

Securitizing infectious disease

SARA E. DAVIES*

Approximately 14.7 million people die each year from known and preventable infectious diseases.¹ Respiratory infection, AIDS, diarrhoeal diseases, tuberculosis (TB) and malaria were the five leading causes of mortality from infectious disease between 2002 and 2006.² At the same time, the possibility of a pandemic influenza represents one of the most serious threats to global health because it is one of the few infections that could be transmitted easily and to which all populations would be equally susceptible.³ In addition to all of this, there are a number of neglected infectious diseases such as guinea worm disease, schistosomiasis, leprosy, Buruli ulcer, cholera, dengue, dengue haemorrhagic fever, measles and human rabies, all of which cause painful debilitating side-effects and/or death, but receive little budgetary support for research or prevention.⁴

In this article I will trace how the international community—in particular, western states and the World Health Organization (WHO)—have combined forces to construct infectious disease as an existential security threat that requires new rules and behaviours for its effective containment. The outcome of this has been the development of international health cooperation mechanisms that place western fears of an outbreak reaching them above the prevention of such outbreaks in the first place. In turn, the desire of the WHO to assert its authority in the project of disease surveillance and containment has led it to develop global health mechanisms that primarily prioritizes the protection of western states from disease contagion.

The WHO has a history of seeking to dominate health agendas, and on previous occasions its own health agenda has been dominated by that of its main

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¹ World Health Organization, *Global defence against the infectious disease threat* (Geneva, 2003), pp. 6, 18.

² WHO, *Global defence*, p. 7; Ellen't Hoen, 'TRIPS, pharmaceutical patents, and access to essential medicines: a long way from Seattle to Doha', in Sofia Gruskin, Michael A. Grodin, George J. Annas and Stephen P. Marks, eds, *Perspectives on health and human rights* (New York: Routledge, 2005), p. 203.

³ 'Editorial: public-health preparedness requires more than surveillance', *Lancet* 364: 9446, 2004, p. 1639; WHO, *The World Health Report 2007. A safer future: global public health security in the 21st century* (Geneva, 2007), p. 47.

⁴ WHO, *Global defence*; Paul Hunt, 'Neglected disease, social justice and human rights: some preliminary observations', Health and Human Rights working paper, no. 4 (Geneva: WHO, 2003).

donor states.⁵ What is important about the political relationship between the WHO and developed states in this case is that the WHO has been a primary actor in constructing the emerging discourse of infectious disease securitization, and western states in particular have been quick to engage with this discourse. Developing states have been noticeable in this process only by their absence as key actors. Nevertheless, the notification and verification of an infectious disease outbreak relies upon its confirmation by the state,⁶ and there has been a collective failure, first, to deal with the possibility that a state or group of states may reject the discourse of securitization and withhold cooperation and second, that the affected state may not be aware of the outbreak. As Checkel argues, the mechanisms by which norms are internalized may result in states acting in very different ways to the same phenomenon.⁷ The result could be that the WHO becomes locked into one social construction of infectious disease that crowds out alternative, potentially more effective, response mechanisms.

As has been argued elsewhere, the problem with securitizing infectious disease is that securitization locks agents into the logic of defining a referent object and an external threat source.⁸ Security, as Buzan et al. argue, can be best defined as a 'self-referential practice, because it is in this practice that the issue become a *security issue*—not necessarily because a real existential threat exists but because the issue is presented as such a threat'.⁹ Therefore, while the WHO ostensibly seeks to fulfil its mandate by securitizing the health of all, states inevitably seek to secure the health of their citizens. The result has been that the WHO has ended up running a global surveillance system that prioritizes western states' concerns. This has occurred, I argue, largely because of the WHO's interest in retaining an authoritative role in the area of global health governance. The conundrum is that in capitulating to western concerns, the WHO may have actually compromised its moral authority and the potential for cooperation with developing states affected by outbreaks.¹⁰

This article will proceed in three sections. The first section will chart the increased awareness of western states during the 1990s that infectious diseases

⁵ Meri Koivusalo and Eva Ollila, *Making a healthy world: agencies, actors and policies in international health* (London: Zed, 1997); People's Health Movement, Medact and Global Equity Gauge Alliance, *Global Health Watch 2005–2006: an alternative world health report* (London: Zed, 2005).

⁶ David L. Heymann, 'Evolving infectious disease threats to national and global security', in Lincoln Chen, Jennifer Leaning and Vasant Narasimhan, eds, *Global health challenges for human security* (Cambridge, MA: Harvard University Press, 2003), p. 114.

⁷ Jeffrey T. Checkel, 'The constructivist turn in international relations theory', *World Politics* 50: 2, 1998, pp. 324–48.

⁸ Obijiofor Aginam, 'Between isolationism and mutual vulnerability: a South–North perspective on global governance of epidemics in an age of globalization', *Temple Law Review* 77: 3, 2004, pp. 297–312; Colin McInnes and Kelley Lee, 'Health and security', *Tidsskriftet politik* 8: 1, 2005, pp. 33–44; Colin McInnes, 'Health, security and the risk society', Nuffield Trust Global Programme on Health, Foreign Policy and Security (London: Nuffield Trust, 2005); Colin McInnes and Kelley Lee, 'Health, security and foreign policy', *Review of International Studies* 32: 1, 2006, pp. 5–23; Barry Buzan, Ole Waever and Jaap de Wilde, *Security: a new framework for analysis* (Boulder, CO: Lynne Rienner, 1998).

⁹ Buzan et al., *Security*, p. 24.

¹⁰ Similar concerns, though with arguments slightly different from mine, are raised by Eric Mack and Philippe Calain: Eric Mack, 'The World Health Organization's new International Health Regulations: incursions on state sovereignty and ill-fated response to global health issues', *Chicago Journal of International Law* 7: 1, 2006, pp. 365–77; Philippe Calain, 'Exploring the international arena of global health surveillance', *Health Policy and Planning* 22: 1, 2007, pp. 2–12.

posed a potential threat to their citizens' health. This increased awareness led to the emergence of infectious diseases as an item on national security agendas. The securitization of infectious disease led western states to increase their support for surveillance and response measures. This created a dilemma for the WHO, because individual acts to securitize disease by individual states posed a potential challenge to the global organization's authority on these matters.

This analysis leads into the second section of the article, which explores the WHO's securitization of infectious disease. This occurred at the same time that securitization by western states was increasing. The rationale for the WHO was that increased awareness of the problem would raise the profile of infectious diseases in general, demonstrate the threat that infectious disease could pose to both developing *and* developed states, and thus prevent western states from creating their own independent national surveillance mechanisms for infectious diseases. I trace how the combination of the WHO's motives led to their argument that the best response to the threat of infectious disease was the creation of the Global Outbreak and Alert Response Network (GOARN), which would manage disease outbreak and alerts at the international level under the WHO's auspices. GOARN has been promoted as the pinnacle of the WHO's authority in global health governance.¹¹ However, I suggest that it may also represent a demonstration of the WHO's attempt to retain its authority and privileged position in the global response to infectious disease.

In the third section of the article I explain why the WHO was so concerned with setting up a surveillance mechanism that retained western interest and support. I suggest that Barnett and Finnemore's work on the constitutive relationship between international organizations and states helps to explain the impact that the securitization of infectious disease has had on the organization and mandate of the WHO.¹² I argue that the widespread assumption that the development of GOARN has been the product of the successful securitization of infectious disease, which will in turn improve compliance with the WHO's new mechanism for global health governance, is flawed. The main problem is that the causes of non-compliance have not been adequately addressed by these new measures. This, I argue, is because the rationale dominating GOARN's construction has largely related to preserving the WHO's authority in surveillance of and response to infectious disease, and maintaining the support of western states by allaying their fears of epidemics reaching their shores.

¹¹ Thomas W. Grein, Kande-Bure O. Kamara, Guénaél Rodier, Aileen J. Plant, Patrick Bovier, Michael J. Ryan, Takaaki Ohshima and David L. Heymann, 'Rumors of disease in the global village: outbreak verification', *Emerging Infectious Diseases* 6: 2, 2000, pp. 97–102; Gro Harlem Brundtland, 'Global health and international security', *Global Governance* 9: 4, 2003, pp. 417–23; David Fidler, *SARS, governance and the globalization of disease* (New York: Palgrave Macmillan, 2004), pp. 163–70; William Burns, 'Openness is key', *Bulletin of the World Health Organization* 84: 10, 2006, pp. 769–70; Calain, 'Exploring the international arena of global health surveillance'.

¹² Michael Barnett and Martha Finnemore, *Rules for the world: international organizations in global politics* (Ithaca, NY: Cornell University Press, 2004).

The securitization of infectious disease by western states

By the late 1970s there was some confidence among public health officials that the risk of infectious disease had decreased. It was widely believed that new treatments, vaccines and knowledge of microbes would lead to the eradication of infectious disease as a major cause of death.¹³ Just a decade later, however, this optimism had proved to be ill-founded. The outbreak and spread of HIV/AIDS, followed by the resurgence of stronger microbe-resistant pathogens, such as malaria, TB, meningitis and dengue fever, were compounded by the fear that bioterrorists might use deadly pathogens as a weapon of war.¹⁴ Since the late 1980s new infectious pathogens have been discovered at the rate of one per year.¹⁵ Serious infectious disease discoveries in the past decade have included Lassa and Marburg haemorrhagic fevers in Africa, variants of Creutzfeldt–Jakob disease in Europe, meningococcal meningitis W135, Nipah virus in Malaysia and the West Nile virus in the Americas.¹⁶ In addition, the recent outbreak of severe acute respiratory syndrome (SARS) and the threat of a pandemic arising from the H5N1 strain of avian influenza have led to the argument that the world cannot escape a potential epidemic influenza that could kill anywhere between 2 million and 12 million people.¹⁷ These developments have all served to increase calls for infectious diseases to be targeted as threats to national security.¹⁸

These developments did not go unnoticed in the West. During the 1990s, awareness of the threat that infectious disease outbreaks could pose to their citizens' health and to their countries' economic and political stability encouraged western governments to develop responses in national security terms. Acute awareness that western states were not immune to this threat was raised by outbreaks of West Nile virus and drug-resistant infectious diseases, such as TB, measles and meningitis, in the United States and Britain, as well as the outbreak of SARS in Canada. In the rest of this section I will briefly demonstrate how infectious disease was increasingly framed as a security threat in the United States, Australia, Canada and Europe up to the turn of the century, and how each of these states, and the European Union, has increasingly seen containment at the source as the primary response required.

¹³ WHO, *A framework for global outbreak alert and response*, WHO/CDS/CSR/2000.2 (Geneva: WHO Department of Communicable Disease Surveillance and Response, 2000), p. 1.

¹⁴ David Sanders and Mickey Chopra, 'Globalization and the challenge of health for all: a view from sub-Saharan Africa', in Kelley Lee, ed., *Health impacts of globalization: towards global governance* (Basingstoke: Palgrave Macmillan, 2003), p. 106.

¹⁵ Angela Merianos and Malik Peiris, 'International Health Regulations (2005)', *Lancet* 366: 9493, 2005, p. 1250.

¹⁶ Heymann, 'Evolving infectious disease threats', pp. 106–8.

¹⁷ WHO, 'Ten things you need to know about pandemic influenza', <http://www.who.int/csr/disease/influenza/pandemic10things/en/index.html>, accessed 2 Dec. 2006.

¹⁸ Jennifer Brower and Peter Chalk, *The global threat of new and reemerging infectious diseases: reconciling US national security and public health policy* (Arlington, CA: Rand, 2003); WHO, *Global defence*; David Fidler, 'Germes, governance, and global public health in the wake of SARS', *Journal of Clinical Investigation* 113: 6, 2004, pp. 799–804; Lawrence O. Gostin, 'Pandemic influenza: public health preparedness for the next global health emergency', *Journal of Law, Medicine and Ethics* 32: 44, 2004, pp. 565–73; Obijiofor Aginam, 'Globalization of infectious diseases, international law and the World Health Organization: opportunities for synergy in global governance of epidemics', *New England Journal of International and Comparative Law* 11: 1, 2005, pp. 59–74; WHO, *World Health Report 2007*.

The United States has been a keen participant in disease surveillance and response since the mid-1990s.¹⁹ The United States Department of Defense (US DoD) has had overseas infectious disease research laboratories located in over 20 countries for nearly ten years. The Global Emerging Infectious Surveillance and Response System (DoD-GEIS) mobile laboratories were set up for the purpose of 'responding to outbreaks of epidemic, endemic and emergent diseases',²⁰ and their location in the DoD, as opposed to the United States Agency for International Development (USAID) or Centre for Disease Control (CDC) demonstrates how seriously the United States views the response to infectious disease as a key national security strategy. Further evidence of American urgency in containing infectious disease outbreaks was demonstrated by its providing complete funding for GOARN's Strategic Health Operations Centre (SHOC) at WHO headquarters to monitor and report on disease outbreaks.²¹

Fidler suggests that there are three reasons for America's increasingly securitized response to infectious disease. The first is the threat of bioterrorism.²² Even before the anthrax attacks in the United States in late 2001, the US government had been warned of the threat posed by the deliberate release of pathogens into cities via subways or cinemas, or dispersed by turbine engines, water or sewerage ducts.²³ As early as 1996 President Clinton identified the need to bolster US biodefence capabilities, resulting in the DoD's development of the GEIS mobile units.²⁴ The US also increased its financial contributions to multilateral infectious disease surveillance operations, committing itself, for example, to the G7 plus Mexico 'Ottawa plan for improving health security', signatories to which agreed to 'strengthen global surveillance and outbreak response' to prepare for biological terrorist attacks.²⁵

Second, Fidler argues that the US government started to connect the continuous evolution of naturally occurring infectious diseases with globalization, coming to the view that such interconnectedness between poor and wealthy travellers increased the risk of infection spreading across the globe.²⁶ Within the United States, public health systems were encountering infectious diseases that they either had thought eradicated or had not seen before: West Nile encephalitis, new strains of measles, multi-drug-resistant tuberculosis, malaria and cyclosporiasis have been diagnosed in the United States as having arrived through water and food either imported or brought in by travellers from overseas.²⁷ A report for the US Institute

¹⁹ David P. Fidler, David L. Heymann, Stephen M. Ostroff and Terry P. O'Brien, 'Emerging and reemerging infectious diseases: challenges for international, national and state law', *International Lawyer* 31: 3, 1997, pp. 773–99.

²⁰ Jean-Paul Chrétien, David L. Blazes, Joel C. Gaydos, Sheryl A. Bedno, Rodney L. Coldren, Randall C. Culpepper, David J. Fryauff, Kenneth C. Earhart, Moustafa M. Mansour, Jonathan S. Glass, Michael D. Lewis, Bonnie L. Smoak and Joseph L. Malone, 'Experience of a global laboratory network in responding to infectious disease epidemics', *Lancet Infectious Diseases* 6: 9, 2006, p. 538.

²¹ Burns, 'Openness is key', p. 769; David Fidler, 'Constitutional outlines', *Temple Law Review* 77: 2, 2004, pp. 247–90; Christian Enemark, 'Pandemic pending', *Australian Journal of International Affairs* 60: 1, 2006, pp. 43–9.

²² Fidler, 'Constitutional outlines'.

²³ Brower and Chalk, *The global threat of new and reemerging infectious diseases*, pp. 10–12.

²⁴ Enemark, 'Pandemic pending', pp. 55–6; Chrétien et al., 'Experience of a global laboratory network', p. 538.

²⁵ WHO, *Global defence*, p. 17.

²⁶ Fidler, 'Constitutional outlines'.

²⁷ Mark S. Smolinski, Margaret A. Hamburg and Joshua Lederberg, eds, *Microbial threats to health: emergence, detection and response* (Washington DC: National Academies Press, 2003), p. 1.

of Medicine argued that the United States needed to enhance the 'global capacity for response to infectious disease threats, focusing in particular on threats in the developing world', and take a 'leadership role in ... a system of surveillance for global infectious disease'.²⁸

Finally, Fidler suggests that the US government realized that infectious disease epidemics in foreign countries could threaten US national interests. For example, HIV/AIDS has been increasingly linked to future state failure and regional instability in the developing world because of the high risk it poses to soldiers and skilled citizens.²⁹ More than 50 million people worldwide have been infected with the human immunodeficiency virus (HIV) since it was first identified in the United States in 1981.³⁰ Today, the disease kills over 4 million people a year, with women and girls at higher risk of infection than boys and men.³¹ In a 1998 paper entitled 'Reducing the threat of infectious diseases', USAID asserted that the 'capacity of all nations to recognize, prevent, and respond to the threat of emerging and re-emerging infectious diseases is the critical foundation for an effective global response'.³² Waiting for the outbreak to arrive and then responding is the last resort, it argued. The first line of defence is the application of 'prevention, treatment and control programs', before the disease reaches US shores.³³ Containment, then, was what USAID recommended as the best defence, to be effected by developing a strong infectious disease surveillance capacity. The crucial factor, argued USAID, was improved coordination between international health organizations and a willingness by states to report serious outbreaks of infectious diseases.³⁴

Among policy-makers in Australia, Canada and the EU, McInnes and Lee have noted a similar realization of the perceived need to plan for infectious disease outbreaks, whether naturally occurring or caused by bioterrorism.³⁵ The emerging consensus has been that any such outbreak would constitute a threat to national security, and thus support for global health security has become a stronger feature in national and EU policy.³⁶

In Australia, particularly since the outbreak of SARS and the re-emergence of H₅N₁ avian flu in 2003, defence strategists, academics, economists and politi-

²⁸ Smolinski et al., *Microbial threats to health*, pp. 8–9.

²⁹ For further reading on the link between HIV/AIDS and security, see Gwyn Prins, 'AIDS and global security', *International Affairs* 80: 5, 2004, pp. 931–52; *International Affairs* 82: 2, 2006, a special issue on AIDS and security; Stefan Elbe, 'Should HIV/AIDS be securitized? The ethical dilemmas of linking HIV/AIDS and security', *International Studies Quarterly* 50: 1, 2006, pp. 119–44.

³⁰ Kelley Lee and Anthony Zwi, 'A global political economy approach to AIDS: ideology, interests and implications', in Kelley Lee, ed., *Health impacts of globalization: towards global governance* (Basingstoke: Palgrave Macmillan, 2003), p. 14.

³¹ Gillian MacNoughton, 'Women's human rights related to health-care services in the context of HIV/AIDS', Health and Human Rights working paper no. 5 (Geneva: WHO, 2004), p. 5; Daniel Tarantola and Sofia Gruskin, 'Children confronting HIV/AIDS: charting the confluence of rights and health', in Sofia Gruskin, Michael A. Grodin, George J. Annas and Stephen P. Marks, eds, *Perspectives on health and human rights* (New York: Routledge, 2005), pp. 235–6.

³² USAID, *Reducing the threat of infectious diseases* (Washington DC, 1998), p. 1, http://www.usaid.gov/our_work/global_health/idstrategy.pdf, accessed 25 Jan. 2008.

³³ USAID, *Reducing the threat of infectious diseases*, p. 2.

³⁴ USAID, *Reducing the threat of infectious diseases*, pp. 3–5.

³⁵ McInnes and Lee, 'Health, security and foreign policy'.

³⁶ However, McInnes and Lee note that this increased interest has 'not supplanted more traditional concerns': McInnes and Lee, 'Health, security and foreign policy', p. 7.

cians have all warned of the dire potential consequences if the government does not prepare at the federal level for a pandemic.³⁷ For example, the Australian Treasury has stated that an outbreak of pandemic influenza could cause a 'recession about half the size of the Great Depression'.³⁸ The websites of both the Australian Attorney General's Department and the Department of Industry, Tourism and Resources have links to pages on 'Being prepared for an influenza pandemic', stating the steps that individuals, companies and hospitals should take in preparing themselves against the 'threat of an outbreak'.³⁹ Alan Dupont has drawn up hypothetical models that indicate at which point the number of soldiers dying from AIDS constitutes a national security threat to Australia in a region destabilized by the ravages of AIDS.⁴⁰ The federal government also recently conducted a hypothetical infectious disease outbreak emergency, in which a 'contaminator' arrived at an Australian airport from an overseas destination and spread an undiagnosed infectious disease throughout the wider community on arrival.⁴¹

In 1997, the Canadian government set up an electronic surveillance system entitled Global Public Health Information Network (GPHIN), which the WHO uses to this day as part of GOARN.⁴² The Canadian government also hosted the first G7 plus Mexico ministerial meeting which led to the Ottawa Plan, referred to above, and the Global Health Security Initiative in November 2001.⁴³ In 2002—the same year that GOARN was introduced—it met in London with representatives of Japan, Mexico, the United States and states from the EU, as well as the WHO, to 'strengthen coordinated responses to improve health security'.⁴⁴ With the spread of SARS to Toronto in 2003, Ottawa's view of how infectious disease can undermine an economy unless earlier surveillance mechanisms are supported changed from recognition of a hypothetical scenario to a reality.⁴⁵ The Canadian government was estimated to have lost \$3 million in the two weeks after SARS was first identified in a Toronto hospital. According to McInnes and Lee, SARS 'demonstrated

³⁷ Jong-Wha Lee and Warwick J. McKibbin, 'Globalization and disease: the case of SARS', Working Papers in International Economics no. 5.03 (Sydney: Lowry Institute for International Policy, 2003); Hugh White, 'More than a dose of flu', *The Age*, 12 Sept. 2005, <http://www.theage.com.au/news/hugh-white/more-than-a-dose-of-flu/2005/09/11/112>, accessed 16 Feb. 2006; Peter Hartcher and John Garnaut, 'Bird flu threatens misery for millions', *Sydney Morning Herald*, 16 Feb. 2006, <http://www.smh.com.au/news/national/bird-flu-threatens-misery-for-millions/2006/02>, accessed 16 Feb. 2006; Michael Richardson, 'Express delivery of H5N1 via migratory birds', *Australian Journal of International Affairs* 60: 1, 2006, pp. 51–8.

³⁸ Hartcher and Garnaut, 'Bird flu threatens misery for millions'.

³⁹ Australian Government, Department of Industry, Tourism and Resources, 'Being prepared for an influenza pandemic', <http://www.industry.gov.au/pandemicbusinesscontinuity/>, accessed 3 Aug. 2006.

⁴⁰ Alan Dupont, 'HIV/AIDS: a major international security issue', paper presented to Asia Pacific ministerial meeting 9–10 Oct. 2001, Australian Government Overseas Aid Program, <http://www.aisaid.gov.au/publications/pdf/security.pdf>, accessed 25 Jan. 2008.

⁴¹ Australian Government, Department of Health and Aging, 'Exercise Cumpston '06', <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/ohp-cumpston.htm>, accessed 25 Jan. 2008.

⁴² Grein et al., 'Rumors of disease in the global village', p. 99; Burns, 'Openness is key', p. 769.

⁴³ Harley Feldbaum and Kelley Lee, 'Public health and security', in Alan Ingram, ed., 'Health, foreign policy and security: towards a conceptual framework for research and policy', UK Global Health Programme working paper no. 2 (London: Nuffield Trust, 2004), p. 23.

⁴⁴ Kelley Lee and Colin McInnes, 'Health, foreign policy and security: a discussion paper', UK Global Health Programme working paper no. 1 (London: Nuffield Trust, 2003), p. 25.

⁴⁵ Aginam, 'Between isolationism and mutual vulnerability', p. 208; Colin McInnes, 'Health and foreign policy', in Alan Ingram, ed., 'Health, foreign policy and security: towards a conceptual framework for research and policy', UK Global Health Programme working paper no. 2 (London: Nuffield Trust, 2004), pp. 30–5.

how policy responses to emerging and re-emerging infectious diseases (ERIDs) can elicit a “garrison mentality” in an effort to prevent the spread of infection. Stricter border controls and attempts to regulate migration have been key features in state responses to the spread of infectious disease.⁴⁶ For Canada, SARS also demonstrated that relative geographical isolation was not a strong enough defence in the face of an epidemic.

Finally, the EU has also sought to boost its shared health responsibilities through treaties and public health surveillance.⁴⁷ Since 2000 the WHO European Region has been discussing the need for strengthened surveillance of infectious diseases so that member states ‘have the capacity to detect and respond to epidemics in a timely manner; and to collect the minimum data necessary for action linked to control measures’.⁴⁸ The EU, like the United States, Australia and Canada, has referred to its public health strategy as a security response, aimed at creating a ‘network for the epidemiological surveillance and control of communicable diseases in the European Union ... A programme of preparedness and response capacity in the event of attacks involving biological and chemical agents’.⁴⁹ The EU has also created an equivalent of the US CDC: the European Centre for Disease Prevention and Control, based in Sweden, which monitors the incidence of infectious disease across Europe. Some EU members, such as the United Kingdom, have also been referring to the risk of disease outbreak in national government policy statements. The British Foreign Office, for example, released a strategy paper in 2003 that described the spread of disease as ‘an ill-effect of globalization and a risk to peace and development’.⁵⁰

Western countries’ awareness of the threat that an infectious disease epidemic could pose to their citizens and economic stability has elicited support among governments for a global strategy to contain infectious disease outbreaks. What this section has sought to demonstrate is that the risk of infectious disease outbreaks has been increasingly portrayed as a threat that western states must take steps to alleviate in the areas of foreign, economic and security policy.⁵¹ At the same time, as the next section will demonstrate, while western states were portraying the risk of infectious disease outbreaks as a threat to national security, the WHO was seeking to assert itself as the pivotal organization for meeting these growing concerns.

The WHO: a coordinated response

The identification of infectious disease as a matter of national security policy presented the WHO with two possibilities. The first, advocated by the WHO itself, was that existing infectious disease regulations needed reform to ensure that international cooperation with the new global health surveillance network would

⁴⁶ McInnes and Lee, ‘Health, security and foreign policy’, p. 9.

⁴⁷ Lee and McInnes, ‘Health, foreign policy and security’, p. 20.

⁴⁸ WHO, ‘Consensus meeting on surveillance of infectious diseases’, report on a WHO Meeting in Grottaferrata, Italy, 4–7 April 2000, EUR/00/5016367 (Copenhagen: WHO Regional Office for Europe, 2000), p. 1.

⁴⁹ Fidler, ‘Constitutional outlines’, p. 256.

⁵⁰ McInnes and Lee, ‘Health, security and foreign policy’, p. 7.

⁵¹ McInnes and Lee, ‘Health, security and foreign policy’, p. 12.

be forthcoming.⁵² The second possibility came from western states, as they started to associate infectious disease outbreaks with security threats. Western countries' awareness of infectious disease and its potential threat to their citizens prompted their interest in a system that would guarantee protection at their borders but could also operate as an effective alert and response, or containment, system in the affected region. As this section will demonstrate, the WHO worked very hard to situate itself as the best institution for managing both options—the reform of regulations concerning epidemic outbreaks and the development of the surveillance system.

Reform of the existing International Health Regulations (IHR) was agreed to by 191 World Health Assembly (WHA) member states in May 1995. The IHR embodied the WHO's mandate for managing the response to an outbreak of one of the three infectious diseases that fall under the IHR mandate (cholera, yellow fever and plague). Upon becoming aware of an outbreak, a state is to notify the WHO, which then sets in place notification procedures to alert neighbouring states, along with quarantine and travel restrictions for the affected state. However, at the 1995 WHA the WHO argued that the existing IHR could not adequately address newly emerging public health emergencies.⁵³

Specifically, the WHO listed five key constraints on the implementation of the IHR. First, the regulations were limited in their coverage (applying only to cholera, yellow fever and plague), and by the 1990s the WHO had to respond to deadly outbreaks of other diseases to which the regulations did not apply. Second, the IHR, and in turn the WHO, depended entirely on the affected government notifying the WHO of an outbreak, and this, the WHO argued, was not always occurring. Third, there was nothing in the IHR to specify how the WHO and the affected country were to collaborate and cooperate in the containment of the disease. The fourth problem was a lack of incentives to encourage compliance. There was nothing the WHO could do to encourage countries weighing the options of alerting the WHO and not doing so to report a disease outbreak. In fact, if a state thought it would not get caught, there were probably more benefits in many cases (in terms of trade and tourism) associated with keeping quiet than with reporting. Finally, there were no risk-reduction measures to prevent the spread of disease.⁵⁴ The response to disease outbreaks largely depended on what the affected country had the capacity to do, with neighbouring or trading partners conducting their own containment measures. The WHO argued that there needed to be an agreed 'checklist' of procedures that every state at risk had to take to reduce the likelihood of the disease spreading and a collective response by all states to contain outbreaks to prevent them from reaching epidemic proportions.⁵⁵

⁵² WHO, 'World Health Assembly adopts new International Health Regulations: new rules govern national and international response to disease outbreaks', WHO Mediacentre, 23 May 2005, http://www.who.int/mediacentre/news/releases/2005/pr_wha03/en/print.html, accessed 11 Jan. 2006; Burns, 'Openness is key'.

⁵³ World Health Assembly, 'Revision and updating of the International Health Regulations', WHA48.7, 12 May 1995.

⁵⁴ WHO, *Global crises—global solutions: managing public health emergencies of international concern through the revised International Health Regulations*, EUR/00/5016367 (Geneva: WHO Department of Communicable Disease Surveillance and Response, 2002), p. 3.

⁵⁵ WHO, *Global crises—global solutions*, p. 3.

The WHO's proposal for IHR reform, and the WHA's agreement to it, came only a year after a political and economic crisis during its response to an outbreak of the plague in India in 1994. The WHO struggled to contain the panic and economic disaster that ensued once the outbreak was confirmed. Alarm spread via international media reports. Trade and travel embargoes were placed on India, while the WHO was unable to contain what it saw as an overreaction to the outbreak under the existing IHR. India's consequent economic losses amounted to US\$1.7 billion, and the WHO was concerned lest this calamity impact on other countries' future willingness to report disease outbreaks.⁵⁶ It has been argued that two lessons were learnt by the WHO from the experience in India in 1994.⁵⁷ The first is that states ought to be protected from the economic devastation that follows report of a disease outbreak; the second is that new measures, giving the WHO more precise and 'far-reaching' capabilities to manage the chain of events following a disease outbreak, might contain panic such as that which ensued in India.⁵⁸

It has taken ten years to achieve the necessary international consensus to complete the task of revising the IHR.⁵⁹ In the meantime, the WHO argued that there was an increased need for global infectious disease surveillance due to a

resurgence in awareness of infectious diseases ... occurring in the context of an information revolution ... the promulgation of unverified and inaccurate information on disease outbreaks often results in an excessive reaction by both the media and politicians leading to panic and inappropriate responses. These responses can lead to unjustified disruption of travel and trade with affected countries, which may result in great economic loss.⁶⁰

Since its mandate was established in 1948, the WHO has been entitled by states to conduct surveillance of disease outbreaks across the world.⁶¹ In tandem with its call for the revision of the IHR, the WHO argued that there was also a need for a global surveillance network which could gather outbreak reports from across the world round the clock, seven days a week, in order to manage outbreak verification and response.⁶² This led to the first global infectious disease surveillance system, the Global Public Health Information Network, being developed in Canada in 1997. The GPHIN is a web-based electronic system that scans the World Wide Web to identify suspected outbreaks of disease.⁶³ Between 2000 and 2002 the surveillance

⁵⁶ WHO, *Global defence*, p. 65.

⁵⁷ WHO, 'Global outbreak alert and response', report of a WHO meeting in Geneva, Switzerland, 26–28 April 2000, WHO/CDS/CSR/2000.3 (Geneva: WHO Department of Communicable Disease Surveillance and Response, 2000), pp. 4, 21.

⁵⁸ WHO, *Global defence*, pp. 64–6.

⁵⁹ For further discussion on the IHR revision process, see WHO, 'Strengthening national capacities for epidemic preparedness and response in support to national implementation of IHR (2005)', report of a WHO meeting in Lyon, France, 2–5 May 2006, WHO/CDS/EPR/LYO/2006.4 (Lyon: WHO Lyon Office for National Epidemic Preparedness and Response, 2006); David P. Fidler and Lawrence O. Gostin, 'The new International Health Regulations: an historic development for international law and public health', *Journal of Law, Medicine and Ethics* 34: 1, 2006, pp. 85–94; Mack, 'The World Health Organization's new International Health Regulations'; Calain, 'Exploring the international arena of global health surveillance'.

⁶⁰ WHO, 'A framework for global outbreak alert and response', WHO/CDS/CSR/2000.2 (Geneva: WHO Department of Communicable Disease Surveillance and Response, 2000), p. 2.

⁶¹ Julius Weinberg, 'Responding to the global challenge of infectious disease', in Martin McKee, Paul Garner and Robin Stott, eds, *International co-operation in health* (Oxford: Oxford University Press, 2001), p. 51.

⁶² WHO, 'Global outbreak alert and response', p. 23.

⁶³ Burns, 'Openness is key', p. 769.

system was improved with the creation of GOARN, which had additional mechanisms for outbreak verification, alert and fieldwork response.⁶⁴ The GPHIN was upgraded to scan in four different languages, as opposed to its original capability of scanning in only English and French.⁶⁵ GOARN was intended to 'improve epidemic disease control by informing key public health professionals about confirmed and unconfirmed outbreaks of international public health importance'.⁶⁶

The WHO had other 'outbreak alert' systems that informed health professionals about the outbreak of specific disease threats, such as FluNet for influenza, RabNet for rabies and DengueNet for Dengue.⁶⁷ The new outbreak verification system would not be merely a mechanism for surveillance of disease outbreak, but would function as a 'global safety net that protects other countries when one nation's surveillance and response systems fail'.⁶⁸ Through the GPHIN, the WHO was to be the first actor on the scene to manage the verification and reporting of disease outbreaks; it would have the chance to negotiate with the affected state and surrounding states (if need be) to prevent the spread of infection and thus to situate itself as the key authority in infectious disease control, in other words, in containing the 'threat'.⁶⁹

The WHO argued that the need for GOARN was made even more apparent by the speed at which the SARS outbreak in 2003 spread to 27 countries in four months: 'inadequate surveillance and response capacity in a single country can endanger national populations and the public health security of the entire world. As long as national capacities are weak, international mechanisms for outbreak alert and response will be needed.'⁷⁰ GOARN, argues the WHO, is vital for effective international containment of infectious disease outbreaks.⁷¹ Furthermore, Roth argues that there 'is no single institution or agency that has all the capacity to approach and tackle such emergencies. WHO is able to achieve the goals of its strategic approach by bringing partners together to focus and coordinate global responses'.⁷²

High-profile outbreaks such as those of H₅N₁ avian influenza in humans and SARS, both occurring in 2003, helped secure support for the WHO's surveillance initiative.⁷³ Between 1997 and 2000 the WHO had also assisted in responding to outbreaks of Rift Valley fever in Kenya and Somalia, monkey pox and Marburg virus infection in the Democratic Republic of Congo (DRC), Ebola haemorrhagic fever in Gabon, relapsing fever in southern Sudan, influenza in Afghan-

⁶⁴ WHO, 'Global outbreak alert and response', p. 3.

⁶⁵ Burns, 'Openness is key', p. 769.

⁶⁶ Grein et al., 'Rumors of disease in the global village', p. 97.

⁶⁷ WHO, 'A framework for global outbreak alert and response', p. 4.

⁶⁸ David L. Heymann and Guénaél Rodier, 'Global surveillance, national surveillance, and SARS', *Emerging Infectious Diseases* 10: 2, 2004, p. 173.

⁶⁹ WHO, 'A framework for global outbreak alert and response', p. 4.

⁷⁰ Heymann and Rodier, 'Global surveillance, national surveillance, and SARS', p. 173.

⁷¹ WHO, 'Global outbreak and alert response network', <http://www.who.int/csr/outbreaknetwork/en/>, accessed 11 Feb. 2006.

⁷² Cathy Roth, 'Epidemic and pandemic alert and response', *Refugee Survey Quarterly* 25: 4, 2006, p. 101.

⁷³ David Fidler, 'Germs, governance, and global public health in the wake of SARS', *Journal of Clinical Investigation* 113: 6, 2004, pp. 799–804; Roth, 'Epidemic and pandemic alert and response'.

istan and epidemic dysentery in Sierra Leone.⁷⁴ In the aftermath of the SARS outbreak, a former director general of WHO wrote that it had been a 'warning' and that 'we must take this opportunity to rebuild our public health protections ... Disease surveillance and response systems are critical, in conjunction with strong national, regional, and global linkages in reporting.'⁷⁵ This sense of urgency is reflected in the fact that during the same period in which the WHO was developing GOARN—between 2000 and 2002—external funding for the surveillance project steadily increased, and indeed has risen by a higher percentage than the amount that was going to communicable disease control.⁷⁶ Thus it is not surprising that the momentum for the WHO's surveillance system occurred at the same time that these same states were increasingly linking infectious disease with national security.⁷⁷

The WHO has also stated that it expects most of its activity to be located in developing countries: 'Many countries have recognized the renewed threat of outbreaks and have sought to strengthen their national surveillance and response capacities. In many other countries similar developments have been very slow due to lack of funds and competing priorities.'⁷⁸ The WHO argues that, given the disparity among countries in public health infrastructure, it makes sense to create an effective international response that deals first with the 'humanitarian needs of other countries that are affected by [the] outbreak'; it goes on to assert that 'it is clear that assisting other countries to deal with outbreak threats actually reduces the risks of international spread'.⁷⁹ Most disease outbreaks 'in developing countries are contributed by nations with complex emergencies'.⁸⁰ During the SARS outbreak, Heymann and Rodier claimed, many states were not quick enough in diagnosing outbreaks of the disease and containing it in time to prevent its international spread.⁸¹ In acknowledgement of this failing, the member states of the WHA passed a resolution calling for 'increasing national capacity development

⁷⁴ WHO, 'A framework for global outbreak alert and response', p. 4.

⁷⁵ Brundtland, 'Global health and international security', p. 422.

⁷⁶ However, it should be noted that in a 2004 interview the director of WHO's Department of Communicable Disease Surveillance and Response (CSR), Guénaél Rodier, stated that while support for GOARN had not been a problem, financial assistance had been, because of the number of programmes competing for funds from western states, the key donors to WHO's budget. See Martin Enserink, 'A global fire brigade responds to disease outbreaks', *Science*, 303: 5664, 12 March 2004, p. 1606, www.sciencemag.org, accessed 25 Jan. 2008. This competition for funding is evident when contributions to surveillance are traced over a period of four years: there was an increase in the WHO 2002/2003 budget; then a decrease in the 2004/2005 budget, and then an increase in the 2006/2007 budget. See WHO, 'Proposed programme budget 2002–2003' (Geneva: WHO Executive Board, 2001), p. 13; WHO, 'Proposed programme budget 2004–2005' (Geneva: WHO Executive Board, 2003); WHO, 'Proposed programme budget 2006–2007' (Geneva: WHO Executive Board, 2005), p. 19, http://who.int/gb/eb/e_pb2006/html, accessed 25 Jan. 2008. Competition within WHO for funding is further discussed in section E1 of People's Health Movement et al., *Global Health Watch 2005–2006*.

⁷⁷ David Fidler argues that the United States has provided substantial financial support for improving global infectious disease surveillance as a 'means to increase national and homeland security against bioterrorism, not as a vehicle for improving global health. Any constructive health consequences for other countries that spill over from improved global surveillance represent a positive externality but are not the primary foreign policy objective.' See David P. Fidler, 'Health as a foreign policy: between principle and power', *Whitehead Journal of Diplomacy and International Relations* 6: 2, 2005, pp. 179–94.

⁷⁸ WHO, 'Global outbreak alert and response', p. 3.

⁷⁹ WHO, 'A framework for global outbreak alert and response', p. 4.

⁸⁰ Grein et al., 'Rumors of disease in the global village', p. 102.

⁸¹ Heymann and Rodier, 'Global surveillance, national surveillance, and SARS', p. 174.

for surveillance and response' and endorsed the ways in which GOARN obtained information about SARS and supported containment efforts.⁸² A second resolution was then passed, encouraging GOARN to strengthen its surveillance capacity and support countries that were attempting to strengthen their own national containment efforts. Jones argues that the containment of SARS should be attributed to the fact that while the CDC in the United States was doing a good job in preventing an outbreak there, 'this job would have been orders of magnitude harder had it not been for the work done by WHO to man the outer defences'.⁸³

However, a key factor in GOARN's work is that it is dependent on the affected state's verification of an outbreak and its granting permission for a WHO field-work response team to enter its territory.⁸⁴ The updated GPHIN system has the capability to locate over 20 reports a day of suspected outbreaks. On request by the affected state, GOARN's SHOC will respond to outbreaks with field teams, specialized protective equipment and medical supplies, as well as robust communications to keep in contact with both state officials and WHO headquarters.⁸⁵ The key phrase here is 'on request'. The WHO argues that this is another reason why its role in global health security is so crucial.⁸⁶ It contends that its international partnerships make it of maximal use in a situation where 'financial, political and institutional' restraints may inhibit cooperation in more specialized, regional surveillance mechanisms.⁸⁷ In addition, WHO representatives argue not only that the WHO's 'coordinated response mechanism' can 'mobilize the appropriate resources that are necessary to contain the outbreak' but that the WHO 'has an international mandate [and this] provides an element of neutrality'.⁸⁸

The principal justification for the establishment of a surveillance system was that 'as long as national capacities are weak, international mechanisms for outbreak alert and response will be needed as a global safety net that protects other countries when one nation's surveillance and response systems fail'.⁸⁹ The WHO has argued that a combination of security interests, recognition of common cause and concern for image will encourage states to cooperate: 'countries will comply because of a sense of global solidarity in the face of a common threat, but also they will comply because they prefer to maintain a good image and look responsible'.⁹⁰

The WHO worked hard during the 1990s to create awareness among governments of the threat that infectious disease posed to humanity by encouraging changes to the IHR and promoting a surveillance system that could alert the affected state and surrounding states to an outbreak of disease—essentially, a containment mechanism. Its success, first in getting states to acquiesce in revised

⁸² Heymann and Rodier, 'Global surveillance, national surveillance, and SARS', p. 174.

⁸³ Bruce Jones, 'Bio-security, nonstate actors, and the need for global cooperation', *Ethics and International Affairs* 20: 2, 2006, pp. 225–28, accessed 25 Jan. 2008.

⁸⁴ WHO, 'A framework for global outbreak alert and response', p. 6; WHO, 'Global outbreak alert and response', p. 14; *Lancet*, 'Editorial: public-health preparedness requires more than surveillance', pp. 1639–40.

⁸⁵ Burns, 'Openness is key'; Roth, 'Epidemic and pandemic alert and response'.

⁸⁶ WHA, 'Global health security: epidemic alert and response', A54/9, 2 April 2001.

⁸⁷ WHO, 'A framework for global outbreak alert and response', p. 6.

⁸⁸ WHO, 'Global outbreak alert and response', pp. 7, 27.

⁸⁹ Heymann and Rodier, 'Global surveillance, national surveillance, and SARS', p. 173.

⁹⁰ Burns, 'Openness is key', p. 770.

IHR that sought to provide stronger incentives for state compliance and create a wider base for their application, and second in creating a surveillance system capable of locating an outbreak no matter where it occurred, has prompted the WHO to herald a new era in global health governance.⁹¹

Previous analysis suggests that the willingness of western states (especially) to place primary responsibility for surveillance in the hands of the WHO represents a trust in the WHO's authority in the area of global health security.⁹² But, as the discussion above has shown, the securitization of infectious disease has been accomplished by both western states and the WHO. Therefore, the assumption that these states have relinquished their attempt to control the infectious disease agenda needs further investigation. As the next section demonstrates, the WHO's authority in infectious disease control has been strengthened partly because it suited the interests of western states to allow this to happen. While there has been a transfer of power that demonstrates the WHO's authority in disease management, this development also reveals a choice by western states to *defer* to the authority of the WHO because it has been able to present itself as best placed to respond to the infectious disease threat. However, has this relationship with the West compromised the WHO's authority? Will its authority be recognized by relevant states when the WHO seeks verification of disease outbreaks and compliance from the host state in disease containment measures?

The third and final section of the article will assess the possible benefits that arise for the WHO and western states from the securitization of infectious disease. It will be argued that the perceived benefits were twofold. First, placing the responsibility for containing the threat into the hands of the WHO would benefit western states. The WHO is promoted as a 'neutral actor',⁹³ and thus, ostensibly, one likely to achieve greater access to potentially hostile states without being labelled as having the same interests as powerful sovereign actors. Western states thus benefit by being 'guarded' from infectious diseases by an international agency. The second benefit is for the WHO itself. The WHO's authoritative role, and thus normative power, is strengthened by the introduction of stricter surveillance and response measures that promotes its authority and position as a key player in global health governance.

Why undertake infectious disease surveillance?

As demonstrated above, there have been substantial moves by governments to securitize health, identifying threats to health as threats to national security. However, since 2003 concerns have been raised about the consequences of securi-

⁹¹ Kelley Lee, *Globalization and health: an introduction* (Basingstoke: Palgrave Macmillan, 2003), pp. 212–14; Nana K. Poku and Alan Whiteside, *Global health and governance: HIV/Aids*, 2003, pp. 1–7; David Fidler, *SARS, governance and the globalization of disease* (New York: Palgrave Macmillan, 2004), pp. 166–70; Aginam, 'Globalization of infectious diseases, international law and the World Health Organization'.

⁹² Lee, *Globalization and health*; Fidler, *SARS, governance and the globalization of disease*; Roth, 'Epidemic and pandemic alert and response'.

⁹³ WHO, 'Global outbreak alert and response', pp. 7, 27.

tizing health, especially infectious disease.⁹⁴ The primary concern has been that the securitization of infectious disease leads to its being viewed as a threat only when those doing the securitizing—in this case, western states—actually feel threatened. When these states feel the threat to them has abated, their support and interest wane, leaving those who remain under threat potentially deprived of the assistance they need.⁹⁵ Even the WHO has repeatedly warned that states should not attempt to conduct their own surveillance and border control measures against the threat of infectious disease, but should instead support the WHO in providing a global surveillance programme.⁹⁶ However, whether a surveillance response to infectious disease is the best response, and whether it accurately reflects the threat of infectious disease compared to other global health concerns (primarily poverty), continues to be widely debated.⁹⁷

In this final section, I want to step aside from both the advocates of and the dissenters from the health securitization movement and take a slightly different angle. I argue that the WHO's initiative to create a global health governance response to infectious disease via revised IHR and GOARN does, whether intentionally or not, favour western states' interests. The policy priority of western states in response to infectious disease has been to safeguard *their* citizens by supporting the development of a surveillance system that aims to prevent epidemics from reaching their borders. This concern enabled the WHO to situate itself in a position of authority in global health governance.⁹⁸ Western states have, in turn, permitted the WHO to occupy this authoritative role because in doing so they could pass responsibility on to the international body and avoid allegations of imperial overstretch by entrusting oversight power to a 'neutral actor'.

McInnes and Lee argue that 'over the past decade, health has once more become defined in terms of risk from selected infectious diseases, and has re-emerged as an issue in foreign and security policy circles'.⁹⁹ The WHO also noted that an increased 'awareness of infectious diseases' occurred near the end of the twentieth century.¹⁰⁰ Its director general, Gro Harlem Brundtland, later went on to insist that it was imperative this awareness should not lead to states isolating themselves from the global effort at reducing the threat of infectious diseases: investment in

⁹⁴ Aginam, 'Between isolationism and mutual vulnerability'; Robert Beaglehole and Ruth Bonita, *Public health at the crossroads: achievements and prospects*, 2nd edn (Cambridge: Cambridge University Press, 2004), p. 276; Alan Ingram, 'Global leadership and global health: contending meta-narratives, divergent responses, fatal consequences', *International Relations* 19: 4, 2005, pp. 381–402; McInnes and Lee, 'Health, security and foreign policy'.

⁹⁵ Aginam, 'Between isolationism and mutual vulnerability'; McInnes and Lee, 'Health, security and foreign policy'.

⁹⁶ WHO, 'A framework for global outbreak alert and response'.

⁹⁷ Ilona Kickbusch, 'Global health governance: some theoretical considerations on the new political space implications', in Kelley Lee, ed., *Health impacts of globalization: towards global governance* (Basingstoke: Palgrave Macmillan, 2003), pp. 192–203; Caroline Thomas and Martin Weber, 'The politics of global health governance: whatever happened to "health for all by the year 2000"?', *Global Governance* 10: 2, 2004, pp. 187–205; Ingram, 'Global leadership and global health'; Ruth Bonita and Colin D. Mathers, 'Global health status at the beginning of the twenty-first century', in Robert Beaglehole, ed., *Global public health: a new era* (Oxford: Oxford University Press, 2005).

⁹⁸ Fidler, *SARS, governance and the globalization of disease*, p. 170.

⁹⁹ McInnes and Lee, 'Health and security', p. 33.

¹⁰⁰ WHO, 'A framework for global outbreak alert and response', p. 1–2.

people and in 'enhanced international cooperation, for health as for many other arenas, are prerequisites for security'.¹⁰¹ Furthermore, she argued, 'a world where a billion people are deprived, insecure, and vulnerable is an unsafe world. The functional separation between domestic and international health problems is losing its usefulness'.¹⁰² Recall that the WHO argues that its mandate puts it in 'a unique position to coordinate infectious disease surveillance and response'.¹⁰³ Thus there was a definitive move to establish the WHO's role in the global response to the potential threat of an infectious disease epidemic.

At this moment, writes Fidler, we see the sustainability of a 'post-Westphalian public health governance dramatically ushered in'.¹⁰⁴ States have realized that their traditional reliance on international governance—regulation between states to manage threats of infectious disease—no longer works. The WHO argues that states have recognized that its 'primary role' is to 'maintain global health security through its global surveillance and response activities';¹⁰⁵ and that while the WHO has no enforcement mechanism, states will comply, for the various reasons noted above to do with self-interest, common interest and public image. Thus the WHO, charged with monitoring state compliance, is in a position to manipulate the international perception of states on the basis of their cooperation with its regime. According to Fidler, SARS was the catalyst that led to the WHO's increase in power, forcing states such as America, Britain and China to accept that there needed to be a 'reallocation of power above and below the sovereign state'.¹⁰⁶ According to this view, the Westphalian rules which preoccupied responses to infectious disease in the past no longer applied.¹⁰⁷ In 2003 SARS and H₅N₁ led states to realize that they were not more powerful than an unidentified microbe which could empty cities, bring about devastating economic collapse and cause immense loss of life. This, argues Fidler, marked the beginning of the post-Westphalian era where governance involves states, intergovernmental organizations and non-state actors.¹⁰⁸ The WHO concurs with Fidler, stating that 'after SARS, it was clear to governments that the [IHR] rules needed to be updated'.¹⁰⁹

Fidler, Lee and the WHO all argue that GOARN is the perfect example of global health governance working.¹¹⁰ GOARN was instrumental in the identification of SARS, as it has been in tracing H₅N₁.¹¹¹ Also noteworthy is that GOARN's infectious disease surveillance in these situations did not rely solely on the cooperation of states: in the case of the SARS outbreak in China, it was the participation of non-state actors in locating reports of the disease on the internet that led

¹⁰¹ Brundtland, 'Global health and international security', p. 419.

¹⁰² Brundtland, 'Global health and international security', p. 420.

¹⁰³ WHO, 'Global outbreak alert and response', p. 4.

¹⁰⁴ Fidler, *SARS, governance and the globalization of disease*, p. 167.

¹⁰⁵ Burns, 'Openness is key', p. 770.

¹⁰⁶ Fidler, 'Constitutional outlines', p. 257.

¹⁰⁷ Fidler, 'Constitutional outlines', pp. 258–9.

¹⁰⁸ Fidler, *SARS, governance and the globalization of disease*; Fidler, 'Constitutional outlines'.

¹⁰⁹ Burns, 'Openness is key', p. 770.

¹¹⁰ Lee, *Globalization and health*; Fidler, *SARS, governance and the globalization of disease*; Heymann, 'Evolving infectious disease threats to national and global security'; Roth, 'Epidemic and pandemic alert and response'.

¹¹¹ Fidler, 'Constitutional outlines', p. 266; Roth, 'Epidemic and pandemic alert and response'.

to the WHO's being alerted to the outbreak. In addition, the WHO's authority in the post-Westphalian era was demonstrated by the unimpeded access it was able to achieve upon entering states; and, as the SARS crisis deepened, it was the WHO that issued travel warnings and managed outbreak response in a number of countries simultaneously.¹¹²

However, as I have shown above, the WHO's efforts were not conducted independently of state support. I explained in the first section of this article that western states have as strong a vested interest as the WHO in developing strong global surveillance of infectious disease. As Jones argued, the WHO manned the 'outer defenses' against SARS while allowing the US CDC, for example, to concentrate on domestic measures of defence.¹¹³ The WHO's primary funding for GOARN has come largely from donations by western states, prominent among them the United States, Canada, Australia and the UK, and from the EU.¹¹⁴ At the same time, the revision of the IHR could not have occurred without all the member states of the WHA consenting to it; the same is true of the WHA resolutions that have supported the strengthened surveillance capability of WHO's GOARN.¹¹⁵ All of these states in their domestic policy have argued strongly for an enhanced international surveillance network; this is demonstrated by the fact that, of the 130 partners in GOARN, a large proportion of the facilities that assist the WHO are located in developed states. Therefore, the claim that the WHO has achieved post-Westphalian authority must be measured against the fact that its authority in surveillance is rooted overwhelmingly in the support and consent of states.

Therefore, what measure of authority has the WHO gained from GOARN? Barnett and Finnemore argue that international organizations seek to shape agendas and rules to build their institutional power in global politics.¹¹⁶ In contrast to neo-realist and neo-liberal arguments which state that international organizations have the capacity to do only what states tell them to do, Barnett and Finnemore argue that international organizations not only have authority independently of states, but that in fact their normative agendas can at times dominate or even direct the purpose of states.¹¹⁷ However, in challenging the post-Westphalian governance argument above, I question whether international organizations such as the WHO can ever conduct actions beyond member states' authority. One key answer to this question that Barnett and Finnemore presented involved the transfer of authority.¹¹⁸ When states turn to international organizations to conduct tasks that they do not wish to do themselves, a measure of authority inevitably passes from state to institution. This creates, over time, a situation where international organizations'

¹¹² David Fidler, 'From international sanitary conventions to global health security: the new International Health Regulations', *Chinese Journal of International Law* 4: 2, 2005, pp. 325–92; Roth, 'Epidemic and pandemic alert and response'; WHO, 'Global outbreak and alert response network', <http://www.who.int/csr/outbreaknet-work/en/>, accessed 11 Feb. 2006.

¹¹³ Jones, 'Bio-security, nonstate actors, and the need for global cooperation'.

¹¹⁴ Beaglehole and Bonita, *Public health at the crossroads*, p. 270.

¹¹⁵ Heymann and Rodier, 'Global surveillance, national surveillance, and SARS', p. 174; Burns, 'Openness is key', pp. 769–70.

¹¹⁶ Barnett and Finnemore, *Rules for the world*.

¹¹⁷ Barnett and Finnemore, *Rules for the world*.

¹¹⁸ Barnett and Finnemore, *Rules for the world*.

power grows as they come to control the agenda surrounding a specific area. With the transfer of authority from state to institution comes the accrual of normative power to the institution that controls the relevant information and functions as a recognized authority in its particular area.¹¹⁹

The WHO has had a long history of directing and managing the tasks of global health awareness, but at the same time its power to direct states to comply with the regulations concerning infectious disease outbreaks has been weak. However, it succeeded in revising the IHR as a result of the West's increased association of infectious disease with a security threat in combination with the WHO's assertion that it was the best authority to manage this concern. In turn, the transfer of responsibility for infectious disease control to the WHO has led to the management of infectious disease outbreak alerts through GOARN. The centralization of authority in the area of infectious disease has led to the WHO gaining authoritative power in that, through its response mechanisms, it can coerce states into complying with the threat of public exposure for non-compliance. Through GOARN, the WHO has the authority to control the release of information surrounding infectious disease outbreaks; but it also has the power to alert the international community when it is not receiving the affected states' cooperation.¹²⁰ Therefore, the WHO's authoritative power resides in its management of information about infectious disease.

The transfer of authority is represented by the WHO essentially acting out the agenda set out by developed states that cannot or do not wish to carry out the programme themselves. This has entrenched the WHO's authority in the global health agenda and increased its power to the point where it now presides over the global response to infectious disease outbreaks. The WHO has secured its position on the global stage as the key referent authority in global health security.¹²¹

However, has this securitization of infectious disease led to the 'breaking' of traditional international governance rules—where states had the primary role in the surveillance and response to infectious disease? On the one hand, the shift of responsibility following the delegation of authority to the WHO has given it the power to secure individuals against infectious disease. The WHO has the capability to locate outbreaks of disease, in some cases before public health officials in the state affected are aware of it themselves, and to take primary responsibility in containing the outbreak. We have seen this in the case of SARS and to a lesser degree with the global response to avian influenza, with Ebola haemorrhagic fever in Gabon, DRC and Uganda, with an unidentified influenza in Madagascar and Afghanistan, and with Rift Valley fever in Kenya and Somalia. The ability of the WHO to report on outbreaks and to alert states to infectious disease location in various parts of the world gives the organization authority and enables it to coerce states to comply with the procedures set out under GOARN. On the other hand, this authority has been *delegated*. While affirming the authoritative role that

¹¹⁹ Barnett and Finnemore, *Rules for the world*, p. 34.

¹²⁰ WHO, 'Global outbreak alert and response'; Burns, 'Openness is key'.

¹²¹ Barnett and Finnemore, *Rules for the world*, pp. 163–7; WHA, 'Global health security: epidemic alert and response'.

international organizations can assert in global politics, we must also remember that the WHO's power has been delegated by a particular set of states to serve their interests. The delegation of tasks by developed states to WHO indicates that the agenda of infectious disease has been placed on the WHO's shoulders by developed states which have chiefly in mind their own narrow interests.¹²²

Conclusion

In this article I have demonstrated that western states have encouraged the disintegration of old international governance rules by delegating authority to the WHO in the area of infectious disease response. This delegation allays western states' concerns by strengthening their domestic borders against the spread of infectious disease epidemics and simultaneously serves the WHO's interests by increasing its authority in global health governance. The revision of the IHR and the development of GOARN have met the needs of western states, while providing authoritative power to the WHO. However, the obstacle of sovereignty has not been overcome. Attempts to verify outbreaks of disease are still dependent for their success on state cooperation. While the WHO relies on its ability to shame non-compliant states by public notification to compel state cooperation, it remains to be seen whether the fear of an epidemic will induce recalcitrant states to cooperate in the midst of an infectious disease outbreak. This is a concern that the WHO has acknowledged,¹²³ as has the UN Secretary General's High Level Panel on Threats, Challenges and Change for Collective Security, in stating that 'the security of the most affluent State can be held hostage to the ability of the poorest State to contain an emerging disease'.¹²⁴

Why, after the securitization of infectious disease, might the WHO's authority in this area still not be strong enough to compel states to verify outbreaks? Largely because the authority that the WHO has sought has been conferred on it by a selected number of states. The WHO and western states have simultaneously securitized infectious disease, with the result that, while western states have been able to ensure that progress made in disease surveillance and response mechanisms primarily suit their national interests, the WHO has been able to increase its presence as a powerful authority in the prevention of infectious disease. However, the WHO's authority derives from its powers under GOARN—a surveillance mechanism that largely does what western states do not wish to be seen doing themselves, namely, forcing developing states to comply with infectious disease alerts. Thus a final note of caution needs to be sounded: in placing such emphasis on the WHO's capacity in this area we must not forget that its power comes not through policing, but only through emphasizing the consequences of states' non-compliance.

¹²² McInnes and Lee, 'Health, security and foreign policy'.

¹²³ WHO, *Global crises—global solutions*; Burns, 'Openness is key'.

¹²⁴ United Nations Secretariat, *A more secure world: our shared responsibility*, report of the Secretary General's High-Level Panel on Threats, Challenges and Change (New York: UN, 2004), p. 14.