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Simon Rushton, Jeremy Youde

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Lorna Weir

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INVENTING GLOBAL HEALTH SECURITY, 1994–2005

*Lorna Weir*¹

Global health security was formed by linking together two previously separate policy fields: health and national/international security. The linkage has resulted in diverse institutional forms of global health security with differing practices, meanings, and effects. In this chapter I provide a pocket genealogy of global health security organized through the World Health Organization (WHO) in the period from 1994 to 2005, one of the many global securities that were first invented in the 1990s. The approach is genealogical in the sense that it provides an historical account of the power/knowledge relations of expertise, combined here with a concern for broader geopolitical relations. It differs from those accounts that implicitly assume “global health security” began only when the phrase entered routine WHO usage from 2001, with scattered preconditions in the 1990s. I show that “global health security” names a governance apparatus, a sociotechnical one, in formation from 1994 by WHO, a process instigated by the United States and its Northern allies. An apparatus rather than a phrase, global health security conjoins human actors, objects, statements, and technical devices in networks formed through authorized expertise. I show that while the phrase “global health security” was used by WHO from 2000 onwards, it referred to a global outbreak detection and rapid response apparatus that had begun to take organizational form from 1995. “Global health security” and “global alert and response” remain synonymous in WHO usage to date.

The chapter is structured around two intersecting themes, each with an active history of scholarship: North–South relations and international security. A number of studies have suggested that the global North has been the main beneficiary of global health security (Aldis 2008; Davies 2010; McInnes & Lee 2006; Rushton 2011). Drawing on and extending previous work with my colleague Eric Mykhalovskiy (Mykhalovskiy & Weir 2006; Weir & Mykhalovskiy 2006, 2010),² I further this line of interpretation by investigating two intersections of the global health security project with North–South geopolitics: the first at its inception between 1992 and 1995 and the second in the political debates about its legal form in 2004–2005. First, I show that the global North, mobilizing in the name of new, emerging, and reemerging diseases (EID), initiated and gave programmatic form to global health security at WHO. Second, I demonstrate that the global South by at least 2004 accepted in principle that EID should be addressed by WHO but objected to the international security elements, especially related to chemical, biological, radiological, and nuclear CBRN incidents, that were attached to global alert and response in the draft revisions to the International Health Regulations (1983) (the main international health law related

to mandatory infectious disease control). Discussion begins here with an outline of how global health security took programmatic form at the WHO, moves to a sketch of the technoscientific apparatus that realized that program, and ends with a discussion of the North–South political struggle around the international security elements in the draft revisions to the International Health Regulations (IHR). In the conclusion I take up the question of global health security in world order.

The program

The impetus for the formation of global health security came from a 1992 national policy report, the U.S. Institute of Medicine's *Emerging Infections: Microbial Threats to Health in the United States* (Lederberg et al. 1992). *Emerging Infections* reframed contagious disease prevention and control through the invention of a new disease concept, EID, that was cast as the most significant problem for public health in the United States and, by extension, the world. The Institute of Medicine (IOM) report first defined the EID concept as “clinically distinct conditions whose incidence in humans has increased” and then spatialized EID in nationally specific terms as “diseases that have emerged in the United States within the past few decades” (Lederberg et al. 1992: 34). As used in *Emerging Infections*, the EID concept implicitly rendered endemic disease with constant or falling incidence as nonthreatening for public health and thus of secondary importance to national and global public health systems. The action lay instead with EID, posed as a national threat to the United States. The report framed EID control as an international problem and recommended that the United States approach WHO to implement a global surveillance system with the capacity to detect and respond to EID outbreaks (Lederberg et al. 1992: 6), a difficult recommendation since EID included novel and previously unknown diseases that would be challenging for public health surveillance to detect.

The United States then sought to export the EID concept. In December 1993, the Canadian federal government's Laboratory Center for Disease Control convened a workshop to discuss Canadian public health policy as it pertained to EID. The report of that workshop, the Lac Tremblant Declaration (1994), signals the formation of a U.S.–Canadian alliance to persuade WHO to act on global surveillance of EID. Dr. Robert Shope, coauthor of the 1992 IOM report, led off the workshop's reports with a summary of *Emerging Infections* and concluded by asking for Canadian support in approaching WHO to undertake global surveillance of EID. Dr. Giorgio Torigiani (Director, Division of Communicable Diseases, WHO) supported the need for an “early warning system” and “an active global surveillance program” in order to “define existing patterns of diseases and identify new diseases that represent a threat to global public health” (Lac Tremblant Declaration 1994: 5). The first recommendation of the Lac Tremblant Declaration (1994: 18) suggests that Canada develop “a national strategy for surveillance and control of emerging and resurgent infections” (Lac Tremblant Declaration 1994: 18) and that Canada participate with WHO in establishing global surveillance of EID.

Two subsequent ad hoc meetings on emerging infectious diseases were held at WHO Headquarters in Geneva on 24–26 April 1994 and 12–13 January 1995. The first WHO meeting in April 1994 was thick on the ground with U.S. expertise. Joshua Lederberg, coauthor of the IOM's *Emerging Infections*, acted as chair. In the discussion that followed reports presented by the United States, Canada, and the IOM, participants remarked that there was a “need to ‘internationalize’ the efforts described during these first presentations, since the focus had been towards the developed world” (WHO 1994: 5). Unnamed participants also observed that, in the context of EID, “[f]or many African nations, this means specifically addressing malaria, tuberculosis and yellow fever” (WHO 1994: 5). The discussion addressed a point untheorized in the IOM Report

and the Lac Tremblant Declaration: lists of emerging diseases would vary across nations and world regions. The comments also revealed that the IOM's approach to EID was situated in a solidly Northern protectionist project to which Southern nations would respond by expanding the range of EID to include infectious diseases significant in their regions. At the second ad hoc meeting in January 1995, WHO staff 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). In so doing, WHO implicitly reframed EID as a problem for all world regions, although only the European Union joined the United States and Canada in providing national/regional reports at the January 1995 meeting.

The IOM's program for dealing with the problem of EID through rapid detection and response (that is, a control rather than a prevention strategy) was carried forward by the World Health Assembly (the legislative body of WHO) in May 1995 when it approved WHA Resolution 48.13, *Communicable Disease Prevention and Control: New, Emerging and Re-emerging Infectious Diseases*. That resolution directed WHO to “improve recognition and response to new, emerging, and re-emerging infectious diseases” (World Health Assembly 1995). This resolution translates EID, the IOM's novel disease concept together with its surveillance and response strategy for EID control, into the normative discourse of international public health endorsed by the WHO's highest political and legislative body.

Thus the Lac Tremblant Declaration, the reports of the 1994 and 1995 WHO meetings, and WHA Resolution 48.13 formed a discourse chain that recontextualized the EID concept from U.S. domestic public health into international public health at WHO. The actors accomplishing the recontextualization were the United States, Canada, and the European Union, which formed an alliance around EID as a need of the global North. The main technical goals of public health action around EID remained constant: early detection of EID outbreaks and rapid response to contain them. But for WHO, programming related to EID demanded a renewal of its presence in communicable disease prevention and control, an area in which the WHO had first made its reputation during the 1950s and 1960s, but that had declined during the period 1970–1995, with the exception of the HIV pandemic (Amrith 2006; WHO 1994: 1). WHO's renewed interest in communicable diseases was not done in the name of integrating health into national development by lowering the incidence of regionally/nationally endemic diseases but in the name of preventing international disease transmission.

Despite its sense of a nation beleaguered by disease threats, *Emerging Infections* nowhere dealt with public health in relation to “traditional” national or international security threats, nor did it discuss CBRN incidents. Its one glancing reference to security explained that the Report “did not address biological warfare because this issue is already under study by another panel within the National Academy of Sciences” (Lederberg et al. 1992: R6). Across the Lac Tremblant Declaration and the reports of the two ad hoc WHO meetings discussed above there occurs only one reference to security: when the ProMED representative remarked that his organization “[i]ncluded in their areas of interest . . . the threats of biological warfare” (WHO 1994: 5). Global health security in its early programmatic form was not on record integrated with international security.

Forming a technoscientific apparatus

In October 1995 a new WHO division called Emerging and Other Communicable Diseases (EMC) was established, with David Heymann as Founding Director, to lead WHO's work in developing global alert and response. None of the WHO personnel from the former Division of

Communicable Diseases were appointed to the new division. EMC quickly developed a strategic plan, “The World on Alert” (WHO 1996), to carry forward WHA Resolution 48.13 and the recommendations of the two ad hoc WHO meetings on emerging infectious diseases. Its strategic vision projects a particular temporal standard, “real time”: public health knowledge is to coincide with the time of outbreak in order to facilitate flexible responses while it is taking place (Weir & Mykhalovskiy 2010: 148–149). Field response was to occur within 24 hours of outbreak alert.

The world on alert was enacted brilliantly in the period 1995–2000 through the formation of a sociotechnical apparatus for early outbreak detection and rapid response.

Building on prior WHO success in organizing international collaborative networks of partners, EMC began from 1997 to develop the Global Outbreak Alert and Response Network (GOARN). In April 2000 the WHO Division of Communicable Diseases Surveillance and Response (the successor to EMC) convened an international meeting “to discuss the challenge of epidemic-prone and emerging diseases faced by the world as we enter the 21st century and the need to build a global network on existing partnerships to deal with these threats” (WHO 2000b: 1). The resulting network, GOARN, was institutionally tasked with “maintaining global health security by ensuring mechanisms for outbreak alert and response” (WHO 2000b: 17). Formalized in 2000, the GOARN partnership was designed to have response capacity for three differing types of outbreak: EID, well-characterized infectious diseases, and accidental or deliberate spread of biological agents (WHO 2000a: 3–4). GOARN thus had (and has) an international security dimension that was integrated into its operations from the late 1990s.

In WHA Resolution 48.13 the World Health Assembly had called for the development of international public health surveillance systems capable of detecting EID. To do this, between 1995 and 2000 WHO experimented with event-based monitoring sourced in nondiagnostic databases such as news, consumer spending, and stock market trends. The databases were thought to be indicators of health practices evident during infectious disease outbreaks. Previous forms of public health surveillance had been based on the case report, that is, an authorized disease diagnosis. Under the IHR (1969), member states were obligated to notify WHO of all cases of cholera, plague, and yellow fever in their territories: specific disease notification. Notification was an official case-based knowledge limited by the fact that sovereign states were regularly unaware of outbreaks occurring in their territories and, even when aware, sometimes did not report due to economic repercussions and national stigma. Event-based monitoring was sourced in unofficial, digitally mediated information that flowed across national borders. Through providers such as ProMED-mail³ and the Global Public Health Intelligence Network (GPHIN)⁴ WHO had access to faster and more complete information than had previously been possible about disease outbreaks and other public health events (see also Davies, chapter 19 in this volume).

Event-based monitoring, however, is an indicative form of knowledge; an outbreak alert shows the likelihood of outbreak, not its actual occurrence. Between 1998 and 2000, EMC developed the Outbreak Verification Team at WHO Headquarters (Geneva) as a social and political solution to aligning unofficial, indicative outbreak alerts with sovereign confirmation of an outbreak. In 2001 WHO and Health Canada formally agreed that GPHIN would supply outbreak alerts to WHO that would in turn undertake to verify the outbreak alerts through its Member States (Mykhalovskiy & Weir 2006: 43).

The technoscientific apparatus known as “global outbreak alert and response” was increasingly also called “global health security” after the May 2001 approval of WHA Resolution 54.14, *Global Health Security: Epidemic Alert and Response* (World Health Assembly 2001). Its title rendered “global health security” equivalent to “epidemic alert and response.” WHA Resolution 54.14 additionally configured global health security to encompass “the risks posed by biological agents,” a phrase that intended both naturally occurring disease and biological weapons.

WHA 54.14, occurring several months before the events now known as 9/11, did no more than authorize the broad surveillance and response already given de facto to GOARN between 1997 and 2000. The international security mandate of global health security was further extended under WHA Resolution 55.16, *Global Public Health Response to Natural Occurrence, Accidental Release or Deliberate Use of Biological and Chemical Agents or Radionuclear Material that Affect Health*, which called on member states to “treat any deliberate use, including local, of biological and chemical agents and radionuclear attack to cause harm also as a global public health threat” (World Health Assembly 2002). This “all-risks” approach to detection and response was designed to address the complete range of transborder events that have acute effects on population health. Chemical, biological, radiological, and nuclear (CBRN) incidents, formerly an international security matter outside WHO’s remit, fell squarely within this all-risks approach. WHA Resolution 55.16 was passed in May 2002 in an international political context affected by U.S. 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. So it came to pass that the powers exercised by WHO from the late 1990s in global alert and response, powers clearly in excess of those mandated under the IHR (1969) (Fidler 2006: 188), were deemed politically acceptable by the World Health Assembly.

Meanwhile, endemic communicable diseases, that is diseases with a high and constant prevalence in a region, were not inscribed within the all-risks framework because they are only rarely associated with transborder epidemics. WHO documentation on the 1998 draft revision to the IHR⁵ explicitly addressed the exteriorization of endemic diseases from global health security: “[i]t is proposed that regularly occurring endemic diseases should not be notified unless an outbreak occurs having particular features that would indicate urgent international importance” (WHO. Regional Office for South-East Asia 1998: 4). Global health security had been fashioned in an experimental space protected by resolutions of the World Health Assembly⁶ and with the full knowledge of WHO Member States, a process that I have elsewhere called “pure governance” (Weir 2012).

Revising the IHR: International security and resistance from the global south

WHO had been institutionally aware from the beginning of its work on global health security that the legal framework of the IHR (1969) was inadequate, embarking on a 10-year revision process in 1995. After an abortive early draft of the IHR in 1998, the final revision process was to wait until 2003–2005. On 12 January 2004 the Intergovernmental Working Group on the Revision of the International Health Regulations, the body WHO tasked with producing a final draft of the IHR for the May 2005 meeting of the World Health Assembly, released a Working Paper (WHO 2004b) (hereinafter “January 2004 IHR Draft”) containing a draft of the IHR. The January 2004 IHR Draft became the basis for consultations organized during 2004 in the six geographical regions of WHO together with comments by its member states and other international organizations. WHO released two further drafts of the IHR on 30 September 2004 (WHO 2004a; hereinafter “September 2004 IHR Draft”) and 24 January 2005 (WHO 2005; hereinafter “January 2005 IHR Draft”). It conducted another round of regional consultations in January and February 2005, but only two reports of those consultations are presently available: the Montevideo Document (2005) and the Third Consultation of the South-East Asia Regional Organization (SEARO) (WHO Regional Office for South-East Asia 2005). As the documentation from the 2004 and 2005 regional consultations and other comments comprises the only publicly available record to date of the positions taken by regions and national governments during the final revision process of the IHR, it provides the basis of analysis here. My comments draw on articles by David Fidler (2005), Alexander Kelle (2007), and the late Jonathan Tucker (2005), which examine

the role international security played in the final IHR negotiations, but my analysis is framed in terms of North–South relations and uses the 2004–2005 reports and comments to characterize regional and national positions.

Although the EID concept originated in the United States, it had achieved strong acceptance across South and North by the time the revisions to the IHR were being considered in 2004–2005. The Eastern Mediterranean Regional Organization (EMRO) and SEARO made statements strongly supporting the integration of EID within the scope of the IHR:

The current International Health Regulations require the reporting of cholera, plague and yellow fever only. This not only stigmatizes those diseases but does not provide for the emergence of new infectious diseases, such as severe acute respiratory syndrome (SARS) which afflicted the world in 2003.

(WHO Regional Office for the Eastern Mediterranean 2004)

The present regulations were issued 35 years ago, in 1969. Increasing globalization and the emergence of new diseases such as severe acute respiratory syndrome (SARS) have highlighted the importance of establishing a more effective basis for coordinating the response to international threats to human health.

(WHO Regional Office for South-East Asia 2004)

No region or member state spoke out against the expansion in the scope of the IHR to cover EID.

There were areas of common concern for Northern and Southern states with respect to the January 2004 IHR Draft. The issue of sovereignty was raised, surprisingly gently, with regional groups and member states maintaining that WHO should have no right of entry into their territories, except by invitation. North and South also called attention to the extensive work and resources that would be required in order to develop the core capacity requirements for their public health systems mandated under the January 2004 IHR draft (Mexico 2004; PAHO 2004a, 2004b; Samoa 2004; WHO Regional Office for Africa 2004; WHO Regional Office for the Western Pacific 2004). The Government of Mexico's comments were straightforward in observing that the burden of implementing the IHR should not fall on the poorest countries:

Updating systems of surveillance and adapting means of notification and response calls for considerable investment in terms of both money and human resources. This may be an obstacle for many countries when it comes to implementing the new Regulations. A study is needed of the investment Members States will need to make in their territory and plans should be drawn up to provide support to those countries whose resources are limited. A policy whereby the wealthy countries provide subsidies or support to the poorest countries needs to be drawn up in order to ensure that international health truly is a global public good.

(Mexico 2004)

EMRO (WHO Regional Office for the Eastern Mediterranean 2004: 11) and SEARO (WHO Regional Office for South-East Asia 2004: 28) noted that they would need external financial support for capacity strengthening related to laboratory facilities, epidemiological and environmental surveillance, communications infrastructure, and emergency preparedness and response.

International security elements were incorporated in the three drafts of the IHR, concentrated in its definitions, notification criteria, and the article (variously numbered 41 and 45 across the

drafts) entitled *Information Sharing During a Suspected Intentional Release*. Disease was defined as “caused by biological, chemical or radionuclear sources” (WHO 2004b, 2004d: Art. 1). This amounted to an international security conception of disease, as distinct from medical conceptions that conventionally focus on pathology present in the human body (rather than weapons classifications). The September 2004 and January 2005 IHR Drafts also contained a concept of “public health threat” as “a serious and direct danger to the health of human populations” (WHO 2004d: Art. 1; WHO 2005: Art. 1). This definition introduced a threat–defense logic into the IHR drafts. Moreover, all three of the 2004–2005 IHR drafts proposed that WHO member states be required to notify WHO about CBRN events (WHO 2004b, Annex 2; WHO 2004d, Annex 2; WHO 2005, Annex 2). Lastly, Article 41 in the January 2004 IHR (renumbered as Article 45 in the September 2004 and January 2005 IHR Drafts), *Information Sharing During a Suspected Intentional Release*, proposed that each member state be required to notify WHO if it suspected intentional CBRN weapons use in its territory whether or not the incident had any public health impact. This article further required states to give WHO all pertinent information, materials, and samples related to CBRN releases.

The United States supported strengthening the international security elements of the IHR drafts. In its initial comments (United States of America 2004a) on the January 2004 IHR Draft, the United States suggested that the definitions be revised to include “suspected intentional release” and that the definition of “public health risk” be modified “to include the possibility that an event may be intentional as well as a natural occurrence.” The United States offered further comments on 27 April 2004 (United States of America 2004b) that sought to strengthen WHO’s powers under Article 41, *Information Sharing During a Suspected Intentional Release*, to provide for “a consultative/facilitative role for the WHO Secretariat through which it could, if asked, assist Member States in their recognition or detection of ‘suspected intentional releases,’ and their investigation, confirmation, and public health response to such releases” (United States of America 2004b: 1). In other words, it was the U.S. government that proposed that WHO have the power to conduct field investigations for suspected intentional CBRN use.

Granting WHO the power to undertake field investigations for suspected treaty violations involving weapons of mass destruction was read by WHO member states in the context of the close connection between WHO and the U.S. Centers for Disease Control and Prevention (CDC). Due to CDC’s leading technical skills in epidemiological investigations, it had become closely associated with WHO’s global health security networks (Calain 2007: 6). Alexander Kelle (2007: 228) observes that the United States and other participants at the intergovernmental negotiations around the revisions to the IHR wished to give WHO the power of investigating CBRN weapons use because they “believed the IHR could be utilized to gather information not otherwise obtainable on such incidents.” One might also remember that the 2004–2005 negotiations around the IHR occurred after the second War in Iraq had begun in 2003 under the pretext of an Iraqi arsenal of bioweapons that UN field investigations had been unable to find. Under these combined conditions, certain WHO members in the global South were concerned that field investigations during suspected intentional CBRN releases would result in espionage within their territories.

It was unsurprising, then, that the proposed integration of CBRN agents into the IHR regime was questioned by some WHO regions, although others, notably the Regional Office for Africa and EMRO, remained silent. The Western Pacific Regional Office (WPRO) noted that its consultation participants had been divided with respect to “[t]he scope of the IHR as it relates to nonbiological hazards (chemical and radiological) . . . some participants believe the scope should be limited to infectious diseases and diseases of unknown aetiology” (WHO Western Pacific Regional Office 2004: 16). The SEARO consultation reported the same range of divided opinion

as the earlier WPRO consultation (WHO Regional Office for South-East Asia 2004: vi). Japan, a member of WPRO from the global North, spoke out against the all-risks approach and noted that, although the sensitivity of global event monitoring would necessarily result in alerts regarding CBRN weapons use, “we do not think it is practical to design the IHR to detect and respond to known chemical and radionuclear incidents” (Japan 2004). Other regions and Member States accepted the all-risks approach to detection and notification (e.g., PAHO 2004b: 1), but were concerned that WHO’s powers of response be restricted so that a conflict of jurisdiction with other international agencies did not arise (Norway 2004; Switzerland 2004; WHO 2004a: 1–2; WHO Regional Office for Europe 2004). The International Atomic Energy Agency (2004) was scathing in its comments on the January 2004 IHR Draft, speaking from the position of an international security agency objecting to what it clearly saw as the incompetent drafting of the IHR with respect to radiological and nuclear materials and weapons use.

The January 2005 IHR draft showed little change in response to these concerns, other than to modify the text of Article 45 to enable each member state to apply its provisions “consistent with its security and law enforcement requirements” (WHO 2005: Art. 45) and to add a definition of “public health risk” as “an event posing a probability of international spread of disease” (January 2005: Art. 1). The governments of Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay, and Venezuela responded by issuing a consensus statement, the Montevideo Document (2005), which gave a strong and systematic critique of international security in the January 2005 IHR Draft. The Montevideo Document began with a recommendation that affirmed the use of public health concepts over threat-defense discourse in the draft IHR: “[w]e propose to replace the concept of *threat* with *risk throughout* the document, especially in the definition of *public health emergency of international concern (PHEIC)*” (Montevideo Document 2005: 1; emphasis in original). In understated language, the Montevideo Document recommended the deletion of Article 45 on the grounds it did not “currently specify the relationship between the notification of an event of an intentional nature and an international public health risk. This broad language exceeds the scope of the IHR” (Montevideo Document 2005: 13). This reasoning accepted the all-risks approach but limited the scope of the IHR to international public health risk. The backers of the Montevideo Document won these points in subsequent negotiations.

During the February 2005 intergovernmental meeting on the revision of the IHR, the international security elements in the January 2005 Draft were debated without resolution. The meeting adjourned, deadlocked, and a final round of negotiations was scheduled for 12–13 May 2005 just prior to the 16–25 May Session of the World Health Assembly (where the revised Regulations were approved unanimously). Alexander Kelle’s (2007: 227) interview research with delegates who had attended the May 2005 negotiations shows that regional groups from EMRO and SEARO, led by delegates from Pakistan and Iran, successfully opposed the inclusion of Article 45. David Fidler (2005: 356, N. 183) notes that Brazil and Iran, acting on behalf of EMRO, had proposed an amendment to the September 2004 IHR Draft deleting Article 45. These negotiations also agreed on deleting explicit mention of CBRN from the final text (Tucker 2005: 342).

The opposition to the international security elements in the draft regulations thus included the EMRO and SEARO together with the majority of South American states that had signed the Montevideo Document and, as I have shown, some members states in WPRO: a Southern bloc. Whether the signers of the Montevideo Document intentionally acted in coordination with EMRO, SEARO, and some member of WPRO is presently unknown. It is likely that at least one power from the global North allied with the Southern bloc: Japan, given the strength of its previous refusal of the international security elements in the IHR Drafts. While the evidence clearly indicates the existence of a Southern bloc, it is not clear to date whether the United States acted alone or in concert with its Northern allies.

This Southern bloc produced a complex compromise in the IHR (2005), which retains an all-risks scope while stripping all references to CBRN from the final text.⁷ The result is a masterpiece of oblique diplomacy. “Public health threat” disappears from the definitions (Article 1), resulting in a general weakening of the threat–defense framing present in 2004–2005 IHR drafts. The definition of disease, however, is sufficiently broad to include harm from CBRN incidents. A similar move occurred in the notification criteria (Annex 2) that includes a reference to “spread of toxic, infectious, or otherwise hazardous materials that may be occurring naturally or otherwise” (IHR 2005; Annex 2, I, 2).⁸ The powers of the WHO are restricted under the IHR (2005) to providing public health responses in the case of international public health emergencies, inclusive of CBRN weapons use (Fidler 2005: 366). If an outbreak is suspected or discovered to be intentionally or unintentionally caused, WHO is obligated to inform the UN Security Council, which would then conduct the investigation, although WHO would be authorized to deal with the public health aspects of the emergency, including the support of UN field investigations (Hjalmarsson et al. 2010: 73–74).

As a result of this compromise, WHO has an international security mandate under the IHR (2005), but one narrower than the United States had desired. The acceptance of all-risks detection and response is binding on the design of national public health systems among WHO members and on WHO. The result is an ongoing integration of all-risks emergency management into public health at a planetary level.

Global health security in world order

The genealogy of global health security has shown its history as shaped by the geopolitical division between the United States and the global South. We have seen that global health security was a strategic initiative initiated and given programmatic form between 1992–1995 by an alliance between the United States, Canada, and the European Union. During the final revision process of the IHR in 2004–2005, there was strong support across North and South for extending the scope of the IHR to encompass EID, but some in the global South objected to the proposed inclusion of CBRN releases in the IHR. The final draft of the IHR became the subject of a sharp geopolitical struggle between South and the United States over the extent of its articulation to international security. Where the United States favored more international security in the IHR, the global South favored less. A Southern bloc with middle power allies limited the extension of WHO’s powers to the public health aspects of international emergencies, regardless of source or origin, but defeated the proposal to grant WHO the more general power of doing field investigations, with mandatory member state cooperation in providing information and samples, for treaty violations involving CBRN releases.

Global health security represents a novel technical division of world order that reiterates the North–South divide. More than half the verified alerts between 1996 and 2009 occurred in sub-Saharan Africa, followed by Southeast Asia, South America, and Latin America (Chan et al. 2010: Fig. 1, 21702). Few verified alerts involved the global North. Now the global South is also subject to a far higher incidence of endemic diseases than the global North. Global health security constitutively excludes epidemically stable endemic disease but reintroduces the excluded spaces of endemic disease as the primary location of verified alerts. Global health security reinscribes the geopolitical divide between North and South, with confirmed outbreaks, and by logical extension international public health emergencies, being primarily located in the global South. In this space of global division, global health security concerts Northern protectionism with the stabilization of international trade relations that benefits the South as the main site of verified alerts and international public health emergencies.

Global health security reinscribes world order geopolitically, but it also revises the governance of world order. From the beginnings of global health security in 1994, WHO consistently took the position that, to be effective, it would require the strengthening of national and local public health systems. Yet the goal of strengthening national core public health capacity in surveillance and response for the sake of preventing and controlling the international spread of disease exists in tension with national and local public health goals. The all-risks standard for alert and response also strains the alignment between global health security and national public health systems. The all-risks standard is governed by what WHO terms a “dual use” strategy that aims to harmonize international security with (what are now) other public health functions. In WHO usage, “dual use” signifies the benefits to both civilian public health and international security thought to arise from strengthening local, national and global surveillance and response capacities (WHO 2007: 17–33. See Kinderhauser 2003: 17). In addition, “dual use” operates strategically as a claim that improved civilian public health surveillance will detect any unusual outbreak, including those related to CBRN agents, and is thus to be preferred to a surveillance system dedicated solely to detecting CBRN incidents (Heymann 2004: vii). In its support of dual use, WHO has been concerned to develop global health security as a program that does not divert scarce public health resources into separate CBRN detection and response systems at the expense of public health needs in the global South, where one in two deaths are from naturally caused infectious diseases. Global health security is thus characterized by internal tensions in its goals and governing strategies in need of empirical investigation to see their effects and how the divisions are symbolically disappeared.

Global health security is characterized by a harmonian ethos of borderlessness that places its actions above the petty divisions of geopolitical world order. *Emerging Infections*, the 1992 IOM report, framed EID as a transborder global microbial threat that would require equally transborder human cooperation in the name of health. The subsequent alert and response apparatus assembled at the turn of the 21st century lightened the significance of national borders and sovereign knowledge for international public health. Event-based monitoring is a phenomenon of the Internet with its capacity to source and circulate electronic data across national borders (particularly weakly encrypted internet borders). Borderlessness seeks to trump geopolitics through inflated universalistic claims that disguise the situatedness of those making them. The humanist value of borderlessness seeks to repeat the control Euroamerican colonialism exercised over public health in the colonial world that was only shaken by decolonization in the second half of the twentieth century (Weir & Mykhalovskiy 2010: 65–77). Limits to borderlessness were raised by the global South during the revision of the International Health Regulations in 2004–2005, an assertion of borders to block field investigations that could well have been used for U.S. intelligence purposes in ways that might damage national security in the South. Borderlessness is a lullaby for Northern hegemony.

Global health security thus inevitably raises questions of global justice. Its apparatus mainly acts to prevent the diseases of poor people in the South from spreading to the North and laterally to other areas in the South. Bracketing off endemic disease to construct the domain of global health security is a constitutive exclusion that violates the principles of cosmopolitanism and borderlessness. If and when the levels of endemic disease in the global South converge with those in the global North, the sociotechnical apparatus now known as global health security would have the possibility of becoming a practice of international solidarity. In this imaginable utopia, global health security would become an apparatus through which differing political regions of the world defended themselves against each other with respect to international public health emergencies. This line of reasoning would lead from the primarily genealogical framing found in my writing here to a philosophical argument focused on the normative question of a just world order on the terrain of human health.

Notes

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- 2 For further information about research methods, including key informant interviews with members of GPHIN (Public Health Agency, Ottawa), ProMED-mail, the Department of Communicable Diseases Surveillance and Response at WHO Headquarters (Geneva), and the Archives of WHO (Geneva), see Weir and Mykhalovskiy (2010: 27–28).
- 3 Established in 1994 as an email list, Pro-MED-mail used the fast pace of internet communications and the low cost of email to internationally exchange information on local outbreaks (Madoff & Woodall 2005).
- 4 GPHIN was a partnership established between WHO and the government of Canada to develop another form of event-based monitoring, one sourced in online news (Weir & Mykhalovskiy 2010: 79–88). GPHIN was designed to operate as a secure, Internet-based global monitoring system that retrieved and analyzed online news, sending alerts to WHO, Health Canada, and its international subscribers. Officially launched by Health Canada in 1998, GPHINs software categorized news articles according to a six-part typology: animal, plant, and human diseases, biologics (such as vaccines and pharmaceuticals), natural disasters, chemical incidents, radiological incidents, and unsafe products (Keller et al. 2009). GPHINs design thus incorporated the detection of CBRN incidents.
- 5 The 1998 Draft IHR is not presently publicly available.
- 6 The WHA resolutions authorizing the alert and response apparatus include WHA48.13, *Communicable Disease Prevention and Control: New Emerging and Re-emerging Infectious Diseases*, WHA48.7, *Revision and Updating of the International Health Regulations*, and WHA54.14, *Global Health Security: Epidemic Alert and Response*.
- 7 See Fidler (2005: 358–379) for a careful discussion of the scope of the IHR (2005).
- 8 The 2007 World Health Report (WHO 2007: 17–33) interprets public health emergencies of international concern to include naturally, accidentally, or deliberately caused foodborne illness, chemical, environmental, natural, nuclear, and radiological disasters, and industrial accidents. These are in addition to outbreaks of known and unknown infectious diseases.

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