial integrity, and international law; but, as the unprecedented Security Council meeting demonstrates, population dynamics - including levels of 'disease' - have now become strategically significant as well.

(Elbe, 2005: 406)

3.1 Global Health Security Narrative: A Process or Isolated Acts

In 2000, the United Nations Security Council convened to discuss the mounting threat of HIV/AIDS throughout the African continent. The reason why the UNSC decided to feature a health issue at the Council's first meeting in the new millennium seems quite intriguing. As Elbe (2005: 403) argues, the agenda of the gathering seemed "both deeply symbolic and also historic" because this was the first time that the Council "considered an illness to pose a threat to international peace and security." Prioritizing HIV/AIDS in the agenda of the UNSC gathering yielded several consequences in addition to the purported threat to international peace and security. In 2014, the UNSC declared Ebola Virus Disease (EVD) a threat to international peace and security (McInnes 2016, 381; UNSC Resolution 2177, 2014). This was the second time since the HIV/AIDS pandemic that UNSC reiterated its role in the maintenance of international peace and security in relation to an infectious disease. Why does this matter? What does the utilization of a security discourse regarding the mitigation of infectious diseases entail?

Firstly, the members of the top agenda-setter for security matters in the international system decided to probe the HIV/AIDS and EVD through a security framework, essentially changing the ways in which (i) the subordinate agencies of the United Nations and (ii) organizations that govern the area of health such as the WHO approached the issue of HIV/AIDS and EVD.¹⁰ Secondly, the decision to frame a health issue as a security problem generated a new agenda in which the health/disease nexus became more politicized (Peterson, 2002; Elbe, 2006: 126; Nunes, 2014: 8-9). The hows and whys of these acts by the UNSC seem essential to understand the changing nature of governance of health/disease.

On the one hand, the question of why relates to the motives of the policy-circle at the UNSC meeting in juxtaposing HIV/AIDS and EVD with security. There already were studies available for the UNSC that addressed the different aspects of the 'international' emanating from infectious diseases. Scholars working under different academic disciplines ranging from Development Studies to Human Rights, from Public Health to Environmental Studies had already been studying the epidemic diseases, especially HIV/AIDS (Elbe, 2006: 121). Thus, the decision to choose a security framework amongst the already existing delineations of epidemics provokes one to discern the politics of the very decision. The argument is that the global health security narrative that started in the 1990s affected the UNSC's decision (i) in 2000 regarding HIV/AIDS, and then (ii) in 2014 vis-à-vis EVD. Building on the analysis of Weir and Mykhalovskiy (2010), this chapter posits that (i) the concept of Emerging Infectious Diseases (EID) that first introduced in the U.S. Institute of Medicine's *Emerging Infections: Microbial Threats to Health in the United States* in 1992, had a tremendous effect in shaping the future of global health governance.

¹⁰ Note that the utilization of security discourse was already under way in the policy circles that shape the agendas of the UNSC and WHO (Weir, 2015: 18-22).

Following that, the other assertion propounds that the concept of EID was heavily infused with the US national security narrative which affected the ways in which the global health governance regime intertwined with the security narrative.

On the other hand, the how question is more about understanding the processes and repercussions of loading infectious diseases with security value. With regard to that, enveloping the infectious diseases with a security connotation also tempts one to comprehend the processes through which the new agenda was realized. Yet, the UNSC's decision to declare HIV/AIDS and EVD a threat to international peace and security was not an isolated instance as argued above. Building on the different analytical conceptualizations of reasons behind the juxtaposition of the contemporary global health narrative with security discourse laid out in Chapter II, this chapter aims at understanding the relationship between global health and security by studying the discourses of key institutions.

With this background, it seems essential to provide a pocket genealogy¹¹ of the forgotten story of how health and security became intertwined to elucidate how and why the contemporary global health governance regime liaised with the security rhetoric. The case of HIV/AIDS had been attracting attention of International Relations scholars, as there had been plethora of studies conducted on the subject in relation to global health governance. Some scholars focused on the changing nature of governance reflexes in contemporary politics by appealing to Foucauldian notions of biopolitics and governmentality (Elbe, 2005; Weir and Mykhalovskiy, 2010; Weir 2015), while some others applied the insights of securitization theory (Elbe, 2006;

¹¹ The original terminology belongs to Weir (2015: 18). I find it useful to call the undertaking as a pocket genealogy because genealogy as methodology in the Foucauldian sense requires more in-depth historical analysis in understanding the very nature of a present phenomenon. Yet, the ethos of the method, regarding its aim to comprehend knowledge/power relations, seems to resonate with the very mindset that this chapter obtains.

McInnes and Rushton 2010; 2012), and social constructivism (McInnes and Lee, 2012). The literature on EVD is still limited to a number of scholarly articles by the time of writing. Thus, what this section aspires to offer is an examination of the processes through which the international community formed sets of policies regarding the mitigation of infectious diseases. Particularly, the focus will generally be on the prevalent international institutions (the United Nations and World Health Organization) that (i) set the agenda for global health governance (ii) and have the mandate to act in times of crisis.

The first part briefly outlines the historical evolution of the current global health governance regime of the WHO and how previously distinct fields of health and national security have been coupled together in the aftermath of the Cold War during the International Health Regulations (IHR) talks in 2004-5. Building on Weir's (2015) analysis regarding the 'invention' (2015: 18) of global health security between 1994 and 2005, the second part extends the inquiry to assess how global health governance respond to the Ebola Crisis between the years of 2013 and 2015. Adopting Neumann's (2008:67) 'anchor points' approach to discourse analysis, in combination with the insights of securitization theory (particularly the nuanced version as outlined by McInnes and Rushton, 2012), this section locates official documents published by the United Nations and World Health Organization to assess the extent to which the discursive powers of these organizations shaped the *modus operandi* of the international effort in the mitigation of the Ebola crisis.

3.2 Global Health Security: The Construction of the Regime

Global health security denotes a novel way of governing the health on a planetary level. As the very term connotes, the aspiration has been to govern health globally

through a security approach. Both terminologies have their historical origins and this section briefly discusses how health has become a security issue on a global level. Since the previous chapter discussed the ways in which this change has been captured by academics, this section particularly evaluates the official documents of the WHO and the UN to assess how the historical evolution of global health security has informed the ways in which the institutional apparatus reacted to the Ebola Crisis between 2013-2015. As Rushton (2011) suggests, the approach should be aimed at understanding the political repercussions of the global health security regime.

3.2.1 The Introduction of the Emerging Infectious Diseases Narrative (1992-1995)

As Weir's (2015) study demonstrates, there are three major documents that could be classified as the foundational texts of the global health security regime. The first document as introduced in the previous chapter is the U.S. Institute of Medicine's *Emerging Infections: Microbial Threats to Health in the United States* (Weir, 2015: 19). The document (1992) had a reactive tone to the contemporary outbreaks of infectious diseases, even from the beginning, as the authors stated that "as the human immunodeficiency virus (HIV) disease pandemic surely should have taught us, in the context of infectious diseases, there is nowhere in the world from which we are remote and no one from whom we are disconnected" (Lederberg *et al.*, 1992: v). The authors' rather reactive tone also appears to feature an implicit notion of alert. This seems quite intriguing as this document was meant to be a policy-prescription document that was published by the U.S. Institute of Medicine. Even though the medical approach to the infectious diseases was carried out throughout the entire document, there seems to be an implicit anxiety informing the authors' tone in writing. This is of course a speculative argument, but there were statements in the

document that may actually be considered as corroborating what has been proposed here. For instance, after providing a brief history of infectious diseases and the evolution of public health measures, the authors (Lederberg *et al.*, 1992: 16-32) formulate a four-step action plan for the future policy formations. Before outlining the next steps, authors stated, and it is worth quoting this in length (Lederberg *et al.*, 1992, 32):

It is unrealistic to expect that humankind will win a complete victory over the multitude of existing microbial diseases, or over those that will emerge in the future. This will be true no matter how well stocked our armamentaria of drugs and vaccines, no matter how well planned our efforts to prevent and control epidemics, and no matter how advanced our basic science and clinical understanding of infectious diseases. Microbes are ranked among the most numerous and diverse of organisms on the planet; pathogenic microbes can be resilient dangerous foes. Although it is impossible to predict their individual emergence in time and place, we can be confident that new microbial diseases will emerge.

Ostensibly, the authors use a rather unscientific way to approach the issue where the language approximated speculation with the terms such as ‘microbes can be resilient’, ‘dangerous foes’ without really corroborating their assertions with empirical evidence. In addition, the committee also used words such as ‘armamentaria’ , ‘victory’ and ‘foe’ which actually utilizes a militaristic discourse where the drugs and vaccines appears to constitute the arms that protect us (in this instance the United States) from the diseases (foes). Such terminology, arguably, carries an us-and-them mentality and apparently had an effect on informing one of the most debated aspects of the global health security regime. I will return to this debate later on in this section, but before that, there is another point that needs further elaboration. Returning to the four-step approach, these sets of policy prescriptions are quite interesting, not just for proposing the new agenda for the mitigation of future infectious, but for being quite influential in shaping the future of global health security. The four-step approach is comprised of:

- (i) Perceiving the Threats
- (ii) Detecting the Threats
- (iii) Understanding Threats
- (iv) Responding to Threats

(Lederberg *et al.*, 1992: 32-33)

Underscoring the inefficacies of the health regime, the authors (Lederberg *et al.*, 1992: 113) call for the establishment of a more active surveillance system arguing that the increased global surveillance “would strengthen U.S. surveillance activities and encourage efforts to develop a global infectious diseases surveillance network.” Elaborating on such narrative, Lederberg *et al.* (1992:134) state that even though the WHO had been involved in monitoring any possible outbreak of infectious diseases and the United States was involved in worldwide surveillance efforts, “current surveillance efforts are not effectively linked; consequently, knowledge of small clusters of emerging diseases, even if detected, is not widely disseminated.” With this background, what Lederberg *et al.* prescribed to the officials was to actively create a surveillance network which would have global reach to monitor emerging infectious diseases (EID).

The concept of EID also has been influential in informing the current global health security regime. So far, there are three themes in IOM’s (U.S. Institute of Medicine) report that were exported to the formation of the global health security regime. These are (i) the embedded us-and-them logic promulgated by the use of the word threat (which later on became a part of North/South divide on the issue of health), (ii) the call for a well-functioning global surveillance system and (iii) the promulgation of the EID concept. A similar conclusion also has been noted in the literature as some scholars (Weir and Mykhalovskiy, 2010: 30) argue that EID reframed how the infectious diseases would be conceptualized in the future

questioning “existing national and international infectious disease control arrangements.”

The first country that the United States approached was Canada. In 1994, the Lac Tremblant Declaration was published. Addressing the policy recommendations that was published in IOM’s report in 1992, the Lac Tremblant Declaration also underscored the importance of establishing a more extensive WHO regime to monitor the EID globally. The WHO’s representative at the meeting, Dr. Giorgio Torrigiani, then the Director of Division of Communicable Diseases at WHO, stated that the WHO had realized the necessity of forming an effective surveillance system recommending that “a worldwide approach” was essentially required which had “an early warning system” (Lac Tremblant Declaration, 1994: 5 quoted in Weir and Mykhalovskiy, 2010: 42). James De Luc, then Medical Officer at the Division of Communicable Diseases at the WHO, also highlighted that “WHO is developing a new program for global monitoring of infectious diseases” (Lac Tremblant Declaration, 1994: 5 quoted in Weir and Mykhalovskiy, 2010: 42). These statements are quite intriguing as the WHO’s two representatives at the meeting almost assured that the WHO was already on board with the policy prescriptions laid out in the IOM report in 1992. Interestingly, as noted in Weir and Mykhalovskiy (2010), “3 of the 5 international participants at the Lac Tremblant workshop” had already contributed to the promulgation of the concept of the EID before. Thus, the Lac Tremblant Declaration, as an extension of IOM’s 1992 report, was an instance where the academics and policy-makers who contributed to the IOM report managed to elaborate on their previous works. It is worth noting that Canada and the United States had slightly different approaches to the concept of EID. Few Canadian academics and policy-makers were hesitant about implementing a such massive

global surveillance system for EID. Yet, this declaration also underscored the importance of extending Canadian surveillance system.

As it is noted above, the WHO's representatives to Lac Tremblant, Dr. Torrigiani and James De Luc, underscored that the WHO was indeed aware of the necessity for exercising a well-functioning global surveillance system. Following the IOM's report (Lederberg *et al.*, 1992) and Lac Tremblant Declaration (1994), two ensuing meetings were held at the WHO Headquarters in 1994 and 1995, respectively. The initial report published in 1994, addressed the 1992 IOM study (WHO, 1994: 1):

Considerable attention has recently been directed to the topic of emerging infections. This issue was brought to the fore of national and international discussions in the book, *Emerging Infection, microbial threats to health in the United States*, published in 1992 by the Institute of Medicine, U.S. National Academy of Science ... Pathogens do no respect international borders, and that an infection acquired in one corner of the globe may lead to an epidemic in a distant country far removed from the original site of infection. Clearly a global approach is needed to address emerging infections, and this task falls squarely among the responsibilities of the World Health Organization.

The initial remarks of the report reveal at least three similarities to the 1992 IOM report. Firstly, the concept of EID was successfully extrapolated to the global arena. Secondly, the North/South divide on the issue of infectious diseases started to become more recognizable. Third, the idea that was promulgated in the 1992 IOM report and Lac Tremblant Declaration that the WHO should lead the efforts in the formation of a global surveillance system found purchase at WHO Headquarters. In his opening speech of the meeting, Dr. Ralph Henderson, then the Assistant Director-General of the WHO, remarked that the WHO had already been involved in "responding to emerging microbial threats to health" (WHO, 1994: 13). He provided the WHO's active involvement in the mitigation of influenza viruses. Regarding the WHO's effort as successful, he stated that "WHO is also a focal point for

surveillance of global infectious diseases, and under International Health Regulations, all countries must report to the WHO cases of cholera, plague and yellow fever” (WHO, 1994: 13).

He was indeed correct in claiming that every state is obliged to notify the WHO about cases of cholera, plague and yellow fever under the International Health Regulations. Yet, what the United States demanded was more ambitious. Elaborating on the four-step plan laid out in the 1992 IOM report, the US representative to the WHO meeting in 1994, Dr. Ruth Berkelman, underscored the need for a more comprehensive global surveillance system that was capable of monitoring “emerging pathogens, the diseases they cause” (WHO, 1994: 3). This narrative also became the crux of the discussion at the 1995 WHO meeting.

Embracing the role that was demanded by the United States, the 1995 WHO report acknowledged that (WHO, 1995: 1) “newspapers, magazines and books now abound with reports of the latest dreaded diseases to emerge, and descriptions of the return of those once thought conquered” and the WHO should be responsible for addressing this turmoil. The report contains the statements of the WHO staff who “applied the EID concept to a long history of WHO programming in communicable disease surveillance and control; antimicrobial resistance, tuberculosis, malaria, influenza, polio, arboviruses, HIV, leishmaniasis, foodborne disease, and a variety of initiatives to digitize knowledge of infectious diseases” (WHO, 1995: 2-6 quoted in Weir, 2015: 20). Elaborating on the WHO’s partnership with national governments, as part of the recommendations section in the report, three suggestions were made for national governments. The first suggestion was that all countries should have the necessary infrastructure that would enable them to diagnose disease endemics in their areas and should have “the ability to refer specimens from suspected uncommon

diseases to an appropriate reference facility” (WHO, 1995: 11). The second point underscored the necessity for having the “epidemiological capacity to investigate outbreaks, collect specimens, and analyze the test results” (WHO, 1995: 11). The final bullet-point stated that all states should have access to a global monitoring system which would be used as a data pool to analyze and detect emerging infectious diseases (WHO, 1995: 11). The reports of the subsequent WHO meetings in 1994 and 1995 were formalized in 1995 with World Health Assembly (the legislative body of WHO) Resolution 48.13, *Communicable Disease Prevention and Control: New, Emerging and Re-emerging Infectious Diseases*. The Resolution urged member states to be a part of the surveillance system, improve their infrastructure to identify diseases, “to enhance [...] communications between national and international services involved in diseases detection”(World Health Assembly, 1995: 2).

IOM’s report in 1992, Lac Tremblant Declaration in 1994 and World Health Assembly’s Resolution 48.13 were the documents that constituted the backbone of the inception of the current global health security regime. In Weir’s (2015: 20) words, these subsequent documents “formed a discourse chain that recontextualized the EID concept from U.S. domestic public health into international public health at WHO.” What does this really entail? Recalling Neumann’s (2008:67) methodological suggestion about locating the anchor points in discourse analysis, the 1992 IOM report appears to be a “canonical text or monument” that was used as the main reference point for the subsequent documents of Lac Tremblant Declaration in 1994 and the World Health Assembly Resolution 48.13. Discursively, the subsequent documents followed what had been presented in the 1992 IOM document.

Note that there were earlier episodes in the history of Europe that might be conceived as instances of attempts at forming a global surveillance system for the

mitigation of diseases. For instance, the International Sanitary Regulations regime that started in 1851 aimed at obliging states to “notify other countries about outbreaks of specified diseases; and maintain adequate public health capabilities at points of disease entry and exit” (Fidler, 2005: 329). This concern amongst ‘the Northern states’ began in the nineteenth century, as the velocity and volume of the trade between European states and their trade partners increased. In other words as the integration of the commerce rapidly increased, “so did the risk of infectious disease being brought into Europe from elsewhere” where the disease was seen “as an exogenous threat which had to be dealt with by means of international cooperation on public health” (McInnes, 2008: 275). There seems to be a continuity between the European conception of diseases in nineteenth century and US-led lobbying against EID at the end of the twentieth century.

Even though there was temporal difference between the occurrences of these events, the underlying logic appears to be reflecting a Northern-bias. Obviously, European states back then, and the United States in its recent efforts do not have to consider the well-being of other states. Yet, when the efforts become so ambitious in their global aspiration; the logic of threat, regarding diseases as exogenous, and juxtaposing the implementation of global policies with national security language causes political discontent amongst the Southern Bloc, especially among the African and Latin American states.

There seems no obvious connotation of security in the previous documents on global health governance. Even though these documents can be considered as the constitutive discursive frameworks that enabled the formation of the global health security regime, there was not an obvious utterance that deemed EID as a security threat in the traditional sense of the word. The underlying logic of threat-defense,

inside-outside, us-them were already evident in these documents, yet “global health security in its early programmatic form was not on record integrated with international security” (Weir, 2015: 20). Initially, the tone of the documents were generally designed as calls for “a paradigm shift in response to how human health is being affected in new ways by global-interconnectedness. The emergence of global health was presented [...] as a natural response to changes in the material world” (McInnes and Lee, 2012: 8). Such line of argumentation actually makes sense because the 1992 IOM report also was a monumental instance where the previous confidence in national health system in the United States was challenged.

Tracking the perceptual changes regarding diseases in the twentieth century, McInnes (2008: 275) notes that in the aftermath of WWII, health was generally conceptualized as a human right. He (McInnes, 2008: 275) also underscores that there had been an ethos of victory being won against the diseases with the widespread use of antibiotics. Yet, in the 1990s, there seemed to be, as discussed above with textual evidence, a perceptual shift regarding infectious diseases. The change in the academic circle also found its policy-proponents as was the case in the WHO meetings. In addition to that, this change, which included a widespread ‘fear’ about the infectious diseases, found purchase on the media outlets. Laurie Garrett’s book titled *The Coming Plague* (1994) Henig’s *A Dancing Matrix: Voyages Along the Viral Frontier* (1993) were published during the inception of the changing perception regarding infectious diseases. For instance, the media outlets also aired the outbreak stories more often than more chronic issues such as obesity, smoking and alcohol misuse (McInnes and Lee, 2012: 10).

In this sense, the narrative on EID "tends to privilege acute and severe infectious disease outbreaks over diseases which do not behave in this manner"

(McInnes and Lee, 2012: 36). It also started to put more emphasis on the importance of “the global over the local,” which later created an “inside/outside dichotomy, where infectious disease outbreaks are seen as threats emanating from ‘outside’ western countries or ‘over there’ in the developing world” (McInnes and Lee, 2012: 40). Even though the security language was not utilized in its full form, the underlying logic of security appeared to be evident in the discourse of these initial documents with its implicit embodiment in the logic of inside/outside and threat/defense.

3.2.2 The Great Leap Forward: The WHO Behind the Wheel (1996 - 2000)

In late 1995, a new sub-agency under the WHO mandate was established. The division was called Emerging and Other Communicable Diseases (EMC). EMC published a strategic plan “to carry forward WHA Resolution 48.13 and the recommendations of the two ad hoc WHO meetings on emerging infectious diseases” (Weir, 2015: 21; WHO, 1996: 2). EMC denoted this new vision as “A World on Alert” with a four-tier plan for future infectious diseases (WHO, 1996):

- strong national disease surveillance and control programmes
- global networks of centers, organizations and individuals to monitor diseases
- rapid information exchange through electronic links to guide policies, international collaboration, trade and travel
- effective national and international preparedness, and rapid response to contain epidemics of international importance

Proposing a similar set of recommendations and policy plans for the future at the WHO meetings in 1994 and 1995 regarding the establishment of a global surveillance system, EMC added two new items to the agenda. The first was a call to

revise the current International Health Regulations (IHR) “to address disease syndromes rather than specific diseases” (WHO, 1996: 4). This call for revision would be the crux of the future clash between the purported Northern and Southern Bloc. The debates on the IHR revision would raise the questions of security of whom and security from what around the 2000s. The repercussions of this call is discussed below.

The other novel suggestion that EMC made was related to the pace of response to future outbreaks. EMC aimed at assisting the national governments in their preparedness regarding future outbreaks. This included the formation of expert teams “in collaboration with WHO Division of Emergency and Humanitarian Action (EHA)” that would be ready for deployment in “24 hours of notification to WHO” at a “site of the outbreak” (WHO, 1996: 8). Note that, even though EMC’s plan included an expanded global surveillance system, it still did not use a language of security. EMC also was tasked with the development of “the Global Outbreak Alert and Response Network (GOARN)” (Weir, 2015: 21).

In 2000, the WHO Department of Communicable Diseases Surveillance and Response, formerly known as EMC, published a report titled *A Framework for Global Outbreak Alert and Response* (GOARN) (WHO, 2000a). Along with previously prioritized EID, the GOARN also was designed to respond to “the accidental and deliberate releases of a biological agent into human and or animal populations” (WHO, 2000a: 3). This had been a novel development, as with the inclusion of this item on the agenda, the WHO extended its monitoring activities to a governance sphere where “international security dimension ... was integrated into its operations” (Weir, 2015: 21). In other words, as it was argued in the document,

GOARN was aimed at increasing “global public health security” (WHO, 2000a: 7). A more extensive report on GOARN was published in the same year (WHO, 2000b). This report located the main confrontation areas at the beginning of the twenty-first century as follows (WHO, 2000b: 4):

- The emergence of new or newly recognized pathogens.
- The recurrence of well-characterized outbreak-prone diseases.
- The accidental or deliberate release of biological agents.

The third bullet-point indicated that the WHO was persistent in adding bio-security to its governance apparatus. Another development had been the introduction of the Global Public Health Intelligence Network (GPHIN), which was “an Internet-based, time-sensitive warning system for global, public health events (from outbreaks over environmental disasters to bio-terrorism), continuously scanning electronic sources for information” (WHO, 2000b: 5). The introduction of the GPHIN system and bio-security governance increased the WHO’s mandate to an extent where the formerly consent-based system of outbreak notification was no longer left to the sovereign states.

Before proceeding with the analysis of the developments in the WHO’s mandate between the years of 1996 to 2000, there had been another international event that reiterated how the global health governance became intertwined with international security. In 2000, the UNSC held a meeting to discuss the accruing threat of HIV/AIDS. Resolution 1308 was “adopted by the Security Council ... on 17 July 2000” (UNSC, 2000: 1). The document acknowledged the UN’s increasing concern regarding the spread of HIV/AIDS. The Resolution 1308 deemed that “the HIV/AIDS pandemic, if unchecked, may pose a risk to stability and security” and it was “Council’s primary responsibility” to preserve “international peace and security.

(UNSC, 2000: 2). Featuring a pandemic disease on the agenda of the institution that has the highest international security mandate indeed changed the future of global health governance.

The concept of EID which was introduced in the 1992 IOM report appeared to be quite effective in shaping the future of global health governance. Between the years of 1996 and 2000, WHO started to expand its mandate on the governance of global health. Formerly absent and rather implicit security language started to appear more often in these years and reached its most recognizable form in the 2000 UNSC Resolution 1308. In other words, “[t]he Security Council’s intervention appeared to act as a catalyst, changing the way in which the disease” was conceptualized (McInnes and Rushton, 2010: 225). The UN’s involvement in HIV/AIDS pandemic started a phase where the former discourse on assistance and surveillance developed throughout the 1990s, and succumbed to the security language (Elbe, 2005; 2006: McInnes 2008; Rushton, 2011) whereas “in the first two decades since the discovery of HIV/AIDS in the mid-1980’s, the disease was conceptualized primarily as a public health and development issue” (Elbe, 2006: 121). In addition to that, WHO’s inclusion of bio-security in its agenda also signified a change. All of these developments also coincided with the changing nature of international landscape where the institutions such as the WHO and the UN started to broaden their mandate. As McInnes (2008: 277) notes, there are “three substantive health issues [that] contributed to the emergence of health on the security agenda.” He outlined these as follows (McInnes, 2008: 277-281):

- the spread of infectious diseases
- HIV/AIDS pandemic
- bioterrorism

The fear of the spread of infectious diseases started to emerge in the early 1990s and this fear essentially resulted in the IOM's report in 1992. The concept of EID was introduced in accordance with such growing anxiety towards the emerging infections. The United States managed to internationalize its concerns through its alliance with Canada and the extrapolation of these concerns to the WHO's agenda. HIV/AIDS and bioterrorism were featured on the agendas of the WHO and finally the UN during late 1990s. WHO's new monitor-and-respond body GOARN was deployed as part of the growing concern of bioterrorism. HIV/AIDS juxtaposed with international security by the UN as the disease, arguably, caused national economies to decline (McInnes, 2008: 280).

In addition to that, the United Nations Security Council feared that the spread of HIV would harness the effectiveness of peace-keeping forces and national security forces which would later damage the ability of the local governments to govern their population (McInnes, 2008: 281). Even though these concerns often failed the fact-check (McInnes and Lee, 2012), "in retrospect, the unprecedented meeting of the Security Council has proved decisive in terms of placing the global AIDS pandemic firmly on the international security agenda and has done much to compel states to increase the political priority this illness receives around the world" (Elbe, 2005: 404). The gradual deployment of a security discourse would generate controversies in the upcoming years, especially after 9/11. The next section outlines how the security discourse prevailed over humanitarian and development frameworks.

3.2.3 IHR Revision Process: Who Is Part of the Cure? Who Is Part of the Disease? (2001-2005)

In May 2001, the WHA Resolution 54.14 titled as *Global Health Security: Epidemic Alert and Response* was approved. Apparently, the deployment of the global health

security narrative became explicit in the WHO's discourse. The document underscores the impact of globalization on the increased pace and velocity of movement and trade and asserts that as an inherent result of this acceleration, "any upsurge in cases of infectious disease in a given country is potentially of concern for the international community" (WHA, 2001: 1). The use of the global health security connotation aggravated tremendously after 9/11 with the increased emphasis given to the possible weaponization of the chemical, biological, radionuclear agents. WHA Resolution 55.16, *Global Public Health Response to Natural Occurrence, Accidental Release or Deliberate Use of Biological Agents or Radionuclear Material that Affect Health* (2002), suggested that the member states should become more attuned to the global health security efforts by establishing national surveillance systems that were capable of monitoring the release of dangerous biological agents (WHA, 2002: 2).

Weir (2015: 22) argues that the WHA resolutions in the new millennium appeared to be influenced by the "international political context affected by US protectionist reactions to the destruction of the World Trade Center and the intentional spread of anthrax in the United States during the fall of 2001." The WHO's increased involvement in the provision of the global health security regime appeared to be violating its "powers clearly in excess of those mandated under the IHR (1969)" (Weir, 2015: 22).

The period, starting from the publication of the IOM report in 1992 to the intentional spread of anthrax in 2001, witnessed an increased attention given to the control and surveillance of the infectious diseases. Even though, the WHO tried to address these concerns by way of issuing several resolutions and implementing new surveillance policies (such as GOARN), these policy descriptions had been reactive,

and did not really address the new frontiers of the global health security. As Fidler (2005: 338) the new frontiers of global health security “were many and complex” including intertwining with a variety of issues such as “globalization, urbanization, migration, breakdown of public health systems, declining effectiveness of antimicrobial therapies, environmental degradation and poverty.” In addition to that, with the intentional release of anthrax in 2001, the concerns regarding the “proliferation of biological weapons” also increased. All of these concerns culminated in the IHR revision process between 2003 and 2005.

The need to revise the IHR was already underscored as early as 1995 (WHO, Resolution 48.7, 1995). The old IHR (1969) was only applicable to three diseases, cholera, plague and yellow fever. Apparently, with the introduction of the EID concept in 1992, the decade long HIV/AIDS pandemic, intentional anthrax release in 2001, and the SARS outbreak in 2003; the old IHR almost became irrelevant to the problems of the contemporary global health security. With this background, the years between 2003-2005 witnessed fierce debates regarding the reformation of the IHR. The debates were generally informed by the division of the political agendas on the geopolitical basis. The North-South gap, which will be discussed in detail in the analysis section that follows, had been surfaced during the IHR revision talks. The question of security from what and security for what essentially framed the discussions. As Rushton (2011: 780) argues “many of the diseases which have been widely framed and officially accepted in the West as major health security risks are endemic in parts of the Global South.” The policy-prescriptions laid out in the new IHR (2005) revitalized the security for whom question as the WHO’s strategies were more in line with a containment strategy rather than prevention (Rushton: 2011). The geopolitical boundaries appeared to be still visible even though the global health

security narrative have attempted to advocate for the borderlessness of the twenty-first century. As Weir (2015: 27) summarizes that in the literature “global health security is characterized by a harmonian [sic] ethos of borderlessness that places its actions above the petty division of geopolitical world order.” Challenging this view, Weir (2015: 27) argues that “borderlessness is a lullaby for Northern hegemony.” In comparison to what IHR (2005: 14) asserts to be the purpose of the new regulations, this assertion may be valid, as the purpose of the IHR was determined as:

The purpose and scope of these Regulations are to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.

In another survey, referring to the prominence of the state as the inevitable geopolitical containment unit that Rushton (2011: 788) argues that:

In terms of the reference object - the ‘security for whom?’ question - it is certainly true that the WHO has attempted to look beyond the state in order to look beyond the state in order to enhance the ability of international community to respond to the threats posed by disease in a globalized world. In security terms it has not, however, brought a change in the referent object [state].

The geopolitics of disease containment would become the focal point of the discussions regarding the policy-prescriptions during the Ebola outbreak. Yet, with the adoption of the new IHR, the global health security narrative that had started in 1992 was legally materialized. The following section discusses how the IHR became a referent document for the successive WHA resolutions.

The reformation of the IHR revitalized the centuries long debate informed by different positions of the purported Northern and Southern states. This was not really unexpected given the almost exclusive leadership of the United States in the

introduction and the establishment of the EID concept as the main narrative of the WHO governance. The EID concept and the US leadership was discussed in relation to the securitization theory above. Unlike the analyses above, which has been limited in their temporal focus, this section attempts to outline the continuities between the first international sanitary conference in 1851, and the debates surrounding the reformation of the International Health Regulations in 2005.

The method that this section deploys is discourse analysis through intertextuality which studies the “connection of texts and meanings through reference to other texts” (Mutlu and Salter, 2012: 114). The main aim is to indicate that the prominence of competing national security narratives were evident since the congregation of the first international sanitary conference. The other point that this section attempts to make is the North-South divide that galvanized the IHR revisions in 2005 was not only caused by the resentments of purported Southern countries due to their *de facto* exclusion from the initial years of the reformation of the WHO governance apparatuses. The debate predates the twenty-first century and also appears to be informed by the continuity of the ‘colonial’ language of the European imperial powers in the late nineteenth century.

There had been eleven international sanitary conferences between the years of 1851 to 1903.¹² Since a detailed examination of all the documents exceeds the boundaries of this research, the focus is on the key points at these conferences in relation to their discursive effects on the IHR revision process in 2005. The first conference was convened in Paris in 1851 with the participation of the delegates of Austria-Hungary, the Two Sicilies, Spain, the Papal States, Great Britain, Greece,

¹² Note that the original documents are in French. Unfortunately, I did not have additional funding for a translator by the time of writing. Admittedly, I had to consult secondary sources. The original documents are available at: <http://ocp.hul.harvard.edu/contagion/sanitaryconferences.html>

Portugal, France, Russia, Sardinia, Tuscany and Turkey (Rosen, 1958: 167). The conference was convened by the French government in an attempt to discuss the quarantine measures regarding the diseases of cholera, yellow fever and plague (Howard-Jones, 1975: 12). Countries were divided in relation to their positions regarding the enforcement of the quarantine measures against any future outbreak of cholera or not. In Howard-Jones' (1975: 16) words, in practical terms, "the first International Sanitary Conference was a fiasco." Perhaps, it was on the grounds that countries did not really agree on any international standards to be taken against cholera. However, the very congregation of the conference set the tone for the subsequent conferences. The emphasis on cholera, yellow fever and plague (the big three in Fidler's terminology) continued to be on the agenda of the successive conferences. In addition to that, 'the big three' continued to be on the agenda of WHO in the twentieth century. Another controversy appeared to generate from the debate regarding the introduction of cholera from the Ottoman soil to Europe.

The European delegates believed that the "cholera penetrated Europe through the Ottoman Empire which had become a breeding ground for this disease, and the [local] authorities had to play a more active role at prevention" (Ersoy, Gungor and Akpınar, 2011: 56). The head of the Turkish delegation, Dr. Bartoletti, disavowed this assertion by claiming that the cholera had arrived in Turkey through the Ottoman pilgrims who had contracted the disease through Indian pilgrims at Mecca (Ersoy *et al.*, 2011: 56). This initial sentiment regarding the origins of the cholera was extrapolated to the discussions in the next century. Moreover, the North-South divide during the IHR (2005) revision process also suffered from a certain degree of Eurocentrism as the Southern countries were seen as the hubs for the reemerging diseases. Rather than really advocating for a multi-lateral approach for the benefit of all the

participant parties, the aim of the convention appeared to be more in line with the protection of the European trade effort.

It was not until the eighth and the ninth sanitary conferences that any agreement had been reached regarding the implementation of preventive international measures. The participant states agreed to “establish common measures for protecting public health during cholera epidemics without uselessly obstructing commercial transactions and passenger traffic” (Fidler, 2005: 329). Even though the participant states generally were located in Europe, the Austria-Hungarian delegate underscored the importance of extending the spatial scope of the agreement by notifying the United States (Howard-Jones, 1975: 70). A similar argument was made by the French delegate, as he pondered that “a similar course be taken with the countries of South America, and through the British Government, with Cyprus, Gibraltar, and Malta” (Howard-Jones, 1975: 70). The signatory states agreed to implement international measures as agreed upon during the eighth international sanitary conference. Howard-Jones (1975: 70) summarizes the agreement as:

The new convention elaborated by the conference was signed by only 10 of its members, Britain, Denmark, Greece, Portugal, Romania, Serbia, Spain, Sweden/Norway, and Turkey all announcing that they would have to refer it to their governments. The conference held its closing session on 15 April. The governments signing the convention pledged themselves to notify each other urgently of any outbreaks of cholera within their territories and agreed that the only goods to be subject to import restrictions were used clothes and bed linen and rags, which were to be either prohibited or disinfected, but not retained in quarantine.

Mecca, and the movement of pilgrims became an important debate subject between conversing parties. In 1893, a cholera outbreak occurred in the Hejaz region which spread into Iran, Russia, Galicia, the Ottoman Empire and Europe. (Ersoy *et al.*, 2011: 66). The sentiment that cholera was indeed an outside disease that had arrived

to Europe started to gain momentum in the belief-systems of the European participants to these conferences. In accordance with that, quarantine measures were deployed, rather elaborately, as there were at least “65 quarantine stations in Anatolia, 17 on the border with Iran and 12 in the Red Sea and the Hejaz” (Şehsuvaroğlu, 1984: 335-338 quoted in Ersoy *et al.*, 2011: 68). Arguably, Europe and the rest mentality existed between the lines of the transcribed international sanitary conference sessions. Even though the European signatories to the conferences also were deploying measures in continental Europe, the belief that, especially regarding cholera, these diseases had arrived in Europe from elsewhere, in this case Asia, started to dominate the narratives (Cumming, 1926: 967). The Pan-American Sanitary Bureau (1902) and Office International d’Hygiène (1907) were founded. The latter was “charged with the collection of disease statistics, the study of epidemic diseases, the implementation of measures passed by the international conferences” (Birn, 2009: 53).

Thus far, the international sanitary conferences and the establishment of the institutional apparatuses during the late nineteenth and early twentieth centuries were discussed. Note that the foci of these conventions had been confined to the three diseases, cholera, plague and yellow fever until the inclusion of typhus and smallpox at the 1926 conference. The limited scope of the international sanitary conventions, arguably, as purported by Fidler (2005: 332) was a result of “the classical regime’s fundamental concern” which had been lessening the burden on European and North American trade created by national responses in those regions to the threat of the importation of ‘Asiatic diseases’.” The international collaboration and negotiation regarding the establishment of an international quarantine and surveillance mechanism regarding the then beckoned diseases of cholera, yellow fever, plague,

typhus and smallpox had been quite arduous. The controversies regarding the enforcement of measures, existence of Euro-centrism, standardization, compliance of the signatory parties were all evident in the negotiation processes of the new IHR between 2003-2005.

In 1969, the name of International Sanitary Regulations was changed to International Health Regulations. During these years, there had not been a significant change made in the provisions of the IHR, with the exception of the removal of the smallpox from the list of infectious diseases in 1981. Due to the unresponsiveness of the IHR to the needs of the twentieth century and decreasing political salience of infectious diseases, the IHR's relevance became obsolete. With the introduction of the concept of EID in the United States in 1992 to the health security lexicon, and the ascendancy of the fear against bioterrorism, the debates regarding the revision of the IHR were revitalized once again (Fidler, 2005; Weir, 2015).

As noted above, the first attempt at reforming the IHR occurred in 1995 with the request of the World Health Assembly. The lobbying efforts of the US policy-makers were immensely significant in prioritizing the revision process. As reflected in Resolution 48.7, the WHO and its member states also were aware of the fact that the old IHR was not really addressing the contemporary global health problems. The main narrative, dating to first international sanitary conference in 1851, were aimed at "ensuring maximum security against the international spread of disease, involving interference with world traffic and trade" (Fidler, 2005: 344). Even though the provisional draft (1998) for the revision of the IHR contained novel ways of policy prescriptions for the reformation of IHR, the embedded tension between state

sovereignty and the WHO's expanding governance regime was the focal point of the document.

During the IHR revision process between 2003-2005, a number of embedded controversies resurfaced. The first one relates to one of the provisional articles “which would require States Parties to provide to WHO all relevant public health information, materials and samples for verification and response purposes if States Parties had evidence of an intentional release of a biological, chemical and radiological agent within their territories” (Fidler, 2005: 356). The issue of sovereignty constituted the crux of the controversies between the Southern and Northern states. Although, nearly all participant states approached the introduction of the concept of EID into the new IHR's mandate positively, the Southern states were utterly skeptical about the inclusion of the surveillance efforts of the chemical, biological, and radiological and nuclear (CBRN) agents (Weir, 2015: 24).

The controversial issues surrounding the 2003-2005 IHR revision process reflected a considerable gap between the South and North. Even though the Southern states generally supported the inclusion of the concept of EID in the new IHR, the references to the CBRN agents were not welcomed in relation to the sovereignty claims. The apparent gap between the perceptions of the North and South was not novel. Since the first international sanitary conference in 1851, the perceptual stances regarding the origins of the diseases, implementation of measures, and establishment of a surveillance system had been generating a divide between the states on the grounds of sovereignty. This divide was revitalized during the IHR revision process in 2003-2004.

3.2.4 Before Ebola, After the IHR: Sovereignty's Changing Nature (2005-2013)

Since its first explicit promulgation in 2001 with the World Health Assembly Resolution 54.14, the global health security narrative became nearly synonymous with global health governance. Approval of the new IHR in 2005 reiterated the dominant security approach regarding health governance which culminated in the 2007 World Health Report. The definition of global health security as posited by this document has been discussed at length in the previous chapter. Yet, it seems essential to provide the definition of the global health security in here as well to underscore how the terminology found purchase at the WHO (WHO, 2007: 1):

Global public health security embraces a wide range of complex and daunting issues, from the international stage to the individual household, including the health consequences of human behavior, weather-related events and infectious diseases, and natural catastrophes and man-made disasters, all of which are discussed in this report.

The report yields conclusions about the three intertwined narratives regarding the nature of global health governance in the twenty-first century. The first one is the acceptance of the global health security phrase as an umbrella terminology. Since the publication of the IOM's report in 1992, the term was clearly infused into the global health governance narrative and managed to become the dominant analytical tool. The second one is the global health security regime, which as purported in the document, had not only been designed to govern the infectious diseases (as intended in 1992) and man-made disasters (intentional use of CBRN), but also deployed as part of an extended governance regime whose ambition was to control environmental disasters and household well-being. This is an all-encompassing governance understanding which was absent during the 1990s. In relation to this reading of the report, the final point yields that the global health security regime had surpassed its original domain of governance by indicating that its governance covers issues

ranging from individual household and health to environmental and weather related catastrophes.

Such reading of the document indeed complicates the main narrative of this research. The previous chapter discusses competing analytical frameworks used in the conceptualization of global health, and argues that the global health security narrative prevailed over others. This chapter reiterates this assumption by taking evidence from the WHO and UNSC documents. Yet, by the time the discussion reaches 2007, another analytical framework appears to become more apparent that is the embedded mentality of biopolitics. Appeals to Foucauldian analytical schemes, especially to biopolitics and governmentality, had been briefly discussed in the previous chapter as part of the literature review (Elbe, 2005; 2010, Weir and Mykhalovskiy, 2010).

This chapter intentionally dismissed the Foucauldian analysis to provide a clearer engagement with the formation of the global health security narrative with an emphasis on *security*. In essence, the security language had affected the analytical conceptualization of the global health governance which then, elicited the formation of a global surveillance system. As Weir and Mykhalovskiy (2010: 1) argue in relation to the extrapolation of the concept of EID to the WHO's agenda, the utilization of the EID led to "the invention of a monitoring/surveillance technique called 'online early warning outbreak detection' and the formation of a politico-juridical regime dealing with international public health emergencies." Elaborating on a similar theme, Elbe and Voelkner (2015: 71), focusing on the sociological aspect of the global health security, propound that:

the rise of health security also represents a critical instance of 'medicalization' insofar as the discourse of health security is a site where the

social forces of medicine are further expanding and intensifying in international politics - to the point that they are now also beginning to shape a range of security discourses and practices.

In other words, the utilization of security discourse resulted in the formation of techno-scientific apparatuses through the global health surveillance system, stockpiling of pharmaceuticals and the increased involvement of medical professionals in the decision making processes (Elbe and Voelkener, 2015: 72-73).

This chapter's focus has been limited to the effects of discursive frameworks in shaping the formation of the global health governance. In particular, the attention is given to the discursive power of the deployment of the security language. The following chapter, as an elaboration on the Foucauldian insight, assesses the sociological repercussions of the utilization of the security language.

3.3 Conclusion

This chapter provided a genealogy of the reformation of the global health security regime. Building on the analytical conceptualizations outlined in Chapter II, this section substantiated the argument that the global health governance regime had been infused with a security narrative. The period starting with the introduction of the EID concept to the adoption of the new IHR in 2005 were under scrutiny. The genealogical study offered how the concept of EID, juxtaposed with a narrative of security, permeated into the reformation of the global health governance regime, eventually connoting the contemporary global health governance efforts as synonymous with the global health security regime. By conducting discourse analysis, this chapter sought to underscore how the concept of EID became the prominent reference point for the assessment of what constitutes a threat or not.

Insights from securitization theory were utilized to understand how a few public health officials and policy-makers managed to securitize the new frontiers of global health by utilizing the concept of EID. Later on, the focus shifted toward the exportation of the concept of EID to the WHO quarters.

The use of the concept of EID, the political divide between North and South, the tension with the WHO's expansive global security narrative and sovereignty of the individual states, and the exponential developments regarding the deployment of global surveillance regimes have all together affect the shaped the ways in which the Ebola outbreak between 2014-15 has been conceptualized. The next section melts the analyses furthered in this chapter by applying them to the case of Ebola. In addition to the assessment of the effects of the global health security regime on the formation of the policy preferences regarding the mitigation of Ebola, the next chapter introduces the concept of global bio-politics to discuss the sociological repercussions of the use of the global health security narrative.

Chapter IV

GLOBAL HEALTH SECURITY AND BIOPOLITICS: THE CASE OF EBOLA

“ [...] despite two decades of political attention and significant investment in global health, the international response to the outbreak of Ebola in West Africa was slow and uncoordinated; neither a vaccine nor a cure were available despite years of research. The Ebola crisis, therefore, could be seen as having revealed the limits or, as some have argued, the outright failure of global health governance.”

(Roemer-Mahler and Rushton, 2016:

375)

4.1 Introduction

The 2014-15 Ebola Crisis that first erupted in West Africa and then spread overseas was the most severe outbreak of Ebola in recorded history. Based on figures available on the WHO's website, as of March 27, 2016, there have been 28,646 cases of Ebola virus disease (EVD), of which 11,323 resulted in death (“WHO's Ebola Response”, 2016). The WHO's African Regional Office “reported an outbreak of Ebola virus disease in Guinea” on March 23, 2014 (“Ebola Features Map”, 2016). Meanwhile the disease spread into neighboring countries Liberia and Sierra Leone. Liberia's Ministry of Health confirmed the first reported case of Ebola in a matter of days following the WHO's report. During the summer, two American aid workers were exposed to Ebola virus. There also had been ongoing “medical evacuations for infected health workers back to the USA and Europe” (McInnes, 2016: 381). The WHO declared the Ebola outbreak as Public Health Emergency of International Concern (PHEIC), as mandated by the revised International Health Regulations in 2005 (WHO, 2014). On September 18, 2014, the UN Security Council declared the outbreak an imminent threat posed against international peace and security through Resolution 2177 (UNSC Resolution 2177, 2014). The US Centers for Disease

Control and Prevention (CDC), which had been quite influential in the reformation of the global health security regime during 1990s, reported that “without additional interventions or changes” in the current prevention and control efforts, the death toll may rise up to 1.4 million (CDC, 2014). The first cases of Ebola in the United States and Europe were reported by the end of 2014 generating fierce debates about the efficacy and utility of the current prevention measures. The public concern in Europe and the United States exponentially was aggravated due to the possibility of an Ebola break in these countries.

Building on these key international developments throughout the course of the Ebola outbreak in 2014, this chapter extends the discourse analysis conducted in Chapter III to assess how the global health security regime mitigated the Ebola crisis between 2014 and 2015. This chapter is eclectic in the sense that it draws literature from different intellectual frameworks to form a more comprehensive understanding regarding the nature of the global health governance. Thus, individual sub-sections in this chapter engages with interlinked yet nuanced aspects of global health governance ranging from the utilization of the security narrative to global biopolitics. Each sub-section introduces different questions and benefits from varying intellectual tools.

Bearing in mind such structure, the general argument in the first sub-section is that the global health security narrative and its real-life apparatuses, that had been in the making since the mid-1990s, had been put to a test during the Ebola crisis between 2014-2015. The first part of this section evaluates the extent to which the global reception of the Ebola crisis had been affected by the already established global health security narrative. Analyzing the discursive frameworks circulated

through the policy documents that the prominent international institutions, namely the UN and the WHO, promulgated throughout the crisis, the first section argues that there are three recurring themes that are evident in the WHO's statements and the UN's bureaucracies that seemed to be informed by the global health security narrative. Firstly, the WHO and the UN documents published throughout the Ebola crisis yield that the global health security narrative prioritizes the state over the people. Such prioritization appears to be informed by the embedded national security narrative that was exported to the global health security regime.

Secondly, the prominence of the state features a certain degree of Western-centrism along with it. This theme already had been evident since the first congregation of the International Sanitary Conference in 1851. Then, as discussed in the previous chapter, the European states regarded cholera as an exogenous disease originating from the Middle East and spreading to the European continent through the Ottoman Empire. The existence of such Western-centrism recurred during the IHR revision process in 2005. As Rushton (2011: 780) argues "many of the diseases which have been widely framed and officially accepted in the West as major health security risks are endemic in parts of the Global South." Such an approach features a certain degree of normative bias which generates doubts over whose security that the global health security regime is actually observing.

The last theme that appeared to be embedded in the global health security narrative is the existence of an implicit biopolitical mindset. The second section draws on literature from the global biopolitics literature (Elbe, 2006; 2010) so as to posit an alternative explanation regarding the rationale behind the inner logic of contemporary global health governance. In particular, the aim is to reformulate the

question asserted by Elbe (2010: 14): How do health security debates also begin subtly to reshape our understanding of security and insecurity in international relations? Thus far, this research generally has focused on how the security narrative had an impact on the formation of different sets of policy choices. The case of Ebola witnessed the culmination of decades long juxtaposition of security and health. Moving beyond explicating one side of the story, this section aims at understanding the other side by particularly emphasizing “how our understanding of security might also be affected or shaped by this 'marriage' to a growing set of global health and medical issues" (Elbe, 2010: 15).

With this background, the first section claims that the ways in which the international community has formed sets of policies regarding the mitigation of Ebola has been affected by the legacy of the three decade long reformation of the global health security narrative. Drawing insights from McInnes’ (2016) study on the relationship between the global health security narrative and the global perception of Ebola, the first section will discuss why and how the Ebola outbreak reached the apex of the global health security agenda. Theoretically, securitization theory as conceptualized by McInnes and Rushton (2012) will be used to demonstrate how securitization as a process, rather than an instance of isolated cases of speech acts, predetermined the policy prescriptions regarding the EVD. To accomplish such a task, the first section subjects the documents that have been promulgated by the UN and WHO and other related agencies to discourse analysis to demonstrate the extent to which the global health security narrative shaped the policy-prescriptions regarding the mitigation of Ebola.

4.2 Ebola Virus Disease: The Lineages Between the Present and the Past

The WHO's role in the mitigation of the EVD has been put under scrutiny by several critiques. For instance, Dr. Joanne Liu, then the international president of *Médecins Sans Frontières* (MSF), poignantly criticized the WHO for lacking “the capacity and expertise to respond to epidemics” (“Remarks by International President of MSF,” 2015). She, being one of the first-hand witnesses of the EVD catastrophe, argued that “ [...] with certainty, we know that the ground response remains totally, and lethally, inadequate” (“Ebola UN Speech,” 2014). Some other commentators exhorted that the WHO's take on the Ebola crisis has been ill-informed with officials underestimating the urgency of the crisis which lead to the delay of the declaration of the crisis as a public health emergency of international concern (Garrett, 2015). Such commentaries surrounding the WHO's leadership regarding the global surveillance of infectious diseases seem quite intriguing as almost three decades had been spent on the formation of a global health security narrative, with its ambitious proponents advocating for the installment of a functioning monitoring system.

Conversely, the first report on the Ebola outbreak was published on March 23, 2014, upon the detection of first Ebola cases in Guinea. The WHO, in coordination with the Guinean government and *Médecins Sans Frontières*, mobilized its laboratories “to prepare for the diagnosis of more cases” (“Key Events in the WHO response,” 2014). The global surveillance system was essentially quite effective as the first WHO team arrived at Guinea after five days of the first report. On April 8, WHO officials stated that the outbreak was “one of the most challenging Ebola outbreaks that we have ever faced” (“Key Events in the WHO response,” 2014). As Kamradt-Scott (2016: 404) underscores that the WHO was actually greatly involved in the detection and assistance efforts vis-à-vis Ebola after the

official declaration of its African Office on March 23, 2014. The WHO had deployed “some 113 technical experts [...] to assist the health authorities in Guinea (88), Liberia (23), Sierra Leone (1) and the WHO African regional office” (Kamradt-Scott, 2016: 404).

Yet, even though the WHO mobilized its efforts in coordination with the national governments of the affected states and a few non-governmental organizations such as MSF, “growing number of deaths in West Africa in the first few months after its identification as Ebola in March 2014 generated comparatively little global attention and a poor international response” (McInnes, 2016: 387). Rather, the EVD started to attract exponential global attention almost after five months since the first diagnosis of the disease in Guinea. The growing attention had been induced due to the growing fear of the spread of the disease outside of “the three most affected countries” (McInnes, 2016: 387). The sense of increased shared risk of the global spread of Ebola carried Ebola to the forefront of security concerns. As McInnes (2016: 387) notes, “once the sense of shared risk was established, so too was the sense of a global crisis, *despite* the very small number of transmissions outside West Africa” [Emphasis in the original].

With this background, the following section examines the key policy documents promulgated by the WHO and the UN, and evaluates whether the WHO’s and the UN’s efforts were indeed inefficient during the crisis. The analyses are tied to the effects of the global health security narrative on the mobilization of international efforts. The documents are being subjected to a discourse analysis where the aim is to understand how the global health security narrative affected the formation of the WHO’s action plan regarding the Ebola outbreak.

4.2.1 On the WHO Statement on the First Meeting of the IHR Emergency Committee on the 2014 Ebola Outbreak in West Africa - August 8, 2014

On August 8, 2014, the WHO declared the Ebola outbreak a public health emergency of international concern (PHEIC) as mandated by the 2005 International Health Regulations (IHR). The declaration was the result of the congregation of “an emergency committee” (Burci and Quirin, 2015: 532). Article 12 of the IHR states that the Director-General to the WHO has the mandate to decide whether to declare a PHEIC or not based on the information available (IHR, 2005: 15). The procedures to be followed by the Director-General to the WHO are clearly outlined in Article 12.2 of the IHR as follows (IHR, 2015: 15):

If the Director-General considers, based on an assessment under these Regulations, that a public health emergency of international concern is occurring, the Director-General shall consult with the State Party in whose territory the event arises regarding this preliminary determination. If the Director-General and the State Party are in agreement regarding this determination, the Director-General shall, in accordance with the procedure set forth in Article 49, seek the views of the Committee established under Article 48 (the “Emergency Committee”) on appropriate temporary recommendations.

Following the procedures as set forth in the IHR, the Director-General convened the emergency committee before declaring the Ebola outbreak a PHEIC. The outcome document, *WHO Statement on the 1st Meeting of the IHR Emergency Committee on the 2014 Ebola Outbreak in West Africa* (2014), outlined the processes through which the decision to declare Ebola a PHEIC was eventuated. The Emergency Committee conversed with the affected/concerned states of Western Africa, which were Guinea, Liberia, Sierra Leone and Nigeria (WHO, 2014). The Committee suggested that the recent Ebola outbreak “constitutes an ‘extraordinary event’ and a public health risk to other States,” thus making the outbreak a PHEIC which necessitates an ‘international response’ (WHO, 2014). The Committee’s advice package is important for at least three reasons. The first reason is that the

recommendations for the states with EVD, generally urges the affected states to declare the crisis as a “national emergency” (WHO, 2014). Secondly, the general tone of the document appears to be heavily influenced by the global health security narrative that had been in the making since 1992. The deployment of the security narrative, with the states constituting the main geopolitical actors responsible for the mitigation and control of the disease, framed the ways in which the EVD was conceptualized by both the national and international audiences. Thirdly, the policy-prescriptions, as tailored by the Committee, resonate with the conclusions of some studies in the literature (Elbe, 2006; 2010) where the authors argue that the relationship between security and health is janus-faced. In other words, our understanding of security also is changing with the infusion of a certain degree of medicalization into the security narrative, which inherently changes the ways in which we conceptualize security. The latter will be discussed in relation to global biopolitics in the second section of this survey. The focus in the first section is on the effects of global health security narrative on the decision-making processes at the WHO and the UN headquarters during the Ebola outbreak. Returning back to the IHR Emergency Committee’s advice, the Committee called for an all-hands-on-deck approach with the governments of the affected states channeling all available means to the control and mitigation of the EVD. As recommended by the Committee (WHO, 2014):

States should activate their national disaster/emergency management mechanisms and establish an emergency operation centre, under the authority of the Head of State, to coordinate support across all partners, and across the information, security, finance and other relevant sectors, to ensure efficient and effective implementation and monitoring of comprehensive Ebola control measures.

What does such a recommendation really entail? The committee is essentially urging states to securitize the EVD so as to implement emergency measures necessary for

the control of the disease. There are two important points to be made in relation to the insights of the securitization theory. Firstly, as purported by the theoretical framework (Buzan, Wæver and de Wilde, 1998: 36), the advisee states are encouraged by the Committee to “securitize issues by declaring something - a referent object - existentially threatened.” The use of a national emergency narrative appears to be consistent with the argument that the state as the referent object is being threatened by the spread of EVD. In fact, the president of Sierra Leone declared a state of emergency on July 31, 2014 (“Sierra Leone Declares Emergency,” 2014). Guinea (“Guinea Declares Public Health Emergency,” 2014), and Liberia (“Liberia Declares State of Emergency,” 2014) followed a similar strategy.

The second point to be made is related to the nuanced version of the reading of securitization as outlined by McInnes and Rushton (2012). Their reading of securitization regards the “speech act [as] the beginning of the process of securitization: [aims at] persuading the audience to accept that the issue is an existential threat” to the survival of the referent object (McInnes and Rushton, 2012: 119). Applying this argument to the Ebola outbreak, the crux of the analysis resides in the determination of the instance where the speech act essentially caused the process of securitization.

Yet, the contemporary socio-political landscape is more complex and subject to nested political processes where actors from different levels of political units are involved in the securitization process. For instance, who is the securitizing actor whose utterances manage to securitize the EVD? The members of the IHR Emergency Committee were actually the first ones to maintain that the state of emergency should be declared by the governments of the EVD positive states. Yet,

their suggestions are not binding; the advisee governments have the right whether to follow their advice or not. With regard to the consent based nature of the application of the advises of the Emergency Committee, it appears that the national governments are the securitizing actors, as they have the power to declare a state of emergency. Then again, the idea that encourages the practical deployment of emergency measures vis-à-vis EVD through the use of security language, originally stemmed from the participants of the IHR Emergence Committee. In essence, the contemporary political landscape is subject to the interplay of the utterances of different actors, which complicates the application of the securitization theory as an analytical theoretical framework.

Acknowledging the changing nature of the contemporary political decision-making, McInnes and Rushton (2012: 123) argue that securitization is a multi-level process where “securitizing moves being made to a range of audiences, from the national up to the global.” The multi-level process approach appears to be more applicable to the contemporary cases as it accounts for multiple actors performing simultaneously in order to securitize an issue.

Yet, when applied to the Ebola outbreak in 2014, such conceptualization of the securitization as a multi-level process falls short in providing a comprehensive understanding regarding underlying determinants of the deployment of security language vis-à-vis EVD. A more genealogical approach appears to be more rewarding in understanding how the history of the formation of the global health security narrative constituted the present. As discussed in Chapter III, the deployment of a security narrative regarding infectious diseases was as old as the first congregation of the International Sanitary Convention in 1851. Then, the

emphasis also had been on the on-spot engagement with the infectious diseases such as cholera, yellow fever and plague. The rationale behind such engagement with the diseases was to “establish common measures for protecting public health during cholera epidemics without uselessly obstructing commercial transactions and passenger traffic” (Fidler, 2005: 329).

Such ethos also was evident in the statement of the IHR Emergency Committee in 2014 as the Committee suggested that the “states should conduct exit screening of all persons at international airports, seaports and major land crossings, for unexplained febrile illness consistent with potential Ebola infection” (WHO, 2014). Returning to the securitization literature, even though the securitizing actors vary due to the existence of a multi-level securitization (McInnes and Rushton, 2012: 123), the referent object - the existentially threatened political body - had been the state. The state had generally been regarded as the geopolitical entity through which a resistance to a threat - war, infectious diseases - should be enacted. The IHR Emergency Committee followed a similar approach in the formulation of its advice to both to the EVD positive and unaffected states.

The global health security regime had been reformed in accordance with such rationale - the state as the referent object - where the concerns of the few policy-makers and public health officials in the United States were integrated into the UN system. Thus, it appears that since its inception in 1992, the global health security regime prescribed a security-driven narrative, which essentially framed the ways in which the policy-makers, both at the international and national levels, approached the medical emergencies.

As in the case of Ebola, both the officials present at the IHR Emergency Meeting on Ebola and the heads of governments of Sierra Leone, Liberia and Guinea already had been influenced by the predetermined policy-choices available to them through the IHR. In other words, the historical dominance of the security narrative, with state as the main referent object, affected the decision-making processes and policy-prescriptions in the mitigation of EVD tremendously. As McInnes (2016: 392) summarizes quite neatly:

The outbreak tied into the narrative's theme of the impact of globalisation on health, through both ideas of shared risk and a globally accepted pathway of response which, when it failed, enhanced the sense of crisis. The outbreak was presented as a global health security risk through speech acts which claimed potential state failure, threats to regional and global security and that the spread of the disease threatened the well-being of citizens outside the region. And the poor response to the outbreak revealed weaknesses in global health governance exacerbating the sense of crisis, as well as the privileging of the national interest in response to exogenous threats.

The prominence of the traditional state-centric approach to the EVD in congruence with the use of individual speech acts by the WHO officials and the heads of the states, which had been affected by the global health security narrative since its inception in 1992, appears to prove the dominance of the security narrative. The existence of the dominant security narrative becomes more apparent with the promulgation of the subsequent WHO and the UN documents.

4.2.2 On the Identical Letters Dated 17 September 2014 From the Secretary-General to the UN to the President of the General Assembly and the President of the Security Council

After Dr. Margaret Chan, the WHO Director-General, declared Ebola a PHEIC, the UN Secretary-General, Ban Ki-moon, issued identical letters to the President of the General Assembly and the President of the UNSC to inform members about the measures that had been taken and would need to be taken in the future. He

propounded that “the Ebola crisis is no longer just a public health crisis, but has become multidimensional, with significant political, social, economic, humanitarian, logistical and security dimensions” (Ki-Moon, 2014). Ki-Moon’s letter outlines a comprehensive plan to contain and mitigate the EVD, which appears to be informed by several other intellectual frameworks varying from humanitarian to security. Yet, his action plan resonates with the advice from the IHR Emergency Committee as the plan necessitated emergency measures to be deployed in mitigation of the crisis. For instance, he informed the presidents of his decision to initiate a new UN Mission, United Nations Missions for Ebola Emergency and Response (UNMEER), which would “provide overarching strategic leadership, coordination and guidance, including through consultations with the Member States and other stakeholders participating in or contributing to the international efforts in response to the Ebola virus disease” (Ki-Moon, 2014).

Ki-Moon (2014) also stated that “the Mission shall remain mindful of the potential peace and security implications, cognizant of the fact that all three affected countries are presently within the ambit of the Peacebuilding Commission.” The argument, which would later be more apparent in the UNSC Resolution 2177, emphasizes that the stability of the political systems of the affected countries appear to be demonstrating what the repercussions of the utilization of a security narrative regarding an infectious disease would look like in real life. Even though he underscores, rather ironically, the humanitarian side of mobilizing international efforts, the addressee of the international help is often the affected states:

No one country, no one organization has the resources to stem the tide of the Ebola crisis. Each Government is ultimately responsible for its own people. The Governments and the people of Africa have asked for our help. We must come together as one United Nations, and we call upon Member States to join us in answering their call (Ban Ki-Moon, 2014).

The next day, the UNSC adopted Resolution 2177. The Resolution is the culmination of Ban Ki-Moon's letter and the IHR Emergency Committee's advice regarding the policy prescriptions. Yet, even though the humanitarian aspect of the Ebola crisis was underscored several times in the document, the main tone of the document reflects the dominance of the global health security narrative.

4.2.3 On the United Nations Security Council Resolution 2177

The UNSC adopted the Resolution 2177 on September 18, 2014. The UNSC's Resolution 2177 draws insights from Ban Ki-Moon's letter and the WHO's recommendations through the IHR Emergency Committee regarding the formation of policy preferences vis-à-vis the mitigation of Ebola crisis. The document extends the emphasis on the political stability of the affected countries by underscoring the imposition of effective border control measures. Resolution 2177 (2014) states that "the peacebuilding and development gains of the most affected countries concerned could be reversed in light of the Ebola outbreak and [...] the outbreak is undermining the stability of the most affected countries concerned [which may] lead to further instances of [...] a deterioration of the political and security climate." However, as McInnes (2016: 389) expounds "the framing of the outbreak as a crisis had less to do with [...] rationalist concerns; [...] rather such framing was because of the manner in which this resonated with a narrative on global health that had been developing, especially since the millenium." His point is indeed quite sound as there had not been any single case of state failure induced by an infectious disease (McInnes and Ruhston, 2012). Notwithstanding the lack of empirical evidence, the UNSC Resolution propounds that such a climate "constitutes a threat to international peace and security" (UNSC Resolution 2177, 2014). The Resolution also endorses the

WHO's leading role in the provision of global health security, and urges member states to abide the IHR.

4.2.4 Global Health Security Narrative: National Security to Biopolitics

There are three recurring themes in these documents that seem to correlate with the main argument of the paper. As stressed several times, the global health security regime is at least a three decade phenomena, whose contemporary reformation was first initiated in 1992. Even then, the policy-prescriptions and concerns bore continuities with the classical regime of international health governance. The classical regime that started with the congregation of 1851 International Sanitary Convention was mainly concerned with the establishment of a notification system “about outbreaks of specified diseases; and maintain adequate public health capabilities at points of disease entry and exit” (Fidler, 2005: 329). The concern regarding the spread of infectious diseases exponentially increased due to the emergence of a new sense of a shrinking world, as the velocity and volume of the trade between European states and their trade partners increased. In other words, as the integration of the commerce rapidly increased, “so did the risk of infectious disease being brought into Europe from elsewhere” where the disease was seen “as an exogenous threat which had to be dealt with by means of international cooperation on public health” (McInnes, 2008: 275).

The effects of the accelerating pace of connection between different spatial and temporal units in the contemporary world has been discussed in Chapter II as part of the literature review. Yet, the effects of globalization, precisely in the aftermath of the Cold War, had tremendously affected the ways in which the distinct political units conceptualized formerly domestic issues such as health. The perception had started to reform itself “as arguments about the national security

implications of infectious disease gradually acquired greater resonance and credence amongst policy-makers within the context of globalization” (Elbe, 2010: 31). The UNSC Resolution 2177 appears to carry out a hundred year old concern regarding the spread of exogenous threats to the North from the South in an increasingly globalized world. In addition to that, the concerns about the effects of diseases on trade and movement of goods were also evident in Resolution 2177. For instance, the Resolution 2177 (2014) features that the UNSC expresses “concern about the impact, including on food security, of general travel and trade restrictions in the region [and reiterates the African Union’s] call on its Member States to lift travel restrictions to enable the free movement of people and trade to the affected states.” With this background, the first recurring theme reflects the North/South divide on the issue of global health security where the main narrative implicitly carried a certain degree of Western-centrism.

The second theme relates to the prominence of the state as the main referent object over the people. Since its inception in 1992, the global health security narrative had been infused with a national security narrative which essentially shaped the formation of the two global control mechanisms: surveillance and emergency response. These mechanisms are “containment focused [...] as the emphasis” is on the identification of the diseases “in order to limit their spread, either domestically or across borders” (Rushton, 2011, 785). The UNSC Resolution 2177 (2014) and the IHR Emergency Committee’s advice generally focused on the containment of the diseases within the national borders of the affected states. The borders of the affected states were emphasized as the main geopolitical delimiter of containment of EVD’s spread from one geopolitical area to another. Thus, there seems to have been two simultaneous instances of securitization occurring throughout the Ebola outbreak.

The first move was attempts by the WHO and the UN to frame the EVD as a threat to global health security. As influenced by the established global health security narrative, which had been infused with the U.S. national security concerns regarding the spread of infectious diseases, and the fear of intentional releases of chemical, biological, radiological and nuclear agents from the beginning, the WHO and the UN continued the trend of imposing a security tag on the EVD through their utterances. In this instance, the EVD (in this case generally through the utterances of the WHO and the UN) declared as an exogenous threat as a challenge to its national security. The formation of the global health security narrative was embedded with a certain degree of Northern bias as the main rationale behind the deployment of the necessary control and surveillance measures had been aimed at protecting the spread of diseases to the North. Rushton (2011: 784) reiterates the existence of such bias as he claims that “those diseases that are linked with security are those which have been constructed in major Western developed nations as security threats and have led to ‘epidemic-induced fear’ among governments and citizens.”

The second instance of securitization occurred when the global health security regime attempted to superimpose a security tag embedded in its advice to the EVD affected states. The declaration of the state of emergencies in Sierra Leone, Guinea and Liberia demonstrates how the global health security narrative also urges the states to deploy security measures in order to contain an infectious disease within the national borders. The crux of this narrative is that the state has been the main referent object whose is existentially threatened.

These themes are surveys on the effects of discursive frameworks on the formation of the global health security regime. They conceptualize how discursive

frameworks have a tremendous effect on the formation of the policy-prescriptions by evaluating their effects through subjecting official documents to discourse analysis. The third point, on the other hand, is more about trying to do the analytical opposite. The policy-prescriptions, informed by the global health security narrative, also are implemented through the deployment of real-life measures. The practical deployment of such measures yield another important aspect of the relationship between health and security. Before introducing the third recurring theme, it seems essential to outline how the existence of the third recurring theme comes about.

As Elbe (2010: 2) suggests, the literature on global health security can be grouped under two main lines of inquiry. The first group of studies generally attempts to understand how health/disease and security concerns “linked empirically” (Elbe, 2010: 7). These studies generally attempt to “identify which health issues have, or could have, a significant impact on security concerns” (Elbe, 2010: 7). Some scholars (Elbe, 2006; McInnes and Lee, 2012; Burci, 2014; McInnes, 2016) approach the health/security nexus from a constructivist point of view. Applying the insights of securitization theory, “many of these studies take a broadly constructivist approach to the study of security practices, and remain sensitive to the inter-subjective nature of portraying social issues as security threats - that is of ‘speaking’ security” (Elbe, 2010: 10).

Thus far, following the approach of the second group of studies according to Elbe’s typology, the main flow of the argument generally focused on the ways through which the global health governance regime had been infused with a security narrative. Starting with the publication of IOM’s report in 1992, ‘the health of nations’ (Price-Smith, 2002) had gradually become (i) a global concern with (ii) a security tag. The hows of the making of the global health security regime has been

discussed through a close reading of the policy-documents, the WHO and the UN resolutions. A partial answer has been provided in relation to the why question. The reasons for the reformation of the global health security regime generally have been linked to a narrative of a national security concern. The answer appears as incomplete as the expansion of national security concerns to cover health issues, especially infectious diseases, do not really yield how a health/disease phenomenon in a geopolitical space became a concern to the governments in another state. As Fidler (2003: 790) argues “the novelty of the recent literature on infectious diseases as a national security issue rests in elevating public health from an obscure, neglected foreign policy area to the heights of the ‘high politics’ of national security.” Yet, this one-sided account of the relationship between health and security generally examines the ways in which health/disease acquire a security tag. However, such accounts as Elbe (2010: 15) argues:

[...] offer us no account of how the practice of security may itself also become transformed as a result of a growing association with non-military issues. In the specific case of health security, the ‘securitization of health’ perspective does not encourage us to ask how our understanding of security might also be affected or shaped by this ‘marriage’ to a growing set of global health and medical issues.

Elaborating on that initial assessment Elbe (2010) underscores the changing nature of our understanding of security/insecurity due to the inter-subjective relationship between health and security. By problematizing the recent health/security nexus, Elbe (2010: 23) inquires whether “the rise of health security [...] also constitute[s] [...] a subtle process through which our understanding of insecurity in international relations is similarly becoming redefined as a medical problem.” Elbe’s analysis underscores the third recurring theme in the WHO and the UN documents: The expansive use of medical language and measures regarding the mitigation of the EVD. The measures vary from the installment of a global health detection system

through the IHR, the deployment of special missions such as UNMEER (UN Mission for Ebola Emergency Response), the deployment of GOARN teams to the affected countries to establish laboratories, works done by NGO's such as MSF and the Red Cross and the use of pharmaceuticals. The next section discusses how this medicalization of security/insecurity became more evident in both the utterances and the operations of the WHO and the UN.

4.3 Global Biopolitics

To understand how such medicalization of security/insecurity emanated from the relationship between health and security, this section will draw ideas from Foucault, particularly from his reflections on “growing preoccupation of modern power with the biological dimensions of human existence” (Elbe, 2005: 405). Problematizing the deployment of power in modern societies, Foucault analyzed the relationship between power and politics through studying the changing nature of the exercise of power and its effects on the organization of socio-political life. As one commentator has noted, Foucault conceptualized power as something that does not have to be “violent, in the sense of being unleashed, passionate, even though its point of application is the body [rather as Foucault emphasized], this exercise of power on the body remains rationally organized and calculated even while being the physical exercise of a force”(Davidson, 2003: xx). Foucault (2003: 88) claimed that “the bourgeois revolution of the eighteenth century and the beginning of the nineteenth century was the invention of a new technology of power whose essential elements were the disciplines.”

Surveying through the instances of the use of disciplinary power in the eighteenth century, Foucault observed (2003: 22) the growing influence of medico-legal opinion which lead to the “constitution of a doctor [as a consultant] who is at

the same time a doctor judge” whose medical opinion on the offences of an individual demonstrates “a transition from [the offender] being accused to being convicted.” As he notes quite poignantly that “the psychiatrist really becomes a judge” (Foucault, 2003: 23). His gradual take on the changing nature of power, from one being static and violent to one being productive, disciplining and normalizing, reflect the change in the governance strategies of the modern state. As his genealogical studies yielded, there had been a change regarding the reception of ‘abnormal’ individuals in the eighteenth century in French society, from the exclusion of the ‘abnormals’ from society to the inclusion of those individuals in society by means of deploying disciplinary exercises to normalize their ‘abnormalities.’ Explicating this assertion, Foucault (2003: 42) notes that:

With expert medico-legal opinion we have practices concerned with abnormal individuals that introduces a certain power of normalization and which, through its own strength and through the effects of the joining together of the medical and the judicial that it ensures, tends gradually to transform judicial power as well as psychiatric knowledge and to constitute itself as the authority responsible for the control of abnormal individuals.

The changing nature of power, from one being exercised through the disciplinary practices to the deployment of power for the purpose of normalization of the ‘abnormalities’ was later on conceptualized as the “power’s hold over life” (Foucault, 1997: 239), had a tremendous effect on the organization of the political life. Such exercise of power reflected the modern conceptualization of politics, as “the acquisition of power over man insofar as man is living being, that the biological came under State control” (Foucault, 1997: 239-240).

Before, linking the idea of ‘power’s hold’ over individual life and society to an analysis of health and security, it is important to clarify the rather complex relationship between power and politics, both of which constitute the very objects of

analysis, as interwoven themes that appear in different forms and frequencies Foucault's studies. The main theme relates to the different shapes and forms of the deployment of power. Understanding the nature of the exercise of power has been inextricably linked to the comprehension of the modern conceptualization of politics. This is so, as in modernity, as Foucault (1997: 49) purports, "a historico-political discourse" emerged in the seventeenth century within which the essence of political activity was defined in congruence with a conceptualization of war as "the ineradicable basis of all relations and institutions of power." Foucault's thesis on the emergence of this historico-political discourse yielded that this discourse "was initially deployed as an instrument of political opposition against sovereign authority [where] political order is nothing more than the conquest and subjugation of one race by another" (Spieker, 2011: 189). Starting with this gradual assertion into the nature of politics and power, he argued that in this discourse:

No matter what philosophico-juridical theory may say, political power does not begin when the war ends. The organization and juridical structure of power, of States, monarchies, and societies, does not emerge when the clash of arms ceases. War has not been averted. War obviously presided over the birth of States: Right, peace and laws were born in the blood and mud of battles (Foucault, 1997: 50).

In dialectic with the philosophical-juridical discourse, "which conceived of the state in terms of an organic homogeneity", the binary conception of the historico-political discourse was "colonized and reconfigured by the state" throughout the eighteenth century (Spieker, 2011: 189; Foucault, 1997: 58-59). The colonization of the historico-political discourse on war, that conceptualized the society in binaries, by the state metamorphosed its "war that is going on beneath order and peace" logic into a functionary tool for governance. The transformed political agenda appropriated the historico-political discourse as to function "as a

principle of exclusion and segregation and, ultimately, as a way of normalizing society” (Foucault, 1997: 61).

Such governance reflexes also were informed by the existence of two simultaneous discourses. The first relates to the biological conception of human existence which emphasized the human existence as “permanent struggle and race struggle” (Foucault, 1997: 60). The second one relates to the social embodiment of this race struggles along the lines of “the theory of evolutionism and the struggle for existence” (Foucault, 1997: 61). Such conceptualization of politics along the lines of a biological and racial struggle, distilled through the historico-political discourse, and appropriated by the state, would become the essence of a new governance discourse - a discourse which will:

[...] become the discourse of a battle that has to be waged not between races, but by a race that is portrayed as the one true race, the race that holds power and is entitled to define the norm, and against those who deviate from that norm, against those who pose a threat to the biological heritage.

Elaborating on this assertion, Elbe (2005: 405) summarizes Foucault’s conceptualization of politics as concerned with the “biological dimensions of human existence” in three recurring themes that are “*biopower*, *anatomo-politics*, and *biopolitics*” [Emphasis in original]. Biopower is the overarching conceptualization of human existence which approaches life and “its mechanism into the realm of explicit calculations and made knowledge-power an agent for the transformation of human life” (Foucault, 1997: 143, quoted in Elbe, 2005: 405).

With that, governance was not only confined to the provision of politico-juridical power by the state; it also started to embody an exercise of power which “is applied to man-as-species [which included the deployment of] a set of processes such as the ratio of births to deaths, the rate of reproduction, the fertility of a population”

(Foucault, 1997: 243). In other words, anatomo-politics is the deployment of “political strategies targeting ‘man-as-body’ in an attempt to make individual bodies more productive and docile” whereas biopolitics is the projection of such rationale to the population level (Elbe, 2005: 405-406).

The exercise of power directed at the normalization of the ‘abnormalities’ in a given society “is assured less through a single apparatus than by an ensemble of multiple regulations and institutions which in the eighteenth century take the generic name of ‘police’ [as] the ensemble of mechanisms serving to ensure order, the properly channeled growth of wealth, and the conditions of preservation of health in general” (Foucault, 2000a: 92). Such transformation is made possible with the expansive role that was played by what had been termed as social medicine. As McInnes and Lee (2012: 147) note, the exercise of power in the contemporary health security regime reveals “a shift away from sovereign power and towards governmentality [where] power is no longer oriented self-referentially towards preserving the power of the state (sovereign power) but rather towards improving the welfare of citizens (governmentality).” The exercise of power in modern societies differs from the traditional deployment of sovereign power and takes the form of a new governance strategy where the complex networks of power materialized through the involvement of different actors and institutions in a given society. Foucault (2000b: 219-220) defines governmentality as:

- 1) The ensemble formed by the institutions, procedures, analyses, and reflections, the calculations and tactics that allow the exercise of this very specific albeit complex form of power, which has as its target population, as its principal form of knowledge political economy, and as its essential technical means apparatuses of security.
- 2) The tendency that, over a long period and throughout the West, has steadily led toward the preeminence over all other forms (sovereignty, discipline, and so on) of this type of power— which may be termed “government”— resulting, on the one hand, in the formation of a whole series

of specific governmental apparatuses, and, on the other, in the development of a whole complex of knowledges.

The formation of this new governance strategy required an expansive institutionalization of state power through the different bureaucracies which intervened in the life of individuals. Such institutional involvement included “a plethora of biopolitical interventions trying to regulate the observed population dynamics, [such as], health insurance systems, old-age pensions”, inoculations and so forth (Elbe, 2005: 406). In addition to that, such an expansive governance strategy was backed by a detailed statistical surveillance which gathered data on the society.

Besides these new governance strategies, the developments in medicine also led to the transformation of the execution of the art which was then generally confined to the “private interactions of doctors and patients that occur in [a] clinical setting” (Elbe, 2010: 19). The expansive influence of social medicine not only covers the private medical treatment but also the application of “wider preventative interventions occurring at the population level and designed to improve public health” (Elbe, 2010: 19). Note that the attempts at improving public health through the measures of public health institutions, improved sanitation and cleanliness of the cities, city physicians did not originate in the eighteenth century (Rosen, 2015). Yet, with the changes in the socio-economic organization of communities, especially in Europe, during the seventeenth and eighteenth centuries, and with the introduction of a new mode of production, “some degree of public regulation of private property and personal behavior was [seen as] essential to protect people from unnecessary hazards to their health” (Fee, 2015: xxiv). Underscoring the correlation between this new mode of governance and the historical changes in the socio-economic organization of societies, Foucault (2000a: 95) expounds that the expansion of medical activities

relate to “preservation, upkeep and conservation of the labor-force” which induced a “necessity for coordinating and [...] controlling” the population with “more adequate uses of power [through] surveillance, analysis and intervention.” The expansive use of surveillance systems, analysis and medical interventions also are the means that global health security had been utilizing. Informed by the discussion on biopolitics, the next section discusses the embedded biopolitical rationale behind the interventions in the Ebola outbreak and discusses how the logic of biopolitics induced a certain degree of medicalization of security/insecurity as embedded in the utterances of the prominent institutions.

The deployment of a security narrative informed the global reception of diseases in the twentieth and twenty-first century was discussed above. The use of the security language also appeared to be informed by the changes in the political strategies aimed at governing the contemporary geo-political space and societies. The expansion of the security agenda appears to be informed by a logic of biopolitics in at least three senses. First, with extension of the contemporary scope of security so as to cover infectious diseases, “security is no longer confined to defending sovereignty, territorial integrity, and international law [but also] population dynamics - including levels of disease” globally (Elbe, 2005: 406). Second: the expansion of the security agenda to cover global health issues was formalized through the establishment of a global surveillance system aimed at monitoring the diseases. In addition to that, the deployment of the security narrative is biopolitical reflecting the complex nature of the use of power by the consenting social groups such as governmental and non-governmental organizations, media outlets and scholars (Elbe, 2005: 407).

The Ebola outbreak and how it has been perceived by a range of actors who were informed by the logic of the global health security narrative also appears to be reflecting the existence of a biopolitical rationale. The first instance which reflects the existence of the embedded biopolitical logic is the existence of a global health surveillance system as attached to the global health security narrative. Since the days of the gradual outbreak, the WHO had been involved in the monitoring of the development of the Ebola outbreak in liaison with its regional offices. The African Regional Office declared the Ebola outbreak on March 23, 2014, which led to the deployment of a Global Outbreak Alert and Response Network (GOARN) team on March 28, 2014 (Kamradt-Scott, 2016: 404). Since the first days of the outbreak, the WHO had been involved in the monitoring of the development of the crisis. The second theme relates to the involvement of a range of actors in the mitigation of the crisis from the UN Security Council to the MSF and Red Cross. Such an all-hands-on-deck approach underscores Foucault's emphasis on the complex nature of the deployment of power by the involvement of the consenting social groups in the probe against a biological threat. The third theme relates to the expansive use of a medical language evident in the utterances of the various actors who were involved in the probe against the Ebola.

As elaborated on by Elbe (2010) and Elbe and Voelkner (2015), the medicalization of insecurity occurs in three ways. The first relates to the intersubjective relationship between health and security where "insecurity is becoming understood more broadly as a medical problem requiring medical expertise and interventions" (Elbe and Voelkner, 2015: 73). In other words, the (in)security is no longer solely conceptualized as a phenomenon in congruence with military and political problems but also by appeals to the medical problems such as infectious

diseases (Elbe and Voelkner, 2015). Reflecting this medicalization, the Ebola outbreak has also been framed as a threat to global health security by the WHO (2014) and the UNSC Resolution 2177 (2014). The second point that Elbe and Voelkner (2015: 72) is that the use of “health security discourses are leading to a greater role for medical professionals in the discussions and decision-making of global security policy, representing a further overall enhancement in the societal role and influence of a range of medical professional.” Demonstrating the validity of this point, the leading role in this emphatic fight against the Ebola were assumed by two doctors. In Ban Ki-Moon’s letter to the Security Council and General Assembly, he stated that Dr. David Nabarro was appointed “as the United Nations System Senior Coordinator for Ebola Virus Disease.” (Ki-Moon, 2014). Elaborating on the establishment of a UN Mission, Ki-Moon also stated that he decided to form the UNMEER after his discussions with Dr. Nabarro and Dr. Margaret Chan, who was the Director-general to the WHO (Ki-Moon, 2014).

The last point that Elbe and Voelkner (2015) raise is about the changing nature of how security is practiced. They claim that “security practice now also has come to involve a growing number of medical countermeasures - including developing, procuring, and stockpiling medical equipment and new pharmacological products” (Elbe and Voelker, 2015: 72-73). As Elbe notes in elsewhere, “millions have been spent on a pharmaceutical response to the Ebola outbreak – and billions more in the past two decades on a pharmaceutical approach to strengthening global health security” (Roemer-Mahler and Elbe, 2016: 500).

4.4 Conclusion

The global health security narrative tremendously affected the ways in which the international community approached the Ebola outbreak. The WHO and the UN immediately consulted the security narrative in their efforts in mobilizing global response to the Ebola crisis. The policy documents that these institutions promulgated throughout the Ebola outbreak appeared to carry out a certain degree of Western-centrism. While the months before the declaration of Ebola as a security threat to international peace and stability by the UN Security Council attracted little attention and confined to the leadership of WHO in liaison with the government of the affected states, the first cases of Ebola in the US and Spain alarmed the UN and the WHO officials in their efforts in mobilizing more resources. Such an approach has raised the question of whose security that the global health security regime is actually overseeing which had been striking many academics and policy-makers. The second point that appears to be evident in the utterances of the WHO and the UN officials is that the state has been regarded as the main referent object throughout the entire conflict. Even though non-governmental organizations such as MSF and Red Cross, and a few officials such as Ban Ki-Moon underscored the importance of the human factor in this catastrophe, the foci of the efforts surrounded the stability of the affected states. The third theme relates to the embedded biopolitical logic within the utilized security narrative. By consulting the works of Foucault, this chapter argued that the global health security narrative and its real life application vis-à-vis the Ebola outbreak appeared to be informed by a logic of biopolitics.

Such a biopolitical dimension was first introduced by the exportation of the new security agenda by the United States to the WHO and the UN quarters. With

that, the global health security regime was intertwined with a logic of intervention in the well-being of society by means of medical interventions. The medicalization of (in)security as conceptualized by Elbe and Voelkner (2015) led to a change in how the (in)security is conceptualized globally. Additionally, there also has been an increase in the number of medical professionals who is involved in the decision-making processes of the institutions that oversee global health security. Thirdly, this medicalization also elicited a change in the ways states practice security . Now, states also are stockpiling vaccines and pharmaceuticals as means for guaranteeing more security for their citizens.

The next chapter problematizes the prominence of the national security narrative within the global health security regime. The chapter attempts to theorize an intellectual resistance point where human security can be emphasized more in relation to the global health security regime. Drawing on the literature from Williams (2005) and Hobbes (1985), the next chapter challenges the contemporary Realist accounts which inform the prominence of the national security argument. The chapter propounds that a sound theoretical conceptualization of Realism should lead to the prominence of the human security.

Chapter V

HUMAN SECURITY MUST BE DEFENDED: WILFUL REALISM

This research has aspired to provide insight into (i) how health and security had been coupled together analytically (Chapter II), (ii) how global health security developed over time politically (Chapter III), and (iii) how these developments shaped the global reception of Ebola outbreak (Chapter IV). These surveys have yielded that a security narrative had been quite dominant in shaping the reformation of global health governance. Amongst competing conceptualizations of security, national security prevailed over the human security approach as evident in the prioritization of state security and stability in the global health security narrative. The politics behind the reformation of global health security also reflected a certain degree of Western-centrism. Since the gradual attempts to reform global health security regime, national security of few states were implicitly prioritized at the expense of the others. In other words, the national security of the states in the Global South (i.e. Sierra Leone, Guinea, Liberia) were not prioritized because the global health security regime emphasized the importance of the national securities of these states in themselves, but rather the regime accommodated to such course as the stability of these states had been important to the national security objectives of the Global North.

In addition to that, the securitization of infectious diseases has had an impact on how we understand (in)security. With the changing nature of governance reflexes due to the altering nature of politics in the eighteenth century, the new state and its institutions exercised a new type of power (bio-power) in its attempts to govern the masses. The state was no longer only oversaw the security of its people regarding exogenous threats such as invading militaries but also involved in the provision of

the well-being of its population through means of techno-scientific interventions (biopolitics). With the increasing impact of medicine and pharmaceuticals as techno-scientific interventions into the well-being of humans and societies, the (in)security was gradually conceptualized with appeals to a medical lexicon. This medicalization of (in)security was juxtaposed to the contemporary securitization efforts of health and also led to the integration of the biopolitical logic that have been mostly evident in the Global North within the apparatuses of the global health security regime.

What this chapter aspires to elicit is a resistance to these various conceptualizations. The global health security regime appeared to be extensively influenced by the discursive frameworks since its inception. This chapter elicits a theoretical resistance scheme upon which the soundness of the analytical schemes can be evaluated. Generally, International Relations scholars engaged with the theoretical conceptualizations of the relationship between health and security after the increased attention given to the HIV/AIDS and CBRN agents during the 2000s. However, this made the theoretical engagements *ex post facto* accounts of the empirical as the global health security regime had already been in the making since the 1990s. Rather than offering a novel way of theorizing health and security, what this chapter attempts to elicit is a theory of health informed by the already existing theories of International Relations, particularly by wilful Realism.

Thus far, Youde (2005) underscored the negligence of International Relations theories in offering a robust conceptualization of health and security in the literature. Even though there had been a plethora of research conducted on the nature of health security since Youde's (2005) study, the general line of the theoretical work either had been confined to the *ex post facto* accounts of health security embodied in the studies informed by the critical theory (Elbe, 2006; McInnes and Rushton 2012) or

succumbed to the straw man versions of realist accounts that prioritized the national security argument. Conversely, this chapter propounds the view that health had already been part of the state's security obligations. In essence, health provision had actually been one of the justifications for the existence of the state. Informed by the social contract tradition, particularly the line of argumentation conveyed in Hobbes' work, this chapter argues that it is theoretically unsound to defend the conceptualization of health on national security grounds. Rather, a realist argument should underscore the prominence of human security as evidenced by Hobbes' arguments on the nature of man and the commonwealth.

5.1 State, Security and Sovereignty

5.1.1 Human or National Security?

While trying to answer the question whose security that the global health security regime is actually overseeing, Rushton (2011: 786-787) reached the conclusion that:

we have two radically different conceptualizations of health security: a statist/national security one, which takes the state as its referent object and is focused primarily on stopping diseases entering or otherwise destabilizing states and societies, and globalist/human security one, which takes the individual as the referent object and is open to the consideration of a much broader range of issues that threaten individual health and well-being.

In correlation with Rushton's (2011) conclusion of the prominence of the statist conception of health security, the global health security regime has tended to prioritize state security over human security. Generally, the utilization of the national security argument was legitimized in accordance with appeals to the effects of infectious diseases on the militaries, state stability and bioterrorism. This deployment draws insights from neorealist arguments. As Youde (2005: 200) conceptualized, "a disease that kills high numbers of troops without engaging in battle, decimates the officer ranks, and prevents states from undertaking training exercises will undermine

a state's ability to ensure its physical security and survival." In the neorealist argument, the well-being of militaries are essentially tied to the survival of the state. Such understanding especially culminated in the cases of HIV/AIDS in UN peace-keeping forces. However, as McInnes (2016: 380) claims the invocation of the national security argument does not really reflect the reality regarding the impact of diseases on any state, as measurable by levels of mortality and morbidity. Yet, the security narrative found purchase both domestically and internationally. If the use of the global health security narrative regarding infectious diseases (i.e. Ebola outbreak) does not really corroborate with the real impact of the diseases what does it actually reveals about the mindset of the policy-makers and how realist is the deployment of the national security argument? The prioritization of the national security argument on realist grounds appears to be theoretically unsound as it is not really supported by the facts. The national security argument even borders on a certain degree of idealism where the misperceptions regarding the effects of the infectious diseases tremendously affected the ways in which the global health security had been formed. Recalling Carr's (1946) emphasis on the aim of Realist theorizing in International Relations, the next section will draw insights from Williams (2005) and Hobbes to defend the case for the prominence of human security:

Where utopianism has become a hollow and intolerable sham, which serves merely as a disguise for the interests of the privileged, the realist performs an indispensable service in unmasking it. But pure realism can offer nothing but a naked struggle for power which makes any kind of international society impossible. Having demolished the current utopia with the weapons of realism, we still need to build a new utopia with the weapons of realism, we still need to build a new utopia of our own, which will one day fall to the same weapons.

(Carr, 1946: 93)

5.1.2 Wilful Realism: Understanding the Essence of Sovereign Power

Contemporary accounts that prioritize the prominence of national security appear to be faulty due to (i) their misperceptions regarding the effects of infectious diseases and (ii) their misconceptions regarding the nature of sovereign power. This section attempts to provide an alternate Realist understanding by answering the call of Williams (2005: 4) when he posits that: “[...] was there not another Realism – within the existing ‘tradition’ – that could be brought into view by challenging contemporary claims about both the nature of Realism and the positions of classical thinkers within its tradition?” Yes, there is. In essence, that Realism is better-informed regarding the nature of the exercise of sovereign power and how it relates to society. With this background, this section introduces the concept of wilful realism in relation to Hobbes’ understanding of sovereign power. Drawing on the insights of this section, the last part emphasizes the theoretical soundness of prioritizing human security over national security.

Wilful Realism attempts to reconstruct realism by re-engaging with the works of canonical texts to challenge the “contemporary understandings of the Realist tradition and its place in International Relations theory” (Williams, 2005: 5). Moving from this assertion, Williams proposes three sub-themes that he associates with wilful realism. Firstly, skepticism questions the confidence of “modern empiricism and rationalism as adequate bases for political knowledge” (Williams, 2005: 5) and elicits an understanding in which “politics of knowledge” is problematized by “a strong advocacy of the need for a politics both informed and suitably chastened by an understanding of limits of knowledge (Williams, 2005: 5-6). Secondly, according to the concept of relationality, “wilful realism does not assume that the nature of either the self or political order is fixed or given” (Williams, 2005: 6). This induces a

certain degree of “a political and ethical sensibility in which the relationship between self and other has significance as a political principle” (Williams, 2005: 6). The third component of wilful Realism is its emphasis on power politics. Williams (2005: 6) argues that “at the centre of wilful Realist analysis is an engagement with the multiple forms of power at work in politics, including those involved in knowledge claims, forms of subjectivity, and structures of authority and action.” Moving from these initial assertions, wilful Realism “seeks a politics of limits that recognizes the destructive and productive dimensions of politics, and that maximizes its positive possibilities while minimizing its destructive potential” (Williams, 2005: 7).

Summarizing these points, Williams (2005: 9) claims that:

The core of this Realist tradition thus does not lie in the concepts of anarchy and rationality as they have come to dominate International Relations theory. It lies instead with questions of the construction of social action and political orders, with the conditions of stable and legitimate political authority, and with the consequences of different, particular, and historically contingent resolutions to these broad political challenges.

Moving from this idea, Williams (2005) draws ideas from Hobbes’ work to underscore how a different take on the concepts of scepticism, relationality, and the power politics are essentially changing the ways in which Realism is conceptualized.

Hobbes’ ideas have been attracting scholars of International Relations for a long time. The concept of the state of nature has attracted many scholars with different theoretical aspirations. Malcolm (2002: 433) argues that the “interpretation of Hobbes put forward by modern International Relations theorists has become fixed and ossified.” He elaborates on this assertion by stating that “if you open almost any standard International Relations textbook, and you will find Hobbes described as an archetypal ultra-realist” (Malcolm 2005, 122). However, as Williams (1996: 215) argues:

if we examine more deeply the foundations of Hobbes's thoughts on international relations [...] a picture emerges that is both significantly at odds with conventional portrayals and that resonates remarkably with many of the most vibrant debates within contemporary debates, such as objectivity and relativity, science and interpretation, and ideas and practices, were at the heart of Hobbes's understandings of politics and of international relations.

5.1.3 The Prominence of the Human Security: Hobbes' Referent Object

One of the neglected themes of Hobbes' writing, has been his emphasis on the human condition. His conceptualization of the state of nature is not human-centric as distilled through Hobbes' philosophical treatment of the ontology of the individual. Even though generally Hobbes' treatment of the commonwealth attracts the scholars of international relations, his emphasis appears to be on the prominence of the individual. In other words, the individual is the starting point that leads to the justification for the establishment of the state. Hobbes (1985: 183) argues that "nature had made men so equal, in the faculties of body and mind; as that though there be found one man sometimes manifestly stronger in body, or of quicker mind than another; yet, when all is reckoned together, the difference between man, and man is not so considerable." Even the weakest of people with regard to "strength of body" may kill the strongest through receiving assistance from other people (Hobbes, 1985: 183). He also argues that the people are equal regarding their wits as no individual would believe that "there be many so wise as themselves" (Hobbes, 1985: 184). From this equality in mind and body, a state of diffidence occurs where every individual has the equal chances of attaining their ends (Hobbes, 1985: 184). Such uncertainty creates a condition of a perpetual possibility of war (Hobbes, 1985: 184-5). Elaborating on this induction, Hobbes (1985: 185) concludes that in the absence of a sovereign power which would "keep them [individuals] in awe," there exists a state of war, which is not solely fought in the form of battles "but in the known disposition thereto, during all the time there is no assurance to the contrary."

With this background, the state of nature is not induced because of people attempting to maximize their security by all means necessary; rather people try to use all means possible to secure themselves because of the state of nature, which causes uncertainty and fear. In the absence of a sovereign power, as Hobbes' (1985: 186) famous dictum suggests, there will be "continuous fear, and danger of violent death; and the life of man [will be] solitary, poor, nasty, brutish and short. Hobbes describes the state of mankind as follows:

"And because the condition of Man, is a condition of Warre of every one against every one; in which case every one is governed by his own Reason; and there is nothing he can make use of, that may not be help unto him, in preserving his life against his enemyes; It followeth, that in such condition, every man has a Right to every thing; even to one another's body. And therefore, as long as this natural Right of every man to every thing endureth, there can be no security to any man, of living out the time, which Nature ordinarily alloweth men to live" (Hobbes, 1985: 189 – 190).

Thus, without a common power to keep everyone in a political order, every person by nature has the right to pursue his/her end by all means necessary to preserve life. Yet, when everyone follows such logic, the predicament of humanity aggravates even further where security becomes even scarcer. Thus, the sovereign power becomes important, as only with the existence of a sovereign power such predicament can be avoided (Hobbes, 1985). This is the justification for the existence of the states that Hobbes provides in his writing. His meditations on the nature of mankind and sovereignty do not focus on the state's existence in itself, rather it focuses on the vitality of the existence of state for the people's well-being. He even claims that if peace could be attained without the medium of the state, it would be indeed more preferable for the individual as then the peace would be attained "without subjection" (Hobbes, 1985: 225).

5.1.4 Wilful Realism and Hobbes' Individual: What They Have to Offer Regarding Global Health Security

With regard to the prominence of human security in Hobbes' writing as argued above, Hobbes' conception of human security appears to be correlating in line with the prominent human security definition as promulgated by the United Nations Development Program's (UNDP) *Human Development Report* in 1994. The conceptualization of human security includes two main features:

Human security can be said to have two main aspects, It means, first, safety from such chronic disease threats as hunger, disease and repression. And second, it means protection from sudden and harmful disruptions in the patterns of daily life - whether in homes, in jobs or in communities.

(UNDP, 1994: 23)

Elaborating on this theme, UNDP report also underscored the importance of conceptualizing security in a more humanitarian line:

For many of them [people], security symbolized protection from the threat of disease, hunger, unemployment, crime, social conflict, political repression and environmental hazards [...] For most people, a feeling of insecurity arises more from worries about daily life than from the dread of a cataclysmic world event.

UNDP, 1994: 22)

Health security also was included in this conceptualization of human security (UNDP, 1994, 24). Thus, what Hobbes provides as legitimate justifications for the establishment of the state regarding the human predicament, appears to be in line with how human security is defined by the UNDP. If that is the case, which one is more informed by a Realist understanding: Designing the global health security regime so as to oversee human security or attempting to secure individual states from exogenous threats through the deployment of national security? Hobbes' sovereign comes into life - or is justified - due to the human desire to live a good and

prosperous life. This desire leads to the acceptance of an overarching authority that regulates the individual's everyday life.

Traditionally, the national security argument was grounded upon the provision of the interests of the citizens. Yet, as “hobbled by economic adversity, outrun by globalization, and undermined from within by bad governance, the capacity of some states to provide this protection has increasingly come into question” (Axworthy, 2001: 19). Human security appears to be more of an intellectual tool for a Realist analyst than national security along these lines as it seems, “human security stands in contrast to state security: whereas the latter focuses on the preservation of the state and its institutions, human security is concerned with risk to individuals” (McInnes and Lee, 2012: 142). In general, however, most advocates of human security do not see it as replacing but rather complementing state security. Indeed, a stable state may be a prerequisite for human security" (142). This may be true, and essentially reflects what Hobbes tried to theorize. Yet, if Axworthy's account of the status of the state in contemporary world politics is correct, then it would be more appropriate to design the global health security regime on human security lines. In this instance, wilful Realism is important in understanding the efficacy of the modern state, especially in analyzing whether or not appeals to national security by Western governments are sound.

As introduced above, wilful Realism underscores the importance of scepticism, relationality and prominence of power politics, which is informed by an understanding of limits of power. Scepticism is defined as “a strong advocacy of the need for a politics both informed and suitably chastened by an understanding of limits of knowledge (Williams, 2005: 5-6). Rather than allocating more resources to the improvement of infrastructure, the global health security regime informed by the

logic of the national security discourses of the few states generally deploy containment measures rather than prevention measures. As Weir And Mykhalovskiy (2010: 4) argue, “global emergency vigilance illustrates the insufficiency of any theory that would reduce the political to either sovereignty or to governance. It is precisely the form of the political beyond both governance and sovereignty that is raised at the site of global emergency vigilance.” Except it is not. The importance of sovereignty as exercised by individual states appears to be resilient in contemporary politics. The WHO’s techno-scientific apparatuses were designed to assist the consenting governments. Eventually, geopolitics challenge such assertions. First, sovereignty still matters. Even though the global emergency vigilance has the capacity to detect and acquire knowledge regarding the emergence/re-emergence/spread of a potential disease/threat/medical condition that would endanger the lives of the greater population, it is still the sovereign state that has the dictate upon the allowance of experts sent to the field. The consent still matters, which constitutes the crux of the resilience of sovereignty.

Since the WHO’s mandate also was gradually designed out of the national security concerns of few Northern states, its mandate generally was designed to contain diseases rather than allocating resources for the long-term assistance. Secondly, the WHO officials were not ready for an outbreak of such magnitude and international assistance was not really materialized until the outbreak stories started to galvanize the Western public. Thus, over-reliance on the WHO’s leadership is not realistic according to the theoretical stance of wilful Realism.

Secondly, according to the concept of relationality, “wilful realism does not assume that the nature of either the self or political order is fixed or given,” which induces a certain degree of “a political and ethical sensibility in which the

relationship between self and other has significance as a political principle” (Williams, 2005: 6). According to this argument, the international efforts should have been mobilized in their full capacity before the fear of the spread of Ebola to the West. If that had been the case, the fear would not have materialized in the first place.

Lastly, wilful Realism “seeks a politics of limits that recognizes the destructive and productive dimensions of politics, and that maximizes its positive possibilities while minimizing its destructive potential” (Williams, 2005: 7). The containment of Ebola may not have been successful as it had been the case with the spread of HIV/AIDS globally. If the deployment of WHO powers would still be confined to the containment of the diseases at source rather than attempting to prevent them from occurring in the first place, the next disease may actually succeed what the Northern states have been afraid of. In addition to that, the containment strategies also induced a burgeoning death toll on Guinea, Sierra Leone and Liberia. A global health security regime designed to contain diseases leaves some people behind while prioritizing others, and this generally was the case with the efforts regarding the mitigation of Ebola. By the time the WHO managed to provide necessary aid in the affected states, the EVD had already claimed the lives of many.

The global health security regime also is not biopolitical in this sense. Some argue that “global emergency vigilance is biopolitical [...] because it aims at the conservation of populations and citizens within and across sovereign states. It has a double and inconsistent logic, one of containing emergencies from spreading into the North, but also a cosmopolitan one of securing human health for all the peoples of the world.” (Weir and Mykhalovskiy, 2010: 5). Yet, a global health security system informed by the national security logic of the few states cannot be entirely

biopolitical as the referent object is not the human but the states. If there was no possibility of the spread of a threat from South to North, would there be still an establishment of global emergency vigilance? Perhaps the double standard is indicative of a discrepancy between - which is still a generalization - the people of the prosperous countries which are experiencing the Foucauldian biopolitics versus the people of the developing world/underdeveloped world where the political reality is still confined to the conditions that the Hobbes' individual experiences. As Kaplan (1994, 60-61) put it quite eloquently, when he was commenting on environmental problems, "we are entering a bifurcated world. Part of the globe is inhabited by Hegel's and Fukuyama's Last Man, healthy, well fed, and pampered by technology. The other, larger, part is inhabited by Hobbes's First Man, condemned to a life that is [indeed] poor, nasty brutish and short."

5.2 Conclusion

There seems to be several theoretical irregularities with regard to the conceptualization of global health governance in the International Relations literature. Since its inception in 1992, with the publication of the publication of the United States Institute of Medicine's *Emerging Infections: Microbial Threats to Health in the United States*, global health governance has been conceptualized in relation to a narrative of national security. As discussed in Chapter III, the concerns of few public health officials and policy-makers in the United States were exported to the United Nations system, through a few zealous WHO bureaucrats who purchased the idea of expanding the WHO's mandate regarding the provision of global health. International Relations literature generally was not really concerned with the debates on global health governance until the early 2000s. The theorizing efforts generally were generally limited to *ex post facto* accounts. With this

background, this chapter attempted to offer a theoretical resistance to the dominant national security narrative that had been affecting the global health security narrative. Drawing insights from wilful Realism and Hobbes' argument on the prominence of human security, this chapter argued that a Realist understanding could essentially theorize about the global health security regime along a human security perspective. Theoretically, the prominence of the human security is more sound than the prominence of the state, as in the long term the national security argument does not allow more room for the establishment of a sound global health security regime.



CHAPTER VI

CONCLUSION

6.1 The Thematic Focus: What Has Been Argued?

This research attempted to understand the processes through which health is governed globally through analyzing the 2014-2015 Ebola outbreak. The complexity of the issue necessitated consultation to different sets of literature. The literature review on the issue of global health governance yielded that global health governance is usually juxtaposed to a security narrative. With this background, this research attempted to elicit an answer to the following question: How and why did contemporary global health governance regime liaised with a security rhetoric which culminated in the case of Ebola?

Chapter II outlined some of the main analytical frameworks that have been used in the conceptualization of health. Influenced by the increasing pace and velocity of the global interaction, these scholars and policy-makers conceptualized health by focusing on different aspects of the phenomenon. Amongst varying sets of conceptualizations, global health prevailed as the prominent analytical framework. In relation to that, a security tag had been used vis-à-vis health. Starting with the 1992 IOM Report, a security narrative had been permeated the conceptualization of global health governance. As such, global health governance became synonymous with the global health security. The prominence of the global over the local and security over the development and/or human rights frameworks tell a story about the changing relationship between the state and the individual. Even though globalization is not a new phenomenon particular to the twentieth and twenty-first centuries, the growing awareness regarding the connectedness of different socio-political spaces appeared to have a tremendous effect on the governance strategies. Temporally, a microbe can

travel from one space to another in matter of hours. Given the global interconnectedness of the economic activity and commercial transportation, such possibility generated concerns regarding the vulnerability of the human life which resulted in the projection of this concern to the state level.

Such vulnerability and its projection to the state-level elicited the deployment of a security narrative. Analyzing the deployment of such a narrative, Chapter III, tracked the evolution of this process by particularly focusing on the years between 1992 to 2013 by drawing on insights from securitization theory. Securitization theory is used in order to understand how the discursive frameworks have been used as means to securitize a phenomenon. With regard to the establishment of the global health governance, the years of gradual reformation witnessed the integration of the concerns of the few policy-makers and politicians in the United States and Canada to the agendas of the WHO. At the WHO headquarters, these lobbying efforts found purchase. The concept of EID, as introduced in the 1992 IOM Report had found itself a place in on the WHO agenda. In accordance with this growing concern, the WHO's techno-scientific apparatuses became more effective in gathering and collecting information regarding infectious diseases. The years 2000 and 2001 witnessed a huge leap forward regarding the emphasis given to the global health security regime. Alarmed by the pandemic HIV/AIDS and intentional release of anthrax, the UNSC became more involved in the provision of global health security. With the UNSC's involvement, the profile of the global health security regime increased, which culminated in the revision of the IHR in 2005. The global health security regime as mandated by the new IHR became globally accepted.

Chapter IV applied this insight to the case of Ebola to assess whether the global health security narrative essentially shaped the ways in which the 2014-2015

Ebola outbreak was mitigated. Through the study of select policy-documents promulgated by the WHO and the UN bureaucracies, this chapter argued that the global health security narrative had an impact on the ways in which the policy-makers formed their policy prescriptions. Informed by the decades long heritage of the global health security narrative, policy-makers immediately turned to containment strategies as suggested by the IHR. The containment strategies reflected the Western-centric aspect of the global health security regime. Rather than deploying long-term preventive measures so as to stop diseases from occurring in the first place, the very nature of global health security regime generally follows containment strategies in which the threat is usually contained before it spread from the source country/ies. Chapter IV also introduced the changing nature of (in)security in relation to the marriage of health and security. Rather than analyzing one side of phenomenon, the deployment of securitization strategies regarding infectious diseases also made it possible for medical language to penetrate into the security lexicon. Such medicalization not only changed the nature of security, but also reflected the changing nature of governance strategies. Drawing insight from Foucault's work on biopolitics, this section discussed how the new conception of human beings as species led to a change in the governance strategies of the state. Concerned with the welfare of their citizens, the new liberal states aimed at intervening into the lives of their population through the use of various institutions. This new governance reflex was also integrated within the global health security regime.

The last chapter argued for the necessity to theorize the resistance against the prominence of the national security narrative embedded in the global health security regime. Drawing on literature from Williams (2005) and Hobbes (1985), this chapter

argued for the case of the theoretical prominence of the human security narrative over the national security. This theoretical resistance challenges the ways in which global health security is practically deployed. Through applying the insights of wilful Realism and Hobbes' arguments, this chapter argued that a Realist understanding of security theoretically leans toward the prioritization of human security over the national security. Future applications of the global health security regime will demonstrate whether the case for human security may reach the apex of the agenda or the national security dominance will continue to dominate the regime.

6.2 The Future of Global Health Governance: Still Security?

With these analyses, ranging from discursive strategies of the policy-makers to the theoretical conceptualization of the changing state-individual relationship, this research attempted to elicit a robust portrayal of global health governance. The story of how global health governance had become pervasively dominated by a security narrative matters as repercussions of this marriage inform the present and the future of the global health governance. The global health security regime features a certain degree of Western-centrism which raises the question of whose security that the global health security regime is really overseeing. This question is important as the lives of many people are dependent on the decisions of the few policy-makers during a crisis such as the 2013-2015 Ebola. If the deployment of the global health security regime would follow a similar path that has been pursued thus far, such as the reliance on containment strategies, likely several questions would be raised regarding its scope and equity.

With this background, in Chapter V, this research attempted to offer a theoretical account which would prioritize the human over the state, thus proposing

an analytical framework to dismantle the unequal features of the global health security regime. This is, of course, a theoretical resistance point rather than a practical one. Yet, as extensively argued in the research, the discursive frameworks are inextricably linked to the empirical, constituting the ways in which we conceptualize health/disease. Thus, the first line of resistance should come at a discursive level which would allow more room for the elaboration of more practical measures.

The future of the global health security regime is still in the making. The decades long heritage of the global health security narrative still dominates the policy-prescriptions of the leading bureaucrats. The reception of the contemporary Zika virus gradually followed a similar path to the previous cases of global reception of infectious diseases. The WHO General Secretary declared Zika a public health emergency of international concern (PHEIC) (“WHO Declares Public Health Emergency”, 2016). Given the widespread geographical dispersion of the Zika virus, the global health security narrative once again alerted the officials and policy-makers. Yet, probing the Zika virus with a security mindset, especially focusing on state security appears be prone to the deficiencies that have been discussed throughout this paper. For instance, the debate surrounding the relationship between Zika’s spread and global warming appears to feature an underlying Western-centrism. The tone of the officials should avoid focusing on the security of the states to avoid such bias. The future will tell how the story is going to unfold.

BIBLIOGRAPHY

- Aradau, C., Huysmans J., Neal A., & Voelkner N. (2015). *Critical Security Methods: New Frameworks for Analysis*. Abingdon, Oxon: Routledge.
- Austin, J.L. (1962). *How to Do Things with Words*. Oxford: Oxford University Press.
- Axworthy, L. (2001). Human Security and Global Governance: Putting People First. *Global Governance*, 7, 19.
- Balzacq, T. (2005). The Three Faces of Securitization: Political Agency, Audience and Context. *European Journal of International Relations* 11(2), 171-201.
- Balzacq, T. (2010). *Securitization Theory: How Security Problems Emerge and Dissolve*. London and New York: Routledge.
- Benatar, S., & Upshur, R. (2011). What Is Global Health? In S. Benatar & G. Brock (Eds.), *Global Health and Global Health Ethics* (pp. 13-23). New York: Cambridge University Press.
- Birn, A. E. (2009). The Stages of International (Global) Health: Histories of Success or Successes of History?. *Global Public Health*, 4(1), 50-68.
- Birn, A. E., Pillay, Y., & Holtz, Z. (2009). *Textbook of International Health: Global Health in a Dynamic World*. New York: Oxford University Press.
- Burci, G. L. (2014) Ebola, the Security Council and the securitization of public health, *QIL, Zoom-In*, 10, 27-39.
- Burci, G. L., & Quirin, J. (2015). World Health Organization and United Nations Documents on the Ebola Outbreak in West Africa. *International Legal Materials*, 54(3), 532-560.
- Buzan, B., Wæver, O., & Wilde, J. D. (1998). *Security: A New Framework for Analysis*. Boulder, CO: Lynne Rienner Publication.
- Buzan, B., & Wæver, O. (2009). Macrosecuritisation and Security Constellations: Reconsidering Scale in Securitisation Theory. *Review of International Studies* 35(2), 253-276.
- Callimachi, R. (2014, September 18). Fear of Ebola Drives Mob to Kill Officials in Guinea. *The New York Times*. Retrieved December 15, 2015, from <http://www.nytimes.com/2014/09/19/world/africa/fear-of-ebola-drives-mob-to-kill-officials-in-guinea.html>.
- Carr, E. H. (1946). *The Twenty Years' Crisis, 1919-1939: An Introduction to the Study of International Relations*. London: Macmillan.
- CDC. (2014). Estimating the Future Number of Cases in the Ebola Epidemic - Liberia and Sierra Leone, 2014–2015. Retrieved May 08, 2016, from <http://www.cdc.gov/mmwr/preview/mmwrhtml/su6303a1.htm>

- Central Intelligence Agency (CIA). (2000) *The Global Infectious Disease Threat and Its Implications for the United States*, National Intelligence Estimate NIE99–17D. Available at: [http://www.fas.org/irp/threat/nie99–17d.htm](http://www.fas.org/irp/threat/nie99-17d.htm) (accessed 10 April 2016).
- Chen, L. (2004). Health as a Human Security Priority for the 21st century. *Paper for Human Security Track III. Helsinki: Helsinki Process*. 5.
- Ciută, F. (2009). Security and the Problem of Context: A Hermeneutical Critique of Securitisation Theory. *Review of International Studies*, 35(2), 301-326.
- Cockerham, W. C., & Cockerham, G. B. (2010). *Health and Globalization*. John Wiley & Sons, Ltd.
- Constitution of the World Health Organization (1946). Retrieved April 17, 2016, from http://www.who.int/governance/eb/who_constitution_en.pdf.
- Cumming, H. S. (1926). The International Sanitary Conference. *American Journal of Public Health*, 16(10), 975-980.
- Curley, M., & Thomas, N. (2004). Human Security and Public Health in Southeast Asia: The SARS Outbreak. *Australian Journal of International Affairs*, 58(1), 17-32.
- Curley, M. G., & Herington, J. (2011). The Securitisation of Avian Influenza: International Discourses and Domestic Politics in Asia. *Review of International Studies*, 37(01), 141-166.
- Daniels, N. (2012). *Just Health: Meeting Health Needs Fairly*. New York: Cambridge University Press.
- Davidson, A. (2003). Introduction. In M. Foucault (Author), *Abnormal: Lectures at the Collège de France 1974-1975* (pp. xvii-xxvi). London: Verso Press.
- Davies, S. E. (2008). Securitizing Infectious Disease. *International Affairs*, 84(2), 295-313.
- Declaration of Alma-Ata International Conference (1978). Retrieved April 17, 2016, from http://www.who.int/publications/almaata_declaration_en.pdf.
- Ebola Features Map. (2016). Retrieved May 01, 2016, from <http://www.who.int/features/ebola/storymap/en/>.
- Ebola Outbreak a Threat to World Peace, Says UN Security Council. (2014, September 18). *The Guardian*. Retrieved November 15, 2015, from <http://www.theguardian.com/society/2014/sep/18/ebola-outbreak-un-security-council-resolution>.
- Ebola UN Speech: "The Response Remains Totally, and Lethally, Inadequate" (2014). Retrieved May 01, 2016, from <http://www.msf.org.uk/article/ebola-un-speech-response-remains-totally-and-lethally-inadequate>.
- Elbe, S. (2005). AIDS, Security, Biopolitics. *International Relations*, 19(4), 403-419.

- Elbe, S. (2006). Should HIV/AIDS Be Securitized? The Ethical Dilemmas of Linking HIV/AIDS and Security. *International Studies Quarterly*, 50(1), 119-144.
- Elbe, S. (2009). *Virus Alert: Security, Governmentality, and the AIDS Pandemic*. Columbia University Press.
- Elbe, S. (2010). *Security and Global Health: Towards the Medicalization of Insecurity*. Cambridge: Polity Press.
- Elbe, S., & Voelkner, N. (2015). The Medicalization of Insecurity. In S. Rushton & J. Youde (Eds.), *The Routledge Handbook of Global Health Security* (pp. 71-80). New York: Routledge.
- Ersoy, N., Gungor, Y., & Akpınar, A. (2011). International Sanitary Conferences from the Ottoman Perspective (1851–1938). *Hygiea Internationalis*, 10(1), 53-79.
- Fee, E. (2015). A Shared Social Vision. In G. Rosen (Author), *A History of Public Health* (pp. xiii-liv). Baltimore, Maryland: Johns Hopkins University Press.
- Fidler, D. P. (2003). Public health and national security in the global age: infectious diseases, bioterrorism, and realpolitik. *Geo. Wash. Int'l L. Rev.*, 35, 790.
- Fidler, D. P. (2005). From International Sanitary Conventions to Global Health Security: The New International Health Regulations. *Chinese Journal of International Law*, 4(2), 325-392.
- Foucault, M. (1997). *Society Must Be Defended: Lectures at the Collège de France 1975-1976*. New York: Picador.
- Foucault, M. (2000a). The Politics of Health in the Eighteenth Century. In Robert Hurley and others (Trans.) *Essential Works of Foucault, Vol III: Power* (pp. 90-105). New York: The New Press.
- Foucault, M. (2000b). Governmentality. In Robert Hurley and others (Trans.) *Essential Works of Foucault, Vol III: Power* (pp. 201-22). New York: The New Press.
- Foucault, M. (2003). *Abnormal: Lectures at the Collège de France 1974-1975*. London: Verso Press.
- Garrett, L. (1994). *The Coming Plague: Newly Emerging Diseases in a World out of Balance*. New York: Farrar, Straus and Giroux.
- Garrett, L. (2015, June 06). The Ebola Review, Part I. Retrieved May 1, 2016, from <http://foreignpolicy.com/2015/06/06/ebola-review-world-health-organization-g-7-merkel/>.
- Gostin, L. O., & Friedman, E. A. (2014). Ebola: A Crisis in Global Health Leadership. *The Lancet*, 384(9951), 1323-1325. doi:10.1016/s0140-6736(14)61791-8.

- Guinea Declares Public Health Emergency over Ebola. (2014, August 14). Retrieved May 01, 2016, from <http://www.reuters.com/article/us-health-ebola-guinea-idUSKBN0GE1J520140814>.
- Hansen, L. (2006). *Security as Practice: Discourse Analysis and the Bosnian War*. New York: Routledge.
- Henig, R. M. (1993). *A Dancing Matrix: Voyages Along the Viral Frontier*. New York: A.A. Knopf.
- Hobbes, Thomas. 1651 [1985]. *Leviathan*. London: Penguin Classics Reprint.
- Howard-Jones, N. (1975). *The Scientific Background of the International Sanitary Conferences, 1851-1938*. Geneva: World Health Organization.
- Huynen, M. M., Martens, P., & Hilderink, H. B. (2005). The Health Impacts of Globalisation: A Conceptual Framework. *Globalization and Health*, 1(1), 3-5.
- International Health Regulations. (1983) *International Health Regulations (1969)*, 3rd ed. Geneva: World Health Organization. Available at: <http://apps.who.int/iris/bitstream/10665/96616/1/9241580070.pdf> (accessed 12 April 2016).
- International Health Regulations. *International Health Regulations (2005)*. (2008). Geneva: World Health Organization. Available at: http://apps.who.int/iris/bitstream/10665/43883/1/9789241580410_eng.pdf.
- International Sanitary Conferences. (n.d.). Retrieved May 07, 2016, from <http://ocp.hul.harvard.edu/contagion/sanitaryconferences.html>.
- Jackson, P.T. (2011). *The Conduct of Inquiry In International Relations*. New York: Routledge.
- Kamradt-Scott, A. (2016). WHO's to Blame? The World Health Organization and the 2014 Ebola Outbreak in West Africa. *Third World Quarterly*, 37(3), 401-418.
- Kaplan, R. D. (1994). The Coming Anarchy. *The Atlantic*, February, 44-76.
- Kawachi, I., & Wamala, S. (2007). Poverty and Inequality in a Globalizing World. *Globalization and Health*, 125, 19-20.
- Key Events in the WHO Response to the Ebola Outbreak. (n.d.). Retrieved May 01, 2016, from <http://www.who.int/csr/disease/ebola/one-year-report/who-response/en/>.
- Ki-Moon, B. (2014, September 18). Identical Letters Dated 17 September 2014 from the Secretary-General addressed to the President of the General Assembly and the President of the Security Council. Retrieved May 01, 2016, from http://www.securitycouncilreport.org/atf/cf/{65BFCF9B-6D27-4E9C-8CD3-CF6E4FF96FF9}/S_2014_679.pdf.

- Kim, C. (2014, September 18). UN Security Council Declares Ebola Threat to Peace and Security. *MSNBC*. Retrieved December 15, 2015, from <http://www.msnbc.com/the-last-word/un-security-council-declares-ebola-threat-peace-and-security>.
- King, G., Keohane R. O, & Verba S. (1994). *Designing Social Inquiry*. Princeton: Princeton University Press.
- Lac Tremblant Declaration. (1994). Proceedings and Recommendations of the Expert Working Group on Emerging Infectious Disease Issues: Lac Tremblant Declaration, *Canada Communicable Disease Report*, 20S2, 1-21.
- Lederberg J., Shope R.E., & Oaks SC Jr. (1992) *Emerging Infections: Microbial Threats to Health in the United States*. Washington, DC: Institute of Medicine/National Academy Press.
- Lee, K. (2003). *Globalization and Health: An Introduction*. Palgrave Macmillan.
- Liberia Declares State of Emergency over Ebola Virus. (2014, August 07). Retrieved May 01, 2016, from <http://www.bbc.com/news/world-28684561>.
- Malcolm, N. (2002). *Aspects of Hobbes*. Oxford: Oxford University Press.
- Malcolm, N. (2005). What Hobbes Really Said. *The National Interest* (Fall), 122-128.
- McDonald, M. (2008.) Securitization and the Construction of Security. *European Journal of International Relations* 14(4), 563-587.
- McInnes, C. (2008). Health. In P. D. Williams (Ed.), *Security Studies: An Introduction* (pp. 274-287). New York: Routledge.
- McInnes, C. (2015). The Many Meanings of Health Security. In S. Rushton & J. Youde (Eds.), *The Routledge Handbook of Global Health Security* (pp. 7-17). New York: Routledge.
- McInnes, C. (2016). Crisis! What Crisis? Global Health and the 2014–15 West African Ebola Outbreak. *Third World Quarterly*, 37(3), 380-400.
- McInnes, C., & Lee, K. (2012). *Global Health and International Relations*. Polity.
- McInnes, C., & Rushton, S. (2010). HIV, AIDS and Security: Where Are We Now? *International Affairs*, 86(1), 225-245.
- McInnes, C., & Rushton, S. (2012). HIV/AIDS and Securitization Theory. *European Journal of International Relations*, 19 (1), 115-138.
- McSweeney, B. (1996). Identity and Security: Buzan and the Copenhagen School. *Review of International Studies* 22(1), 81–93.
- Mutlu, C. E., & Salter, M. B. (2013). Discursive Turn. In M.B. Salter & C. E. Mutlu (Eds.), *Research Methods in Critical Security Studies: An Introduction* (pp. 113-119). New York: Routledge.

- Neumann, I. B. (2008). Discourse Analysis. In A. Klotz, & D. Prakash (Eds.) *Qualitative Methods in International Relations: A Pluralist Guide. Research Methods Series* (pp. 61-77). London, UK: Palgrave Macmillan.
- Nunes, J. (2014). *Security, Emancipation and the Politics of Health: A New Theoretical Perspective*. New York: Routledge.
- Nunes, J. (2015). The Politics of Health Security. In S. Rushton & J. Youde (Eds.), *The Routledge Handbook of Global Health Security* (pp. 60-70). New York: Routledge.
- Ogata, S., & Cels, J. (2003). Human Security-Protecting and Empowering the People. *Global Governance*, 9: 273.
- Peterson, S. (2002). Epidemic Disease and National Security. *Security Studies*, 12(2), 43-81.
- Price-Smith, A. T. (2002). *The Health of Nations: Infectious Disease, Environmental Change, and Their Effects on National Security and Development*. Cambridge, MA: MIT Press.
- Remarks by International President of MSF Dr. Joanne Liu at the Gates Foundation Global Partner Forum. (2015). Retrieved May 01, 2016, from <http://www.msf.org/article/remarks-international-president-msf-dr-joanne-liu-gates-foundation-global-partner-forum>.
- Roemer-Mahler, A., & Elbe, S. (2016). The Race for Ebola Drugs: Pharmaceuticals, Security and Global Health Governance. *Third World Quarterly*, 37(3), 487-506.
- Roemer-Mahler, A., & Rushton, S. (2016). Introduction: Ebola and International Relations. *Third World Quarterly*, 37(3), 373-379.
- Rosen, G. (2015). *A History of Public Health* [1958]. Baltimore, Maryland: Johns Hopkins University Press.
- Rushton, S. (2011). Global Health Security: Security for Whom? Security from What? *Political Studies*, 59: 779-796.
- Searle, J. R. (1969). *Speech Acts: An Essay in the Philosophy of Language*. London: Cambridge University Press.
- Shepherd, L. J. (2013). *Critical Approaches to Security: An Introduction to Theories and Methods*. Routledge.
- Sierra Leone Declares Ebola Public Health Emergency. (2014, July 31). Retrieved May 01, 2016, from <http://www.bbc.com/news/world-africa-28579890>
- Singer, P. W. (2002). AIDS and International Security. *Survival*, 44(1), 145-158.
- Spieker, J. (2011). Foucault and Hobbes on Politics, Security, and War. *Alternatives: Global, Local, Political*, 36(3), 187-199.
- Stritzel, H. (2007). Towards a Theory of Securitization: Copenhagen and Beyond. *European Journal of International Relations* 13(3), 357-383.

- Stuckler, D., & McKee, M. (2008). Five Metaphors about Global-health Policy. *The Lancet*, 372(9633), 95-97.
- Şehsuvaroğlu, B.N. (1959). Türkiye Karantina Tarihine Giriş [Introduction to the History of the Quarantine in Turkey, Introduction a l'histoire de la quarantaine en Turquie], *Journal of the İstanbul University School of Medicine*, 22(1).
- UNDP. (1994). *Human Development Report 2004: Cultural Liberty in Today's Diverse World*. New York, NY: Oxford University Press.
- United Nations Security Council. (2000, July). Resolution 1308. Available at: <https://documents-dds-ny.un.org/doc/UNDOC/GEN/N00/536/02/PDF/N0053602.pdf?OpenElement>. (accessed 10 April 2016).
- United Nations Security Council. (2011, June). Resolution 1983. Available at: [http://www.un.org/en/ga/search/view_doc.asp?symbol=S/RES/1983\(2011\)](http://www.un.org/en/ga/search/view_doc.asp?symbol=S/RES/1983(2011)). (accessed 10 April 2016).
- United Nations Security Council. (2014, September 18). Resolution 2177. Available at: [http://www.un.org/en/ga/search/view_doc.asp?symbol=S/RES/2177%20\(2014\)](http://www.un.org/en/ga/search/view_doc.asp?symbol=S/RES/2177%20(2014)). (accessed 10 April 2016).
- Van Dijk, T. A. (2001) Critical Discourse Analysis. In D. Schiffrin, D. Tannen, & H. E. Hamilton (Eds.), *The Handbook of Discourse Analysis* (pp. 352-371). Malden: Blackwell Publishers Inc.
- Walker, R.B.J. (1993). *Inside/Outside: International Relations as Political Theory*. Cambridge: Cambridge University Press.
- Weir, L. (2015). Inventing Global Health Security, 1994-2015. In S. Rushton & J. Youde (Eds.), *The Routledge Handbook of Global Health Security* (pp. 18-31). New York: Routledge.
- Weir, L., & Mykhalovskiy, E. (2010). *Global Public Health Vigilance: Creating a World on Alert*. New York: Routledge.
- WHO. (1994) *Report of WHO Meeting on Emerging Infectious Diseases*, Geneva: World Health Organization. Available at: http://apps.who.int/iris/bitstream/10665/62042/1/CDS_BVI_94.2.pdf (accessed 10 April 2016).
- WHO. (1995) *Report of the Second WHO Meeting on Emerging Infectious Diseases*, Geneva: World Health Organization. Available at: http://apps.who.int/iris/bitstream/10665/61106/1/WHO_CDS_BVI_95.2.pdf (accessed 10 April 2016).
- WHO. (1996) *Emerging and Other Communicable Disease: Strategic Plan 1996–2000* (WHO/EMC/96.1). Geneva: World Health Organization. Available at: http://apps.who.int/iris/bitstream/10665/63593/1/WHO EMC_96.1.pdf (accessed 10 April 2016).

- WHO. (2000a) *A Framework for Global Outbreak Alert and Response*. Available at: [http://www.who.int/csr/resources/publications/surveillance/whocdscsr2002.pdf? ua=1](http://www.who.int/csr/resources/publications/surveillance/whocdscsr2002.pdf?ua=1) (accessed 10 April 2016).
- WHO. (2000b) *Global Outbreak Alert and Response: Report of a WHO Meeting*. Available at: [http://www.who.int/csr/resources/publications/surveillance/whocdscsr2003.pdf? ua=1](http://www.who.int/csr/resources/publications/surveillance/whocdscsr2003.pdf?ua=1) (accessed 10 April 2016).
- WHO. (2007). *The World Health Report 2007 – A Safer Future: Global Public Health Security in the 21st Century*, Geneva: WHO.
- WHO. (2014). Statement on the 1st meeting of the IHR Emergency Committee on the 2014 Ebola outbreak in West Africa. (2014, August 08). Retrieved May 01, 2016, from <http://www.who.int/mediacentre/news/statements/2014/ebola-20140808/en/>.
- WHO Declares Public Health Emergency Around Zika Virus (2016, February 01) Retrieved May 14, 2016, from http://www.huffingtonpost.com/entry/world-health-org-zika-virus-emergency_us_56af781ae4b077d4fe8ec2ac.
- WHO's Ebola Response. (2016). Retrieved May 01, 2016, from <http://www.who.int/csr/disease/ebola/en/>.
- Williams, M. C. (1996). Hobbes and international relations: a reconsideration. *International Organization*, 50(02), 213-236.
- Williams, M. C. (2005). *The Realist Tradition and the Limits of International Relations*. Cambridge: Cambridge University Press.
- Williams, P. D. (2008). *Security Studies: An Introduction*. London: Routledge.
- Wishnick, E. (2010). Dilemmas of Securitization and Health Risk Management in the People's Republic of China: The Cases of SARS and Avian Influenza. *Health Policy and Planning*, 25(6), 454-466.
- World Health Assembly. (1995) *Communicable Disease Prevention and Control: New, Emerging and Re-emerging Infectious Diseases* , WHA 48.13, 12 May.
- World Health Assembly. (2001) *Global Health Security: Epidemic Alert and Response*, WHA 54.14, 21 May. Available at: http://apps.who.int/gb/archive/pdf_files/WHA54/ea549.pdf (accessed 10 April 2016).
- World Health Assembly. (2002) *Global Public Health Response to Natural Occurrence, Accidental Release or Deliberate Use of Biological and Chemical Agents or Radionuclear Material that Affect Health* , WHA 55.16, 18 May. Available at: http://apps.who.int/gb/archive/pdf_files/WHA55/ewha5516.pdf (accessed 10 April 2016).
- Youde, J. (2005). Enter the Fourth Horseman: Health Security and International Relations Theory. *Whitehead J. Dipl. & Int'l Rel.*, 6, 193.