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The 2014 Ebola outbreak“

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Abbreviations

ACDCP	Africa Centres for Disease Control and Prevention
Africa CDC	Africa Centres for Disease Control and Prevention
AIDS	Acquired Immuno Deficiency Syndrome
ASEOWA	African Union Support to Ebola Outbreak in West Africa
AU	African Union
AVOHC	African Volunteer Health Corps
BSE	Bovine Spongiform Encephalopathy
CDC	Centers of Disease Control and Prevention
CFE	Contingency Fund for Emergencies
CSCT	‘Classical’ Security Complex Theory
ECOWAS	Economic Community of West African States
EU	European Union
EVD	Ebola Virus Disease
FENSA	Framework of Engagement with Non-State Actors
H1N1	Subtype of Influenza A viruses
H5N1	Subtype of Influenza A viruses, type of avian influenza virus
HIV	Human Immunodeficiency Virus
ICM	Independent Commission on Multilateralism
IHR	International Health Regulations
IOAC	Independent Oversight and Advisory Committee
MERS	Middle East Respiratory Syndrome
MSF	Médecins Sans Frontières
PEF	Pandemic Emergency Financing Facility
PHEIC	Public Health Emergency of International Concern
R&D Blueprint	Blueprint for Research and Development Preparedness and Response
SARS	Severe Acute Respiratory Syndrome
UK	United Kingdom
UN	United Nations
UNMEER	United Nations Mission for Emergency Ebola Response
US	United States (of America)
WHA	World Health Assembly
WHE	WHO Health Emergencies Programme
WHO	World Health Organization

1. Introduction

When the question of “What incidents pose a risk to security?” arises, infectious diseases are, possibly, not among the topics that immediately come to mind. However, it is archaeologically as well as historically proven that infectious diseases played an important role throughout human history. Hippocrates already addressed the spread of diseases and their connection to climate, nutrition and living conditions. Throughout history, some infectious diseases were successfully erased (e.g. smallpox), some others have re-emerged several times (e.g. cholera, yellow fever, influenza virus, Ebola virus). Yet, some persistent infectious diseases (e.g. HIV/ AIDS, malaria, tuberculosis) still claim millions of deaths around the globe every year.¹

As the world of today is highly globalised, it is much easier to transport people, goods and services to any place on earth. While this can be a major advantage, simultaneously it is disadvantageous as it becomes much easier for infectious diseases to spread. The US National Intelligence Council stated in its 2017 report: “Unaddressed deficiencies in national and global health systems for disease control will make infectious disease outbreaks more difficult to detect and manage, increasing the potential for epidemics to break out far beyond their points of origin.”² Infectious diseases can have severe effects on all sectors of a nation, entire regions and even the entire globe. Therefore, health topics, which also includes infectious diseases, are nowadays featured in numerous national security strategies as well as in security strategies of regional and international organisations. Furthermore, infectious diseases frequently emerge on the agenda of economic, regional and international meetings as well as in international organisations.

Before continuing, it is important to clarify two points. Firstly, the definition of the term “infectious disease”.³ For example, the World Health Organization (WHO) defines it as follows: “Infectious diseases are caused by pathogenic microorganisms, such as bacteria, viruses, parasites or fungi; the diseases can be spread, directly or indirectly, from one person to another. Zoonotic diseases are infectious diseases of animals that can cause disease when transmitted to humans.”⁴ Secondly, (national) security strategies/ white papers frequently do not differentiate between the terms “infectious disease” and “pandemic”. Yet, not every infectious disease becomes a pandemic (e.g. 2014 Ebola outbreak). This master’s thesis differentiates between the two terms.

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1. Philip S. Brachman, “Infectious diseases- past, present, and future,” *International Journal of Epidemiology* 32, no. 5 (2003): 684, <https://doi.org/10.1093/ije/dyg282>; J. N. Hays, *Epidemics and Pandemics. Their Impacts on Human History* (Santa Barbara, CA: ABC-CLIO, 2005), 5–7.
 2. National Intelligence Council, “Global Trends. Paradox of Progress,” <https://www.dni.gov/files/documents/nic/GT-Full-Report.pdf>, 25, (Accessed: 6 March 2018).
 3. Terms such as epidemic, pandemic and several others are explained in more detail later in this thesis. The WHO defines more than 40 infectious diseases, among them are tuberculosis, malaria, HIV/ AIDS, Ebola virus, Yellow fever, Avian influenza, influenza (seasonal), cholera. WHO, “Fact sheets: Infectious diseases,” http://www.who.int/topics/infectious_diseases/factsheets/en/, (Accessed: 10 March 2017).
 4. WHO, “Infectious diseases,” http://www.who.int/topics/infectious_diseases/en/, (Accessed: 10 March 2017).

1.1 Why are infectious diseases a security risk?

One might wonder how and why infectious diseases pose a risk to security? The subsequent section answers this question. It has to be noted that several of the causes are interconnected. Yet, they are only explained briefly at this point as the examples throughout this master's thesis (especially chapters 8.1 to 8.4) provide a more profound understanding. Infectious diseases can constitute a threat to national and global security for various reasons. The following categorisation is derived from those of Cecchine/ Moore and the Institute of Medicine.⁵ The categories are: mortality and morbidity, economic impact, societal and governmental disruptions and the breakdown of essential public services.⁶

Mortality and morbidity are the most direct impact infectious diseases have. While this is per se no risk to security, the aftermath is. Furthermore, some infectious diseases are known to have high morbidity and mortality rates. For instance, the Ebola virus has an average fatality rate of 50 percent, with variations from as low as 25 to as high as 90 percent. High fatality rates can lead to severe disruptions, especially when a certain demographic group is affected. Two of the many examples would be: One, the 1918 influenza pandemic where young adults had a 20 times higher mortality rate. Two, HIV/ AIDS which (can) result in death as well as in a drop of life expectancy; in some states to under 40 years (e.g. sub-Saharan Africa). Low life expectancy can, in turn, result in several other disadvantageous effects to all sectors of a state. Two examples, among others, are a diminished workforce or fewer people available for military service.⁷ The latter can lead to severe challenges for the military forces. Their health is key for the protection of the state in general. Especially during times of war or military operations abroad (e.g. militaries during the 1918 influenza pandemic) or in case of a bioterrorism attack. Bioterrorism itself is another example of how infectious diseases can pose a risk to security (chapter 6.2).

Infectious diseases can also have a direct and indirect impact on economies. Examples of indirect impacts are a decrease in or a loss of productivity, trade, travel and tourism. An example of the direct impact of infectious diseases are the costs to either combat them or to rebuild structures or sectors afterwards; often with financial aid from the international community of states (e.g. HIV/ AIDS, 2014 Ebola outbreak). Another example of the economic effects of infectious diseases is malaria. According to Cecchine/ Moore, there is a suggestion that if malaria had been eradicated decades ago, Africa's gross domestic product would be about one third higher.⁸

5. Now called: National Academy of Medicine.

6. Gary Cecchine and Melinda Moore, "Infectious Disease and National Security. Strategic Information Needs," https://www.rand.org/content/dam/rand/pubs/technical_reports/2006/RAND_TR405.pdf, 17, (Accessed: 6 May 2017); Joshua Lederberg, Robert E. Shope and Stanley C. Oaks, eds., *Emerging Infections. Microbial Threats to Health in the United States* (Washington, DC, 1992), 34–112.

7. Cecchine and Moore, "Infectious Disease," 17; WHO, "Ebola virus disease," <http://www.who.int/mediacentre/factsheets/fs103/en/>, (Accessed: 11 March 2017); Hays, *Epidemics and Pandemics*, 387 & 440; Jeffery K. Taubenberger and David M. Morens, "1918 Influenza: the Mother of All Pandemics," *Emerging infectious diseases* 12, no. 1 (2006): 19, <https://doi.org/10.3201/eid1201.050979>; Michael B. A. Oldstone, *Viruses, Plagues, and History: Past, Present and Future* (Oxford: Oxford University Press USA, 2009), 307.

8. Cecchine and Moore, "Infectious Disease," 17.

Societal and governmental disruptions are another reason why infectious diseases are a security risk. This can manifest itself in various ways. Firstly, fear can lead people to make non-rational choices. For example, health workers who stayed home during the 2014 Ebola outbreak, since they feared contracting the disease. This resulted in hospitals being closed and sick people being turned away. It has to be noted that the Ebola virus can be spread in different ways. Its main method of transmission is either through contact with infected animals or through contact with infected body fluids (e.g. blood). Furthermore, it can survive on surfaces, textiles and medical equipment for several hours. This fact increases the probability of contracting this highly infectious disease- even after having taken appropriate precautions. Another example is health staff that wore special clothing to avoid infection, but looked unfamiliar to the public. In addition, the removal of infected people from their communities; with some never returning, resulted in infected individuals being hidden. Secondly, the death of people in high positions, which can contribute to a power and/ or a decision vacuum. Thirdly, the restrictions on rights can also lead to societal and governmental disruptions. For instance, violence/ riots against officials (e.g. health workers, police) because of movement restrictions, curfews and quarantines. Fourthly, the discrimination and stigmatisation of sick people, such as ostracising infected people for their illness or tracking by the state (e.g. HIV/ AIDS, 2014 Ebola outbreak). Fifthly, the shrinkage/ loss of a demographic group can be named in this category as well. Sixthly, distrust in governments, which can have several effects. One, when the public does not understand why the government is not able to fight infectious diseases successfully. Two, in the case of the 2014 Ebola outbreak the disease was not taken seriously by the public. The primary reason why was, among others, rumours that the disease was invented by the government to receive financial aid. Three, distrust can also lead to an increase in migration.⁹ This, in turn, can lead to the spread of infectious diseases. Lastly, the “vulnerability to economic or military competition from other nations.”¹⁰

The last category of why infectious diseases are a security risk is the complete or partial breakdown of essential public services. For example, the breakdown of core health systems in West Africa during the 2014 Ebola outbreak. In worst cases, infectious diseases can lead to weak and collapsed states, which can foster regional instability and/ or terrorism. This may, according to Price-Smith, be an indirect threat to the national security of (other) states.¹¹

9. Cecchine and Moore, “Infectious Disease,” 18; Lawrence O. Gostin and Eric A. Friedman, “A retrospective and prospective analysis of the west African Ebola virus disease epidemic: robust national health systems at the foundation and an empowered WHO at the apex,” *The Lancet* 385, no. 9980 (2015): 1902–3, [https://doi.org/10.1016/S0140-6736\(15\)60644-4](https://doi.org/10.1016/S0140-6736(15)60644-4); WHO, “Frequently asked questions on Ebola virus disease,” <http://www.who.int/csr/disease/ebola/faq-ebola/en/>, (Accessed: 11 March 2017); CDC, “Ebola. Transmission,” <https://www.cdc.gov/vhf/ebola/transmission/index.html>, (Accessed: 11 March 2017); WHO, “Ebola virus disease”; UN, “Timeline,” <https://ebolaresponse.un.org/timeline>, (Accessed: 1 June 2018); Christian Enemark, “Is Pandemic Flu a Security Threat?,” *Survival* 51, no. 1 (2009): 201–2, <https://doi.org/10.1080/00396330902749798>.

10. Cecchine and Moore, “Infectious Disease,” 18.

11. Marie-Paule Kieny et al., “Health-system resilience: reflections on the Ebola crisis in western Africa,” *Bulletin of the World Health Organization* 92, no. 12 (2014): 850, <https://doi.org/10.2471/BLT.14.149278>; Andrew T. Price-Smith, *Contagion and Chaos: Disease, Ecology, and National Security in the Era of Globalization* (Cambridge, MA: MIT Press, 2009), 2 & 200.

1.2 The securitisation of infectious diseases

Now, that the question of why and how infectious diseases can pose a risk to security has been explained briefly, the following section illustrates the securitisation of infectious diseases.

According to Price-Smith, “the securitization of health is not novel at all, but hearkens back to a classical (republican) vein of thought that pervades the discipline of political science and its various subdisciplines.”¹² Kamradt-Scott/ McInnes declare that the 1918 influenza pandemic was the first infectious disease to be framed as a risk to national and international security.¹³ Yet, Elbe argues that “it was the AIDS pandemic- and not swine flu- that must be credited with first prompting policy makers to recognise the security threat posed by infectious diseases.”¹⁴ Despite the disagreements among researchers about the exact beginnings of securitising infectious diseases, some infectious disease outbreaks in recent history were accelerators for putting health security on the agenda of states as well as regional and international organisations. The 2003 SARS outbreak was an example, which demonstrated the rapid spread of infectious diseases in today’s highly globalised world. Furthermore, it demonstrated the consequences an infectious disease can have on “economic growth, trade, tourism and social stability, especially when its perceived risk is many times higher than its actual risk.”¹⁵ The perception of risks and its role in the securitisation of infectious diseases is briefly addressed in chapters 9.2.1 and 9.2.3.2.1. The H5N1 virus was another prominent example of an infectious disease (outbreak) causing international sensation. Furthermore, it is, according to Elbe, “a classic example of a securitization process”; with its advantages and disadvantages.¹⁶ The 2009 H1N1 pandemic was another addition to the securitisation of health topics. One of the latest examples of a health issue raising national and international attention was the 2014 Ebola outbreak. Various deficiencies at the national and international level (chapters 8.2 to 8.3) led Sands/ Mundaca-Shah/ Dzau to the assumption that “Ebola demonstrated how ill-prepared we are for such infectious-disease crises.”¹⁷ Or as Horton/ Das put it: “Thanks to Ebola, global health security is now a priority.”¹⁸

12. Price-Smith, *Contagion and Chaos*, 196.

13. Adam Kamradt-Scott and Colin McInnes, “The securitisation of pandemic influenza: Framing, security and public policy,” *Global public health* Volume 7, Supplement 2 (2012): 106, <https://doi.org/10.1080/17441692.2012.725752>.

14. Stefan Elbe, “Pandemics on the Radar Screen: Health Security, Infectious Disease and the Medicalisation of Insecurity,” *Political Studies* 59, no. 4 (2011): 850–51, <https://doi.org/10.1111/j.1467-9248.2011.00921.x>.

15. A. J. Tatem, D. J. Rogers, and S. I. Hay, “Global Transport Networks and Infectious Disease Spread,” in Hay; Graham; Rogers, *Global Mapping of Infectious Diseases: Methods, Examples and Emerging Applications*, 302.

16. Stefan Elbe, “Haggling over viruses: the downside risks of securitizing infectious disease,” *Health policy and planning* 25, no. 6 (2010): 479, <https://doi.org/10.1093/heapol/czq050>.

17. Peter Sands, Carmen Mundaca-Shah, and Victor J. Dzau, “The Neglected Dimension of Global Security: A Framework for Countering Infectious-Disease Crises,” *The New England journal of medicine* 374, no. 13 (2016): 1281, <https://doi.org/10.1056/NEJMSr1600236>.

18. Richard Horton and Pamela Das, “Global health security now,” *The Lancet* 385, no. 9980 (2015): 1805, [https://doi.org/10.1016/S0140-6736\(15\)60909-6](https://doi.org/10.1016/S0140-6736(15)60909-6).

1.3 Selection of the 2014 Ebola outbreak

The subsequent section illustrates the reasons why the 2014 Ebola outbreak was selected for this master's thesis.

When discussing infectious diseases, one case stands out as a “reference point”. Namely, the 1918 influenza pandemic, which was one of the deadliest infectious diseases in modern history; killing between 25 and 100 million people.¹⁹ Further, it changed the standards for treating infectious diseases as well as for hygiene. Finding an infectious disease comparable to the 1918 influenza pandemic proved to be difficult. Selectable cases were: the 1957 Asian influenza, the 1968 Hong Kong influenza, HIV/ AIDS, the 2003 SARS outbreak, the Avian flu, the 2009 H1N1 pandemic, malaria, tuberculosis and the 2014 Ebola outbreak. The definition of three pre-set conditions helped to narrow the options down.

The first pre-set condition was the time of the outbreak. In particular, the choice of a case that occurred approximately 100 years after the 1918 influenza pandemic. This resulted in the elimination of the 1957 Asian influenza and the 1968 Hong Kong influenza. Malaria, tuberculosis and HIV/ AIDS were dismissed as well. The reason why is that all three infectious diseases are continuously being transmitted. This would make the time frame of the case and the available data too broad.

The second pre-set condition was to find a case with a severity comparable to the 1918 influenza pandemic. Therefore, SARS (774 fatalities of a total of 8,000 cases) and the Avian flu (280 fatalities within five years) were discarded.²⁰ During the 2014 Ebola outbreak 11,310 of 28,616 cases ended in fatalities- that is 39.5 percent. As mentioned before, the average fatality rate of the Ebola virus is 50 percent, with variations from 25 to 90 percent.²¹ The WHO declared the outbreak “the most severe acute public health emergency seen in modern times.”²² The virus' severity also demonstrated that even developed states (e.g. United States, United Kingdom, Spain, Italy) had difficulties containing it; regardless of their high standards of hygiene and access to the best medical equipment.²³

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19. Hays, *Epidemics and Pandemics*, 385; Taubenberger and Morens, “1918 Influenza,” 15–16; Jane Evans, “Pandemics and National Security,” 1, no. 1 (2010): 105, <http://globalsecuritystudies.com/Evans%20PANDEMICS.pdf>, (Accessed: 8 September 2017); John M. Barry, *The Great Influenza. The Story of the Deadliest Pandemic in History* (London: Penguin Books, 2009), 397.
 20. WHO, “Summary of probable SARS cases with onset of illness from 1 November 2002 to 31 July 2003,” http://www.who.int/csr/sars/country/table2004_04_21/en/, (Accessed: 28 March 2017); WHO, “Cumulative Number of confirmed human cases for avian influenza A (H5N1) reported to WHO, 2003-2016,” http://www.who.int/influenza/human_animal_interface/EN_GIP_20160404cumulativenumberH5N1cases.pdf, 1, (Accessed: 25 March 2017).
 21. Suspected, probable and confirmed cases/ deaths are included in these numbers. WHO, “Ebola data and statistics (b). Situation summary,” <http://apps.who.int/gho/data/view ebola-sitrep ebola-summary-20160511?lang=en>, (Accessed: 27 March 2017); WHO, “Ebola virus disease”.
 22. WHO, “Experimental therapies: growing interest in the use of whole blood or plasma from recovered Ebola patients (convalescent therapies),” <http://www.who.int/mediacentre/news/ebola/26-september-2014/en/>, (Accessed: 5 April 2018).
 23. WHO, “Ebola Situation Reports,” <http://apps.who.int/ebola/ebola-situation-reports>, (Accessed: 3 May 2018).

The third pre-set condition was the possibility of treatment. In the case of the H1N1 pandemic, treatment was almost immediately available. This left the Ebola virus as the only option as it was not treatable until the end of 2016.²⁴

As the 2014 Ebola outbreak in West Africa is now considered to have been “only” an epidemic, one might wonder why this disease has been chosen. Firstly, because of all the abovementioned reasons. Secondly, as the outbreak confirmed the world’s ill-preparedness for severe and fast transmitting infectious diseases.

The number of sources discussing the 2014 Ebola outbreak and its aftermath is growing rapidly; with a great variety of focuses. However, in the research it is absent as to whether the outbreak changed the evaluation of infectious diseases as a security risk in security strategies of regional and international organisations as well as in national security strategies of states. Therefore, this master’s thesis aims to fill this gap.

As several infectious diseases (SARS, H5N1, H1N1) have been accelerators for securitising infectious diseases, it is hypothesised that the 2014 Ebola outbreak was yet another catalyst in this development.

1.4 Structure

In the following, the structure and the content of this master’s thesis are outlined.

Chapter two defines relevant terms. Chapter three describes the research questions, the knowledge void the thesis aims to fill as well as its limitations. Chapter four introduces the hypothesis. Chapter five presents the method and methodology used to answer the research questions and to support or refute the hypothesis. Chapter six illustrates the state of the art of infectious diseases as a security risk. Chapter seven provides a short, historical overview of infectious diseases. An excursus of the 1918 influenza pandemic as well as facts about and a timeline of the 2014 Ebola outbreak is also given. Chapter eight debates the factors for the (re-)emergence and spread of infectious diseases, in general, and in specific to the 2014 Ebola outbreak. Chapter nine focusses on the securitisation theory- the theoretical basis of this thesis.²⁵ Chapter ten analyses the security strategies and resolutions of regional and international organisations (World Health Organization, United Nations, European Union and African Union). Chapter eleven reviews the national security strategies of the G7 member states as well as those of the three most affected states by the 2014 Ebola outbreak- Sierra Leone, Guinea and Liberia.

24. WHO, “Final trial results confirm Ebola vaccine provides high protection against disease,” <http://www.who.int/en/news-room/detail/23-12-2016-final-trial-results-confirm-ebola-vaccine-provides-high-protection-against-disease>, (Accessed: 15 February 2017).

25. This chapter is purposely placed at this point of the thesis. The reason why is that the previous two chapters are key for a better understanding of the topic, in general, and the theory, in specific.

A section also aims to identify similarities and differences between the security strategies. Chapter twelve concludes this master's thesis.

2. Definitions of terms

As this master's thesis focus is on infectious diseases as a security risk and the Ebola virus, this chapter defines some essential terms. Medical terms are discussed as shortly as is possible and are intended to be easily comprehensible. The main sources for the definitions are the English Oxford Dictionary and the Merriam-Webster Dictionary. Where these sources do not offer a definition of a term or where it is not elaborate, additional sources (the World Health Organization and/ or the Centers for Disease Control and Prevention (CDC)) is used.

Infectious disease

The Oxford English Dictionary does not define the term "infectious disease", but "infectious" and "disease" separately.

For "infectious" the dictionary presents the following definition:²⁶

"Causing or spreading disease, esp. of an epidemic nature; of, relating to, or characterized by the spread of disease. In later use: spec. (capable of) causing or transmitting infection." As well as: "Capable of spreading from one individual to another; occurring in epidemics; transmissible, communicable; spec. transmitted by indirect means, as by contaminated water or food, arthropod vectors, etc., rather than by close contact with an infected individual. In later use also: caused by a microorganism or other biological agent."

The dictionary's definition of "disease" is:²⁷

"The condition of being (more or less seriously) out of health; illness, sickness." As well as: "An individual case or instance of such a condition; an illness, ailment, malady, disorder."

The Merriam-Webster Dictionary presents this definition of "infectious disease":

"A disease caused by the entrance into the body of organisms (as bacteria, protozoans, fungi, or viruses) which grow and multiply there."²⁸

The World Health Organization's definition is:

"Infectious diseases are caused by pathogenic microorganisms, such as bacteria, viruses, parasites or fungi; the diseases can be spread, directly or indirectly, from one person to another. Zoonotic diseases are infectious diseases of animals that can cause disease when transmitted to humans."²⁹

26. EOD, "Infectious," <http://www.oed.com.uaccess.univie.ac.at/view/Entry/95275>, (Accessed: 17 May 2018).

27. EOD, "Disease," <http://www.oed.com.uaccess.univie.ac.at/view/Entry/54151>, (Accessed: 17 May 2018).

28. MWD, "Infectious disease," <https://www.merriam-webster.com/medical/infectious%20disease>, (Accessed: 19 May 2018).

29. WHO, "Infectious diseases".

Epidemic

The Oxford English Dictionary defines the term as follows:

“Prevalent among a people or a community at a special time, and produced by some special causes not generally present in the affected locality.”³⁰

The Merriam-Webster Dictionary offers the following definition:

“Affecting or tending to affect a disproportionately large number of individuals within a population, community, or region at the same time.”³¹

Endemic

In the Oxford English Dictionary, the term is defined as:

“Habitually prevalent in a certain country, and due to permanent local causes.”³²

The Merriam-Webster Dictionary presents this definition:

“Restricted or peculiar to a locality or region.”³³

Pandemic

The Oxford English Dictionary defines the term as follows:

“Epidemic over a very large area; affecting a large proportion of a population. Also: of or relating to such a disease.”³⁴

In the Merriam-Webster Dictionary “pandemic” is defined as:

“Occurring over a wide geographic area and affecting an exceptionally high proportion of the population.”³⁵

Outbreak

The Oxford English Dictionary presents the following definition:

“A sudden increase in the incidence of a disease; an epidemic of infectious disease, esp. when relatively localized.”³⁶

30. EOD, “Epidemic,” <http://www.oed.com.uaccess.univie.ac.at/view/Entry/63307>, (Accessed: 17 May 2018).

31. MWD, “Epidemic,” <https://www.merriam-webster.com/dictionary/epidemic>, (Accessed: 19 May 2018).

32. EOD, “Endemic,” <http://www.oed.com.uaccess.univie.ac.at/view/Entry/61919>, (Accessed: 17 May 2018).

33. MWD, “Endemic,” <https://www.merriam-webster.com/dictionary/endemic>, (Accessed: 19 May 2018).

34. EOD, “Pandemic,” <http://www.oed.com.uaccess.univie.ac.at/view/Entry/136746>, (Accessed: 17 May 2018).

35. MWD, “Pandemic,” <https://www.merriam-webster.com/dictionary/pandemic>, (Accessed: 19 May 2018).

36. EOD, “Outbreak,” <http://www.oed.com.uaccess.univie.ac.at/view/Entry/133458>, (Accessed: 17 May 2018).

The Merriam-Webster Dictionary defines the term as:³⁷

“A sudden rise in the incidence of a disease.” As well as: “A sudden increase in numbers of a harmful organism and especially an insect within a particular area.”

The World Health Organization offers this definition:

“A disease outbreak is the occurrence of cases of disease in excess of what would normally be expected in a defined community, geographical area or season. An outbreak may occur in a restricted geographical area, or may extend over several countries. It may last for a few days or weeks, or for several years.”³⁸

The Centers for Disease Control and Prevention’s definition of “outbreak” is:³⁹

“Outbreak carries the same definition of epidemic, but is often used for a more limited geographic area. [...] A common-source outbreak is one in which a group of persons are all exposed to an infectious agent or a toxin from the same source. If the group is exposed over a relatively brief period, so that everyone who becomes ill does so within one incubation period, then the common-source outbreak is further classified as a point-source outbreak. [...] A propagated outbreak results from transmission from one person to another. Usually, transmission is by direct person-to-person contact, as with syphilis. Transmission may also be vehicleborne (e.g., transmission of hepatitis B or HIV by sharing needles) or vectorborne (e.g., transmission of yellow fever by mosquitoes). In propagated outbreaks, cases occur over more than one incubation period.”

Security strategy

The Oxford English Dictionary does not define the term “security strategy”, but “security” and “strategy” separately. However, it offers a definition for “strategy document”:

“A document outlining a plan, scheme, or course of action, esp. of a long-term or ambitious nature, typically for a business or other organization.”⁴⁰

The Merriam-Webster Dictionary does not define the term “security strategy” either, but offers the following definitions for “security” and “strategy”.

For “security” it provides the following definition:⁴¹

“The quality or state of being secure.” As well as: “Measures taken to guard against espionage or sabotage, crime, attack, or escape.” Also: “An organization or department whose task is security.”

37. MWD, “Outbreak,” <https://www.merriam-webster.com/dictionary/outbreak>, (Accessed: 19 May 2018).

38. WHO, “Disease outbreaks,” http://who.int/topics/disease_outbreaks/en/, (Accessed: 10 March 2017).

39. CDC, “An Introduction to Applied Epidemiology and Biostatistics. Lesson 1: Introduction to Epidemiology. Section 11: Epidemic Disease Occurrence,” <https://www.cdc.gov/opphss/csels/dsepd/ss1978/lesson1/section11.html>, (Accessed: 11 March 2017).

40. EOD, “Strategy,” <http://www.oed.com.uaccess.univie.ac.at/view/Entry/191319>, (Accessed: 17 May 2018).

41. MWD, “Security,” <https://www.merriam-webster.com/dictionary/security>, (Accessed: 19 May 2018).

The term “strategy” is defined as:⁴²

“The science and art of employing the political, economic, psychological, and military forces of a nation or group of nations to afford the maximum support to adopted policies in peace or war.” As well as: “A careful plan or method.”

White paper

The Oxford English Dictionary presents this definition:

“A parliamentary consultation paper or Command Paper outlining proposals for future policy or legislation on a particular subject.”⁴³

In the Merriam-Webster Dictionary “white paper” is defined as:⁴⁴

“A government report on any subject.” As well as: “A detailed or authoritative report.”

Public health

The Oxford English Dictionary defines the term as follows:

“The health of the population as a whole, esp. as monitored, regulated, and promoted by the state (by provision of sanitation, vaccination, etc.). Also: the branch of medicine dealing with this (including hygiene, epidemiology, prevention of infectious diseases, etc.).”⁴⁵

The Merriam-Webster Dictionary offers the following definition:

“The art and science dealing with the protection and improvement of community health by organized community effort and including preventive medicine and sanitary and social science.”⁴⁶

Global health

The Oxford English Dictionary does not define the term “global health”, but defines “global” and “health” separately.

For “global” the dictionary presents the following definition:

“Relating to or encompassing the whole of anything or any group of things, categories, etc.; comprehensive, universal, total, overall.” As well as: “Of, relating to, or involving the whole world, worldwide.”⁴⁷

“Health” is defined as:

“Soundness of body; that condition in which its functions are duly and efficiently discharged.”⁴⁸

42. MWD, “Strategy,” <https://www.merriam-webster.com/dictionary/strategy>, (Accessed: 19 May 2018).

43. EOD, “White Paper,” <http://www.oed.com.uaccess.univie.ac.at/view/Entry/399483>, (Accessed: 17 May 2018).

44. MWD, “White Paper,” <https://www.merriam-webster.com/dictionary/white%20paper>, (Accessed: 19 May 2018).

45. EOD, “Public health,” <http://www.oed.com.uaccess.univie.ac.at/view/Entry/239546>, (Accessed: 17 May 2018).

46. MWD, “Public health,” <https://www.merriam-webster.com/dictionary/public%20health>, (Accessed: 19 May 2018).

47. EOD, “Global,” <http://www.oed.com.uaccess.univie.ac.at/view/Entry/79019>, (Accessed: 17 May 2018).

48. EOD, “Health,” <http://www.oed.com.uaccess.univie.ac.at/view/Entry/85020>, (Accessed: 17 May 2018).

The Merriam-Webster Dictionary does not define the term “global health” either. Though it presents the following definitions for “global” and “health”.

For “global” this definition is provided:

“Of, relating to, or involving the entire world.”⁴⁹

For the term “health”, the dictionary offers the following definition:⁵⁰

“The general condition of the body.” As well as: “General condition or state.”

Communicable disease

The Oxford English Dictionary does not define the term “communicable disease”, but defines “communicable” and “disease” separately.

For “communicable” the dictionary presents this definition, among others:

“Esp. of a disease: that can be transmitted directly or indirectly from one person or animal to another; infectious.”⁵¹

The definition of the term “disease” has been listed above.

In the Merriam-Webster Dictionary, “communicable disease” is defined as:

“An infectious disease transmissible (as from person to person) by direct contact with an affected individual or the individual’s discharges or by indirect means (as by a vector).”⁵²

Ebola

In the Oxford English Dictionary, the term is defined as:

“A tropical African filovirus known to infect humans and certain other primates, causing epidemics of severe, usually fatal haemorrhagic fever in humans.”⁵³

The Merriam-Webster Dictionary offers the following definition:

“Any of several filoviruses (genus Ebolavirus and especially species Zaire ebolavirus) of African origin that cause an often fatal hemorrhagic fever.”⁵⁴

The World Health Organization’s definition of “Ebola” is:

“Ebola virus disease (EVD), formerly known as Ebola haemorrhagic fever, is a severe, often fatal illness in humans. The virus is transmitted to people from wild animals and spreads in the human

49. MWD, “Global,” <https://www.merriam-webster.com/dictionary/global>, (Accessed: 19 May 2018).

50. MWD, “Health,” <https://www.merriam-webster.com/dictionary/health>, (Accessed: 19 May 2018).

51. EOD, “Communicable,” <http://www.oed.com.uaccess.univie.ac.at/view/Entry/37303>, (Accessed: 17 May 2018).

52. MWD, “Communicable Disease,” <https://www.merriam-webster.com/medical/communicable%20disease>, (Accessed: 19 May 2018).

53. EOD, “Ebola,” <http://www.oed.com.uaccess.univie.ac.at/view/Entry/249580>, (Accessed: 17 May 2018).

54. MWD, “Ebola virus,” <https://www.merriam-webster.com/dictionary/Ebola%20virus>, (Accessed: 19 May 2018).

population through human-to-human transmission. The average EVD case fatality rate is around 50%. Case fatality rates have varied from 25% to 90% in past outbreaks.”⁵⁵

The Centers for Disease Control and Prevention defines the term as:⁵⁶

“Ebola is a rare and deadly disease. [...] Ebola outbreaks start when a person is infected through contact with an infected animal, such as a fruit bat or primate (monkeys and apes). The disease can then spread from person to person through contact with infected blood or body fluids. Healthcare workers and family and friends in close contact with Ebola patients are at the highest risk of getting Ebola because they may come in contact with infected body fluids.”

Influenza

The Oxford English Dictionary presents this definition:

“An acute, highly infectious viral disease of humans, which typically occurs in seasonal (winter) outbreaks or as major epidemics or pandemics, is characterized by the sudden onset of fever and chills, headache, muscle pain, weakness, and cough, and can result in death (esp. in the elderly, and usually from viral or secondary bacterial pneumonia); (also) an outbreak, epidemic, or instance of this disease. Frequently with distinguishing word, usually indicating the geographical origin or viral source of an epidemic. Also (loosely): a relatively severe common cold or similar acute respiratory infection.”⁵⁷

In the Merriam-Webster Dictionary “influenza” is defined as:⁵⁸

“An acute, highly contagious, respiratory disease caused by any of three orthomyxoviruses: (1) or influenza A: moderate to severe influenza that in humans is marked especially by sudden onset, fever, sore throat, fatigue, muscle aches, inflammation of the respiratory mucous membranes, and cough, that has numerous variants caused by subtypes (such as H1N1, H2N2, or H3N2) of an orthomyxovirus (species Influenza A virus of the genus Influenzavirus A) infecting humans and various animals (such as birds or pigs), and that may occur in seasonal epidemics or sometimes pandemics following mutation in the causative virus (2) or influenza B: influenza with less severe symptoms that is caused by an orthomyxovirus (species Influenza B virus of the genus Influenzavirus B) infecting only humans and especially children and that may occur in seasonal epidemics but not pandemics (3) or influenza C: mild influenza that is often asymptomatic, is caused by an orthomyxovirus (species Influenza C virus of the genus Influenzavirus C) infecting only humans, and does not occur in epidemics or pandemics.” As well as: “Any of various human respiratory infections of undetermined cause.” Also: “Any of various

55. WHO, “Ebola virus disease”.

56. CDC, “Ebola,” <https://www.cdc.gov/dotw/ebola/index.html>, (Accessed: 17 May 2018).

57. EOD, “Influenza,” <http://www.oed.com.uaccess.univie.ac.at/view/Entry/95531>, (Accessed: 17 May 2018).

58. MWD, “Influenza,” <https://www.merriam-webster.com/dictionary/influenza>, (Accessed: 19 May 2018).

virus diseases of domestic animals marked especially by fever, respiratory symptoms, and inflammation of mucous membranes.”

The Centers for Disease Control and Prevention’s definition of “influenza” is:⁵⁹

“Flu is a contagious respiratory illness caused by influenza viruses that infect the nose, throat, and sometimes the lungs. It can cause mild to severe illness, and at times can lead to death. [...] Most experts believe that flu viruses spread mainly by tiny droplets made when people with flu cough, sneeze or talk. These droplets can land in the mouths or noses of people who are nearby. Less often, a person might get flu by touching a surface or object that has flu virus on it and then touching their own mouth, nose or possibly their eyes. [...] Some otherwise healthy adults may be able to infect others beginning 1 day before symptoms develop and up to 5 to 7 days after becoming sick. [...] It is very difficult to distinguish flu from other viral or bacterial respiratory illnesses based on symptoms alone.”

This chapter defined some essential terms for this master’s thesis. The following chapter presents the research questions.

59. CDC, “Key Facts About Influenza (Flu),” <https://www.cdc.gov/flu/keyfacts.htm>, (Accessed: 5 April 2018).

3. Research questions

This chapter illustrates the knowledge void this master's thesis aims to fill. Further, the research questions are presented and the thesis' limitations are explained.

According to Maslow's "Hierarchy of Needs", security and safety are basic needs. This also includes health among other examples. In addition, health and security are topics that affect every human being to a greater or lesser extent. The rise of health security and the evaluation whether infectious diseases are a risk to national and global security have been up for discussion for a long time. HIV/ AIDS, the outbreaks of SARS and H5N1 and the H1N1 pandemic were accelerators for the (securitisation) debate, resulting in the push of health into the field of security on both national and international agendas. The 2014 Ebola outbreak is one of the latest examples causing worldwide sensation. Firstly, because it demonstrated limitations in technology advances (e.g. lack of treatment) as well as a lack of international cooperation. Secondly, as it fuelled the discussion of the securitisation of health, in general, and of infectious diseases, in particular. Supporters of the securitisation of health/ infectious diseases argue that it increases awareness and mobilises. Critics of securitising infectious diseases counter that pushing health into the field of security might imply that health is not important enough by itself, yet needs to be paired with security to show its importance. In addition, some critics argue that it could lead to a legitimisation of revoking certain laws and/ or human rights.⁶⁰

There are numerous sources available, which discuss the 2014 Ebola outbreak in West Africa and its aftermath/ consequences; with focus on various aspects of national, regional and international areas. Absent in the research is an analysis whether the outbreak changed the evaluation of infectious diseases as a security risk in (national) security strategies/ resolutions of regional and international organisation as well as of states. This master's thesis intends to fill the aforementioned gap.

Therefore, the two research questions are:

1. Which changes did the 2014 Ebola outbreak cause in the evaluation of infectious diseases as a security risk in security strategies/ resolutions?
2. Which changes did the 2014 Ebola outbreak cause in the evaluation of infectious diseases as a security risk in national security strategies/ white papers?

Limitations

The analysis' focus is on the middle and system level. To answer the first research question, the security strategies or resolutions of three international organisations (World Health Organization,

60. Barry Buzan, Ole Wæver and Jaap de Wilde, *Security. A New Framework for Analysis* (Boulder, CO, London: Lynne Rienner, 1998), 29; Horton and Das, "Global health security now," 1805.

United Nations, European Union) as well as of one regional organisation (African Union) are reviewed.

The World Health Organization (WHO) was selected for three reasons. One, because the topic of infectious diseases is a health topic and is, therefore, a part of the field of activity of the organisation. Two, because the WHO was the leading international organisation in the response to the 2014 Ebola outbreak. Three, because it is the most widely recognised international health organisation. Therefore, there is a stronger focus on the WHO as opposed to the other organisations.

The United Nations (UN) was chosen for two reasons. Firstly, as it also played an important role in the response to the outbreak. Secondly, because it is the biggest international organisation.

The European Union (EU) was selected for two reasons. One, it was part of the Ebola response. Two, several cases of Ebola were reported in member states of the European Union.

For a regional organisation, the African Union (AU) was chosen. Firstly, as it is the biggest African organisation. Secondly, it was also part of the Ebola response. The Economic Community of West African States (ECOWAS) was also involved in the response to the outbreak. It was not selected for two reasons. One, as it is a subregional organisation, it does not represent as many states when compared to the other organisations. Two, because the analysis is already extensive enough.

To answer the second research question, the national security strategies/ white papers of ten states (G7 member states, Sierra Leone, Guinea and Liberia) are examined. The choice of Sierra Leone, Guinea and Liberia is obvious, as they were the three states most affected by the outbreak. The choice of the G7 member states was made as the analysis of a total of ten states is sufficiently narrow for a master's thesis.

It is acknowledged that the backgrounds (e.g. historical, political, societal) as well as dynamics within states and/ or among regional and international organisations affect (national) security strategies/ resolutions. In addition, the perception of infectious diseases as a security risk also plays a role in their securitisation. The latter, is discussed briefly in chapter 9.2.3.2.1, even though the topics are not (further) debated in this thesis. Its focus is on the (proposed) changes the 2014 Ebola outbreak caused in (national) security strategies/ resolutions of regional and international organisations and states. Whether the identified changes are advantageous/ disadvantageous or excessive/ sufficient is not judged.

In this chapter, the knowledge void, the research questions and the limitations of this thesis were presented. The following chapter introduces the hypothesis.

4. Hypothesis

As the previous chapter introduced the research questions, this chapter presents the hypothesis of this master's thesis.

Enemark states that “the health threats most suitable for securitization are outbreaks of infectious diseases.”⁶¹ The HIV/ AIDS virus, the outbreaks of SARS and H5N1 and the H1N1 pandemic, all have commonality in that they were caused by infectious diseases. Further, they were securitised to a greater or lesser extent. The 2014 Ebola outbreak is one of the latest examples that has been discussed around the globe.

When a topic is securitised on the international level (macrosecuritisation) it is considered so relevant, that it has priority over everything else.⁶² Regarding the pushing of a health topic onto international agendas/ into the field of security, the UN resolution 1308 in 2000 on HIV/ AIDS was the first resolution, which announced that the infectious disease “if unchecked, may pose a risk to stability and security.”⁶³ Yet, the UN resolution 2177 was a milestone. The resolution, passed by the UN Security Council in September 2014, declared the Ebola outbreak, the first health issue ever, to be a “threat to international peace and security.”⁶⁴

When one looks at the middle level (e.g. states), Elbe argues that “the widespread perception of microbes as “invaders” coming from “outside” maps neatly onto a pre-existing idea of national security involving the protection of populations against external threats.”⁶⁵ In most cases the state might do everything to protect its citizens from the risk (of infectious diseases)- even if this includes emergency action (e.g. closing down schools/ borders, traveller screening, travel/ trade bans, quarantine, mass vaccination). Yet, securitisation can only happen, if an audience accepts the securitisation move done by an actor. The audience can be the state itself if the securitisation happens on the international level or the public of a state if the securitisation happens on the middle level.⁶⁶

As some infectious disease outbreaks have been accelerators for securitising infectious diseases, the hypothesis of this master's thesis is:

“The 2014 Ebola outbreak led to a further securitisation of infectious diseases.”

61. Christian Enemark, *Disease and Security. Natural plagues and biological weapons in East Asia*, Contemporary security studies (London: Routledge, 2007), 8.

62. Buzan, Wæver and Wilde, *Security*, 29.

63. UN, “S/RES/1308(2000),” [https://undocs.org/S/RES/1308\(2000\)](https://undocs.org/S/RES/1308(2000)), 2, (Accessed: 10 May 2017).

64. UN, “S/RES/2177(2014),” [https://undocs.org/S/RES/2177\(2014\)](https://undocs.org/S/RES/2177(2014)), 1, (Accessed: 1 October 2017).

65. Stefan Elbe, “Should health professionals play the global health security card?,” *The Lancet* 378, no. 9787 (2011): 220, [https://doi.org/10.1016/S0140-6736\(11\)61114-8](https://doi.org/10.1016/S0140-6736(11)61114-8).

66. Buzan, Wæver and Wilde, *Security*, 21–31; Barry Buzan and Ole Wæver, “Macrosecritisation and security constellations: reconsidering scale in securitisation theory,” *Review of International Studies* 35, no. 2 (2009): 253–54, <https://doi.org/10.1017/S0260210509008511>.

Hypothesis

After the introduction of the hypothesis in this chapter, the subsequent chapter describes the method and methodology.

5. Method and methodology

This chapter presents the method and methodology used in this thesis. The analysis' procedure, its purpose and limitations are explained.

To answer the research questions and to support or refute the hypothesis, primary and secondary qualitative sources are used in this master's thesis. Primary sources include (national) security strategies, white papers as well as resolutions and other official documents. Secondary sources include mainly political science-related books and journal articles. Medical journal articles and books are utilised where necessary/ useful. Tertiary sources are used in individual cases.

The two research questions of this master's thesis are:

1. Which changes did the 2014 Ebola outbreak cause in the evaluation of infectious diseases as a security risk in security strategies/ resolutions?
2. Which changes did the 2014 Ebola outbreak cause in the evaluation of infectious diseases as a security risk in national security strategies/ white papers?

The first research question is answered by reviewing primary sources, the security strategies, of international (WHO, UN, EU) and regional (AU) organisations. Where a security strategy is absent, the analysis is undertaken based on (mainly) resolutions adopted during and after the 2014 Ebola outbreak. Regarding the selected organisations, the focus is on the WHO, as it is the most widely recognised international health organisation and infectious diseases are a health topic. Therefore, recommendations, official reports by panels/ committees and proposals to reform/ advance the WHO's work are utilised in addition to resolutions where helpful. For the other organisations, statements and proposals are not used. For the UN, the focus is on the General Assembly and the Security Council resolutions. For the EU, its security strategy is examined. The AU's analysis concentrates on the AU Assembly and the AU Executive Council. As more decisions are available for the AU as compared to resolutions, these are mainly used. Where necessary, additional official documents/ websites provided by the selected organisations are utilised.

The second research question is answered by reviewing and comparing primary sources- the national security strategies/ white papers of the G7 member states, Sierra Leone, Guinea and Liberia. It needs to be clarified that the G7 are not analysed as a group itself, but they were selected to limit the number of studied states. Further, it has to be added that only official and publicly available documents are used.

5.1 Analysis of (national) security strategies

The reason why (national) security strategies/ white papers were selected for the analysis is them being a helpful source to identify proposed changes and reactions to international occurrences.

For the EU and all states, the current and the previous (national) security strategy are examined and compared. This is done in two steps. The first step is to screen sources based on pre-selected keywords. The pre-selected keywords are:

- Ebola, disease, infectious disease, health, outbreak, epidemic, pandemic, H1N1, SARS, global health, health security, national security, international security, risk (in regard to health), threat (in regard to health).

The second step is the analysis itself based on pre-defined questions to structure the results:

- Are infectious diseases evaluated a (national) security risk?
- Is public/ global health discussed?
- Is the 2014 Ebola outbreak mentioned?
- Is international cooperation evaluated as a necessity in the fight of infectious diseases?
- Are there noticeable differences between the previous and the current (national) security strategy/ white paper?

The keywords and questions are a helpful tool to identify changes regarding the evaluation of infectious diseases as a security risk between the previous and the current (national) security strategy/ white paper. For the states, which either only published one document or which did not update it in the previously determined timeframe, the research question cannot be answered and the hypothesis cannot be supported or refuted.

The analysis of the national security strategies/ white papers has a further objective. Namely, to compare them so as to identify similarities and differences among them. This is done for all states, regardless of the timeliness of their documents. To compare them, the pre-defined questions, as well as the two additional ones listed below, are answered jointly:

- Is globalisation named as a factor for the emergence and spread of infectious diseases?
- Are biological agents/ weapons evaluated as a security risk?

5.2 Analysis of resolutions

Where no security strategy is available for a selected organisation (WHO, UN, AU), resolutions are reviewed instead.

A list of pre-selected keywords is used to filter the enormous amount of resolutions for relevant ones. The analysis' focus is mainly on resolutions, which discuss the 2014 Ebola outbreak or which name it as the reason for change/ reform.

The pre-selected keywords are:

- Ebola, infectious disease, communicable disease, health, outbreak, epidemic, pandemic, security (in regard to health)

For the United Nations the list of keywords is extended with:

- United Nations Mission for Emergency Ebola Response, UNMEER, High-Level Panel on the Global Response to Health Crises, Global Health Crises Task Force

5.3 Support/ refutation of the hypothesis

The Copenhagen School's securitisation theory is the theoretical basis of this master's thesis. The hypothesis: "The 2014 Ebola outbreak led to a further securitisation of infectious diseases." is linked to it. The theory is implemented in the results of the analysis. Based on that, the hypothesis is supported or refuted. Secondary literature, which debates securitisation, is utilised where helpful.

Limitations

The timeframe determined for the analysis of (updated) (national) security strategies/ white papers/ resolutions is January 2014 until May 2017. This period was chosen as the Ebola outbreak began in December 2013 and was declared to be over in June 2016. The timeframe was extended to May 2017 to enable a broader study of as many updated documents as possible.

This chapter illustrated the method and methodology used in this thesis. It was described how the analysis of (national) security strategies/ white papers/ resolutions is undertaken as well as its aims. Further, it was explained how the hypothesis is supported or refuted. In the following chapter, the state of the art, regarding infectious diseases as a security risk, is examined.

6. State of the Art

Humankind battled infectious diseases throughout history. The 1918 influenza pandemic, the 1957 Asian influenza and the 1968 Hong Kong influenza were the most severe cases in the past 100 years. Recent examples, which drew worldwide attention, include HIV/ AIDS, the outbreaks of SARS and H5N1, the 2009 H1N1 influenza pandemic and the 2014 Ebola outbreak. This chapter illustrates the state of the art regarding infectious diseases as a security risk. Firstly, the inclusion of infectious diseases into security, including a quick excursus on bioterrorism, is explained. Secondly, the risk of infectious diseases to national and global security is examined. Thirdly, it is discussed whether preparedness or prevention should be preferred in the fight of infectious diseases.

6.1 Infectious diseases- a (new) security risk?

The inclusion of infectious diseases as a risk to security has been up for debate for decades. Until the end of the Cold War, the definition of security was narrow, namely military and state-centred. Fidler states: "Prior to the 1990s, infectious disease control, of whatever variety, was a neglected aspect of international relations."⁶⁷ Since the end of the Cold War, the definition of security has developed from a narrow to a wider view, as "scholars of international politics have speculated that emerging and re-emerging infectious diseases may also constitute a threat to international security."⁶⁸ The narrow and the wider view of security is illustrated in chapter 9.1.1. Pirages was among the first researchers in the field of political science to discuss the "relationship among public health, governance, and security."⁶⁹ He concluded in 1995: "Infectious diseases are potentially the largest threat to human security lurking in the post-cold war world."⁷⁰ Political scientists, who also study the link between infectious diseases and security include Price-Smith, Elbe, Ostergard, Peterson, Singer, Huang, Youde, McInnes.⁷¹

Davies describes: "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."⁷² Enemark explains that "a [...] disease might be deemed a security issue [...] when its effects impose or threaten to impose an intolerable burden on society."⁷³ Other scientists, such as Price-Smith, are vaguer: "Health is the fulcrum of material power, and therefore it is central to the interests of the

67. David P. Fidler, "Germs, governance, and global public health in the wake of SARS," *Journal of Clinical Investigation* 113, no. 6 (2004): 800, <https://doi.org/10.1172/JCI200421328>.

68. Price-Smith, *Contagion and Chaos*, 1.

69. Price-Smith, *Contagion and Chaos*, 6.

70. Dennis Pirages, "Microsecurity: Disease Organisms and Human Well-Being," *The Washington Quarterly* 18, no. 4 (1995): 11, <https://doi.org/10.1080/01636609509550167>.

71. Price-Smith, *Contagion and Chaos*, 6.

72. Sara E. Davies, "Securitizing infectious disease," *International Affairs* 84, no. 2 (2008): 298, <https://doi.org/10.1111/j.1468-2346.2008.00704.x>.

73. Enemark, "Is Pandemic Flu a Security Threat?," 191.

modern sovereign state.”⁷⁴ Sands/ Mundaca-Shah/ Dzau warn that whether or not infectious diseases are perceived as a risk to security, “the rate of emergence of new infectious diseases appears to be increasing.”⁷⁵ The Independent Commission on Multilateralism agrees: “Pandemics and epidemics are occurring at an unprecedented rate in the recent years, spurred by globalization, environmental changes, and a crowded world population.”⁷⁶ How these factors contribute to the (re-)emergence and spread of infectious diseases is illustrated in chapter 8. Brachman agrees with the Commission: “We are now aware that emerging and re-emerging infections have become a significant worldwide problem.”⁷⁷

However, the impact of infectious diseases is not novel. Satcher already stated in 1995: “Infectious diseases remain the leading cause of death worldwide.”⁷⁸ Evans points out that 30 percent of approximately 50 million deaths in 1990 were due to diseases, but not even one percent because of war.⁷⁹ The 2006 US “National Strategy for Pandemic Influenza” agrees: “In terms of its scope, the impact of a severe pandemic may be more comparable to that of war or a widespread economic crisis than a hurricane, earthquake, or act of terrorism.”⁸⁰ The report of the “High-Level Panel on the Global Response to Health Crises”⁸¹ partly complies: “Over the past century, the death toll from communicable diseases has been similar to the number of people killed in conflict and natural disasters, even though the latter two receive far more attention.”⁸² Peterson and Price-Smith agree “that disease had a greater potential for the internal destabilization of states than for fomenting wars between sovereign states.”⁸³ Lo/ Thomas describe: “Health challenges- whether from infectious diseases or biohazards- represent a clear and distinct form of security threat; one that requires extraordinary measures or special organizations to properly address.”⁸⁴ This statement includes both- the natural and intentional dissemination of infectious diseases. Simultaneously, it links the wider with the narrow view of security. Enemark declares that “the impact of particular health challenges is serious enough to warrant the prioritisation traditionally.”⁸⁵

According to Cliff et al., biological weapons are one of the biggest and direct threats to global security. In the past, it used to be more difficult to get access to them as compared to nowadays.

74. Price-Smith, *Contagion and Chaos*, 1.

75. Sands, Mundaca-Shah and Dzau, “Neglected Dimension,” 1284.

76. ICM, “Global Pandemics and Global Public Health,” <https://www.ipinst.org/wp-content/uploads/2017/10/Global-Pandemics-and-Global-Public-Health1.pdf>, 1, (Accessed: 3 May 2018).

77. Brachman, “Infectious diseases,” 684.

78. David Satcher, “Emerging Infections: Getting Ahead of the Curve,” *Emerging infectious diseases* 1, no. 1 (1995): 2, <https://doi.org/10.3201/eid0101.950101>.

79. Evans, “Pandemics and National Security,” 101.

80. Homeland Security Council, “National Strategy for Pandemic Influenza. Implementation Plan,” <https://www.cdc.gov/flu/pandemic-resources/pdf/pandemic-influenza-implementation.pdf>, 2, (Accessed: 12 November 2017).

81. In the following referred to as “High-Level Panel”.

82. UN, “A/70/723: Protecting humanity from future health crises. Report of the High-level Panel on the Global Response to Health Crises,” <http://undocs.org/en/A/70/723>, 28, (Accessed: 25 November 2017).

83. Price-Smith, *Contagion and Chaos*, 191.

84. Catherine Lo Yuk-ping and Nicholas Thomas, “How is health a security issue? Politics, responses and issues,” *Health policy and planning* 25, no. 6 (2010): 449, <https://doi.org/10.1093/heapol/czq063>.

85. Enemark, “Is Pandemic Flu a Security Threat?,” 195.

Jumping back to the statement by the US National Strategy for Pandemic Influenza. It is noteworthy as it prioritises health over terrorism, which dominated US politics after 11 September 2001. While the former topic falls into the wider view of security, the latter falls into the narrow one.⁸⁶

6.2 Excursus: Bioterrorism

Bioterrorism is one factor for the (re-)emergence and spread of infectious diseases. Others are illustrated in chapter 8. This excursus is relevant, for three reasons. One, the securitisation theory is the theoretical basis of this thesis. Two, the common denominator of transmission is the (potential) risk to security. Three, the Ebola virus is among the most threatening infectious pathogens.

Infectious pathogens are typically disseminated deliberately; unless it is by accident. Therefore, bioterrorism can be linked to the field of military security, the narrow view of security. According to Price-Smith, the debate about linking health and (global) security was stopped because of the attacks of 11 September 2001. In the following time period, terrorism was evaluated to be the biggest threat to security (of the US). This was “affirmed” by the anthrax attacks in the same year. He explains that after the attacks, health and infectious diseases were mainly discussed in regard to bioterrorism.⁸⁷

6.2.1 Agents

The list of agents, which pose a major risk to public health if disseminated is rather short.⁸⁸ The CDC classifies them into three categories, from A (“high priority agents [...] that pose a risk to national security”) to C (“emerging pathogens that could be engineered for mass dissemination”).⁸⁹ Anthrax, Botulism, Plague, Smallpox, Tularemia and viral haemorrhagic fevers, which includes the Ebola virus, are classified into Category A.⁹⁰

6.2.2 Anthrax attacks 2001

While bioterrorism has a long history that goes back to the 14th century, the anthrax attacks of 2001 are probably the best-known example. The attacks happened between September and

86. A. D. Cliff et al., *Infectious Diseases. A Geographical Analysis*, Oxford geographical and environmental studies (Oxford: Oxford University Press, 2009), 472 & 482; Price-Smith, *Contagion and Chaos*, 191.

87. Price-Smith, *Contagion and Chaos*, 191.

88. Cliff et al., *Infectious Diseases*, 473; Tatem, Rogers and Hay, “Global Transport Networks,” 303; CDC, “General Fact Sheets on Specific Bioterrorism Agents,” <https://emergency.cdc.gov/bioterrorism/factsheets.asp>, (Accessed: 17 May 2018).

89. CDC, “Bioterrorism Agents/ Diseases,” <https://emergency.cdc.gov/agent/agentlist-category.asp>, (Accessed: 5 June 2017).

90. CDC, “Bioterrorism Agents/ Diseases”.

November 2001 in the US. In the first period, more infections happened through contact with the skin, in the second period infections through inhalation were dominant. In both periods there were a total of 22 cases with five being fatal. The fatality rate of anthrax is around 95 percent if untreated. There are treatments available (vaccine etc.). However, the challenge with anthrax lies in its short incubation period, the difficulty of diagnosis and the treatment of a large group of people who are (possibly) exposed to the agent.⁹¹

6.3 Infectious diseases- a risk to national and/ or global security?

There is no agreement as to whether infectious diseases pose a risk to national or global security or to both. States allocate different amounts of attention to infectious diseases in their national security strategies. Regional and international organisations also focus on the topic to a greater or lesser extent. This is analysed thoroughly in chapters 10 and 11.

Evans and Elbe link infectious diseases with national security. Evans states: "Infectious diseases threaten national security, both internally and externally."⁹² She cites HIV/ AIDS, SARS and the 2009 H1N1 influenza as examples. Elbe explains: "The rise of the new health security paradigm has even seen some health issues becoming formally incorporated into national security strategies."⁹³

Others tie infectious diseases to global security. As did Satcher back in 1995: "Infectious diseases [...] cause enormous human suffering, deplete scarce resources, impede social and economic development, and contribute to global instability."⁹⁴ In 2000, in the UN resolution 1308 it was determined that "if unchecked, [HIV/ AIDS] may pose a risk to stability and security."⁹⁵ This resolution was ground-breaking as it was the first time a public health topic had been lifted to this status. Brachman describes that geographically localised infectious diseases can have worldwide impact (e.g. Ebola).⁹⁶ The World Bank declares: "A global disease outbreak [...] represents a top global catastrophic risk."⁹⁷ The 2006 US National Strategy for Pandemic Influenza warns: "A pandemic would [...] have significant implications for the economy, national security, and the basic functioning of society."⁹⁸ The 2015 established "Commission on a Global Health Risk Framework for the Future" points out that "potential pandemics should be considered not just as important health risks but as major threats to [...] global [...] security."⁹⁹

91. Tatem, Rogers and Hay, "Global Transport Networks," 303; Cliff et al., *Infectious Diseases*, 473–79; CDC, "A History of Anthrax," <https://www.cdc.gov/anthrax/resources/history/>, (Accessed: 6 June 2017).

92. Evans, "Pandemics and National Security," 105.

93. Elbe, "Should health professionals play the global health security card?," 220.

94. Satcher, "Emerging Infections," 2.

95. UN, "S/RES/1308(2000)," 2.

96. Brachman, "Infectious diseases," 684.

97. The World Bank, "Pandemic Risk and One Health," <http://www.worldbank.org/en/topic/health/brief/pandemic-risk-one-health>, (Accessed: 10 October 2017).

98. Homeland Security Council, "National Strategy for Pandemic Influenza," 1.

99. Sands, Mundaca-Shah and Dzau, "Neglected Dimension," 1282–83.

Other sources link infectious diseases to be a risk for both- national and global security. In 2000, the US National Intelligence Council stated that (re-)emerging infectious diseases will pose a threat to US citizens (both nationally and internationally) and to armed forces overseas. Further, they will aggravate instability in states/ regions of high interest for the US.¹⁰⁰ Sands/ Mundaca-Shah/ Dzau explain: "Every government needs to recognize that protecting its people from infectious-disease threats is an integral part of national security."¹⁰¹ They continue: "Pandemics are the neglected dimension of global security."¹⁰² Chan/ Store/ Kouchner claim: "Pandemics, emerging diseases and bioterrorism are readily understood as direct threats to national and global security."¹⁰³

6.4 Infectious diseases- prevention, preparedness or both?

The following section examines whether preparedness, prevention or both is the key to fighting infectious diseases.

Brachman, the WHO and Mukherjea focus on prevention. Brachman describes: "We are making progress in controlling and preventing infectious diseases but we must not become complacent."¹⁰⁴ The WHO declares in its revision of the International Health Regulations:

The purpose and scope of these Regulations are to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.¹⁰⁵

Yet, Mukherjea warns that "isolating specific threats only as they seem to emerge creates fits and starts of attention but very little consistent, systemic thought about prevention."¹⁰⁶

Evans and Cliff et al. are among researchers aiming for preparedness. Evans claims that "preparedness- not prevention- is the solution to this escalating problem [of infectious diseases]."¹⁰⁷ Cliff et al. conclude: "Strengthened national and global surveillance and outbreak preparedness form a front line of response to the threat."¹⁰⁸ The "High-Level Panel" agrees and explains that "the broad range of actions and systems [need] to strengthen preparedness, surveillance, alert and response."¹⁰⁹

100. National Intelligence Council, "The Global Infectious Disease Threat and Its Implications for the United States," https://www.dni.gov/files/documents/infectiousdiseases_2000.pdf, 5, (Accessed: 13 May 2017).

101. Sands, Mundaca-Shah and Dzau, "Neglected Dimension," 1284.

102. Sands, Mundaca-Shah and Dzau, "Neglected Dimension," 1287.

103. Margaret Chan, Jonas G. Store, and Bernard Kouchner, "Foreign policy and global public health: working together towards common goals," *Bulletin of the World Health Organization* 86, no. 7 (2008): 498, <https://doi.org/10.2471/BLT.08.056002>.

104. Brachman, "Infectious diseases," 685.

105. WHO, "WHA 58.3: Revision of the International Health Regulations," http://www.who.int/ipcs/publications/wha/ihr_resolution.pdf, 14, (Accessed: 16 September 2017).

106. Ananya Mukherjea, "The social politics of pandemic influenzas: the questions of (permeable) international, inter-species, and interpersonal boundaries," in Mukherjea, *Understanding Emerging Epidemics: Social and Political Approaches*, 138.

107. Evans, "Pandemics and National Security," 100.

108. Cliff et al., *Infectious Diseases*, 482.

109. UN, "A/70/723," 23.

Others aim for a combination of prevention and preparedness (e.g. World Bank).¹¹⁰ Sands/Mundaca-Shah/ Dzau agree: “Investment in prevention and preparation is worth much more than spending on response, and the best response is a well-prepared one.”¹¹¹ Mukherjea declares that it would be more important “to produce public health and emergency systems that are always prepared and that focus on real prevention rather than just controlling scared populations after a disease threat materializes.”¹¹²

This chapter examined the state of the art regarding infectious diseases as a security risk. In the beginning, the inclusion of infectious diseases into security was illustrated. This was followed by an excursus to bioterrorism. Subsequently, it was discussed whether infectious diseases are a risk to national or global security. Lastly, it was debated whether preparedness or prevention is the preferable option. The following chapter provides an overview of infectious diseases throughout history, with focus on the 1918 influenza pandemic and the 2014 Ebola outbreak.

110. The World Bank, “Pandemic Risk”.

111. Sands, Mundaca-Shah and Dzau, “Neglected Dimension,” 1287.

112. Mukherjea, “Social politics,” 127.

7. Infectious diseases throughout history

Infectious diseases have claimed millions of lives throughout history and have been documented well. The chapter starts with a brief overview of infectious diseases- whether epidemic or pandemic- to understand their impact on humankind.¹¹³ This is followed by an excursus about the 1918 influenza pandemic. Subsequently, the Ebola virus is illustrated and a timeline chronicling the events of the 2014 Ebola outbreak is presented.

7.1 Infectious diseases until 1900

The first documented infectious disease outbreak dates back to the epidemic in Athens, “Plague of Athens”, 430-427 B.C.E.¹¹⁴ For 25-35 percent of the Athenian population the epidemic was fatal.¹¹⁵

Another major epidemic was the “Plague of the Antonines”, which began in 165 and lasted approximately until 180 C.E.¹¹⁶ It caused about five million deaths among the Roman Empire’s population.¹¹⁷

The “Plague of Cyprian” was said to be equally, or even more, devastating.

The first plague pandemic, the “Plague of Justinian”, lasted from 541-544 C.E. The reported mortality rate varies enormously, between 5,000-10,000 daily. Rosen claims that this pandemic was fatal for a quarter million people.¹¹⁸

The “Black Death” or “Great Plague”, the second plague pandemic, began in 1346 and lasted approximately until 1353. The reported fatality rate varies from 30-40 percent. Other estimations suggest a mortality rate of up to 60 percent of the European population.¹¹⁹

According to Tatem/ Rogers/ Hay, the bubonic plague killed at least 200 million people between the 14th and the 17th century.¹²⁰

The third cholera pandemic lasted from 1839 until 1856 and spread nearly worldwide. The mortality rate was between 5-15 percent of the affected cities’ population.¹²¹

113. The dates/ time frames of infectious diseases and numbers of fatalities varies among sources. These differences are recognised, but “neglected” as this chapter focusses on the impact of infectious diseases.

114. B.C.E.: Before the Common/ Christian era.

115. Hays, *Epidemics and Pandemics*, 1.

116. C.E.: Common/ Christian Era.

117. Hays, *Epidemics and Pandemics*, 17.

118. Hays, *Epidemics and Pandemics*, 18; William Rosen, *Justinian's Flea: Plague, Empire, and the Birth of Europe* (New York: Viking, 2007), 3.

119. Hays, *Epidemics and Pandemics*, 41–43.

120. Tatem, Rogers and Hay, “Global Transport Networks,” 295–96.

121. Hays, *Epidemics and Pandemics*, 227–31.

7.2 Infectious diseases after 1900

The influenza pandemic of 1918-1919 came in three waves. The number of deaths varies immense- from 25 million to 50 million, even figures as high as 100 million are argued.¹²²

In 1957 the “Asian Influenza” was the next influenza, killing between one and two million people.¹²³

Between 1968-1970, the “Hong Kong influenza” spread globally. This pandemic was the third influenza pandemic in the 20th century, resulting in between one to four million deaths.¹²⁴

HIV/ AIDS was first reported in 1981 and has claimed between 20-42 million lives since then. By the end of 2014, about 37 million people were living with HIV. Aside from the possibility of death, it can also have effects on life expectancy. For example, in parts of sub-Saharan Africa, the life span dropped from about 55 to under 40 years within about 20 years.¹²⁵

In February 2003, the first case of SARS was reported. It spread to North America, South America, Europe and Asia before being contained. 774 of the more than 8,000 cases were fatal.¹²⁶

The Avian flu, also called “bird flu”, re-emerged in 2003 and 2004 after it first infected humans in 1997. It is one of a few influenza viruses, which infects animals and humans. After its re-emergence, it spread from Asia to Europe and Africa. Because of the comprehensive data and experience available with influenza viruses, the WHO has reported the number of worldwide deaths at around 280 cases between 2003-2009.¹²⁷

The H1N1 virus, also called “swine flu” (2009-2010), had its origin in “animal influenza viruses and is unrelated to the human seasonal H1N1 viruses that have been in general circulation among people since 1977.”¹²⁸ It was first identified in spring 2009 in North America and spread to more than 200 states and territories. In June 2009, the WHO declared it to be a pandemic. The organisation confirmed more than 18,000 deaths resulting from the H1N1 virus. It also announced that the actual number is higher, but numerous fatalities were not examined or identified as related to the influenza. A 2012-published study estimated the number of deaths caused by H1N1 pandemic to be about 200,000 and additional more than 80,000 deaths associated with it.¹²⁹

122. Hays, *Epidemics and Pandemics*, 385; Taubenberger and Morens, “1918 Influenza,” 15–16; Evans, “Pandemics and National Security,” 105; Barry, *The Great Influenza*, 397.

123. Encyclopaedia Britannica, “Asian flu of 1957,” <https://www.britannica.com/event/Asian-flu-of-1957>, (Accessed: 27 March 2017).

124. Encyclopaedia Britannica, “Hong Kong flu of 1968,” <https://www.britannica.com/event/Hong-Kong-flu-of-1968>, (Accessed: 27 March 2017).

125. UNAIDS, “Fact sheet,” <http://www.unaids.org/en/resources/campaigns/globalreport2013/factsheet>, (Accessed: 27 March 2017); WHO, “HIV/ AIDS,” <http://www.who.int/gho/hiv/en/>, (Accessed: 27 March 2017); Hays, *Epidemics and Pandemics*, 440.

126. CDC, “CDC SARS Response Timeline,” <https://www.cdc.gov/about/history/sars/timeline.htm>, (Accessed: 28 March 2017); WHO, “Summary of probable SARS cases”.

127. WHO, “Influenza (Avian and other zoonotic),” [http://www.who.int/en/news-room/fact-sheets/detail/influenza-\(avian-and-other-zoonotic\)](http://www.who.int/en/news-room/fact-sheets/detail/influenza-(avian-and-other-zoonotic)), (Accessed: 25 March 2017); WHO, “Cases for avian influenza A (H5N1)”.

128. WHO, “What is the pandemic (H1N1) 2009 virus?,” http://www.who.int/csr/disease/swineflu/frequently_asked_questions/about_disease/en/, (Accessed: 27 March 2017).

129. WHO, “What is the pandemic (H1N1) 2009 virus?,” WHO, “Pandemic (H1N1) 2009- update 101,” http://www.who.int/csr/don/2010_05_21/en/, (Accessed: 28 January 2017); Fatimah S. Dawood et al., “Estimated global mortality associated with the first 12 months of 2009 pandemic influenza A H1N1 virus circulation: a modelling study,” *The Lancet Infectious Diseases* 12, no. 9 (2012), [https://doi.org/10.1016/S1473-3099\(12\)70121-4](https://doi.org/10.1016/S1473-3099(12)70121-4).

The Ebola virus was first documented in 1976 simultaneously in-what is now called- South Sudan and in a village in the Democratic Republic of Congo. The disease re-emerged in 2014 in West Africa, claiming 11,310 confirmed deaths until May 2016.¹³⁰

7.3 Persistent infectious diseases

Some infectious diseases were not mentioned in the overview. They are persistent and have been re-emerging for centuries (e.g. malaria, tuberculosis, cholera).

Malaria was first reported in Ancient Rome. In 2016, 91 states continued to have cases of malaria. For that year only, the WHO estimated over 200 million cases of malaria and more than 440,000 deaths. The organisation's goal is to decrease cases and deaths resulting from malaria each by 90 percent by 2030 and erase it in a minimum 35 states.¹³¹

Tuberculosis' origins are argued about among scientists. However, Robert Koch discovered the bacteria responsible for the disease in 1882. In 2016, more than one and a half million people died from tuberculosis. The WHO estimates that almost 500,000 people have a multidrug-resistant tuberculosis. The organisation aims to decrease deaths resulting from tuberculosis by 95 percent and to reduce new tuberculosis cases by 90 percent by 2035.¹³²

Cholera became a pandemic in 1817 after being endemic in India for some time before that. If untreated, it can lead to death within hours. Between one to four million people get infected every year, resulting in up to about 140,000 deaths. Nowadays, cholera is either epidemic or endemic (e.g. parts of Africa, South America and southern Asia).¹³³

7.4 Excursus: The 1918 influenza pandemic

The reasons for this excursus are: One, the 1918 influenza pandemic was the most significant and widespread infectious disease in modern history, claiming millions of deaths. Taubenberger/Morens even call it the "mother of all pandemics" as it had a 5-20 times higher mortality rate as compared to the "typical" influenza.¹³⁴ Two, it changed the standards for treating infectious diseases and for hygiene. It is, therefore, a "reference point" when discussing infectious diseases. Three, it demonstrated the possible effects an infectious disease can have on various sectors. This excursus starts with an overview of the course of the pandemic. Subsequently, the reasons

130. Oldstone, *Viruses, Plagues, and History*, 219.; WHO, "Ebola data and statistics: Situation summary".

131. Hays, *Epidemics and Pandemics*, 9; WHO, "Malaria," <http://www.who.int/mediacentre/factsheets/fs094/en/>, (Accessed: 26 March 2017).

132. Hays, *Epidemics and Pandemics*, 466; WHO, "Tuberculosis," <http://www.who.int/en/news-room/factsheets/detail/tuberculosis>, (Accessed: 26 March 2017).

133. Hays, *Epidemics and Pandemics*, 193–200; WHO, "Cholera," <http://www.who.int/mediacentre/factsheets/fs107/en/>, (Accessed: 10 April 2017); Tatem, Rogers and Hay, "Global Transport Networks," 298.

134. Taubenberger and Morens, "1918 Influenza," 15 & 20.

for its severity, the factors that contributed to its spread and the pandemic's effects on sectors is illustrated.

7.4.1 Facts about influenza

The World Health Organization defines influenza as follows: "A viral respiratory infection that affects the nose, throat, bronchi and, occasionally, the lungs. [...] [It] is characterized by sudden onset of high fever, aching muscles and joints, headache and severe malaise, non-productive cough, sore throat and rhinitis."¹³⁵ Influenza is transmitted via air (e.g. coughing or sneezing) or via direct contact (e.g. shaking hands). According to the CDC, it might also be possible to contract influenza via surfaces with the virus on it, when touching one's mouth, eyes or nose afterwards. The usual duration of the infection is about one week, while most people do not require medical treatment. However, in some cases (e.g. very young, elderly, people with certain medical conditions) influenza can lead to serious complications of existing medical conditions, pneumonia and even death. It is possible to transmit influenza already one day before the development of symptoms and up to seven days after. During seasonal epidemics the disease tends to spread swiftly. There exist three types of influenza viruses (A, B and C), which are known to infect humans. Influenza A viruses are classified into subtypes (hemagglutinin (H) and neuraminidase (N)) and strains (e.g. H1N1, H3N2 (e.g. "Hong Kong influenza") etc.). The H1N1 virus is mostly associated with the 2009 influenza pandemic ("swine flu"), while a variation of a H1N1 virus also caused the 1918 influenza pandemic.¹³⁶

7.4.2 The three waves of the 1918 influenza pandemic

The pandemic lasted from 1918 until 1919 and came in three waves. Approximately 20 to 40 percent of the world population (around 500 million people) got infected. While other influenza pandemics had a fatality rate of less than 0.1 percent, the 1918 influenza pandemic one was more than two and a half percent. The reported number of deaths varies immensely- from 25 over 50 million to as high as 100 million people.¹³⁷

There exist different opinions about the origins of the 1918 influenza pandemic. One, it began in Spain, as it is often called "Spanish Flu". Hays argues this is as a result of it appearing there in spring of 1918. Oldstone, in turn, explains that because Spain did not participate in World War I,

135. WHO, "Influenza," <http://who.int/topics/influenza/en/>, (Accessed: 11 April 2017).

136. WHO, "Influenza (Seasonal)," <http://www.who.int/mediacentre/factsheets/fs211/en/>, (Accessed: 27 April 2017); CDC, "Key Facts About Influenza"; WHO, "Influenza"; CDC, "Types of Influenza Viruses," <https://www.cdc.gov/flu/about/viruses/types.htm>, (Accessed: 5 April 2018); Jeffery K. Taubenberger, "The Origin and Virulence of the 1918 "Spanish" Influenza Virus," *Proceedings of the American Philosophical Society* 150, no. 1 (2006): 90.

137. Hays, *Epidemics and Pandemics*, 385; The World Bank, "Pandemic Risk"; CDC, "Past Pandemics," <https://www.cdc.gov/flu/pandemic-resources/basics/past-pandemics.html>, (Accessed: 7 June 2018); Evans, "Pandemics and National Security," 105; Oldstone, *Viruses, Plagues, and History*, 306; Taubenberger and Morens, "1918 Influenza," 15–16; Barry, *The Great Influenza*, 397.

it had no reason to hide diseases from opponents. Two, the pandemic began in the US and spread to Europe during the war. Three, its origin may have been in China, as several influenza pandemics first appeared there.¹³⁸

The first wave

Researchers and sources are not unified as to the exact time frames of each wave and the states/ areas the pandemic spread to. Hays claims, the first wave began in March 1918 and transmitted through the US to Europe, Asia and Australia. Taubenberger/ Morens call the first wave “the spring wave” and mark its beginning to March 1918 too, whereas they only mention the US and Europe as areas the pandemic spread to. Yet, they state there is a possibility it spread to Asia as well.¹³⁹

The second wave

Hays claims that the second wave started in August 1918 and lasted until November. According to him, it started with the pandemic’s re-emergence in France and its transmission from Europe to the US and Africa. In the following months, the influenza pandemic spread to Asia, Siberia and some Pacific islands (Guam, Western Samoa, Tahiti). Only Iceland and American Samoa had zero cases. Taubenberger/ Morens claim the second wave, which they call “the fall wave”, started in September 1918, but they agree with Hays that the end was in November. However, they do not point out specific states, which battled the pandemic as they only disclose that the second wave spread globally.¹⁴⁰

The third wave

Hays is specific about the third wave. He explains it began in January 1919 and occurred in the US and Australia. Taubenberger/ Morens mention the third wave only briefly by stating it appeared in numerous states in early 1919. According to Hays, the last wave was mild in contrast to the first two ones. Taubenberger/ Morens disagree and claim that the first wave was mild compared to the latter two.¹⁴¹

7.4.3 Reasons for the severity of the 1918 influenza pandemic

According to Taubenberger/ Morens, the 1918 influenza pandemic claimed so many lives as three influenza waves occurred within a year; a precedent. In addition, the spring and fall wave happened at a time of the year unusual for an influenza virus. Taubenberger/ Morens, Hays and

138. Taubenberger and Morens, “1918 Influenza,” 15–16; Oldstone, *Viruses, Plagues, and History*, 309; Hays, *Epidemics and Pandemics*, 385 & 393–394.

139. Hays, *Epidemics and Pandemics*, 385–86; Taubenberger and Morens, “1918 Influenza,” 17.

140. Hays, *Epidemics and Pandemics*, 386–87; Oldstone, *Viruses, Plagues, and History*, 308; Taubenberger and Morens, “1918 Influenza,” 17.

141. Hays, *Epidemics and Pandemics*, 387–88; Taubenberger and Morens, “1918 Influenza,” 16–17.

Oldstone agree that the 1918 influenza pandemic was outstanding because of its severity for young adults. In general, young children or old people have higher mortality rates with the majority of infectious diseases. This usually shows as an “U-shape” in graphs. The 1918 influenza pandemic was different. The graph was a “W-shape” as young adults (18-35) had a more than 20 times higher mortality. This caused nearly half of the pandemic-related fatalities. Hays states that the Asian and African population had a higher possibility of death because of the pandemic. While the low caste in India as well as the American Indian had a high mortality rate, the African Americans did not. This leads Hays to the assumption that there is no clear connection between class and/ or race and mortality during the pandemic.¹⁴²

7.4.4 Factors for the spread of the 1918 influenza pandemic

Hays names several causes that benefitted the pandemic’s rapid transmission and reactions to it. Firstly, World War I: during the war, large armies were in Europe. The demand for soldiers and labourers was great, which led to the transportation of masses of people. This in turn, led to contagion because of the large number of people on the crowded ships. Further, the war front itself involved a higher risk of infection along with other infectious diseases (e.g. typhus, tuberculosis), which resulted in a further weakening of people’s immune systems. In addition, people often protested against the war and the millions of lost lives. These gatherings were another factor for the rapid spread. Secondly, growing population and cities, which led to more people living in more crowded areas, enabled the 1918 influenza pandemic’s dissemination. Thirdly, steamships and railroads advanced the transportation of larger crowds, which was a risk itself in transmitting infectious diseases. Fourthly, faster transportation accelerated the pandemic’s spread. For example, in areas in Africa without no railroad, the 1918 influenza disseminated much slower compared to areas with railroads.¹⁴³

7.4.5 Reactions to the 1918 influenza pandemic

Reactions to the pandemic, as pointed out by Hays, include the closing of public buildings, the wearing of gauze masks, prohibitions on spitting¹⁴⁴ and the fumigation of areas. Quarantines were also put in place, albeit with limited effects due to the rapid and global spread. However, Australia had an efficient quarantine as it was able to keep the second wave of the influenza pandemic out. American Samoa and Alaska are other examples of successful quarantines. While vaccinating

142. Taubenberger and Morens, “1918 Influenza,” 17 & 19; Oldstone, *Viruses, Plagues, and History*, 307; Hays, *Epidemics and Pandemics*, 387 & 394.

143. Hays, *Epidemics and Pandemics*, 387–93.

144. During that time, chewing tobacco was popular; with the side effect of spitting.

the population was not successful, doctors could only focus on minimising infected people's pain. Another reaction to the pandemic was people trying to flee from it; mostly unsuccessful.¹⁴⁵

7.4.6 Effects on necessary public services

According to Hays, the effects of the 1918 influenza pandemic were not only severe because of the high mortality, but it also led to the collapse of necessary public services in several states. Even nowadays, governments aim to avoid this scenario. Two examples underscore the pandemic's effects on various sectors. During the war in 1918, when labour was already in high demand, the pandemic's rapid transmission resulted in millions of sick and dead people. This was too much for the states to keep running. Particularly morticians and gravediggers were required; both of which were only available in limited numbers.

As mentioned above, the mortality rate was much higher in Asia and Africa compared to Western states. In Nigeria, for example, this resulted in a labour shortfall, which led to difficulties for the food production. As a result, the cultivation of another crop, demanding less labour, was chosen. This changed agriculture and human diets. In India, the case was similar. The high mortality among young adults caused a decline in population growth and a shrinkage of labour in the agricultural sector. Its effects appeared in the following decades.¹⁴⁶

Taubenberger/ Morens raised the question whether a 1918-comparable pandemic could appear again and conclude that with comparable conditions it could be similarly devastating.¹⁴⁷ They add: "Even with modern antiviral and antibacterial drugs, vaccines, and prevention knowledge, the return of a pandemic virus equivalent in pathogenicity to the virus of 1918 would likely kill >100 million people worldwide."¹⁴⁸ A pandemic virus with the (alleged) pathogenic potential of some recent H5N1¹⁴⁹ outbreaks could cause substantially more deaths."¹⁵⁰ According to the WHO, the annual deaths resulting from influenza epidemics, lie between 250,000 and 500,000.¹⁵¹ With this number in mind, Taubenberger/ Morens' statement clearly points out the risk infectious diseases can pose to a society and to the security of states, regions and even on a global scale.

145. Hays, *Epidemics and Pandemics*, 390–95.

146. Hays, *Epidemics and Pandemics*, 387–95.

147. Taubenberger and Morens, "1918 Influenza," 20.

148. Calculating the world population with seven and a half billion people, the mortality rate of such an influenza pandemic would be around one point three percent.

149. H5N1 is a highly infectious type of bird flu. While it is uncommon for this type of influenza virus to spread to humans, there is a possibility of the virus changing over time. It could, therefore, become a threat to humans, as its mortality rate of infected humans is around 60 percent. WHO, "FAQs: H5N1 influenza".

150. Taubenberger and Morens, "1918 Influenza," 21.

151. WHO, "Influenza (Seasonal)".

7.5 The 2014 Ebola outbreak

Based on the thesis's focus on the 2014 Ebola outbreak, it is key to understand this disease. Therefore, this section starts with a quick explanation of the Ebola virus to understand and emphasize its threat. Subsequently, a timeline of the outbreak illustrates its quick spread.

The Ebola virus first emerged in 1976 in Africa in- what is now called- South Sudan and in a village in the Democratic Republic of Congo (known as Zaire until 1997). It got its name from a river near this village. The mortality rate was 53 percent in South Sudan and 88 percent in the Democratic Republic of Congo. Over the decades the virus re-emerged several times, mainly in Africa, with two bigger outbreaks in 1995 and 2007; both times in the Democratic Republic of Congo. Both outbreaks had a fatality rate of around 75 percent. In 2014, the Ebola virus re-emerged in West Africa and led to more cases within this outbreak alone, than in all prior outbreaks combined.¹⁵²

7.5.1 Facts about the Ebola virus

Incubation time with the Ebola virus is from two to 21 days. People begin to be contagious when they start to have symptoms. In the beginning, “the dry phase”, symptoms include “sudden onset of fever, intense weakness, muscle pain, headache and sore throat.”¹⁵³ Later, in “the wet phase”, infected people “develop vomiting and diarrhoea [...], rash, impaired kidney and liver function, and in some cases, both internal and external bleeding.”¹⁵⁴ Until the end of 2016, there was no treatment available for the Ebola virus. It was only possible to treat specific symptoms and re-hydrate with fluids (oral or intravenous).¹⁵⁵ On 23 December 2016, the WHO announced: “An experimental Ebola vaccine was highly protective against the deadly virus in a major trial in Guinea [...]. The vaccine is the first to prevent infection from one of the most lethal known pathogens.”¹⁵⁶ However, there are no long-term studies available as of yet. Plus, it is unclear whether the vaccine would be effective (enough) should the strain change.

The Ebola virus can be spread in several ways. It can be contracted “through contact with infected animals (usually following butchering, cooking, or eating).”¹⁵⁷ Its main transmission is via direct contact with infected body fluids (e.g. blood). It can also survive in body fluids for numerous days at room temperature. Dissemination through droplets from an infected person is another possibility of spread. Further, the Ebola virus can survive on surfaces and items (e.g. doorknobs, countertops, clothes, bedding, gloves, protective equipment, medical waste) for several hours.

152. Oldstone, *Viruses, Plagues, and History*, 219; WHO, “Ebola virus disease”.

153. WHO, “Frequently asked questions”.

154. WHO, “Frequently asked questions”.

155. WHO, “Ebola virus disease”.

156. WHO, “Final trial results”.

157. WHO, “Frequently asked questions”.

Burial ceremonies can be another method of transmission. It is even possible to contract the disease through sexual contact with an infected or recovered person; however, studies on this are ongoing. The average fatality rate of the Ebola virus is 50 percent, with variations from 25 percent to as high as 90 percent. Ebola survivors are “immune” to the disease. Yet, it is unclear whether the immunity is for some time, lifelong or to a certain strain only.¹⁵⁸

7.5.2 Timeline of the 2014 Ebola outbreak

The focus of the subsequent timeline is one, to provide an extensive overview of the outbreak, which builds the basis for the following chapters. Two, the data presented is focused on political science and the topic of this master’s thesis, in specific. While the timeline aims to be as thorough as possible, it is not chronicling all events.

The Ebola outbreak began in December 2013, near the border of Sierra Leone, Guinea and Liberia. A two-year-old contracted the virus, but because of unawareness of the disease it was not detected as an Ebola case by Guinean health officials. The virus would later spread to urban areas, which had not happened in previous outbreaks.¹⁵⁹

In the beginning, the outbreak was downplayed by Sierra Leone, Guinea and Liberia. According to the report of the “High-Level Panel”, this happened because of political reasons, as the affected states feared the international community’s reaction and a possible declaration of a Public Health Emergency of International Concern (PHEIC). In addition to the delayed report, the WHO and other organisations underestimated the outbreak and its dimensions. For a better understanding of the events listed in this timeline, it is key, at this point, to briefly name further causes that contributed to the (re-)emergence and spread of the Ebola virus. The factors, the role of fear and the deficiencies at the international level are discussed in chapters 8.1 to 8.4. Firstly, the public did not take the outbreak seriously. Secondly, the public distrusted the government and health workers. An example of this distrust is health staff that wore special clothing to avoid infection, but looked unfamiliar to the already sceptical public. Plus, there were rumours the disease was invented to receive aid from the international community. Thirdly, the removal of infected people who never returned to their communities. This resulted in families hiding sick family members and unsafe burials continued to take place. Fourthly, violence/ riots against officials (e.g. health workers, educators, police, media). Fifthly, lack of treatment resulting from the absence of health personnel who feared contagion. Lastly, the stigmatisation of infected people and survivors.¹⁶⁰

158. CDC, “Ebola. Transmission”; Oldstone, *Viruses, Plagues, and History*, 216–17; WHO, “Frequently asked questions”; WHO, “Ebola virus disease”.

159. CDC, “Ebola. Transmission”; UN, “Timeline”; Gostin and Friedman, “Analysis,” 1902.

160. UN, “A/70/723,” 25 & 30; CDC, “Ebola. Transmission”; Gostin and Friedman, “Analysis,” 1902; UN, “Timeline”.

In March 2014, the Ebola virus was confirmed in Guinea and Liberia. To avoid transmission, Senegal closed the border to Guinea.

In early April the WHO Assistant Director-General Health Security already stated that the ongoing Ebola outbreak was a very challenging one.¹⁶¹ Reasons why were, aside from the wide dispersal in Guinea and Liberia, “high levels of public anxiety, rumours and misperceptions.”¹⁶²

Sierra Leone made a confirmation of Ebola in late May of 2014.

In June, Sierra Leone closed several schools and the borders to Liberia and Guinea.¹⁶³ How this and other extreme measures can affect a state and even whole regions is illustrated in chapters 8 and 9. On 21 June Médecins Sans Frontières (MSF) director of operations announced that Ebola was “out of control”.¹⁶⁴ At the end of the month, the Ebola virus was confirmed in and across three states. The numbers of infections rose fast, even among health staff, and resulted in numerous deaths.¹⁶⁵

In July, the Ebola virus spread to Nigeria through an airline passenger. At that time already the outbreak was the most severe in history. A Nigerian airline discontinued flights to the capitals of Sierra Leone and Liberia. In the following months, several other airlines also suspended their flights to the capitals of Sierra Leone, Guinea and Liberia or to the states altogether. Liberia closed its borders, schools/ universities and banned football events. In addition, a quarantine for parts of the state was declared.¹⁶⁶

In early August, American and Spanish patients, who had contracted the Ebola virus, were flown out to the US and Spain. To slow down/ stop transmission, Liberia instructed the cremation of Ebola fatalities. On 8 August, the WHO’s Director-General issued a PHEIC. Days later, the WHO authorised the application of untested drugs and vaccines. In the same month, Liberia imposed a nationwide curfew and a “cordon sanitaire”, which provoked violence. At the end of August, a traveller from Guinea spread the virus to Senegal. At the same time, Liberia began to deny sailors entry to the state through its seaports. Over the months, international financial aid slowly started to flow. By September, it reached more than 900 million US Dollars; with the biggest donations by the World Bank and the US.¹⁶⁷

In the beginning of September, Guinea closed its schools. Plus, several journalists and health workers were killed as rioters protested against the presence of health personnel. Later in September, Sierra Leone enforced a nationwide three day lockdown to educate households about the Ebola virus.¹⁶⁸ On 18 September, the UN Security Council passed resolution 2177, in which it was determined “that the unprecedented extent of the Ebola outbreak in Africa constitutes a

161. UN, “Timeline”.

162. UN, “Timeline”.

163. UN, “Timeline”.

164. Médecins Sans Frontières, “Ebola in West Africa: ‘The epidemic is out of control’,” <http://www.msf.ca/en/article/ebola-west-africa-epidemic-out-control>, (Accessed: 18 June 2017).

165. UN, “Timeline”; Gostin and Friedman, “Analysis,” 1902.

166. UN, “Timeline”.

167. UN, “A/70/723,” 26; UN, “Timeline”; Gostin and Friedman, “Analysis,” 1902.

168. UN, “Timeline”.

threat to international peace and security.”¹⁶⁹ This resolution was a milestone for several reasons. Firstly, it was supported by 134 members. Secondly, it is one of only three resolutions, in which the UN Security Council addressed a global health concern. Thirdly, it was the first resolution, in which the UN Security Council declared the international peace and security to be threatened by a health issue. On 19 September, the UN General Assembly adopted resolution 69/1 on Ebola by consensus. The same day, the UN Secretary-General established the UN Mission for Emergency Ebola Response (UNMEER) with the duty of helping response in affected regions.¹⁷⁰ UNMEER is the first “UN emergency health mission.”¹⁷¹ In the following months, the international community organised, according to the report of the “High-Level Panel”, “the largest ever epidemic response effort in history.”¹⁷² The financial support exceeded six billion US Dollars. Material donations included communication, medical and infrastructural equipment among others. Several Non-Governmental Organisations (e.g. MSF) managed the work on the front lines.¹⁷³ On 26 September, the WHO declared the Ebola outbreak to be “the most severe acute public health emergency seen in modern times.”¹⁷⁴ At the end of September, the virus spread to the US (Texas) where it was diagnosed with a traveller from Liberia and two nurses also contracted it. Later, a medical worker from New York, who had helped in Guinea, also got infected with Ebola. Hence, people were screened thoroughly and some states put workers, who returned from affected areas, in quarantine.¹⁷⁵

In October, riots broke out in a district in Sierra Leone to block the quarantine of a suspected Ebola patient. Consequently, a daytime curfew was instituted. Meanwhile, Ebola had spread to Mali. UNMEER began its work on 30 October with a set operation date of 30 days. The Mission reached its goal¹⁷⁶ to get the crisis under control by December 2014. In the following months, fewer cases were reported in all of the most affected states (Sierra Leone, Guinea, Liberia).¹⁷⁷

At the end of 2014, Liberia exchanged mandated cremation with safe burials.

In January 2015, a clinical trial for a probable treatment for Ebola began in Liberia. In the same month, Guinean schools re-opened after being closed for about four months. Sierra Leone lifted

169. UN, “S/RES/2177(2014),” 1.

170. Michael R. Snyder, “Security Council Response to Ebola Paves Way for Future Action,” <https://theglobalobservatory.org/2014/12/security-council-response-ebola-action/>, (Accessed: 23 June 2017); UN, “A/RES/69/1: Measures to contain and combat the recent Ebola outbreak in West Africa,” <https://undocs.org/A/RES/69/1>, (Accessed: 26 November 2017); WHO, “WHO and UN response to Ebola,” <http://who.int/un-collaboration/partners/ebola/en>, (Accessed: 26 November 2017); Gostin and Friedman, “Analysis,” 1903; UN, “UN Mission for Ebola Emergency Response (UNMEER),” <http://ebolaresponse.un.org/un-mission-ebola-emergency-response-unmeer>, (Accessed: 8 June 2017).

171. UN, “UNMEER”.

172. UN, “A/70/723,” 26.

173. UN, “A/70/723,” 26.

174. WHO, “Experimental therapies”.

175. Gostin and Friedman, “Analysis,” 1903.

176. “The United Nations had set targets for December 1 [2014] of 70 percent of burials being done safely and 70 percent of new cases being placed in treatment facility in order to end the outbreak.” UNifeed, “Unmeer/ Banbury Nabarro Presser,” <http://www.unmultimedia.org/tv/unifeed/asset/1255/1255450/>, (Accessed: 1 February 2018).

177. UN, “Timeline”; UNifeed, “Unmeer/ Banbury Nabarro Presser”; Gostin and Friedman, “Analysis,” 1903.

movement limitations, but re-established them only a month later after new cases were reported. Senegal re-opened the border to Guinea.¹⁷⁸

In February, tests for a new vaccine to treat Ebola began in Liberia. Guinea permitted the application of an experimental drug to fight the virus. Sierra Leone imposed quarantine over several hundreds of homes for a duration of three weeks. In addition, health personnel were sent out to look for hidden Ebola-infected people. After seven months, Liberia re-opened its schools and borders and lifted the nationwide curfew.

At the end of March, Sierra Leone imposed a three-day shutdown to reach zero cases. After this, several hundred new probable Ebola cases were discovered.¹⁷⁹

In April, the UN Secretary-General appointed the “High-Level Panel on Global Response to Health Crises”. Its assignment was “to make recommendations to strengthen national and international systems to prevent and manage future health crisis, taking into account lessons learned from the response to the outbreak of the Ebola virus disease.”¹⁸⁰ In addition, the Secretary-General also established the “Global Health Crises Task Force” “to monitor the implementation of the recommendations of the High-level Panel.”¹⁸¹ Its work began in July 2016 and was set out for one year.¹⁸²

In May, a confirmed case of Ebola was reported in Italy.

In July, the UN Secretary-General, the governments of Sierra Leone, Guinea and Liberia, the AU, the African Development Bank, the EU and the World Bank came together at the “International Ebola Recovery Conference”. On 31 July 2015, UNMEER closed.¹⁸³

Gostin/ Friedman stated in May 2015 that “until there are zero cases, the epidemic is not over. Reasonable concerns persist that Ebola could become endemic in Guinea and Sierra Leone, or re-emerge in Liberia.”¹⁸⁴ The risk of a re-emergence of the Ebola virus proved to be true as all three most affected states were declared free from transmission one or more times. Yet, new cases were reported afterwards.

At the end of March 2016, the PHEIC for the Ebola outbreak was terminated.

In June 2016, the WHO confirmed the end of the Ebola outbreak for the last time.¹⁸⁵

178. UN, “Timeline”.

179. UN, “Timeline”.

180. UN, “Secretary-General Appoints High-Level Panel on Global Response to Health Crises,” <https://www.un.org/press/en/2015/sga1558.doc.htm>, (Accessed: 15 October 2017).

181. UN, “Global Health Crises Task Force,” <http://www.un.org/en/global-health-crises-task-force/index.html>, (Accessed: 15 October 2017).

182. UN, “Global Health Crises Task Force”.

183. UN, “Timeline”; UN, “A/70/723,” 85.

184. Gostin and Friedman, “Analysis,” 1903.

185. UN, “Timeline”; UN, “A/70/723,” 27; WHO, “WHO statement on end of Ebola flare-up in Sierra Leone,” <http://www.who.int/mediacentre/news/statements/2016/end-flare-ebola-sierra-leone/en/>, (Accessed: 5 August 2017); WHO, “End of the most recent Ebola virus disease outbreak in Liberia,” <http://www.who.int/mediacentre/news/releases/2016/ebola-liberia/en/>, (Accessed: 5 August 2017); WHO, “Statement on the 9th meeting of the IHR Emergency Committee regarding the Ebola outbreak in West Africa,” <http://www.who.int/mediacentre/news/statements/2016/end-of-ebola-pheic/en/>, (Accessed: 13 May 2018); WHO, “Ebola outbreak 2014-2015,” <http://www.who.int/csr/disease/ebola/en/>, (Accessed: 15 August 2017).

According to the World Health Organization, the number of confirmed cases in the West Africa region was 15,227. After adding suspected, probable and cases after 2015, this number increases to 28,616- almost double than the confirmed cases. One reason for this big difference in numbers is the difficulty to diagnose the virus as it can be hard to differentiate it from malaria, typhoid fever and meningitis. Another reason is the stigmatisation of the Ebola virus and disease in general. This prevented sick people from seeking help and consequently numerous cases were not documented. In 11,310 cases the disease was fatal.¹⁸⁶

This chapter began with an overview of infectious diseases to illustrate their impact throughout history. Subsequently, the 1918 influenza pandemic was described, as it is a “reference point” when discussing infectious diseases. After this, the Ebola virus was explained and a timeline of events of the 2014 Ebola outbreak was outlined, which builds the basis for understanding the following chapters. The factors for the (re-)emergence and spread of infectious diseases, in general, and in specific to the 2014 Ebola outbreak, are debated in the next chapter.

186. WHO, “Ebola data and statistics (a). Situation summary,” <http://apps.who.int/gho/data/node.ebola-sitrep.ebola-summary?lang=en>, (Accessed: 27 March 2017); WHO, “Situation Report: Ebola Virus Disease. 10 June 2016,” http://apps.who.int/iris/bitstream/handle/10665/208883/ebolasitrep_10Jun2016_eng.pdf, 1, (Accessed: 20 March 2017); WHO, “Ebola virus disease”; Oldstone, *Viruses, Plagues, and History*, 21.

8. Factors for the (re-)emergence and spread of infectious diseases and of the Ebola virus in 2014

This chapter focusses on causes that contribute to the (re-)emergence and spread of infectious diseases. It starts with the role of globalisation and is followed by the discussion of factors, in general, and in specific to the 2014 Ebola outbreak. With the latter, the emphasis is on the national level. Subsequently, the deficiencies at the international level are explained. Lastly, the general role of the media and fear is illustrated.

8.1 Infectious diseases and globalisation

Globalisation reached a new level over the past decades and often accelerates the transmission of infectious diseases as well as their effects.¹⁸⁷ As former WHO Director-General Jong-wook expressed: “Diseases do not respect national boundaries.”¹⁸⁸ Lo/ Thomas take it a step further: “Globalization is eroding state borders and thereby creating new transnational health challenges.”¹⁸⁹ Smolinski agrees: “In the highly interconnected and readily traversed “global village” of our time, one nation’s problem soon becomes every nation’s problem as geographical and political boundaries offer trivial impediments to such threats.”¹⁹⁰ Price-Smith is more precise and explains that the spread of pathogens and infectious diseases is not only distributed via trade, but also by tourism, migration, population density, degradation of environment, conflicts (international and intra-state) as well as the resource distribution between developed and developing states.¹⁹¹ The “Independent Commission on Multilateralism” (ICM) agrees: “Dramatic social, political, economic, environmental, and demographic changes are expected to increase the conditions that give rise to pandemics.”¹⁹²

8.2 Infectious diseases and the reasons for their (re-)emergence and spread

In 1992, the Institute of Medicine illustrated the (re-)emergence and spread of infectious diseases based on six categories of factors. They are: “human demographics and behaviour, technology and industry, economic development and land use, international travel and commerce, microbial adaptation and change [and the] breakdown of public health measures.”¹⁹³ While this

187. Márcia Grisotti and Fernando Dias de Avila-Pires, “The concept of emerging infectious disease revisited,” in Mukherjee, *Understanding Emerging Epidemics: Social and Political Approaches*, 65; Price-Smith, *Contagion and Chaos*, 199 & 206.

188. WHO, “World Health Assembly adopts new International Health Regulations,” http://www.who.int/mediacentre/news/releases/2005/pr_wha03/en/, (Accessed: 27 February 2018).

189. Lo Yuk-ping and Thomas, “Health,” 449.

190. Mark S. Smolinski, Margaret A. Hamburg and Joshua Lederberg, eds., *Microbial Threats to Health: Emergence, Detection, and Response* (Washington, DC, 2003), xvii.

191. Price-Smith, *Contagion and Chaos*, 5.

192. ICM, “Global Pandemics and Global Public Health,” 3.

193. Lederberg, Shope and Oaks, *Emerging Infections*, 47.

classification is not universal, it is helpful to group factors. As they and categories are often interdependent/ influence each other, several causes are listed more than once. Each factor is discussed, in general, and in specific to the 2014 Ebola outbreak- with emphasis on the national level.

8.2.1 Human demographics and behaviour

There are several ways that human demographics and behaviour can be a factor in the (re-)emergence and spread of infectious diseases. Firstly, there is population movement due to migration or refugees, which can result in the spread of infectious diseases to new areas of the world. Secondly, population growth, which can either lead to urbanisation or overcrowding in cities. When it leads to urbanisation, it is often involved with the interaction of diseases specific for a certain region and/ or with the interaction of wildlife. Both circumstances can be causes for the (re-)emergence and spread of infectious diseases. According to the World Bank, each year more than two million people die because of zoonotic diseases. When population growth leads to overcrowding in cities, including slums and prisons, the risk of the transmission of infectious diseases is increased. Thirdly, (changes of) certain lifestyles (e.g. changes in sexual habits, substance abuse). For example, in the case of HIV/ AIDS the spread of the infectious disease is higher in urban areas.¹⁹⁴ However, Satcher claims, behavioural/ lifestyle changes can also prevent certain infections (e.g. HIV/ AIDS, antibiotic resistance) nearly entirely by influencing “people to behave in ways that minimize the transmission of infections and maximize the efforts of medical interventions.”¹⁹⁵ Despite disadvantages of certain lifestyles, people living in cities have, according to Pirages, better overall health, which is related to enhanced diets and medical care.¹⁹⁶

Human behaviour played an important role in the spread of the 2014 Ebola outbreak. Firstly, as previously explained, the Ebola virus is a zoonotic disease. Contagion is possible in various ways. By direct contact with infected animals, living close to/ with them, butchering, cooking or eating them. People in West Africa often live close to (their) animals, which can contribute to transmission. Secondly, people live nearby with their family members in unhygienic circumstances, which can foster the dissemination of the virus. Thirdly, burial ceremonies can also be responsible for a spread and were during the 2014 Ebola outbreak. Fourthly, it may be possible to transmit the disease through sexual contact with an infected or recovered person. Yet,

194. D. L. Balk et al., “Determining Global Population Distribution: Methods, Applications and Data,” in Hay; Graham; Rogers, *Global Mapping of Infectious Diseases: Methods, Examples and Emerging Applications*, 139 & 144; Grisotti and Dias de Avila-Pires, “The concept,” 65; Lederberg, Shope and Oaks, *Emerging Infections*, 48-49 & 54-55; Pirages, “Microsecurity,” 7–9; The World Bank, “Pandemic Risk”; Tatem, Rogers and Hay, “Global Transport Networks,” 301.

195. Satcher, “Emerging Infections,” 4.

196. Pirages, “Microsecurity,” 7.

this factor is still being studied. Fifthly, citizens in West Africa did not take the outbreak seriously. The reason why was distrust in governments and in health workers as the public believed the infectious disease was constructed by the government. Sixthly, fear also influenced the public's behaviour. For example, unfamiliar clothes worn by health personnel as well as removed family members, who never returned to their communities. Because of that, families hid sick family members and unsafe burials continued to take place. The absence of local health workers from work was another reason for the transmission of the Ebola virus. Personnel feared contagion with the virus, which resulted in health facilities being closed. Hence, infected people only got basic treatment instead of the special treatment they required. In addition, because of the stigmatisation of infected people, the immunity of Ebola survivors to the disease was neglected for months. They would have been a valuable factor in the combat of the disease. Lastly, people were violent towards health officials (e.g. health workers, educators, police, journalists). Therefore, the response on first detected cases was more difficult.¹⁹⁷ The discussed reasons illustrate that different behaviour would likely have saved thousands of infections and deaths.

8.2.2 Technology and industry

The evolution of technology and industry has brought immense improvements with it. These developments influence a variety of sectors (infrastructure, economy, health, etc.). For example, the development of machines, the advancements in medical diagnostics or the development of (new) pharmaceuticals can be named, among others. Another effect is the faster and further transportation of people, food and goods. This can boost economies because of tourism and new business ties. The faster transfer of medical equipment and staff in case of infectious disease outbreaks is another advantage. On the other hand, the advancements can be disadvantageous. Firstly, infectious diseases can be spread through handling or transport of food. For instance, when it is contaminated or when certain animals/ insects (e.g. mosquitoes), carrying a disease, are transported along with the food. Secondly, modifications of/ or new agricultural procedures can also be a factor for the spread of diseases. Thirdly, the rise of antimicrobial resistance, which is closely linked with the over-prescription and overuse of antibiotics. Fourthly, there is the manipulation of agents to use them for a bioterrorism attack.¹⁹⁸

Despite the advancements in technology, there exist infectious diseases where no successful treatment is available. In the 1990s, Pirages already criticised that a cure had yet to be found for viruses like the cold or the Ebola virus. About 20 years later there was still no proven vaccine/

197. WHO, "Frequently asked questions"; Gostin and Friedman, "Analysis," 1903; CDC, "Ebola. Transmission"; WHO, "Ebola virus disease"; UN, "Timeline".

198. Lederberg, Shope and Oaks, *Emerging Infections*, 57-58 & 63-65; Cliff et al., *Infectious Diseases*, 473–82; Tatem, Rogers and Hay, "Global Transport Networks," 302–6; CDC, "General Fact Sheets".

treatment available for Ebola. However, at the end of 2016, the WHO announced a vaccine had been developed. Yet, there are no long-term studies available on possible long-term effects.¹⁹⁹

Several of the aspects named above contributed to the spread of the Ebola virus in 2014. First and foremost, there were the weak health systems of Sierra Leone, Guinea and Liberia. The lack of rapid diagnostics resulting from the absence of technical equipment and health workers without proper training resulted in undetected cases. It was pointed out before that the Ebola virus is difficult to diagnose as the symptoms are similar to those of malaria, typhoid and meningitis. This presents itself in the difference of confirmed and suspected Ebola cases. The number of confirmed cases was more than 15,000. After adding suspected, probable and the cases after 2015, this number increases to 28,616; nearly double the confirmed cases. Secondly, the lack of treatment (e.g. a vaccine) was another factor in the transmission of the virus, as it was only possible to treat the symptoms, but not the disease itself. Thirdly, the lack of infrastructure. Even if there would have been effective medical care available, the inadequacy of infrastructure and transportation services would have resulted in it taking too long to obtain the necessary treatment for the patients or in difficulties getting it to them. Fourthly, there was a deficiency in communication. Citizens of developed states can get and exchange information via text message services, radio, television, internet and newspapers around the clock. In Sierra Leone, Guinea and Liberia this was not the case. The reason why is that in rural areas the population often lacks access to these forms of communication as newspapers or internet access is often limited to urban areas. This resulted in uninformed citizens, who were scared by people, dressed in protective gear, who arrived in their villages and took sick people with them. With some never returning to their communities.²⁰⁰

8.2.3 Economic development and land use

Numerous sources agree on the effects of infectious diseases to the economic sector. Frenk states that health has developed into “a key element of [...] sustainable economic growth.”²⁰¹ Davies agrees and points out that infectious diseases “have the potential to weaken many societies, political systems and economies simultaneously.”²⁰² Price-Smith adds that infectious diseases can have destabilising effects including, besides the high mortality rate, “the destruction of human capital, economic disruption, [...] and the deteriorating relations between the people

199. Pirages, “Microsecurity,” 9; WHO, “Final trial results”.

200. WHO, “Ebola virus disease”; Sands, Mundaca-Shah and Dzau, “Neglected Dimension,” 1281; WHO, “Ebola data and statistics (c). Situation summary,” <http://apps.who.int/gho/data/view ebola-sitrep ebola-summary-20160504?lang=en>, (Accessed: 27 March 2017); Gostin and Friedman, “Analysis,” 1902.

201. Julio Frenk, “Dean’s message: H1N1 and comprehensive health security,” <https://www.hsph.harvard.edu/news/magazine/winter10frenk/>, (Accessed: 14 April 2017).

202. Sara E. Davies, “National Security and Pandemics,” (UN Chronicle), August 2013 <https://unchronicle.un.org/article/national-security-and-pandemics/>, (Accessed: 10 March 2018).

and an often draconian state.”²⁰³ According to him, in the worst cases, infectious disease outbreaks can lead to weak and collapsed states, foster terrorism and/ or regional instability. This “may indirectly threaten the national security of many developed states.”²⁰⁴ In 1995, Pirages explained that there exist many areas in the world, where the population grows rapidly, but the economic growth is little. In these regions, health and sanitation infrastructure is often absent, but essential in preventing the (re-)emergence and spread of diseases. Sands/ Mundaca-Shah/ Dzau declare that infectious diseases and states’ reactions to them- whether in behaviour or policy- pose a risk to the economic sector as they can impact it enormously.²⁰⁵ The relationship between the economic sector and the securitisation of infectious diseases is described in chapter 9.2.2. Possible financial consequences are presented in a calculation by the World Bank. The organisation estimates that the potential losses through a flu pandemic are “\$3 trillion in global economic losses, equivalent to 4.8% of gross domestic product.”²⁰⁶ The majority of this amount would be caused directly. For example, through (changes in) behaviour of consumers and/ or labour deficits. Past examples, which illustrated the effects of infectious disease outbreaks on the economic sector include the SARS outbreak and the 1994 outbreak of plague in India. The latter caused 52 deaths, but more than one billion US Dollars in economic expenses. Of the 8,000 worldwide SARS-cases, 774 were fatal. Yet, its economic effects were estimated between 30-140 billion US Dollars. Another, in the previous section already explained, factor for the (re-)emergence and spread of infectious diseases is the pace of trade. This does not necessarily have to be seen as unfavourable. Yet, the global distribution of food increases the risk of hazards such as bacterial food contamination.²⁰⁷

Regarding land use, the downsides are, for example, dam building and/ or reforestation. The former can lead to an increase of mosquito-borne diseases. Reforestation can cause an increase in wildlife interaction.²⁰⁸ The relation between wildlife interaction and human behaviour was discussed in chapter 8.2.1.

Climate change is another possible cause for the (re-)emergence and spread of infectious diseases. Back in 1992, when the Institute of Medicine presented these categories, climate change/ global warming was not researched as much as nowadays. However, the Institute offered some scenarios about how global warming can be linked to infectious diseases. Firstly, they assumed that mosquito-borne viruses would increase as a result from rising temperatures. Secondly, they predicted a rise in sea levels or changes in rainfall, which would also result in an increase in mosquito-borne viruses. Thirdly, they concluded that increased humidity could be a

203. Price-Smith, *Contagion and Chaos*, 3.

204. Price-Smith, *Contagion and Chaos*, 200.

205. Pirages, “Microsecurity,” 7; Sands, Mundaca-Shah and Dzau, “Neglected Dimension,” 1284.

206. The World Bank, “Pandemic Risk”.

207. The World Bank, “Pandemic Risk”; WHO, “Summary of probable SARS cases”; Tatem, Rogers and Hay, “Global Transport Networks,” 297; Lederberg, Shope and Oaks, *Emerging Infections*, 69.

208. Lederberg, Shope and Oaks, *Emerging Infections*, 71–73.

factor in the (re-)emergence and spread of infectious diseases. However, they pointed out that whilst climate change might foster certain infectious diseases, it could also diminish others.²⁰⁹

As the Ebola virus is a zoonotic disease, it is closely related to general farming (land use), but also to butchering as possible methods of transmission. Both are also a part of/ influence the economy of a state. Economic growth is, in turn, related to health infrastructure. Sierra Leone's, Guinea's and Liberia's health systems are very weak. In addition, they have a deficiency of health personnel and infrastructural resources. However, a resilient health system is a necessity to be able to deal with infectious diseases, like the Ebola virus.²¹⁰ This is illustrated later in this chapter. In the beginning of 2014, the International Monetary Fund estimated the gross domestic product to be about eleven percent, six percent and four and a half percent for Sierra Leone, Liberia and Guinea. In August, when the number of Ebola cases rose fast, the numbers were reduced to eight percent and (approximately) two and a half percent. This is a reduction between one third and more than half of the original numbers. Simultaneously, it demonstrates the immense impact infectious diseases can have. In December 2014, a World Bank study, focussing on the economic impact of the 2014 Ebola outbreak, described two potential scenarios. One, "Low Ebola" with an estimated end of the outbreak by the beginning of 2015 and about 20,000 cases. Two, "High Ebola" with the outbreak increasing in severity into 2015 with about 200,000 cases. It estimated the West African gross domestic product loss by 2015 at about four billion US Dollars with "Low Ebola" and 32 billion US Dollars with "High Ebola". The "High-Level Panel on the Global Response to Health Crises" estimated the economic loss resulting from the 2014 Ebola outbreak for Sierra Leone, Guinea and Liberia to more than two billion US Dollars and the loss for the wider West African region at one billion US Dollars.²¹¹ It explains:

Following the Ebola outbreak in Guinea, rice production fell by 20 per cent in 2014 compared with 2013, coffee production by 50 per cent and cocoa production by 33 per cent. Both self-employment and wage-employment decreased. In Sierra Leone, the outbreak led to the loss of an estimated 180,000 jobs. [...] [In Liberia,] small businesses have collapsed, markets have closed down, and farming activities have been abandoned. [...] In Guinea, fishery exports fell by 40 per cent, while rubber exports experienced a similar decline in Liberia. In all three Ebola-affected countries, international investors postponed new projects or pulled out altogether. [...] [In addition,] hotel occupancy fell sharply. [...] The Gambia, which has never had a case of Ebola virus disease, saw a 65 per cent decrease in tourism.²¹²

Another estimation calculated the costs of the outbreak to "\$6 billion in direct expenses and at least \$15 billion in economic losses. Recovery plans for Guinea, Liberia, and Sierra Leone developed in April, 2015, total more than \$4.5 billion."²¹³

209. Lederberg, Shope and Oaks, *Emerging Infections*, 76–77.

210. Gostin and Friedman, "Analysis," 1902.

211. UN, "Timeline"; UN, "A/70/723," 27 & 30.

212. UN, "A/70/723," 29–30.

213. Gostin and Friedman, "Analysis," 1904.

8.2.4 International travel and commerce

The advances in technology and industry make it possible to travel fast and far. This can be advantageous as tourism and business opportunities can boost the economies of states. Plus, in case of an international (health) crisis, medical equipment and staff can be transported to nearly every place in the world within hours or days. On the downside, the advancements in transportation have made it easier to contract infectious diseases. As Tatem/ Rogers/ Hay point out: “Pathogens [...] now move further, faster and in greater numbers than ever before.”²¹⁴ This results in infectious diseases typical for a certain area in the world, but untypical for others, are spreading to new areas.²¹⁵ Balk et al. agree: “Disease emergence may be causally related to population dynamics, travel and trade routes.”²¹⁶ One does not necessarily have to travel far to contract/ transmit an infectious disease. For example, a passenger, sitting next to someone on a short-haul flight, can be infected (without knowing) and disseminate a disease. This can have disadvantageous effects as the report of the “High-Level Panel” declares: “Recent experience has shown that when countries are affected by outbreaks, tourism and international trade collapse.”²¹⁷

During the 2014 Ebola outbreak international travel contributed to the spread of the virus. For example, travellers and health workers, which returned from affected states to Europe (Spain, Italy, UK) and the US. This made it possible for the disease to spread (e.g. to Nigeria, to the US) (or at least trigger the fear of dissemination) to areas far away from its origin. In addition, several airlines suspended flights to affected areas/ states.²¹⁸ The effects on commerce as a result of the outbreak (e.g. production of products, export and tourism decline) were discussed in chapter 8.2.3.

8.2.5 Microbial adaptation and change

Another factor for the (re-)emergence and spread of infectious diseases is the possibility of rapid evolution and adaption of pathogens.²¹⁹ This can result in them evolving into a different or stronger strain, for which no cure exists. In the case of influenza, Taubenberger/ Morens state that since 1918 “all influenza A pandemics [...], and indeed almost all cases of influenza A worldwide [...], have been caused by descendants of the 1918 virus.”²²⁰ As disclosed in the excursus to the 1918 influenza pandemic, Taubenberger/ Morens describe the possible risk of an influenza pandemic as: “The return of a pandemic virus equivalent in pathogenicity to the virus of 1918 would likely

214. Tatem, Rogers and Hay, “Global Transport Networks,” 294.

215. Pirages, “Microsecurity,” 10.

216. Balk et al., “Determining Global Population Distribution,” 144.

217. UN, “A/70/723,” 30.

218. UN, “Timeline”.

219. Lederberg, Shope and Oaks, *Emerging Infections*, 84.

220. Taubenberger and Morens, “1918 Influenza,” 15.

kill >100 million people worldwide. A pandemic virus with the (alleged) pathogenic potential of some recent H5N1 outbreaks could cause substantially more deaths.”²²¹ In contrast, the Institute of Medicine claimed in 1992: “The emergence of resistance in a known infectious agent may be a greater threat to public health than the emergence of a new disease.”²²²

Microbial adaptation and change was not a factor during the 2014 Ebola outbreak. In general, it is possible for pathogens to change or adapt over time. This can lead to antibiotic or antimicrobial resistance. In the case of the Ebola outbreak, this possibility would not have mattered, as there was no effective treatment available against the infectious disease. As previously mentioned, in December 2016, the WHO announced a vaccine able to treat the Ebola virus.²²³ Yet, if the virus changes/ adapts, it could set researchers back as the current vaccine might not be effective (enough) for a mutated strain.

8.2.6 Breakdown of public health measures

The last category, defined by the Institute of Medicine, is the breakdown of public health measures, which can occur because of various scenarios. One, because of war, which does not necessarily have to mean war in the state of origin, but also includes troops being deployed in foreign states. Depending on the type of mission (military, field, etc.) the forms of infectious diseases (e.g. respiratory, zoonotic) can differ too. Two, as a result of natural disasters; when they cause, for instance, damage to health facilities or death of health personnel. Infectious diseases often emerge in the aftermath of such events (e.g. cholera after hurricane Matthew in Haiti). Another scenario for a breakdown is economic collapse.²²⁴ This was already discussed in chapter 8.2.3.

In general, states with already weak health systems have a higher probability of collapsing compared to strong, resilient ones. The ICM explains: “It is impossible to respond effectively to health crises without building the capacity of national healthcare systems, which are not only essential to the health of populations, societies, and economies, but also key to preventing their spread across international borders.”²²⁵ Measures, which help to contain infectious diseases and their outbreaks, include “vaccination, proper hygiene, water and sewage treatment, and safe food-handling and distribution practices.”²²⁶ In addition, the notification of the public about an emerging infectious disease is essential (e.g. WHO on the international level). As Grisotti/ Avila-Pires claim: “Under-notification is at the basis of many emergent diseases.”²²⁷

221. Taubenberger and Morens, “1918 Influenza,” 21.

222. Lederberg, Shope and Oaks, *Emerging Infections*, 92.

223. WHO, “Final trial results”.

224. Lederberg, Shope and Oaks, *Emerging Infections*, 106–12.

225. ICM, “Global Pandemics and Global Public Health,” 3.

226. Lederberg, Shope and Oaks, *Emerging Infections*, 106.

227. Grisotti and Dias de Avila-Pires, “The concept,” 68.

Even though the health systems of the three most affected states did not break down completely during the 2014 Ebola outbreak, essential health services were disrupted severely due to the factors illustrated in the following. Firstly, a resilient national health system is critical to fighting infectious diseases. The health systems of Sierra Leone, Guinea and Liberia are very weak. According to the “High-Level Panel”, the Ebola outbreak displayed the contrast between strong and weak health systems. More than 11,000 people died because of the Ebola virus in the three states. In contrast, developed states were able to contain the infectious disease after only a few transmissions. However, Mali, Nigeria and Senegal, which also have rather weak health systems, were able to stop the spread in their states as well. The Panel lists adequate preparedness and proactive reaction as reasons for this. Secondly, the three states have a deficiency in health personnel.²²⁸ Gostin/ Friedman explain: “International recommended thresholds for doctors, nurses, and midwives range from 223 (WHO) to 345 (International Labour Organization) per 100000 population. The Ebola-affected countries have about one-fifth to less than one-tenth of these recommendations.”²²⁹ Thirdly, health personnel also lacked training. Especially for an infectious disease like the Ebola virus, which symptoms can be misinterpreted as malaria, typhoid fever or meningitis. Consequently, numerous cases were not detected and healthcare workers got infected themselves during the treatment of patients or stayed home fearing infection. This led to health facilities being closed and infected people only got basic medical care, whereas they would have needed special treatment. Fourthly, deficiency of infrastructural resources was another factor. Fifthly, the outbreak was downplayed by authorities and underestimated. Sixthly, public distrust and rumours (e.g. the government fabricated the outbreak, witchcraft) as well as fear (e.g. unfamiliar looking clothing of health personnel, hiding of infected people, stigmatisation of survivors) influenced the public's behaviour.²³⁰

8.3 Deficiencies at the international level

How the previously discussed factors contributed to the spread of the Ebola virus in 2014, was illustrated in the previous sections, which focussed mainly on the national level. In the following, the shortcomings on the international level are examined. While the section emphasises the Ebola outbreak, the explanations can be applied to infectious disease outbreaks in general.

The biggest failure on the international level was the ignorance of the outbreak (for too long). After the first reported case in December 2013, it took the international community about six months, to start extensive help.²³¹ As Sands/ Mundaca-Shah/ Dzau recap: “The international response

228. Kieny et al., “Health-system resilience,” 850; Gostin and Friedman, “Analysis,” 1903; UN, “A/70/723,” 32; WHO, “Ebola virus disease”.

229. Gostin and Friedman, “Analysis,” 1903.

230. WHO, “Ebola virus disease”; UN, “A/70/723,” 6; Gostin and Friedman, “Analysis,” 1903; WHO, “Report of the Ebola Interim Assessment Panel,” <http://www.who.int/csr/resources/publications/ebola/report-by-panel.pdf>, 20, (Accessed: 26 September 2017).

231. Gostin and Friedman, “Analysis,” 1903; UN, “A/70/723,” 25.

was slow, cumbersome, and poorly coordinated. Rapid diagnostics, protective equipment, effective therapeutics, and a vaccine were lacking.”²³² The “Ebola Interim Assessment Panel” also judged the WHO’s response in several aspects.²³³ The “High-Level Panel” explains: “Experience with the Ebola outbreak in West Africa has shown that- before successful control measures were initiated- each case of Ebola on average resulted in two further infections.”²³⁴ Therefore, the late reaction increased the number of Ebola cases and deaths.

Several scientists criticised the lack of preparedness for an event like the 2014 Ebola outbreak, tying it to the underfunding of international organisations; particularly to the WHO. Back in 1995, Pirages already criticised the underfunding of the WHO or the CDC.²³⁵ Gostin/ Friedman state: “The Ebola outbreak in west Africa should have been the type of moment for which WHO was created. Instead, the epidemic exposed long-understood failings.”²³⁶ They assign blame for this to several reasons. One, a budget cut in 2011 of 500 million US Dollars resulting in a loss of jobs at the headquarters, the emergency response unit and the Regional Office for Africa. Two, failure in negotiating important treaties. Three, a lack of operational function, even though the WHO’s legitimacy, alliances and legal authority are exceptional. As a result of the 2014 Ebola outbreak, several scientists proposed drastic changes in the international health system and the WHO, in particular. In general, Sands/ Mundaca-Shah/ Dzau warn of underinvesting in health, as they expect it will lead to a possible disaster. In contrast, they do not view “overinvesting” as disadvantageous as it could help solve other important health issues (e.g. fighting tuberculosis, malaria, antimicrobial-resistant pathogens).²³⁷

8.4 Infectious diseases and the role of the media and fear

Aside from globalisation and the illustrated factors for the (re-)emergence and spread of infectious diseases, the media and fear also play a role in outbreaks of infectious diseases. Particularly regarding the perception of a health risk. How fear played a role during the 2014 Ebola outbreak was discussed in chapter 8.2.1.

In general, it can be advantageous, when people get informed about possible threats and/ or how to avoid contagion/ transmission of infectious diseases. Mukherjea states: “Emerging epidemics have garnered increasing amounts of journalistic and public awareness.”²³⁸ Although, she criticises that in most cases attention is focused on single cases or financial help.²³⁹ Recent examples include Ebola, Zika and others. The role of the media can also be disadvantageous, as

232. Sands, Mundaca-Shah and Dzau, “Neglected Dimension,” 1281.

233. WHO, “Report of the Ebola Interim Assessment Panel”.

234. UN, “A/70/723,” 29.

235. Pirages, “Microsecurity,” 12.

236. Gostin and Friedman, “Analysis,” 1903.

237. Gostin and Friedman, “Analysis,” 1903–7; Sands, Mundaca-Shah and Dzau, “Neglected Dimension,” 1283–87.

238. Mukherjea, “Social politics,” 127.

239. Mukherjea, “Social politics,” 127.

Pirages already pointed out in 1995. He referred to the 1976 Ebola outbreak in- what is now called- South Sudan and the Democratic Republic of Congo:

News travels swiftly through the emerging global village. Fifty years ago nobody would have taken much notice of odd happenings on the Ebola River in Africa. With CNN²⁴⁰ now acting as the town crier, even a few dozen deaths in a remote corner of the planetary village become newsworthy. Thus, even if nothing had changed, people would still feel that the world was becoming a more virulent place.²⁴¹

Price-Smith agrees and explains that fear can be “spread” easily through the media (e.g. SARS outbreak).²⁴² Sands/ Mundaca-Shah/ Dzau agree with Pirages and Price-Smith:

In our media-connected world, fear spreads even more quickly than infections. Fueled by television and social media, fears of infectious diseases, whether rational or unwarranted, drive behavior and policy changes, triggering travel bans, quarantines, and blocks on trade that can quickly escalate beyond what is scientifically justified.²⁴³

Stern declares that “fear is disproportionately evoked by certain characteristics of risks, including: involuntary exposure, unfamiliarity, and invisibility.”²⁴⁴ Examples for reactions out of fear include the 1994 outbreak of plague in India, when people fled the region in masses within days as well as the outbreaks of BSE and SARS, when states imposed trade embargoes and travel restrictions.²⁴⁵ The same course of action occurred during the 2014 Ebola outbreak. Other extreme measures imposed during the outbreak are described in chapter 9.2.3.3. Hartl stated regarding the outbreak: “The word Ebola conjures up more fear than any other word in the medical vocabulary. That is the biggest problem with this outbreak.”²⁴⁶

This chapter discussed the factors that contribute to the (re-)emergence and spread of infectious diseases. This was done in two ways; one, in general, and two, in specific to the 2014 Ebola outbreak with focus on the national level. Subsequently, the shortcomings on the international level and the role of the media and fear were also explained. The following chapter illustrates and debates the theory of this master’s thesis.

240. Cable News Network.

241. Pirages, “Microsecurity,” 6.

242. Price-Smith, *Contagion and Chaos*, 5.

243. Sands, Mundaca-Shah and Dzau, “Neglected Dimension,” 1284.

244. Jessica Stern, “Dreaded Risks and the Control of Biological Weapons,” *International Security* 27, no. 3 (2002): 102, <https://doi.org/10.1162/01622880260553642>.

245. Enemark, “Is Pandemic Flu a Security Threat?,” 198; Price-Smith, *Contagion and Chaos*, 202.

246. W. Wallis, “Cordon sanitaire tightens around west African states to beat Ebola,” (Financial Times), 22 August. <https://www.ft.com/content/d7419538-2a0e-11e4-8139-00144feabdc0>, (Accessed: 12 February 2018).

9. Theory

As illustrated before, the evaluation of infectious diseases as a security risk has been up for debate for a long time. HIV/ AIDS, SARS, H5N1, H1N1 have been securitised to a greater or lesser extent and have been accelerators for the securitisation of infectious diseases. This is the reason why the securitisation theory was chosen as the theoretical basis of this master's thesis.²⁴⁷ This chapter starts with an introduction to the Copenhagen School. Firstly, there is a short discussion of the evolution of security studies from a narrow to a wider view. Levels of analysis, sectors and regions are then described. This is followed by the main section of this chapter- the securitisation theory. After a general introduction to the theory, every essential step/ part of a securitisation is illustrated. For a better understanding, practical examples, with a focus on infectious diseases, are included. Lastly, medicalisation is briefly explained as it is linked to the securitisation of infectious diseases.

9.1 Introduction to the Copenhagen School

Security studies have developed significantly over the past five decades. Back in the Cold-War era, they were narrowed down to a military and state-centred view. In the 1970s and 1980s (rise of the economic and environmental topics) and later in the 1990s (rise of concerns with identity issues and transnational crime) discontent of this narrow view rose.²⁴⁸ Nowadays, security studies incorporate different types of security, including comprehensive security by the Copenhagen School.

9.1.1 Narrow versus wider view of security

Traditionalists were against widening the view and argued it would lead to the point where the "essential meaning became void."²⁴⁹ Walt, a realist, states that widening security studies too far "runs the risk of expanding [it] excessively; by this logic, issues such as pollution, disease, child abuse, or economic recessions could all be viewed as threats to "security".²⁵⁰ However, he is not against adding economics into the field of security, as long as it relates to military issues.²⁵¹ While most supporters of a narrow view of security are prepared to broaden the definition of the term, they demand that "military conflict [...] [is] the defining key to security."²⁵² Wideners of security studies include, among others, Ullman, Buzan, Wæver, de Wilde, Nye and Haftendorn. Buzan

247. This chapter is purposely placed at this point of the thesis. The reason why is that the previous two chapters are key for a better understanding of the topic, in general, and the theory, in specific.

248. Buzan, Wæver and Wilde, *Security*, 1–2.

249. Buzan, Wæver and Wilde, *Security*, 2.

250. Stephen M. Walt, "The Renaissance of Security Studies," *International Studies Quarterly* 35, no. 2 (1991): 212, <https://doi.org/10.2307/2600471>.

251. Buzan, Wæver and Wilde, *Security*, 4.

252. Buzan, Wæver and Wilde, *Security*, 3.

as well as Ullmann have both broadened the definition of threat away from the narrow view towards a wider explanation.²⁵³ Buzan pleads for “retaining a distinctively military subfield of strategic studies within a wider security studies.”²⁵⁴ He defines security as follows:

Security is taken to be about the pursuit of freedom from threat and the ability of states and societies to maintain their independent identity and their functional integrity against forces of change which they see as hostile. The bottom line of security is survival.²⁵⁵

His approach to broadening the concept of security, as presented in “People, States and Fear. An Agenda for International Security Studies in the Post-Cold War Era”, incorporates, according to Stone, neo-realist ideas as well as constructivist ones.²⁵⁶ She describes: “He looks at security from all angles going from micro to macro, also addressing the social aspects of security and how people or societies construct or “securitize” threats.”²⁵⁷ Further, she points out that Buzan also analyses every facet that has an (advantageous or disadvantageous) effect on security.²⁵⁸

According to Buzan/ Waever/ de Wilde, a wider agenda not only needs an extension of knowledge and understanding, it also has two other effects. One, it expands the call for state mobilisation to act on a wider variety of topics compared to the narrow view. Two, it raises the term security to a level where it is considered as a “universal good thing”.²⁵⁹

9.1.2 Levels of analysis

In “Security. A New Framework for Analysis”, Buzan/ Waever/ de Wilde aim to create a concept of security that embodies the narrow and the wider view with strictly defined criteria as to what is considered a security issue. They divide security into levels of analysis, sectors and regions.²⁶⁰

Levels of analysis have been up for debate for quite some time. Buzan/ Waever/ de Wilde describe them as “objects for analysis that are defined by a range of spatial scales, from small to large.”²⁶¹ Further, they consider levels as contributors “for where things happen rather than sources of explanation in themselves.”²⁶² Within levels one can theorise, but they are not theories themselves. To some extent, one can use levels to locate actors engaging in international relations (e.g. UN at the system level, EU at the subsystem level). For some actors it is more difficult to locate them (e.g. a lobby group supporting farmers interests is located at the subunit level; transnational organisations could be found on the subunit, the subsystem and the system

253. Buzan, Wæver and Wilde, *Security*, 2.

254. Buzan, Wæver and Wilde, *Security*, 2.

255. Barry Buzan, “New patterns of global security in the twenty-first century,” *International Affairs* 67, no. 3 (1991): 432, <https://doi.org/10.2307/2621945>.

256. Marianne Stone, “Security According to Buzan: A Comprehensive Security Analysis,” <https://pdfs.semanticscholar.org/4bca/7cbbacd65c0f7d46f39b58a3739918c1607e.pdf>, 2, (Accessed: 19 June 2018).

257. Stone, “Security According to Buzan,” 2.

258. Stone, “Security According to Buzan,” 2.

259. Buzan, Wæver and Wilde, *Security*, 4.

260. Buzan, Wæver and Wilde, *Security*, 4–6.

261. Buzan, Wæver and Wilde, *Security*, 5.

262. Buzan, Wæver and Wilde, *Security*, 5.

level).²⁶³ In “People, States and Fear”, Buzan defined three levels of analysis: individuals, states and international systems. In “Security. A New Framework for Analysis”, Buzan/ Wæver/ de Wilde add two more levels:²⁶⁴

1. International systems: the largest units that interact or are interdependent; they have no system level above them (e.g. the entire planet).
2. International subsystems: units grouped inside the international system, which can be differentiated from the whole system by their specific structure or intensity of interacting with or being interdependent on each other. Subsystems can be regional (e.g. ASEAN²⁶⁵), but do not have to be (e.g. OPEC²⁶⁶).
3. Units: a conglomerate of subgroups, organizations, communities and individuals, so independent and united that differentiation from others is obvious; they are positioned at the higher levels (e.g. states, nations, transnational companies).
4. Subunits: groups of individuals who organised themselves within a unit and aim for an effect of their actions within the unit (e.g. lobbies).
5. Individuals: the core of most social sciences analysis.

9.1.3 Sectors

In “People, States and Fear” Buzan defines five sectors- the military, the environmental, the economic, the societal and the political sector. He declares:

Generally speaking, military security concerns the two-level interplay of the armed offensive and defensive capabilities of states, and states’ perceptions of each other’s intentions. Political security concerns the organizational stability of states, systems of government and the ideologies that give them legitimacy. Economic security concerns access to the resources, finance and markets necessary to sustain acceptable levels of welfare and state power. Societal security concerns the sustainability, within acceptable conditions for evolution, of traditional patterns of language, culture and religious and national identity and custom. Environmental security concerns the maintenance of the local and the planetary biosphere as the essential support system on which all other human enterprises depend.²⁶⁷

Buzan explains that all five sectors are strongly linked with each other. Military action can pose a risk to all parts of the state. They fall into a particular category- security related- as they include the use of force. Political threats are as much of a risk for a state as military ones are. Yet, their identification is more difficult as they can take different forms. Compared to military and political threats, societal, economic and environmental ones are more difficult to characterise. For example, societal risks are often connected with political, but also with military ones. Often language, religion and culture are involved.²⁶⁸ According to Stone, weak states often do not have

263. Buzan, Wæver and Wilde, *Security*, 6.

264. Barry Buzan, *People, States and Fear. An Agenda for International Security Studies in the Post-Cold War Era* (New York, London: Harvester Wheatsheaf, 1991), 35–269; Buzan, Wæver and Wilde, *Security*, 6.

265. Association of Southeast Asian Nations.

266. Organization of the Petroleum Exporting Countries.

267. Buzan, *People, States and Fear*, 19–20.

268. Buzan, *People, States and Fear*, 20 & 117–123.

the ability to deal with different identities and cultures. The reason why is that identities and cultures are subjective and therefore have a chance of being politically discriminated against or segregated.²⁶⁹ Economic threats are, according to Buzan, the most challenging ones to handle, as the economic sector is a quite complex one. He describes that developed and developing states have different concerns/ priorities regarding economic security. Ecological risks are difficult to characterise as well. Primarily, as they can be divided into two types. One, natural disasters (e.g. earthquakes, storms, plagues). Two, larger-scale ecological threats (e.g. ozone layer, greenhouse warming).²⁷⁰ Buzan declares: “Very few states have the capability to control these macro-developments by themselves, and so the appeal to national security has no practical logic unless it can be linked to collective action.”²⁷¹ In other words: the international community of states needs to find strategies to tackle these risks as they are (often) global (e.g. 2014 Ebola outbreak). The topic of macrosecuritisation is discussed later in this chapter (9.2.4). Further, Buzan illustrates that the shift of priorities among the five sectors caused the widening of security studies. In “People, States and Fear”, he observed that economic and ecological threats were on the rise compared to military ones. He also addressed that there is a linkage between sectors.²⁷² Regarding Buzan’s definition of sectors, it is striking that public health is neither considered important enough to define it as its own sector, nor does it fit in one of the five defined sectors. One can argue that the widening of security studies was still debated and ongoing during the 1990s and the world was not as globalised as it is today. Yet, several (re-)emergences and the resultant spread of infectious diseases illustrate their risk should not be underestimated.

9.1.4 Regions

Buzan explains that “in security terms, ‘region’ means that a distinct and significant subsystem of security relations exists among a set of states whose fate is that they have been locked into geographical proximity with each other.”²⁷³ Buzan/ Wæver/ de Wilde point out that resulting from the discontinuation of bipolarity in the post-Cold War era, great powers seem “to avoid wider political engagements unless their own interests are immediately and strongly affected.”²⁷⁴ This behaviour leads the authors to the assumption that regions are forced into resolving their own issues (e.g. first months of the 2014 Ebola outbreak).²⁷⁵ They state: “Regions are objects of analysis in themselves, particular locations where one can find outcomes and sources of

269. Stone, “Security According to Buzan,” 5.

270. Buzan, *People, States and Fear*, 123–33.

271. Buzan, *People, States and Fear*, 132–33.

272. Buzan, *People, States and Fear*, 133–34.

273. Buzan, *People, States and Fear*, 188.

274. Buzan, Wæver and Wilde, *Security*, 9.

275. Buzan, Wæver and Wilde, *Security*, 9.

explanation.”²⁷⁶ Regarding levels of analysis, Buzan/ Waever/ de Wilde consider regions as a specific form of subsystem (e.g. EU, ASEAN).²⁷⁷

9.1.4.1 Security complex

The “classical” security complex theory (CSCT) was introduced by Buzan in “People, States and Fear”. There, he describes that “regional security subsystems can be seen in terms of patterns of amity and enmity that are substantially confined within some particular geographical area.”²⁷⁸ In other words: the majority of states fear their neighbour states more than those further away. Therefore, the common order of security interdependence within the international system is that of regional groups. These are labelled “security complexes”. According to Buzan/ Waever/ de Wilde, all states are interdependent regarding security. This interdependence is higher in regional complexes- with regards to both competition or joint interests.²⁷⁹ In “Security. A New Framework for Analysis”, Buzan/ Waever/ de Wilde define security complexes as: “A set of states whose major security perceptions and concerns are so interlinked that their national security problems cannot reasonably be analyzed or resolved apart from one another.”²⁸⁰ The authors illustrate that “security complexes are subsystems [...] in their own right.”²⁸¹ Security complexes lie between the domestic and the system level. Furthermore, the CSCT declares the regional scale to be the most important one. In addition, it is postulated that the existence of security complexes is common and anticipated. In the case of their absence, the question is why. Two conditions can explain an absenteeism. One, when no local complex is developed due to inadequate security interplay. Two, when the process of security actions between domestic states is restrained by the potent appearance of outside powers; this is called “overlay”.²⁸² According to the authors, an advantage of the CSCT is “that it draws attention away from the extremes of national and global security and focuses it on the region, where these two extremes interplay and where most of the action occurs.”²⁸³ It should, therefore, not be excluded when discussing security.

9.2 Securitisation theory

After the previous brief introduction to comprehensive security, the theoretical basis of this master’s thesis, the securitisation theory, is illustrated in the following.

276. Buzan, Wæver and Wilde, *Security*, 9.

277. Buzan, Wæver and Wilde, *Security*, 9.

278. Buzan, *People, States and Fear*, 190.

279. Buzan, Wæver and Wilde, *Security*, 11; Buzan, *People, States and Fear*, 190.

280. Buzan, Wæver and Wilde, *Security*, 12.

281. Buzan, Wæver and Wilde, *Security*, 13.

282. Buzan, Wæver and Wilde, *Security*, 11-12 & 14.

283. Buzan, Wæver and Wilde, *Security*, 14–15.

9.2.1 Introduction to the securitisation theory

The securitisation theory was developed during the 1990s by the Copenhagen School and is strongly linked to Ole Wæver. Before a general introduction to securitisation is provided and each step/ part is explained, it is helpful to briefly summarise the securitisation process. Securitisation requires an actor, an audience, an existential threat and a referent object. The first step is the identification of an existential threat to a referent object, which differs among sectors and levels. It is followed by the acceptance of the threat by an audience. The third step is the implementation of emergency action to tackle the threat. Finally, when the threat is under control, the issue moves to the desecuritisation phase. This is when the issue moves back into a normal mode (of politics). If the audience does not accept the existential threat as such, it is called a securitisation move. There will be no emergency action and no desecuritisation, as the issue is not securitised in the first place.²⁸⁴ It has to be mentioned that not all steps are passed through all the time.

When asking what makes a topic a security issue, Buzan/ Wæver/ de Wilde point out that the term “in international relations” is important, as “international security has its own distinctive, more extreme meaning” and security means something different in the everyday life.²⁸⁵ The authors describe that in the narrow view of security,

security is about survival. It is when an issue is presented as posing an existential threat to a designated referent object ([...] the state, incorporating government, territory, and society). The special nature of security threats justifies the use of extraordinary measures to handle them.²⁸⁶

Looking at a wider view of security, it depends on the sectors and level of analysis how the terms “existential threat” and “emergency measures” are defined.²⁸⁷ These terms are discussed later in this chapter (9.2.3.1.2, 9.2.3.1.3 and 9.2.3.3). According to Buzan/ Wæver/ de Wilde, “the distinguishing feature of securitization is a specific rhetorical structure (survival, priority of action [...]). This definition can function as a tool for finding security actors and phenomena in sectors.”²⁸⁸ In addition, securitisation can be ad hoc or institutionalised (e.g. military sector).²⁸⁹

Buzan/ Wæver/ de Wilde define security as “the move that takes politics beyond the established rules of the game and frames the issue either as a special kind of politics or as above politics. Securitization can thus be seen as a more extreme version of politicization.”²⁹⁰ Theoretically, any public issue can be identified as either nonpoliticised, politicised or securitised. Nonpoliticised means that “the state does not deal with it and it is not in any other way made an issue of public debate and decision.”²⁹¹ Politicised means that “the issue is part of public policy, requiring

284. Buzan, Wæver and Wilde, *Security*, 21–31.

285. Buzan, Wæver and Wilde, *Security*, 21.

286. Buzan, Wæver and Wilde, *Security*, 21.

287. Buzan, Wæver and Wilde, *Security*, 21.

288. Buzan, Wæver and Wilde, *Security*, 26.

289. Buzan, Wæver and Wilde, *Security*, 26–27.

290. Buzan, Wæver and Wilde, *Security*, 23.

291. Buzan, Wæver and Wilde, *Security*, 23.

government decision and resource allocations or, more rarely, some other form of communal governance.”²⁹² Securitised means that “the issue is presented as an existential threat, requiring emergency measures and justifying actions outside the normal bounds of political procedure.”²⁹³ Buzan/ Wæver/ de Wilde declare that “although in one sense securitization is a further intensification of politicization [...], in another sense it is opposed to politicization.”²⁹⁴ In reality, it depends greatly on the state where an issue is placed. Lo/ Thomas explain: “Cultural and religious agendas can and do have a significant impact on responses to health threats, with different social and political priorities altering the way in which a health challenge is successfully securitized (or not).”²⁹⁵ Buzan/ Wæver/ de Wilde agree: “Different states and nations have different thresholds for defining a threat.”²⁹⁶ For example, some states will politicise religion, while others will not. Some states will securitise culture, others not.²⁹⁷ The authors argue that “securitization, like politicization, has to be understood as an essentially intersubjective process.”²⁹⁸ Furthermore, it is “socially constructed.”²⁹⁹ Plus: “It is always a political choice to securitize or to accept a securitization.”³⁰⁰ It is important to add, that a “link between politicization and securitization does not imply that securitization always goes through the state.”³⁰¹

Wæver points out that “the field of security is constituted around relationships between wills.”³⁰² For example: “environmental threats are generally unintentional. This, by itself, does not make the threats any less serious, although it does take them out of the realm of will.”³⁰³ The same can be said about infectious diseases. Here, Wæver’s statement can be linked with the one of Kamradt-Scott/ McInnes about pandemic influenza: “Pandemic influenza is not naturally a security threat but rather needs to be constructed as such.”³⁰⁴ It has to be noted that the Copenhagen School has its roots in constructivism, which is closely linked with perceptions. How they are interconnected with securitising infectious diseases is illustrated below as well as later in this chapter (9.2.3.2.1).

Securitisation focusses mainly on the middle level of international politics (e.g. states and transnational companies). This is because the middle level is firstly, “the most active [...] because of the facility with which collective political units can construct each other as threats.”³⁰⁵ Secondly, as securitisation (especially finding audiences) at other levels is more difficult: at the individual

292. Buzan, Wæver and Wilde, *Security*, 23.

293. Buzan, Wæver and Wilde, *Security*, 23–24.

294. Buzan, Wæver and Wilde, *Security*, 29.

295. Lo Yuk-ping and Thomas, “Health,” 452.

296. Buzan, Wæver and Wilde, *Security*, 30.

297. Buzan, Wæver and Wilde, *Security*, 23–24.

298. Buzan, Wæver and Wilde, *Security*, 30.

299. Buzan, Wæver and Wilde, *Security*, 31.

300. Buzan, Wæver and Wilde, *Security*, 29.

301. Buzan, Wæver and Wilde, *Security*, 24.

302. Ole Wæver, “Securitization and Desecuritization,” in *On Security*, ed. Ronnie D. Lipschutz, New directions in world politics (New York: Columbia University Press, 1995), 63.

303. Wæver, “Securitization and Desecuritization,” 63.

304. Kamradt-Scott and McInnes, “Securitisation,” 99.

305. Buzan and Wæver, “Macrosecritisation and security constellations,” 253.

level the individual is the referent object, whereas at the system level the referent object is in a way all humankind.³⁰⁶ When securitisation is focused on national security, Elbe claims:

Here the focus has been predominantly on the threat posed by naturally emerging and re-emerging infectious diseases in the context of an increasingly globalised and interdependent world economy. [...] The widespread perception of microbes as “invaders” coming from “outside” maps neatly onto a pre-existing idea of national security involving the protection of populations against external threats.³⁰⁷

Enemark states: “The health threats most suitable for securitization are outbreaks of infectious diseases.”³⁰⁸ Yet, Price-Smith warns that “the securitization of disease should in no way be focused exclusively on the effects of one pathogen.”³⁰⁹

9.2.2 Effects of securitisation

According to Buzan/ Wæver/ de Wilde, the securitisation of an issue done by the state or nation as an actor will lead to consequences, as a result of changes in operation, irrespective of whether the securitisation was done “right” or not.³¹⁰

According to them, the advantages of securitisation can be: “focus, attention, and mobilization”³¹¹, which includes the release of resources (e.g. financial or personnel).³¹² Some examples are: the “1994 United Nations Human Development Report”³¹³, in which health security is embedded in the bigger topic of human security, the UN Security Council resolution 1308, which declared HIV/AIDS “if unchecked, may pose a risk to stability and security”³¹⁴ and the development of pandemic plans- with great variation in their expansion. The advantages can happen on the national level when health/ infectious diseases is/ are linked with national security.³¹⁵

Other effects of securitisation can be advantageous or disadvantageous. Firstly, according to Elbe, historically the state’s role was to provide security for its citizens and its decision to be in charge of providing it. According to him, this is the reason why there is a “greater and more high-level state involvement in the handling of an issue.”³¹⁶ Secondly, according to Sands/ Mundaca-Shah/ Dzau, the effect of securitisation depends on how an issue is framed. The authors criticise that the expenses are insufficient when infectious disease outbreaks are framed as health problems or as risks to security or survival. According to Behnke, when an issue or a protagonist

306. Buzan and Wæver, “Macrosecritisation and security constellations,” 253–54.

307. Elbe, “Should health professionals play the global health security card?,” 220.

308. Enemark, *Disease and Security*, 8.

309. Price-Smith, *Contagion and Chaos*, 198.

310. Buzan, Wæver and Wilde, *Security*, 30.

311. Buzan, Wæver and Wilde, *Security*, 29.

312. Elbe, “Haggling over viruses,” 479.

313. UNDP, “Human Development Report 1994,”

http://hdr.undp.org/sites/default/files/reports/255/hdr_1994_en_complete_nostats.pdf, (Accessed: 4 December 2017).

314. UN, “S/RES/1308(2000),” 2.

315. Elbe, “Should health professionals play the global health security card?,” 220.

316. Elbe, “Haggling over viruses,” 481–82.

is framed as a threat to the state or society, it creates a national identity. He concludes that states constantly securitise for the purpose of creating a national identity.³¹⁷

Examples of possible disadvantages of securitisation include the “threat-defence”. As Wæver explains: “Addressing an issue in security terms still evokes an image of threat-defense, allocating to the state an important role in addressing it. This is not always an improvement.”³¹⁸ With the topic of infectious diseases/ global health security, this threat-defence/ state-centred reaction can lead to various difficulties. For a better understanding, they are categorised in two groups. One, the implementation of emergency action. States can command the shutting down of borders, seaports, schools and universities, limitations on freedom of movement, curfews, quarantine as well as mass vaccination and/ or prescription of medication. During the 2014 Ebola outbreak, all these measures were applied. States can also implement emergency actions to (try to) stop an infectious disease from spreading to their territory. They can include the closing of borders, traveller screening, quarantine of travellers from affected states, suspension of flights to affected areas/ states, but also a ban of goods from affected regions. All the aforementioned measures are discussed in more detail later in this chapter (9.2.3.3). Two, the “threat-defence” can, as a result, have effects on various sectors of a state; especially the economic sector. The consequences to the economic sector can be multifaceted. Health/ infectious diseases can influence sustainable growth, destabilise states/ regions, which can, in worst cases, lead to weak or even collapsed states. This, in turn, can foster terrorism. Financial consequences can be enormous as well. For example, the SARS outbreak resulted in less than 800 fatalities, yet the economic effects were estimated between 30-140 billion US Dollars. For the 2014 Ebola outbreak, a World Bank estimation calculated the African gross domestic product loss resulting from the outbreak at about four billion US Dollars. The assessment of the “High-Level Panel on the Global Response to Health Crises” was about two billion US Dollars for the most affected states by Ebola and one billion US Dollars for the wider African region. Another estimation calculated six billion US Dollars in direct costs and 15 billion US Dollars in economic loss. In other words: the outbreak led to a loss of jobs and businesses as well as a drop in farming and production/ export of certain goods. In addition, it also affected the tourism of Ebola-free states.³¹⁹ A thorough discussion of the connection of health/ infectious diseases and the economy was done in chapter 8.2.3. Another disadvantage of securitisation can be difficulties in international cooperation and global health politics. For example, the 2006 H5N1 outbreak and Indonesia’s reaction to it. Back then,

317. Sands, Mundaca-Shah and Dzau, “Neglected Dimension,” 1284; Andreas Behnke, “No way out: desecuritization, emancipation and the eternal return of the political- a reply to Aradau,” *Journal of International Relations and Development* 9, no. 1 (2006): 65, <https://doi.org/10.1057/palgrave.jird.1800070>.

318. Wæver, “Securitization and Desecuritization,” 47.

319. Gostin and Friedman, “Analysis,” 1902–9; UN, “Timeline”; Elbe, “Haggling over viruses,” 480; Frenk, “Dean’s message”; Price-Smith, *Contagion and Chaos*, 3 & 200; WHO, “Summary of probable SARS cases”; Tatem, Rogers and Hay, “Global Transport Networks,” 297; WHO, “Ebola virus disease”; UN, “A/70/723,” 27–30.

Indonesia made the decision to stop sharing its virus samples³²⁰ of the H5N1 virus with the international community.³²¹ Elbe explains that Indonesia did this, partly, to achieve “greater access to vaccines and other benefits derived from the virus-sharing mechanism [...] for developing countries.”³²² According to him, the securitisation of the H5N1 virus had two effects. One, virus samples became an important “item” and were used to further national interests.³²³ Two, the risk of a pandemic led governments “to secure access to pharmacological counter-measures for reducing the spread of H5N1.”³²⁴ He states that the way the governments around the world responded to the threat of a H5N1 pandemic is “a classic example of a securitization process.”³²⁵ It also showed the “policy advantages and drawbacks that accrue when issues become securitized specifically in the field of global health.”³²⁶

Various researchers (e.g. Sands/ Mundaca-Shah/ Dzau, Kamradt-Scott/ McInnes, Lo/ Thomas, Elbe) illustrate that the securitisation of infectious diseases is often not focused on the health sector, but focused on the economic sector and social stability.³²⁷ Kamradt-Scott/ McInnes name the 1997 H5N1 outbreak, the 2003 SARS outbreak and the 2009 H1N1 outbreak as accelerators for this tendency. Socio-political stability was, according to Lo/ Thomas, the reason for Chinas avoidance of securitisation during the 2003 SARS outbreak. They describe that during a later H5N1 outbreak, Vietnam and Thailand also prevented securitisation. While the former wanted to evade economic-political expenses, the latter feared disadvantageous effects on their poultry exports. Yet, it was the poultry farmers who demanded determination of the threat and the distribution of emergency resources.³²⁸ Disadvantageous effects on the economic sector resulting from an infectious disease outbreak were noticeable during and after the 2014 Ebola outbreak. Examples were cited in the previous paragraph and in chapter 8.2.3.

In short: advantages of securitisation include the increased awareness of a topic and mobilisation. Disadvantages encompass a threat-defence view, difficulties in international cooperation and consequences for the economic sector.³²⁹

320. Virus sharing is an important factor of international health politics. Even though it is not mandatory to share samples, it was- until Indonesia's decision- an implicitness to share. One, for research reasons (e.g. changes in a strain), two, for medical reasons (e.g. development/ production of vaccines and other treatments).

321. Elbe, “Haggling over viruses,” 477.

322. Elbe, “Haggling over viruses,” 481.

323. Elbe, “Haggling over viruses,” 477.

324. Elbe, “Haggling over viruses,” 477.

325. Elbe, “Haggling over viruses,” 479.

326. Elbe, “Haggling over viruses,” 479.

327. Kamradt-Scott and McInnes, “Securitisation”; Sands, Mundaca-Shah and Dzau, “Neglected Dimension”; Lo Yuk-ping and Thomas, “Health”; Elbe, “Pandemics”.

328. Kamradt-Scott and McInnes, “Securitisation,” 100; Lo Yuk-ping and Thomas, “Health,” 448–51.

329. Elbe, “Haggling over viruses”; Wæver, “Securitization and Desecuritization”; Sands, Mundaca-Shah and Dzau, “Neglected Dimension”.

9.2.3 Steps of securitisation

As was previously summarised, securitisation requires, among other elements, an actor, an audience, an existential threat and a referent object. In the following, each necessary factor/ step is described.

9.2.3.1 Step one: Speech Act

The first step of securitisation is the identification of an existential threat to a referent object. Using language theory, security can be looked at as a “speech act.” This means, that “the utterance itself is the act. By saying it, something is done.”³³⁰ A policy maker, announcing “security” shifts an issue “into a specific area, and thereby claims a special right to use whatever means are necessary to block it.”³³¹ Yet, Wæver states that “the speech act “security” is [...] more than just a word.”³³² It is necessary to be able to stop a problem threatening security. For example: When threatened by a foreign army, a nation needs to have an army strong enough to resist the threat. Until the audience accepts a topic as a security issue, it is called a “securitisation move”.³³³ Buzan/ Wæver/ de Wilde explain that, when contemplating a securitisation move, “one has to weigh the always problematic side effects of applying a mind-set of security against the possible advantages of focus, attention, and mobilization.”³³⁴ Buzan/ Wæver illustrate:

Securitisations can be bound together positively (where a group of actors share, or partly share, a definition of threat and referent object), or negatively (where actors, or groups of actors, construct each other as threats) in the process forming potentially durable patterns of security interdependence.³³⁵

Only after the move is accepted, the topic is securitised.³³⁶

9.2.3.1.1 Actor

An actor performs a speech act. Theoretically, an actor can attempt to securitise any topic/ situation. In reality, it will be more successful with some topics than with others.³³⁷ “Security action is usually taken on behalf of, and with reference to a collectivity. The referent object is that which you can point to and say: ‘it has to survive, therefore it is necessary to [...]’.”³³⁸ In other words: “If we do not tackle this problem, everything else will be irrelevant (because we will not be here or

330. Wæver, “Securitization and Desecuritization,” 55.

331. Wæver, “Securitization and Desecuritization,” 55.

332. Wæver, “Securitization and Desecuritization,” 58.

333. Wæver, “Securitization and Desecuritization,” 58; Buzan, Wæver and Wilde, *Security*, 25.

334. Buzan, Wæver and Wilde, *Security*, 29.

335. Buzan and Wæver, “Macrosecritisation and security constellations,” 256.

336. Buzan, Wæver and Wilde, *Security*, 25.

337. Buzan, Wæver and Wilde, *Security*, 40; Buzan and Wæver, “Macrosecritisation and security constellations,” 255.

338. Buzan and Wæver, “Macrosecritisation and security constellations,” 255.

will not be free to deal with it in our own way).³³⁹ Regarding infectious diseases the action is taken on behalf of citizens/ humankind. However, “actors and their securitisations remain essentially egoistical and self-centred, and the system atomised.”³⁴⁰ Actors can include individuals (health professionals, doctors (e.g.: Gostin, Fidler, Price-Smith), policy makers and politicians (e.g. then-Senator Obama)) as well as bureaucracies, governments, lobbyists, pressure groups up to international organisations.³⁴¹

9.2.3.1.2 Security problem/ existential threat

The actor defines an issue as a security problem of which he claims it is or can be an existential threat to a referent object if it does not get handled with certain measures. Buzan/ Waever/ de Wilde explain that military and non-military threats need to comply with rigidly defined criteria to be looked at as a security issue.³⁴² Waever defines security problems as:

Developments that threaten the sovereignty or independence of a state in a particularly rapid or dramatic fashion, and deprive it of the capacity to manage by itself. This, in turn, undercuts the political order. Such a threat must therefore be met with the mobilization of the maximum effort. [...] In naming a certain development a security problem, the “state” can claim a special right, one that will, in the final instance, always be defined by the state and its elites.³⁴³

By claiming an issue needs to be handled with extraordinary measures as (otherwise) it poses a risk to humanity or it will restrict the freedom of action if it is ignored; the term security becomes a “self-referential practice”. This means the topic develops into a security issue as it is presented as such, not because it is, in fact, a threat. The use of securitisation is a possibility for power holders to attain control over an issue.³⁴⁴

The difference between “security” and “insecurity” is, according to Waever, the response to a security problem. Both have the existence of a security problem in common. With “security”, the response is that some form of action is taken. With “insecurity”, there is no response to the security problem. An example is the different reaction of states and their citizens to infectious disease outbreaks. Some states will take measures to gain control over the outbreak, whilst others will avoid securitisation for different reasons. The absence of security problems would mean complete security. Waever points out that this situation would not be labelled as such and thus never emerges.³⁴⁵ He explains: “Consequently, transcending a security problem by politicizing it cannot happen through thematization in security terms, only away from such terms.”³⁴⁶

339. Buzan, Wæver and Wilde, *Security*, 24.

340. Buzan and Wæver, “Macrosecuritisation and security constellations,” 256.

341. Buzan, Wæver and Wilde, *Security*, 40; Kamradt-Scott and McInnes, “Securitisation,” 100-101.

342. Buzan, Wæver and Wilde, *Security*, 5.

343. Wæver, “Securitization and Desecuritization,” 54.

344. Buzan, Wæver and Wilde, *Security*, 24; Wæver, “Securitization and Desecuritization,” 54.

345. Wæver, “Securitization and Desecuritization,” 56.

346. Wæver, “Securitization and Desecuritization,” 56.

9.2.3.1.3 Existential threat and referent object

Buzan/ Waever/ de Wilde declare that an “existential threat can only be understood in relation to the particular character of the referent object in question.”³⁴⁷ In addition, Buzan/ Waever illustrate: “Size or scale seems to be one crucial variable in determining what is or is not a successful referent object of security.”³⁴⁸ According to Buzan/ Waever/ de Wilde, the nature of existential threats varies across levels of analysis and sectors.³⁴⁹ The state and/ or political entities are the referent object in the military sector. Numerous democracies train their military for purposes beyond the defence of the state (e.g. peacekeeping or humanitarian interventions). However, these activities “cannot be viewed as concerning existential threats [...] or even as emergency action.”³⁵⁰ Existential threats in the political sector are usually defined in regard to sovereignty; occasionally also to the ideology of the state: “Anything that questions recognition, legitimacy, or governing authority” represents an existential threat to sovereignty.³⁵¹ On the international level, existential threats can be “situations that undermine the rules, norms, and institutions” that form international regimes.³⁵² It is a challenge to determine the referent objects and existential threats for the economic sector. The reason why is, as the status of the national economy is not an existential threat; unless the viability of the population is at risk. Large-scale identities able to function non-partisan from the state (e.g. nations, religions) are the referent object in the societal sector. For the environmental sector, the spectrum of referent objects is broad. It includes concrete topics, like the survival of particular species or environments (e.g. rainforest), but also large-scale subjects (e.g. sustainment of planetary climate and biosphere).³⁵³

9.2.3.2 Step two: Acceptance by the audience

The second step of securitisation is the acceptance by an audience. For an issue to be securitised, a securitisation move must be accepted by the targeted audience, which is usually the public.³⁵⁴ According to Buzan/ Waever/ de Wilde, accepting a securitisation move does not mean that it happened “in civilized, dominance-free discussion; it only means that an order always rests on coercion as well as on consent. Since securitization can never only be imposed, there is some need to argue one’s case.”³⁵⁵ When the topic is denied by the audience, it still is just a securitisation move.³⁵⁶

347. Buzan, Wæver and Wilde, *Security*, 21.

348. Buzan and Wæver, “Macrosecuritisation and security constellations,” 255.

349. Buzan, Wæver and Wilde, *Security*, 21–22.

350. Buzan, Wæver and Wilde, *Security*, 22.

351. Buzan, Wæver and Wilde, *Security*, 22.

352. Buzan, Wæver and Wilde, *Security*, 22.

353. Buzan, Wæver and Wilde, *Security*, 22–23.

354. Buzan, Wæver and Wilde, *Security*, 25.

355. Buzan, Wæver and Wilde, *Security*, 25.

356. Buzan, Wæver and Wilde, *Security*, 25.

9.2.3.2.1 Perception of risks

Before moving to the next step of securitisation, it is necessary to briefly illustrate how the perception of risks influences actors, moves and audiences.

In general, all states and people “share a universal physical threat perception against themselves as referent objects, from nuclear weapons [...] through disease.”³⁵⁷ However, one has to distinguish between an objective (a real threat) and a subjective threat (a perceived threat).³⁵⁸ Buzan/ Wæver/ de Wilde explain: “It is not easy to judge the securitization of an issue against some measure of whether that issue is “really” a threat; doing so would demand an objective measure of security that no security theory has yet provided.”³⁵⁹ Already in 1980 Slovic/ Fischhoff/ Lichtenstein observed: “Society appears to react more strongly to infrequent large losses of life than to frequent small losses.”³⁶⁰ The 2014 Ebola outbreak is an example of such an event drawing (worldwide) attention. The 2002 “World Health Report” agrees with Slovic/ Fischhoff/ Lichtenstein: “The higher the dread factor levels and the higher the perceived unknown risks, the more people want action to reduce these risks, including through stricter government regulation and legislative controls.”³⁶¹ According to Elbe, the H5N1 virus is an example for how perceived threats and fear can force governments into action: “The considerable international anxiety around H5N1 created immense domestic pressures for governments to be seen to be taking the strongest possible action to protect citizens against a pending pandemic.”³⁶² Buzan/ Wæver/ de Wilde explain that sometimes the reaction to a securitisation by a nation matters to other nations as it affects the response of actors to a security problem. This behaviour affects the interaction of securities in the international system.³⁶³

9.2.3.3 Step three: Emergency action

After the issue has been accepted by the audience, the next step is the implementation of emergency action to tackle the threat. To move the securitised issue into emergency mode various participants as well as their cooperation are necessary for the successful securitisation of an issue.³⁶⁴ Measures utilised to tackle issues can include “isolation, quarantine and contact tracing, [...] traveller screening, [...] closing schools and cancelling mass spectator events.”³⁶⁵ During the 2014 Ebola outbreak, all the listed actions were applied. Some of them by the most

357. Buzan and Wæver, “Macrosecuritisation and security constellations,” 264.

358. Buzan, Wæver and Wilde, *Security*, 30.

359. Buzan, Wæver and Wilde, *Security*, 30.

360. Paul Slovic, Baruch Fischhoff, and Sarah Lichtenstein, “Facts and Fears: Understanding Perceived Risk,” in *Societal Risk Assessment: How Safe is Safe Enough?*, ed. Richard C. Schwing and Walter A. Albers, General Motors Research Laboratories (Boston, MA: Springer US, 1980), 208.

361. WHO, “The World Health Report 2002: Reducing Risks, Promoting Healthy Life,” http://www.who.int/whr/2002/en/whr02_en.pdf, 32, (Accessed: 30 April 2018).

362. Elbe, “Haggling over viruses,” 480.

363. Buzan, Wæver and Wilde, *Security*, 30.

364. Lo Yuk-ping and Thomas, “Health,” 450.

365. Elbe, “Haggling over viruses,” 480.

affected states itself; for example: the closing of borders, seaports, schools and universities as well as the ban of football events. Movement limitations/ curfews, quarantines and a shutdown were also enforced.³⁶⁶ During the implementation of these extreme measures, “photographs appeared in news media of police brutally attacking the public for breaching curfews.”³⁶⁷ Related to this, the “Independent Commission on Multilateralism” declares that the outbreak “deteriorated security, with local police and military using lethal force to quarantine areas and rioting mobs attacking and killing officials.”³⁶⁸ Other possibilities of emergency action can include mass vaccination and the prescription of pharmaceuticals. For example, during the 2014 Ebola outbreak, Guinea allowed the application of experimental drugs. However, a sudden and high demand for medical countermeasures can lead to shortages in the supply and production. Other extreme measures were applied to avoid the spread to other states. For example: closing of borders, traveller screening, quarantine of travellers from Ebola-affected states, suspension of flights to affected areas/ states.³⁶⁹ The report of the “High-Level Panel” illustrates that during the 2014 Ebola outbreak “approximately 70 countries imposed more than 500 different measures.”³⁷⁰ According to Horton/ Das, “more authoritarian-minded governments [...] [might] use health crises as justification for sometimes extreme curbs on liberty or the political, economic, and social rights of citizens.”³⁷¹ Lo/ Thomas explain that the emergency mode can be avoided “by restricting information flows, actors and resources.”³⁷² They point out that securitisation may be prevented in states with authoritarian political systems, even if they accept basic freedoms as well as in states with plural democratic systems, even if they are weaker when compared to Europe.³⁷³

9.2.3.4 Step four: Desecuritisation

When the threat is under control, the final step is to move the issue to the desecuritisation phase. Buzan/ Hansen state: “Desecuritisation [...] is the movement of an issue out of the threat-danger modality of security and into the logic of politics, where compromise, solutions and debate is made possible to a much larger extent.”³⁷⁴ Behnke illustrates that desecuritisation happens when there is no speech act and not because a speech act declared an issue to be desecuritized.³⁷⁵ Another way of achieving desecuritisation is, according to Waeber, when a topic stays securitized “to keep

366. Gostin and Friedman, “Analysis,” 1902–9; UN, “Timeline”.

367. Horton and Das, “Global health security now,” 1805.

368. ICM, “Global Pandemics and Global Public Health”.

369. Elbe, “Haggling over viruses,” 480; UN, “Timeline”; Gostin and Friedman, “Analysis,” 1902–9.

370. UN, “A/70/723,” 30.

371. Horton and Das, “Global health security now,” 1805.

372. Lo Yuk-ping and Thomas, “Health,” 451.

373. Lo Yuk-ping and Thomas, “Health,” 450.

374. Barry Buzan and Lene Hansen, *The Evolution of International Security Studies* (Cambridge: Cambridge University Press, 2009), 216–17.

375. Behnke, “No way out,” 65.

the responses in forms that do not generate security dilemmas and other vicious spirals.”³⁷⁶ Buzan/ Waever/ de Wilde claim that “deseuritization is the optimal long-range option.”³⁷⁷ Waever believes that deseuritisation “would be more effective than securitizing problems.”³⁷⁸ However, according to Buzan/ Hansen, deseuritisation is not, invariably, desirable, namely when it is used to suppress an issue. Politicisation should take the place of deseuritisation instead of silence.³⁷⁹ While Buzan/ Waever/ de Wilde recommend deseuritisation, they clarify that “in specific situations one can choose securitization- only one should not believe this is an innocent reflection of the issue being a security threat; it is always a political choice to securitize or to accept a securitization.”³⁸⁰

9.2.4 Macrosecuritisation

The previous sections and the cited examples focussed mainly on securitisation on the middle level, namely states. For studying securitisation at the system level, Buzan/ Waever introduce “macrosecuritisation”, which is defined the same way as securitisation is.³⁸¹ Yet, “the key difference is that they are on a larger scale than the [...] middle level [...] and seek to package together securitisations from that level into a ‘higher’ and larger order.”³⁸²

The advantages of a successful macrosecuritisation can be immense: “It can define, demonstrate and legitimate leadership. It can support claims to exceptionalism and special rights. It can facilitate and sustain alliance formation. And it can help to demarcate spheres of influence and boundaries of containment.”³⁸³ When securitisation happens on the international level, it is so existential and relevant that it needs to be “dealt with decisively by top leaders prior to other issues.”³⁸⁴ According to Elbe, there has been a

tendency by many policy makers to try to deliberately shift global health from the mould of ‘low’ politics, and to make global health a more pressing concern of ‘high’ politics, by actively seeking the securitization of health through the agenda on global health security.³⁸⁵

For example, the 2014 Ebola outbreak was dealt with by the WHO, the UN and other organisations such as the CDC and MSF. In addition, there are several other, previously mentioned, examples such as the UN resolution 1308 in 2000, the outbreaks of SARS (2003) and H5N1 (2005) as well as the 2009 H1N1 pandemic.

376. Ole Wæver, “The EU as a security actor: Reflections from a pessimistic constructivist on post-sovereign security orders,” in *International Relations Theory and the Politics of European Integration. Power, security, and community*, ed. Morten Kelstrup and Michael C. Williams (London: Routledge, 2000), 253.

377. Buzan, Wæver and Wilde, *Security*, 29.

378. Wæver, “Securitization and Deseuritization,” 57.

379. Buzan and Hansen, *The Evolution of International Security Studies*, 217.

380. Buzan, Wæver and Wilde, *Security*, 29.

381. Buzan and Wæver, “Macrosecuritisation and security constellations,” 257.

382. Buzan and Wæver, “Macrosecuritisation and security constellations,” 257.

383. Buzan and Wæver, “Macrosecuritisation and security constellations,” 268.

384. Buzan, Wæver and Wilde, *Security*, 29.

385. Elbe, “Haggling over viruses,” 484.

Yet, according to Lo/ Thomas, “even within international organizations it is difficult to securitize a health threat due to political considerations.”³⁸⁶ They add: “The fact that the target audience for such regional or international organizations are the member states- whose interests are the ones being infringed- only further complicates the ‘acceptance’ stage of securitization.”³⁸⁷ According to Lo/ Thomas, states have various possibilities to react to the securitisation of issues by international politics. One, they can reject the securitisation. They try to justify their behaviour by saying “that states hold the monopoly on the speech act and any acts by organizations seeking to articulate a threat are invalid.”³⁸⁸ As previously explained, authoritarian systems/ politicians have a higher tendency to avoid securitisation (e.g. China during the 2003 SARS outbreak, Vietnam during the H5N1 outbreak). Two, states decide how to respond to a successful securitisation on the international level. Firstly, they can more or less “deny” the threat (e.g. ascertain priorities differently so it leads to desecuritisation). Secondly, they can act against international politics/ organisations.³⁸⁹ Lo/ Thomas illustrate: “States will react against the actions by international organizations where either their own national interests are jeopardized or where the organization is perceived as having exceeded its mandate and infringed on members’ sovereign rights.”³⁹⁰ As examples for this argument the following can be cited: the reaction of states after the UN resolution 1308 on HIV/ AIDS and Indonesia’s decision during the H5N1 outbreak to stop sharing its virus samples. Thirdly, they can try to promote national interests on the international level. Here, the Indonesian decision to stop sharing virus samples can also be provided as an example.

9.2.5 Criticism of the securitisation theory

Several researchers have criticised the securitisation theory in the past. Lo/ Thomas criticise that “although its analytical framework is generally accepted, its utility remains contested; especially in non-European and non-state settings.”³⁹¹ They add that “its applicability remains unclear” and that “there are contextual problems in applying securitization to issues of health insecurities.”³⁹² McInnes/ Lee are discontent with the term “existential threat”. They declare:

Health issues rarely represent existential threats to the state in the way in which nuclear weapons or invasion might; but neither do many other issues which are considered ‘security’ threats. Thus, the term ‘existential’ as used by the Copenhagen School appears to set the threshold excessively high and ‘extreme’ or ‘exceptional’ might be a more accurate description of the nature of the threat.³⁹³

386. Lo Yuk-ping and Thomas, “Health,” 448.

387. Lo Yuk-ping and Thomas, “Health,” 450.

388. Lo Yuk-ping and Thomas, “Health,” 448.

389. Lo Yuk-ping and Thomas, “Health,” 448.

390. Lo Yuk-ping and Thomas, “Health,” 450.

391. Lo Yuk-ping and Thomas, “Health,” 447.

392. Lo Yuk-ping and Thomas, “Health,” 450.

393. Kamradt-Scott and McInnes, “Securitisation,” 96-97.

Stritzel partially criticises the securitisation theory, claiming it is “too undertheorized and contradictory to provide clear guidance for detailed empirical analyses.”³⁹⁴ He also claims Buzan/ Waever/ de Wilde are apparently neglecting “the complexity and historical contingency of the concept of security.”³⁹⁵ He adds that the emergence of new security risks seems to destroy “understandings of security but also a previous clear demarcation of ‘internal’ and ‘external’ in security affairs.”³⁹⁶ However, Buzan and Waever are aware of the securitisation theory’s “shortcomings in terms of silences, non-verbal securitisations, causal explanations, and the need to refine the understanding of audience(s).”³⁹⁷

9.2.6 Medicalisation

Medicalisation started during or even before the 1960s. It can be illustrated as a development where non-medical problems become classified and considered as medical ones. Yet, it is important to focus the definition on the medical part.³⁹⁸

The difference between securitisation and medicalisation is, according to Elbe, that the latter brings “greater awareness of the limitations that continue to surround modern medical practice.”³⁹⁹ Aside from sociologists, anthropologists, physicians and historians have also supported the concept of medicalisation in the past.⁴⁰⁰ Elbe states:

Various scholars have already been able to trace such medicalisation processes in relation to a diverse set of social phenomena ranging from addiction, alcoholism, childbirth, ageing and baldness, all the way through to homosexuality, compulsive gambling, menopause, hyperactivity, post-traumatic stress disorder and obesity.⁴⁰¹

In short: every topic can be medicalised. According to Elbe, one advantage of medicalisation is that it has led to the development of new therapies. Yet, it is possible that side effects of new pharmaceuticals only show after they are used on larger and longer scales when compared to the shorter duration of clinical studies. One example is the Ebola virus. It took nearly 40 years, after the first big outbreaks in Africa in the 1970s to develop a vaccine to treat the disease. However, there are no long-term studies available examining the possible side effects. One disadvantage of medicalisation is pandemic preparedness. Elbe warns that focussing too much on medical countermeasures holds the risk that one might think there is security, when there is in fact not (e.g. stockpiling of pharmaceuticals such as Tamiflu).⁴⁰²

394. Holger Stritzel, *Security in Translation. Securitization Theory and the Localization of Threat*, New Security Challenges (Basingstoke, Hampshire: Palgrave Macmillan, 2014), 12.

395. Stritzel, *Security in Translation*, 15.

396. Stritzel, *Security in Translation*, 17.

397. Buzan and Wæver, “Macrosecritisation and security constellations,” 254.

398. Elbe, “Pandemics,” 858–59.

399. Elbe, “Pandemics,” 862.

400. Elbe, “Pandemics,” 858–59.

401. Elbe, “Pandemics,” 859.

402. Elbe, “Pandemics,” 862–64.

Elbe lists three aspects, which illustrate the growth of medicalisation. Firstly, the rise of health security redefines security (partly) as a medical problem. Secondly, medical and public health experts as well as health programmes play a growing role in the medicalisation of health and subsequently in foreign and security policy. In addition, health organisations (e.g. WHO) have been empowered with more legal powers. Lastly, the boosting of health security leads to a significant change in the allocation of security; particularly regarding pharmaceutical interference. As for shaping medicalisation in international politics, Elbe names the HIV/ AIDS virus, the 2003 SARS outbreak and the H5N1 virus as accelerators and describes why. The HIV/ AIDS virus was the first infectious disease which linked health with security. The 2003 SARS outbreak demonstrated that infectious diseases pose a risk to security even if they do not threaten a nation in the traditional meaning of security. In other words: if an infectious disease leads to high mortality rates and poses a threat to the economic sector, it may be seen as a security risk.⁴⁰³ The H5N1 virus resulted in infectious diseases, which only “might” pose a threat in the future, being added to the medical dimension of security. This extension increased the medical aspect of security regarding infectious diseases to the broadest extent possible. In addition, the perception of infectious diseases being a risk to national and international security has to be added to the “real” threat they pose.⁴⁰⁴

This chapter gave a brief overview of the evolution of security studies as well as a brief introduction to the comprehensive security. Subsequently, the securitisation theory (effects, steps, macrosecuritisation, criticism) was discussed. Lastly, medicalisation was explained. The following chapter analyses selected organisations to answer the research question and to support or refute the hypothesis of this master’s thesis.

403. The focus on the economic sector regarding the securitisation of infectious diseases has been pointed out by Sands/ Mundaca-Shah/ Dzau, Kamradt-Scott/ McInnes, and Lo/ Thomas as well. Sands, Mundaca-Shah and Dzau, “Neglected Dimension”; Kamradt-Scott and McInnes, “Securitisation”; Lo Yuk-ping and Thomas, “Health”.

404. Elbe, “Pandemics,” 849-855 & 862.

10. Analysis of security strategies/ resolutions

Why and how infectious diseases pose a risk to security was discussed and illustrated throughout this thesis. This was undertaken in general, but also in specific to the 2014 Ebola outbreak in West Africa. The consequences of weak health systems, delayed international response and action as well as deficient coordination were highlighted. This chapter reviews the security strategies/ resolutions of selected organisations, after explaining the analysis conducted and the aims thereof.

10.1 The analysis

In the following analysis, the focus is on the system level (regional and international organisations). While chapter 5 described how the analysis is conducted exactly, it is necessary at this point to repeat the most important parameters.

The security strategy (EU) or resolutions (WHO, UN, AU) are examined- with focus on the WHO.⁴⁰⁵ This is accomplished in two steps. The first step is the screening of the sources based on pre-selected keywords and the second step is the review itself. The EU document is studied on the basis of pre-defined questions to identify changes between the previous and the current one regarding the evaluation of infectious diseases as a security risk. As there is no security strategy available for the WHO, the UN and the AU (in effect for the whole organisation), resolutions are examined instead. A list of pre-selected keywords is used to filter the enormous amount of resolutions for relevant ones. Here, the focus is on resolutions, which discuss the 2014 Ebola outbreak or which name it as the reason for change/ reform. The emphasis is on announced or already implemented changes. The timeframe determined for the analysis is January 2014 until May 2017.

The first of two objectives is to answer the first research question: Which changes did the 2014 Ebola outbreak cause in the evaluation of infectious diseases as a security risk in security strategies/ resolutions? The second objective is to support or refute the hypothesis: "The 2014 Ebola outbreak led to a further securitisation of infectious diseases." This is done by implementing the securitisation theory into the review.

The analysis starts with the WHO, followed by the UN, the EU and the AU. The study of each organisation is completed in three parts. Firstly, by a conclusion, which consists of a short summary of results, secondly, the answer to the research question and thirdly, the support or refutation of the hypothesis.

405. The reasons why each organisation was selected are described in chapter 3.

10.2 World Health Organization

In general, a nation's public health sector is responsible for securing its citizens health. In particular, the state should protect them from diseases and contain the disease when an outbreak occurs.⁴⁰⁶ On the international level the WHO takes this role. The WHO's constitution says:

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States.⁴⁰⁷

The WHO tries to protect humankind from health emergencies by coordinating its work among three levels- state, regional and global level. Emergencies are classified in grades one to three; with three being the highest severity level. The 2014 Ebola outbreak was classified a grade three for a duration of nearly two years (July 2014-June 2016).⁴⁰⁸ Gostin/ Friedman state that "the Ebola outbreak in west Africa should have been the type of moment for which WHO was created."⁴⁰⁹ Yet, the outbreak revealed several weak points within the organisation as well as failures in the response to the outbreak. In January 2015, the WHO held a special session on Ebola resulting in resolution EBSS3.R1. This resolution as well as the 68th World Health Assembly (WHA) were starting points to initiate a substantial reform.⁴¹⁰

10.2.1 Resolution EBSS3.R1

The WHO declared in resolution EBSS3.R1: "Recognizing the urgent need for an improved and more effective and coordinated response capacity for the international community, and especially for WHO and Member States, in responding to health-related emergencies."⁴¹¹ In the resolution the Executive Board requests the Director-General, among other points,

to further develop mechanisms for the use of existing emergency stand-by capacities [...]; [...] to apply lessons learnt to future WHO work [...]; [...] [to] identify gaps and formulate concrete needs in order to prevent and respond more effectively to future outbreaks [...]; [...] to strengthen the emergency operational capabilities of the Organization.⁴¹²

406. Alexander Kelle, "Securitization of International Public Health: Implications for Global Health Governance and the Biological Weapons Prohibition Regime," *Global Governance* 13, no. 2 (2007): 217.

407. WHO, "Constitution of the World Health Organization," http://www.who.int/governance/eb/who_constitution_en.pdf, 1, (Accessed: 26 May 2017).

408. WHO, "A70/9: Health Emergencies: WHO response in severe, large-scale emergencies," http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_9-en.pdf, 1–2, (Accessed: 23 May 2017).

409. Gostin and Friedman, "Analysis," 1903.

410. WHO, "World Health Assembly gives WHO green light to reform emergency and response programme," <http://www.who.int/mediacentre/news/releases/2015/wha-23-may-2015/en/>, (Accessed: 26 May 2017).

411. WHO, "EBSS3.R1: Ebola: ending the current outbreak, strengthening global preparedness and ensuring WHO's capacity to prepare for and respond to future large-scale outbreaks and emergencies with health consequences," http://apps.who.int/gb/ebwha/pdf_files/EBSS3/EBSS3_R1-en.pdf, 2, (Accessed: 25 May 2017).

412. WHO, "EBSS3.R1," 5–7.

The Executive Board also pointed out “the urgent need to encourage and maximize efforts on scientific, epidemiological and biological research, including the sharing of samples and epidemiological data.”⁴¹³ In addition, the Director-General was ordered, among others,

to take all necessary steps to ensure that, in the case of outbreaks and emergencies with health consequences, funding can be speedily reallocated and disbursed to areas of most need [...]; [...] to commission an interim assessment, by a panel of outside independent experts, on all aspects of WHO’s response, from the onset of the current outbreak of the Ebola virus disease [...]; [...] [to establish] an IHR Review Committee panel of experts [...] to conduct an assessment of the overall prevention, preparedness and response to the outbreak of the Ebola virus disease and the effectiveness of the International Health Regulations (2005) [...]; [...] [and] to engage within the United Nations system on lessons learnt from this response for improving coordination and effectiveness for future outbreaks.⁴¹⁴

Resulting from the resolution, several panels/ committees were created to identify failures and to make recommendations to reform the organisation so as to be better prepared in the future.

The panels/ committees include the:

- “Ebola Interim Assessment Panel”⁴¹⁵
- “Director-General’s Advisory Group on Reform of WHO’s Work in Outbreaks and Emergencies with Health and Humanitarian Consequences”⁴¹⁶
- “Secretary-General’s High-Level Panel on the Global Response to Health Crises”⁴¹⁷
- “Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response”⁴¹⁸
- “Harvard-LSHTM⁴¹⁹ Independent Panel on the Global Response to Ebola”⁴²⁰
- “Commission on a Global Health Risk Framework for the Future”⁴²¹

All recommendations made were summarised thematically and by panel/ committee.⁴²² At the 69th WHA in May 2016, the member states “have agreed to one of the most profound transformations in the Organization’s history.”⁴²³ The reforms focus is on six areas: “unified WHO emergency programme, global health emergency workforce, IHR core capacities and resilient national health systems, improvements to the IHR, accelerated research and development, and international

413. WHO, “EBSS3.R1,” 9.

414. WHO, “EBSS3.R1,” 9–10.

415. WHO, “Report of the Ebola Interim Assessment Panel”.

416. WHO, “Advisory Group on Reform of WHO’s Work in Outbreaks and Emergencies with Health and Humanitarian Consequences,” http://www.who.int/about/who_reform/emergency-capacities/advisory-group/en/, (Accessed: 26 May 2017).

417. UN, “A/70/723”.

418. WHO, “A69/21: Report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response,” http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_21-en.pdf, (Accessed: 26 May 2017).

419. LSHTM stands for: London School of Hygiene & Tropical Medicine.

420. Suerie Moon et al., “Will Ebola change the game? Ten essential reforms before the next pandemic. The report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola,” *The Lancet* 386, no. 10009 (2015), [https://doi.org/10.1016/S0140-6736\(15\)00946-0](https://doi.org/10.1016/S0140-6736(15)00946-0).

421. Commission on a Global Health Risk Framework for the Future and National Academy of Medicine, *The Neglected Dimension of Global Security: A Framework to Counter Infectious Disease Crises* (Washington, DC: National Academies Press (US), 2016). <https://doi.org/10.17226/21891>.

422. WHO, “Recommendations to WHO on its work in health emergencies and WHO’s response to those recommendations,” http://www.who.int/about/who_reform/emergency-capacities/emergencies-recommendations-response.pdf, (Accessed: 25 May 2017).

423. WHO, “Renewed Partnerships build momentum for WHO’s new Health Emergencies Programme,” http://www.who.int/about/who_reform/emergency-capacities/en/, (Accessed: 29 May 2017).

financing/ Contingency Fund.”⁴²⁴ The most important programmes/ reform points are discussed in the following.

10.2.2 WHO Health Emergencies Programme

Four out of six panels/ committees⁴²⁵ recommended the establishment of a “WHO Centre for Emergency Preparedness and Response”. However, as a result of the reactions of member states, the Director-General decided to establish a programme.⁴²⁶ The “WHO Health Emergencies Programme (WHE)”⁴²⁷ was created in May 2016.

The WHE Programme “represents a fundamental development for the Organization, complementing WHO’s traditional technical and normative role with new operational capacities and capabilities for its work in outbreaks and humanitarian emergencies.”⁴²⁸ It is set out to accelerate the WHO’s response to emergencies and to make it more transparent.⁴²⁹ The Programme’s principles are: “One workforce, one budget, one set of rules and processes, and one set of standard performance metrics.”⁴³⁰ Head of the Programme is an Executive Director with various authorities; one of them is the ability to relocate personnel within three days. The progress and work of the WHE Programme is monitored by the “Independent Oversight and Advisory Committee (IOAC)”. The committee consists of health experts and was founded by the Director-General.⁴³¹ By the end of 2017 the goal of staffing all “priority positions in headquarters, regional offices and priority countries will be completed.”⁴³²

Financing of the Programme “require[s] a combination of core financing of the Programme for baseline staff and activities at the three levels of the Organization, full financing of the WHO Contingency Fund for Emergencies [...], and crisis-specific financing for activities in protracted crises.”⁴³³

WHO Health Emergencies Programme- one year later

A year after the establishment of the WHE Programme, the IOAC’s report was presented at the 70th WHA. The report identifies advancements since the creation of the Programme, weaknesses which need to be addressed and makes recommendations to better the Programme.⁴³⁴ Two

424. WHO, “Renewed Partnerships”.

425. The exceptions are the “Director-General Advisory Group on Reform of WHO’s Work in Outbreaks and Emergencies with Health and Humanitarian Consequences” and the “Review Committee on the Role of the IHR (2005) in the Ebola Outbreak and Response”. WHO, “Recommendations to WHO,” 1.

426. WHO, “Recommendations to WHO,” 1.

427. The Programme is also referred to as: “WHE”.

428. WHO, “A69/30: Reform of WHO’s work in health emergency management,” http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_30-en.pdf, 1, (Accessed: 28 May 2017).

429. WHO, “A69/30,” 1.

430. WHO, “A69/30,” 2.

431. WHO, “A69/30,” 2-3 & 5.

432. WHO, “A69/30,” 6.

433. WHO, “A69/30,” 6.

434. WHO, “A70/8: Report of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme,” http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_8-en.pdf, 3, (Accessed: 22 July 2017).

statements from the report need to be pointed out as they show the WHO's willingness to learn from past failures. One, the "WHO is making efforts at all levels to transform itself into an operational organization in emergencies."⁴³⁵ Two, the "WHO is demonstrating that it can be a reliable and competent partner."⁴³⁶ However, the report alerts to the fragility of the advancements made as the "WHO's "no regrets" policy has not yet been fully embedded into all areas of crisis response."⁴³⁷ Furthermore, it criticises that the WHE Programme created more than 1,400 positions, but has yet to recruit personnel for more than half of them. The advice is given to open recruiting from internal to external. At the same time, it warns of hiring too many temporary staff as they might lack motivation as compared to long-term contracted staff. The long recruitment process of around 87 days, which is a major disadvantage in health emergencies, is another point that is disapproved of. In contrast, the report recommends that the WHE Programme build a pool of pre-screened and pre-approved candidates able to immediately start their work in the field. It is acknowledged that donors are more certain for the WHO's field work as the organisation shows it is capable of coordination and response at the same time. In addition, the organisation is complimented on its improvements in responding to emergencies. The advancements of the WHE Programme in strengthening teams by incorporating national and regional staff is also noticed. Yet, the WHO is advised to clearly clarify roles and phases in the event of health emergencies as the current process is complex.⁴³⁸

10.2.3 Contingency Fund for Emergencies

The "Contingency Fund for Emergencies (CFE)" was already proposed by the WHO in 2011. Yet, it was only established in May 2015 during the Ebola outbreak and is now part of the WHE Programme.⁴³⁹

The CFE was created to start its work, in case of health emergencies, immediately for up to three months until other resources are available. The fund gives the WHO the opportunity to release resources and to have standby workforce to rapidly start their work. The release of funds will be made in three steps: in the first step, immediately when an emergency is reported. In the second step, within 24-48 hours after the beginning of an emergency and in the third step, 72 hours after the start of an emergency. The CFE will also fund the "Global Health Emergency Workforce" to immediately respond to emergencies as well as the WHO's guidance and coordination of health

435. WHO, "A70/8," 11.

436. WHO, "A70/8," 11.

437. WHO, "A70/8," 4.

438. WHO, "A70/8," 4–11.

439. WHO, "EB130/5 Add.6: WHO reform. Managerial reform: contingency fund for outbreaks," http://apps.who.int/gb/ebwha/pdf_files/EB130/B130_5Add6-en.pdf, (Accessed: 30 July 2017); WHO, "Contingency Fund for Emergencies (CFE)," http://www.who.int/about/who_reform/emergency-capacities/contingency-fund/en/, (Accessed: 30 July 2017); WHO, "The WHO Contingency Fund for Emergencies," http://www.who.int/about/who_reform/emergency-capacities/contingency-fund.pdf, (Accessed: 30 May 2017).

emergencies (e.g. rapid deployment of staff, installation of technical equipment and/ or offices in the field, train local authorities).⁴⁴⁰

The CFE is financed in two ways: one, through voluntary contributions and two, through retrospective financing from other emergency funding sources. By April 2016, the WHO only received 26.9 million of the targeted 100 million US Dollars of the CFE. By April 2017, the CFE had collected a total of 37 million US Dollars. This is an increase of 37.5 percent within one year and can be interpreted as a genuine will to reform the WHO. In its 2017 report, the IOAC criticised the effectiveness of the CFE and advised the WHO to adapt their plans for the fund.⁴⁴¹

10.2.4 Implementation of the International Health Regulations

The “International Health Regulations (IHR)” were adopted in 2005 and entered into force in 2007. They are “a global framework that has contributed significantly to an increase in information sharing, risk assessment and coordination of response in relation to international public health risks and emergencies.”⁴⁴²

At the 69th WHA, the suggestions of the “Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response”⁴⁴³ were presented and decision WHA 69.14 was adopted.⁴⁴⁴ The committee’s aim was to develop

a draft global implementation plan for the recommendations of the Review Committee that includes immediate planning to improve delivery of the International Health Regulations (2005) by reinforcing existing approaches, and that indicates a way forward for dealing with new proposals that require further Member State technical discussions.⁴⁴⁵

The global implementation plan introduces modalities and approaches to enforce the recommendations. In addition, it classifies six areas of action.⁴⁴⁶ These areas are:

accelerating States Parties’ implementation of the International Health Regulations (2005) [...]; [...] strengthening WHO’s capacity to implement the International Health Regulations (2005) [...]; [...] improving the monitoring and evaluation of and reporting on core capacities under the International Health Regulations (2005) [...]; [...] improving event management, including risk assessment and risk communication [...]; [...] additional health measures and enhancing compliance with the Temporary Recommendations and advice given by the Director-General

440. WHO, “The WHO Contingency Fund for Emergencies,” 4.

441. WHO, “The WHO Contingency Fund for Emergencies,” 4–5; WHO, “A69/30,” 6–7; WHO, “Contingency Fund for Emergencies (CFE) income and allocations,” http://www.who.int/about/who_reform/emergency-capacities/contingency-fund/en/, (Accessed: 30 July 2017); WHO, “A70/8,” 8.

442. WHO, “A70/15: Implementation of the International Health Regulations (2005). Global Implementation Plan,” http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_15-en.pdf, 5, (Accessed: 29 July 2017).

443. The Review Committee was established in May 2015 with the aim to review the efficiency of the IHR (2005) regarding the 2014 Ebola outbreak, to review the status of implementation of the proposals made by the Review Committee in 2011 and their impact on the 2014 Ebola outbreak and to make recommendations to improve the IHR (2005). WHO, “The Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response,” <http://www.who.int/ihr/review-committee-2016/en/>, (Accessed: 21 July 2017).

444. WHO, “A70/16: Implementation of the International Health Regulations (2005). Global Implementation Plan,” http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_16-en.pdf, 1, (Accessed: 29 July 2017).

445. WHO, “A70/16,” 1.

446. WHO, “A70/16,” 2.

under the International Health Regulations (2005) [...]; and [...] rapid sharing of scientific information.⁴⁴⁷

In 2016, simulation exercises were held in 17 states. The exercises were mainly conducted at the national and subnational level, while some had regional or global range. The aim was to test, among others, preparedness, coordination ability, response to certain infectious disease outbreaks as well as the implementation of the IHR. The simulations demonstrated shortcomings and presented solutions to strengthen preparedness and response. The WHO declares that once the global implementation plan is adopted and fully implemented, the IHR implementation will be accelerated.⁴⁴⁸

10.2.5 Research and development

The establishment of the “blueprint for research and development preparedness and response (R&D Blueprint)” is another result of the 2014 Ebola outbreak in West Africa. Work to develop a Blueprint began in June 2015 because of resolution EBSS3.R1.⁴⁴⁹ Its goal

is to reduce delays between the identification of an outbreak and the deployment of effective medical interventions to save lives and minimize socioeconomic disruption. Areas under the Blueprint include product research and development for diagnostics, vaccines, therapeutics and vector control tools, as well as necessary and relevant research in social sciences and epidemiology.⁴⁵⁰

How mortality and the economy are linked with infectious diseases was illustrated in chapters 1.1 and 8.2.3.

A 2017 report points out that the 2014 Ebola outbreak and the Zika outbreak emphasised the importance of having a R&D Blueprint available before an outbreak occurs to rapidly react to it. The Blueprint includes the establishment of a platform for sharing technologies⁴⁵¹, which have the capability to boost research and development- even in low and middle-income states. One aim is to develop and produce products within months as compared to years. Another objective is the development of affordable products, stemming from such a platform, so they can be distributed among people at risk. In addition, any proposal must be able to address more than three pathogens on the priority list of pathogens to be debated.⁴⁵² The list of pathogens with priority for research and development was revised for 2017 and only contains diseases “for which there are

447. WHO, “A70/16,” 2.

448. WHO, “A70/15,” 3–4.

449. WHO, “A70/10: Research and development for potentially epidemic diseases,” http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_10-en.pdf, 1, (Accessed: 29 July 2017).

450. WHO, “A70/10,” 1.

451. By February 2016, WHO had received 35 proposals. The six most auspicious included: three vaccine platforms, one diagnostics platform, one immunotherapy platform and one platform encompassing all product flows. WHO, “A70/10,” 4.

452. WHO, “A70/10,” 2–4; WHO, “Public consultation on ideas for platforms technologies,” http://www.who.int/medicines/ebola-treatment/public_consult_platform-tech/en/, (Accessed: 29 August 2017).

no medical countermeasures available.”⁴⁵³ It includes among others: the Ebola virus⁴⁵⁴, MERS, SARS and the Zika virus.⁴⁵⁵

In September 2016, a memorandum of understanding with the “Coalition for Epidemic Preparedness Innovations” was signed. Its goal is the funding and coordination of the development of new vaccines to avoid and control infectious diseases.⁴⁵⁶ In addition, the WHO establishes “global norms for sharing data and results, and elaborating mechanisms for collaboration and data sharing during public health emergencies.”⁴⁵⁷

10.2.6 Human resources

A WHO report states that between 2013 and 2016 staff increased by 11 percent. Simultaneously, workforce costs were reduced.⁴⁵⁸ This increase in workforce personnel comes after an earlier reduction of personnel, as Gostin/ Friedman explain: “In May, 2011, [...] WHO experienced a half-billion dollar budget cut, losing 300 headquarter jobs. WHO’s emergency response unit lost nearly two-thirds of its staff; the Regional Office for Africa (AFRO) lost nine of 12 emergency response specialists.”⁴⁵⁹

The increase in workforce personnel started at the same time as the first case of the Ebola virus occurred in West Africa (December 2013) and was, therefore, not initiated by the outbreak. However, it can be hypothesised that the outbreak is partly responsible for the recent expansion in staff, as the Executive Board declared in resolution EBSS3.R1: “Among others, the shortcomings in WHO’s human resources systems and processes slowed down the response to Ebola virus disease.”⁴⁶⁰

10.2.7 Framework of Engagement with Non-State Actors

Another reform stemming from the 2014 Ebola outbreak is the “Framework of Engagement with Non-State Actors (FENSA)”. Its aim was to be established before the 70th WHA in May 2017 and

453. WHO, “A70/10,” 4.

454. It has to be pointed out that the WHO announced a vaccine that has been proven to be effective in December 2016. This raises the question why the Ebola virus is on the priority list for 2017. Possible answers to this question could be: one, the decision for the priority list has been made before the vaccine was announced at the end of December 2016 or two, that no long-term studies, which examine possible side effects, are yet available for the vaccine and, therefore, the virus continues to be on the list.

455. WHO, “A70/10,” 4.

456. WHO, “A70/10,” 5.

457. WHO, “A70/10,” 5.

458. WHO, “A70/45: Human resources: annual report,” http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_45-en.pdf, 1, (Accessed: 30 July 2017).

459. Gostin and Friedman, “Analysis,” 1904.

460. WHO, “EBSS3.R1,” 8.

to be fully operable within two years. Intergovernmental negotiations started at the end of 2014 and took more than one and a half years.⁴⁶¹ FENSA is a framework, which

covers all engagements with non-State actors at all levels of the Organization. It sets out the rationale, principles, benefits and risks of engagement, and defines four groups of non-State actors [...] and five types of engagement [...]. Management of conflict of interest and other risks of engagement are addressed through a process of due diligence, risk assessment and risk management, with increased transparency through the creation of a register of non-State actors.⁴⁶²

Changes to the previous model include an online public register, which lists non-state actors in engagement with the WHO so as to make the organisation's work more transparent. The register includes, for example, MSF International, International Medical Corps, International Rescue Committee, IntraHealth International Inc. and World Vision International. According to the Center for International Disaster Information, these organisations were all part in the response to the 2014 Ebola outbreak in West Africa.⁴⁶³ In addition, the register consists of "an electronic workflow, a process for due diligence, a guide for staff, and a dedicated coordination mechanism [...] to ensure consistent implementation of the Framework at all three levels of the Organization."⁴⁶⁴ The electronic workflow was announced to start its work in early 2017.⁴⁶⁵

In the beginning of 2017, the WHO announced cooperation with five non-state actors: "Bill & Melinda Gates Foundation; Grand Challenges Canada; International Rescue Committee; Knowledge Ecology International; and The Fred Hollows Foundation" and terminated official relations with several others.⁴⁶⁶ At the 70th WHA in May 2017 it was announced that "the WHO register of non-State actors and the electronic workflow have been built and are currently being piloted and rolled out."⁴⁶⁷ It was added, that the WHO still expects the timely and full implementation of FENSA.⁴⁶⁸

10.2.8 Conclusions World Health Organization

The 2014 Ebola outbreak illustrated two points. One, despite all the advances in technology, medicine and research, infectious disease outbreaks can still cause major disruptions across all sectors and regions, even globally. Two, the need for WHO reform. The WHO stated in 2015: "As

461. WHO, "WHA69.10: Framework of engagement with non-State actors," http://www.who.int/about/collaborations/non-state-actors/A69_R10-FENSA-en.pdf, 2, (Accessed: 5 August 2017); WHO, "EB140/41: Engagement with non-State actors," http://apps.who.int/gb/ebwha/pdf_files/EB140/B140_41-en.pdf, 1, (Accessed: 5 August 2017).

462. WHO, "EB140/41," 1.

463. WHO, "EB140/41," 1; WHO, "WHO Register of non-State actors (Pilot)," <http://apps.who.int/register-nonstate-actors/search.aspx>, (Accessed: 31 August 2017); Center for International Disaster Information, "Non-Governmental Organizations Responding to Ebola," <https://www.cidi.org/ebola-ngos/#.W6uuqnszbIX>, (Accessed: 5 August 2017).

464. WHO, "EB140/41," 2.

465. WHO, "EB140/41," 2.

466. WHO, "EB140(10): Engagement with non-State actors," [http://apps.who.int/gb/ebwha/pdf_files/EB140/B140\(10\)-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/EB140/B140(10)-en.pdf), 1, (Accessed: 5 August 2017).

467. WHO, "A70/52: Engagement with non-State actors," http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_52-en.pdf, 3, (Accessed: 30 July 2017).

468. WHO, "A70/52," 3.

part of its overall reform, WHO will improve the way it responds to outbreaks and emergencies with health and humanitarian consequences across the risk management cycle (preparedness, response and early recovery).⁴⁶⁹ Resulting from the 2014 Ebola outbreak and the recommendations in internal and external panels/ committees, the WHO initiated a major reform, which already began in 2015. The reform includes, among others, the establishment of the WHE Programme, the CFE, the R&D Blueprint, FENSA, to further implementation of the IHR (2005) and modifications in human resources.

The WHE Programme's aim is to accelerate the response to emergencies and to make the response more transparent. This goal is represented in the Programme's slogan: "One workforce, one budget, one set of rules and processes, and one set of standard performance metrics."⁴⁷⁰ In the area of the emergency communication network advancements are visible. Staff, comprising 150 persons, are to be deployed to assist in case of public health emergencies or humanitarian crisis. The elaborated plan for public emergency communication is adjusted to the incident management system of the WHE Programme and is already implemented. A part of the WHE Programme is the CFE. Even though already proposed in 2011, it took until the 2014 Ebola outbreak to adopt this plan. The fund is set out to rapidly release money after the report of an emergency (in three steps within the first 72 hours). Regarding the implementation of the IHR (2005), work on a global implementation plan has started. The plan introduces modalities and approaches to enforce the recommendations of the "Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response" and to implement them. However, this plan has yet to be adopted. The R&D Blueprint's goal is to rapidly provide necessary medical intervention in emergencies. In addition, the Blueprint is set out to establish platforms to improve product research as well as the development of diagnostics and vaccines. The WHO also makes improvements in human resources. While staff increased by 11 percent between 2013 and 2016, costs were reduced (e.g. by the adaption of travel policies). FENSA provides a framework which encompasses all collaborations at all levels of the WHO with non-state actors- classified into groups and types of engagement.⁴⁷¹ Progress is also being made to correct weaknesses in regard to financial collaborations to assure the correct handling of funds.

469. WHO, "The WHO Contingency Fund for Emergencies," 5.

470. WHO, "A69/30," 2.

471. WHO, "A70/50: Overview of WHO reform implementation," http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_50-en.pdf, 5–7, (Accessed: 30 July 2017); WHO, "EB130/5 Add.6," 1; WHO, "Contingency Fund for Emergencies (CFE)"; WHO, "The WHO Contingency Fund for Emergencies"; WHO, "A70/16," 1–2; WHO, "A70/15," 4; WHO, "A70/10," 1; WHO, "A70/45," 1; WHO, "EB140/41," 1.

In addition, the collection of financial contributions⁴⁷² from member states increased by eight percent; from 80 percent in 2015 to 88 percent in 2016. The reform also affects the WHO's work. Now, the organisation's focus is on the state level and to adapt its work on a regional and global level. Yet, financing the WHO's work is still a challenge; especially due to the new WHE Programme.⁴⁷³ While all these reforms look promising, member states and the organisation itself share the responsibility of making the reform a long-lasting success.

The 2014 Ebola outbreak initiated the most profound reform the WHO ever experienced. This includes the establishment of new programmes/ funds, the adaption of the WHO's work among three levels with focus on the state level, improvement of the IHR (2005) and reforms in human resources. The reform is set out to increase the organisation's preparedness, response and communication in times of (health) emergencies as well as rapid recovery afterwards. Therefore, the 2014 Ebola outbreak intensified the WHO's evaluation of infectious diseases as a security risk.

Securitisation on the system level (e.g. international organisations) was discussed in chapter 9.2.4. There, it is pointed out that macrosecuritisation, as introduced by Buzan/ Waever, aims to bundle up securitisations from the middle level (e.g. states) into a "higher" order.⁴⁷⁴ In addition, securitisation on the international level means that a topic is so existential and relevant that it needs to be "dealt with decisively by top leaders prior to other issues."⁴⁷⁵ Buzan/ Waever explain that advantages of successful macrosecuritisation can be immense as it can, among others, "define, demonstrate and legitimate leadership."⁴⁷⁶ The WHO aims to do this through a profound reform, which includes the establishment of several new programmes and funds. The creation of the WHE Programme has to be mentioned as an example for legitimisation of leadership. Its slogan is: "One workforce, one budget, one set of rules and processes, and one set of standard performance metrics."⁴⁷⁷ In addition, its goal is to accelerate the WHO's response to emergencies.

472. The WHO's constitution states that all member states are obliged to pay their contribution (in time). If a member state fails to pay its contribution, its voting rights can be lifted. Out of the three most affected states by the 2014 Ebola outbreak, Guinea has suspended voting rights. As of February 2017, Sierra Leone had outstanding contributions justifying the suspension of its voting rights. WHO, "A70/41: Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution," http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_41-en.pdf, 1–2, (Accessed: 29 July 2017). However, at the 70th WHA Sierra Leone's voting rights were not suspended. WHO, "WHA 70.8: Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution," http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_R8-en.pdf, 1–2, (Accessed: 30 July 2017). This leads to the assumption that either Sierra Leone has paid its contributions, at least to an amount where the suspension of voting rights is not at risk anymore, or that the states debts were abated to help the state dealing with the aftermath of the outbreak. The same assumptions can be made for Liberia. WHO, "A70/41," 8.

473. WHO, "A70/50," 5 & 2; WHO, "A70/41," 1.

474. Buzan and Wæver, "Macrosecuritisation and security constellations," 257.

475. Buzan, Wæver and Wilde, *Security*, 29.

476. Buzan and Wæver, "Macrosecuritisation and security constellations," 268.

477. WHO, "A69/30," 2.

In general, advantages of securitisation include the increase of awareness and mobilisation (e.g. release of financial/ human resources). Examples are the creation of 1,400 positions by the WHE Programme, the accelerated establishment of the CFE including an increase in paid contributions for the fund within a year and an increase in workforce within the WHO. Several researchers illustrate that the securitisation of infectious diseases is often not focused on the health sector, but on the economic sector and social stability. An example is the R&D Blueprint, which aims to reduce socioeconomic disruption.⁴⁷⁸ In its report, the “Ebola Interim Assessment Panel” pointed out: “By September 2014, it was essential to take highly visible action to generate political and financial support from the global community.”⁴⁷⁹ The increase of awareness and mobilisation (e.g. release of resources) occurred during the 2014 Ebola outbreak and is ongoing, as is the WHO’s reform. Therefore, the hypothesis is supported for the WHO.

10.3 United Nations

10.3.1 Resolution 2177 and 69/1

On 18 September 2014, the UN Security Council passed resolution 2177, in which it determines “that the unprecedented extent of the Ebola outbreak in Africa constitutes a threat to international peace and security.”⁴⁸⁰ This resolution was groundbreaking in the history of the UN for three reasons. One, it was the first resolution, in which the UN Security Council declared the international peace and security was threatened by a health issue. Two, it is one of only three resolutions, in which the UN Security Council addresses a global health concern. Three, 134 member states supported the resolution. Never before has another UN Security Council resolution received so much support.⁴⁸¹

The Ebola outbreak in West Africa was also a topic at the UN General Assembly’s 69th session on 19 September 2014. Resolution 69/1 explains: “Underscoring the urgent need to contain this public health crisis owing to its possible grave humanitarian, economic and social consequences.”⁴⁸² This statement is yet another example, which illustrates the risks infectious diseases pose. The resolution was adopted by consensus.⁴⁸³

478. WHO, “A69/30,” 1; Buzan, Wæver and Wilde, *Security*, 29; Elbe, “Haggling over viruses,” 479; Sands, Mundaca-Shah and Dzau, “Neglected Dimension”; Kamradt-Scott and McInnes, “Securitisation”; Lo Yuk-ping and Thomas, “Health”; Elbe, “Pandemics”; WHO, “A70/10,” 1.

479. WHO, “Report of the Ebola Interim Assessment Panel,” 14.

480. UN, “S/RES/2177(2014),” 1.

481. WHO, “WHO and UN response to Ebola”; Snyder, “Security Council Response to Ebola”.

482. UN, “A/RES/69/1,” 1.

483. WHO, “WHO and UN response to Ebola”.

10.3.2 United Nations Mission for Emergency Ebola Response (UNMEER)

On 19 September 2014, the Secretary-General established the “United Nations Mission for Emergency Ebola Response (UNMEER)” with the duty to help the response in affected regions. UNMEER was the first “UN emergency health mission”.⁴⁸⁴ Its aim was to immediately help in the fight of the Ebola outbreak and to reach zero cases as quickly as possible.⁴⁸⁵ The precise goals were to “stop the outbreak, treat the infected, ensure essential services, preserve stability [and to] prevent further outbreaks.”⁴⁸⁶ In addition, the Mission’s focus was to

reinforce government leadership; deliver a rapid impact on the ground; closely coordinate and collaborate with actors outside the United Nations; tailor responses to the particular needs in the different countries; reaffirm the leadership of WHO on all health issues; and identify benchmarks for transition post-emergency and ensure that actions strengthen systems.⁴⁸⁷

UNMEER closed, according to plan, on 31 July 2015.⁴⁸⁸

10.3.3 High-Level Panel on the Global Response to Health Crises

In April 2015, the Secretary-General appointed the “High-Level Panel on Global Response to Health Crises” to make recommendations to bolster systems for health emergencies while incorporating the lessons learned from the 2014 Ebola outbreak. In its report “Protecting humanity from future health crises” the “High-Level Panel” analyses the response to the Ebola outbreak in West Africa and examines possible ways of action starting with preparedness, observation, warning, up to the reaction to a health emergency.⁴⁸⁹ The report also declares that “containing an Ebola outbreak is a challenge for any health system.”⁴⁹⁰

As explained in chapters 1.1 and 8.2.3, the economic impact is one of several reasons why infectious diseases are a security risk. All the following examples illustrate how infectious diseases can influence the economic sector of affected states, but also of an entire region. The Panel’s report points out that Sierra Leone, Guinea and Liberia have to deal with a combined economic loss of more than two billion US Dollars.⁴⁹¹ In their resolutions, the UN General Assembly and the UN Security Council often alerted that the 2014 Ebola outbreak could reverse the gains made in the three states. Especially the implementation of extraordinary measures (e.g. travel and trade restrictions, closing of borders/ schools, quarantine) can have pronounced effects. The UN Security Council asked member states in resolution 2177 to lift travel and trade

484. UN, “UNMEER”.

485. UN, “UNMEER”.

486. UN, “UNMEER”.

487. UN, “A/69/404: United Nations Mission for Ebola Emergency Response and the Office of the Special Envoy on Ebola,” <https://undocs.org/A/69/404>, 2, (Accessed: 25 November 2017).

488. UN, “UNMEER”.

489. UN, “Secretary-General Appoints High-Level Panel”; UN, “A/70/723,” 23.

490. UN, “A/70/723,” 25.

491. UN, “A/70/723,” 27.

restrictions.⁴⁹² The “High-Level Panel’s” report documents the UN’s concern regarding reversed gains with the subsequent numbers:

Following the Ebola outbreak in Guinea, rice production fell by 20 per cent in 2014 compared with 2013, coffee production by 50 per cent and cocoa production by 33 per cent. Both self-employment and wage-employment decreased. In Sierra Leone, the outbreak led to the loss of an estimated 180,000 jobs. [...] [In Liberia,] small businesses have collapsed, markets have closed down, and farming activities have been abandoned. [...] In Guinea, fishery exports fell by 40 per cent, while rubber exports experienced a similar decline in Liberia. In all three Ebola-affected countries, international investors postponed new projects or pulled out altogether. [...] [In addition,] hotel occupancy fell sharply.⁴⁹³

Yet, the outbreak also affected the wider West African region. The report estimates the total loss for the region at one billion US Dollars.⁴⁹⁴

10.3.4 Pandemic Emergency Financing Facility

In December 2015, the UN General Assembly asked member states in resolution 70/183 to

support the initiative of the World Bank to develop a pandemic emergency financing facility towards ensuring that the world has the financial resources to quickly deploy trained health workers, equipment, medicines and whatever else is required to respond to health emergencies.⁴⁹⁵

The “Pandemic Emergency Financing Facility (PEF)” was established in May 2017 as a result of the 2014 Ebola outbreak. The World Bank, the WHO, Germany, Japan and a cooperation with the private sector made the creation possible. The PEF is designed to close a gap in the early phase of emergencies where financial aid is limited. The PEF and the WHO’s newly established CFE will complement each other. While the CFE is set up to immediately release resources for health or humanitarian emergencies, the PEF is set up to make funds immediately available and to cover for the poorest states in case of an outbreak. In addition, it only acts on pre-defined viruses and when a certain level of severity is reached.⁴⁹⁶ As of 2017, the PEF “covers six viruses that are most likely to cause a pandemic. These include new Orthomyxoviruses (new influenza pandemic virus A), Coronaviridae (SARS, MERS), Filoviridae (Ebola, Marburg) and other

492. UN, “A/RES/69/291: Implementation of the recommendations contained in the report of the Secretary-General on the causes of conflict and the promotion of durable peace and sustainable development in Africa,” <https://undocs.org/A/RES/69/291>, 9, (Accessed: 28 December 2017); UN, “A/RES/70/292: Implementation of the recommendations contained in the report of the Secretary-General on the causes of conflict and the promotion of durable peace and sustainable development in Africa,” <https://undocs.org/A/RES/70/292>, 10, (Accessed: 28 December 2017); UN, “A/RES/69/290: New Partnership for Africa’s Development: progress in implementation and international support,” <https://undocs.org/A/RES/69/290>, 4, (Accessed: 28 December 2017); UN, “A/RES/70/295: New Partnership for Africa’s Development: progress in implementation and international support,” <https://undocs.org/A/RES/70/295>, 4, (Accessed: 28 December 2017); UN, “S/RES/2177(2014),” 1 & 4; UN, “S/RES/2188(2014),” [https://undocs.org/S/RES/2188\(2014\)](https://undocs.org/S/RES/2188(2014)), 1, (Accessed: 28 November 2017).

493. UN, “A/70/723,” 29–30.

494. UN, “A/70/723,” 30.

495. UN, “A/RES/70/183: Global health and foreign policy: strengthening the management of international health crises,” <https://undocs.org/A/RES/70/183>, 8, (Accessed: 28 November 2017).

496. The World Bank, “Pandemic Emergency Financing Facility. Frequently Asked Questions,” <http://www.worldbank.org/en/topic/pandemics/brief/pandemic-emergency-facility-frequently-asked-questions>, (Accessed: 21 October 2017).

zoonotic diseases (Crimean Congo, Rift Valley, Lassa fever).⁴⁹⁷ In addition, the PEF can also fund international agencies who have an involvement in outbreak-response in affected states. The PEF's aim is to increase the response to outbreaks, reduce the loss of lives and the costs of outbreak-response. In the long run, the PEF should help with better preparedness for outbreaks and bolster health systems, among other benefits.⁴⁹⁸

While one of two windows (cash window) is expected to be operational in the beginning of 2018, the second window (insurance window) has already been operational since July 2017.⁴⁹⁹ Partly, this was made possible by the World Bank launching bonds to fund the PEF, which was "the first time that World Bank bonds are being used to finance efforts against infectious diseases, and the first time that pandemic risk in low-income countries is being transferred to the financial markets."⁵⁰⁰

10.3.5 Global Health Crises Task Force

In June 2016, the Secretary-General established the "Global Health Crises Task Force" to supervise and impact the implementing of the recommendations of the "High-Level Panel on the Global Response to Health Crises". Other tasks are to boost the preparedness of the UN, to keep up the profile of global health matters and to provide essential input to bolster the international capability to react to health emergencies. The "Task Force's" work began in July 2016 and was set out for one year.⁵⁰¹

The final report of the "Global Health Crises Task Force" was published in July 2017. It discusses the progress made regarding the Panel's 27 recommendations and where future activity or monitoring is needed.⁵⁰²

10.3.6 The risks of infectious diseases according to the United Nations

In the following, the UN's evaluation of infectious diseases as a security risk is further illustrated. Between 2014 and 2017, the UN General Assembly and the UN Security Council expressed their "concern about the potential reversal of the gains made by the affected countries in peacebuilding,

497. The World Bank, "Pandemic Emergency Financing Facility".

498. The World Bank, "Pandemic Emergency Financing Facility".

499. The World Bank, "Pandemic Emergency Financing Facility".

500. The World Bank, "World Bank Launches First-Ever Pandemic Bonds to Support \$500 Million Pandemic Emergency Financing Facility," <https://www.worldbank.org/en/news/press-release/2017/06/28/world-bank-launches-first-ever-pandemic-bonds-to-support-500-million-pandemic-emergency-financing-facility>, (Accessed: 30 October 2017).

501. UN, "Global Health Crises Task Force".

502. UN, "Global Health Crises Task Force. Final Report," <http://www.un.org/en/pdfs/Final%20Report.Global%20Health%20Crises%20Task%20Force.pdf>, (Accessed: 15 October 2017); UN, "Progress on the 27 recommendations of the High-Level Panel on the Global Response to Health Crises: Annex to the Final Report of the Global Health Crises Task Force," <http://www.un.org/en/pdfs/Annex%20to%20the%20Final%20Report.Progress%20on%2027%20recommendations%20of%20the%20High-Level%20Panel.pdf>, (Accessed: 23 March 2018).

political stability and the reconstruction of socioeconomic infrastructure in recent years” in several of their resolutions.^{503 504} The UN General Assembly also cautioned against the effects of the 2014 Ebola outbreak “on political, social, economic, humanitarian, logistical and security spheres.”⁵⁰⁵ The UN Security Council also addressed possible implications of infectious disease outbreaks on security in resolution 2177: “The outbreak is undermining the stability of the most affected countries concerned and, unless contained, may lead to further instances of civil unrest, social tensions and a deterioration of the political and security climate.”⁵⁰⁶

In its resolutions on “Global health and foreign policy” the UN General Assembly explained that “health is a precondition for and an outcome and indicator of [...] sustainable development and that, despite progress made, challenges in global health [...] still remain and demand persistent attention.”⁵⁰⁷ In the “2030 Agenda for Sustainable Development”, the UN General Assembly made aware that “global health threats, more frequent and intense natural disasters, spiralling conflict, violent extremism, terrorism and related humanitarian crises and forced displacement of people threaten to reverse much of the development progress made in recent decades.”⁵⁰⁸ The UN Security Council alerted of something similar in resolution 2242, in which it stated that pandemics are one of several risks related to a “changing global context of peace and security.”⁵⁰⁹ In resolution 2341, the UN Security Council warned that the interdependency of sectors (e.g. health sector) leads to being a possibly higher target “of threats and vulnerabilities that raise new security concerns.”⁵¹⁰

The UN General Assembly underscored that the member states play an essential role in the preparation for and response to outbreaks of infectious diseases. Yet, it is aware that outbreak-response needs to be improved. This includes early alerts preparedness, resilience on all levels (local to international) as well as improved and more efficient international coordination to health emergencies.⁵¹¹ Numerous cited statements illustrate why and how infectious diseases are a security risk, as is explained throughout this master’s thesis (especially chapters 1.1 and 8).

503. UN, “A/RES/69/1,” 1.

504. UN, “A/RES/69/291,” 9.; UN, “A/RES/70/292,” 10; UN, “A/RES/69/290,” 4; UN, “A/RES/70/295,” 4; UN, “S/RES/2177(2014),” 4; UN, “S/RES/2188(2014),” 1.

505. UN, “A/69/404,” 2; UN, “A/RES/70/183,” 3.

506. UN, “S/RES/2177(2014),” 1.

507. UN, “A/RES/69/132: Global health and foreign policy,” <https://undocs.org/A/RES/69/132>, 1–2, (Accessed: 5 January 2018); UN, “A/RES/70/183,” 1; UN, “A/RES/71/159: Global health and foreign policy: health employment and economic growth,” <https://undocs.org/A/RES/71/159>, 2, (Accessed: 5 January 2018).

508. UN, “A/RES/70/1: Transforming our world: the 2030 Agenda for Sustainable Development,” <https://undocs.org/A/RES/70/1>, 5, (Accessed: 28 December 2017).

509. UN, “S/RES/2242(2015),” [https://undocs.org/S/RES/2242\(2015\)](https://undocs.org/S/RES/2242(2015)), 2, (Accessed: 28 November 2017).

510. UN, “S/RES/2341(2017),” [https://undocs.org/S/RES/2341\(2017\)](https://undocs.org/S/RES/2341(2017)), 2, (Accessed: 28 November 2017).

511. UN, “A/RES/70/183,” 2–3; UN, “A/RES/69/135: Strengthening of the coordination of emergency humanitarian assistance of the United Nations,” <https://undocs.org/A/RES/69/135>, 2, (Accessed: 5 January 2018); UN, “A/RES/71/159,” 2–5.

10.3.7 Conclusions United Nations

The UN General Assembly dealt with the 2014 Ebola outbreak to a greater extent than the UN Security Council. Resolution 2177 by the UN Security Council was unprecedented for three reasons. One, it was the first resolution, in which the UN Security Council declared international peace and security was to be threatened by a health issue. Two, it is one of only three resolutions, in which the UN Security Council addressed a global health concern. Three, it was the resolution with the most support of member states.⁵¹² Another precedent was the establishment of UNMEER, which was the first “UN emergency health mission.”⁵¹³ Its aim was to reach zero cases as quickly as possible. UNMEER closed, according to plan, at the end of July 2015. The “High-Level Panel” was established in April 2015 by the Secretary-General to make recommendations to bolster systems for health emergencies while incorporating lessons learned from the 2014 Ebola outbreak. In its report, the Panel described the outbreaks socioeconomic effects on the affected states. It estimated the economic loss for Sierra Leone, Guinea and Liberia at more than two billion US Dollars and for the wider West African region at one billion US Dollars. In June 2016, the Secretary-General established the “Global Health Crises Task Force” to supervise the implementation of the recommendations by the “High-Level Panel”. The World Bank’s PEF was created in May 2017. It is intended to close a gap in the early phase of emergencies where financial aid is limited, to increase the response to outbreaks, reduce the loss of lives and the costs of outbreak-response. Some aims for the future are to help with better preparedness for outbreaks and to bolster health systems. The PEF complements the WHO’s CFE and will cover for the poorest states during an infectious disease outbreak. As of 2017, the Ebola virus is among the viruses covered by the PEF.⁵¹⁴

Even before the 2014 Ebola outbreak, the UN took the risk of infectious diseases seriously. Between 2014 and 2017, the UN General Assembly and the UN Security Council warned of the outbreaks effects on various sectors (political, security etc.) and of the possibilities of unrest and social tensions. Therefore, the 2014 Ebola outbreak intensified the UN’s evaluation of infectious diseases as a security risk.

The UN Security Council’s declaration of the 2014 Ebola outbreak as “a threat to international peace and security”⁵¹⁵ illustrated once again, how a health issue was pushed onto the agenda of “high” politics. By doing so, the actor (UN) tries to protect the referent object (humankind) from an existential threat (Ebola virus), but also from a variety of possible consequences on several sectors. Or to cite Buzan: “If we do not tackle this problem, everything else will be irrelevant

512. WHO, “WHO and UN response to Ebola”; Snyder, “Security Council Response to Ebola”.

513. UN, “UNMEER”.

514. UN, “UNMEER”; UN, “Secretary-General Appoints High-Level Panel”; UN, “A/70/723,” 27 & 30; UN, “Global Health Crises Task Force”; The World Bank, “Pandemic Emergency Financing Facility”.

515. UN, “S/RES/2177(2014),” 1.

(because we will not be here or will not be free to deal with it in our own way).⁵¹⁶ This does not necessarily imply the Ebola virus was about to eliminate humankind, but due to its fast spread and incurability there was a possibility the outbreak would become a pandemic. The UN General Assembly alerted in resolution 69/1 of “its possible grave humanitarian, economic and social consequences.”⁵¹⁷ This statement is significant as it underscores the illustration of various researchers that securitisation is often focussed on the economy and social stability.⁵¹⁸ Waever explained in 1995 that when one announces “security”, one also needs to be able to tackle the problem.⁵¹⁹ The UN aimed to stop the spread of the Ebola virus with UNMEER. One of UNMEER’s goals was to “reaffirm the leadership of WHO on all health issues.”⁵²⁰ As previously illustrated, one of the advantages of macrosecuritisation is the legitimisation of leadership. Mobilisation is another advantage of securitisation. Here, UNMEER and the rapid establishment of the PEF can be named as examples. This is underscored by the “Ebola Interim Assessment Panel’s” report, in which it declares that the Secretary-General’s leadership was essential for mobilising the international community, increasing awareness as well as releasing financial and personnel resources.⁵²¹ In addition, the following two statements by the UN Security Council need to be pointed out. In resolution 2242, it warned that pandemics are one of several risks related to a “changing global context of peace and security.”⁵²² Resolution 2341 made aware that the interdependency of sectors (e.g. health sector) leads to being a potentially higher target “of threats and vulnerabilities that raise new security concerns.”⁵²³ While both statements are not referring to the 2014 Ebola outbreak, they can still be used as examples to support the hypothesis. Therefore, and taking the illustrations into account, the hypothesis is supported for the UN.

10.4 European Union

The 2003 EU security strategy is 14 pages long. It does not contain a chapter that deals with infectious diseases, nor a paragraph that discusses the importance of health or the risk of the transmission of infectious diseases.

The topic of diseases is briefly addressed in the section “Global Challenges”. There, the strategy states: “In much of the developing world, poverty and disease cause untold suffering and give rise to pressing security concerns.”⁵²⁴ With reference to the threat of infectious diseases, the document declares: “AIDS is now one of the most devastating pandemics in human history and

516. Buzan, Wæver and Wilde, *Security*, 24.

517. UN, “A/RES/69/1,” 1.

518. Sands, Mundaca-Shah and Dzau, “Neglected Dimension”; Kamradt-Scott and McInnes, “Securitisation”; Lo Yuk-ping and Thomas, “Health”; Elbe, “Pandemics”.

519. Wæver, “Securitization and Desecuritization,” 55 & 58.

520. UN, “A/69/404,” 2.

521. WHO, “Report of the Ebola Interim Assessment Panel,” 24.

522. UN, “S/RES/2242(2015),” 2.

523. UN, “S/RES/2341(2017),” 2.

524. EU, “A Secure Europe In A Better World,” 2, (Accessed: 27 May 2017).

contributes to the breakdown of societies. New diseases can spread rapidly and become global threats.”⁵²⁵ As pointed out in chapter 1.1, societal disruptions are one of several reasons why infectious diseases are a security risk. To tackle threats and challenges, the strategy affirms that “there are few if any problems we can deal with on our own. [...] International cooperation is a necessity.”⁵²⁶ And adds: “The European Union has the potential to make a major contribution, both in dealing with the threats and in helping realise the opportunities.”⁵²⁷

In 2016, the EU published its global strategy. The most noticeable difference to the previous document is its length- 56 pages. Yet, a chapter that discusses public/ global health or infectious diseases is still absent.

In the foreword, Frederica Mogherini⁵²⁸ explains that cooperation is needed to tackle current risks: “None of our countries has the strength nor the resources to address [...] [the] threats and seize the opportunities of our time alone.”⁵²⁹ In the passage “Engagement”, it is pointed out that “in a more connected world, the EU will reach out and engage with others.”⁵³⁰ This includes states, regional and international organisations as well as non-state actors. In the passage “Political Economy of Peace” the strategy describes that the EU is aware that greater cooperation in several areas (e.g. health) is a necessity to promote healthy economies. The connection between health and the economy was debated in chapters 1.1 and 8.2.3. In the section “Resilience in our Surrounding Regions” it is declared that the EU will establish a common approach to reach its several policies, health among them.⁵³¹ Pandemics are addressed in the paragraph “Pre-emptive Peace”: “We will [...] redouble our efforts on prevention, monitoring root causes such as human rights violations, inequality, resource stress, and climate change- which is a threat multiplier that catalyses water and food scarcity, pandemics and displacement.”⁵³² In the section “A Peaceful and Prosperous Mediterranean, Middle East and Africa”, the document illustrates:

We will invest in African peace and development as an investment in our own security and prosperity. [...] We will build stronger links between our trade, development and security policies in Africa, and blend development efforts with work on migration, health, education, energy and climate, science and technology.⁵³³

How several of the listed topics are linked with each other was explained in chapter 8. The section “Deepening” states that health, among others, can be promoted through international

525. EU, “A Secure Europe In A Better World,” 2.

526. EU, “A Secure Europe In A Better World,” 13.

527. EU, “A Secure Europe In A Better World,” 14.

528. High Representative of the Union for Foreign Affairs and Security Policy & Vice President of the European Commission.

529. EU, “Shared Vision, Common Action: A Stronger Europe. A Global Strategy for the European Union’s Foreign And Security Policy,” http://europa.eu/globalstrategy/sites/globalstrategy/files/regions/files/eugs_review_web_0.pdf, 3, (Accessed: 27 May 2017).

530. EU, “Shared Vision, Common Action,” 17.

531. EU, “Shared Vision, Common Action,” 39, 31 & 26.

532. EU, “Shared Vision, Common Action,” 29.

533. EU, “Shared Vision, Common Action,” 36.

agreements. In the paragraph “Developing” it is declared, with reference to health, that the EU will more actively pursue prevention as well as the identification and response to pandemics. The document also points out that the advances in biotechnology can lead to security risks.⁵³⁴ The link between biological agents and security was also described in chapters 1.1 and 6.2.

10.4.1 Conclusions European Union

The 2016 EU global strategy still does not contain a chapter that addresses public/ global health or infectious diseases. Compared to the one of 2003, in which health was not mentioned once, the current one refers to it a few times briefly. Even though infectious diseases are not named once, pandemics are briefly discussed twice (“The Priorities of our External Action”, “Global Governance for the 21st Century”). Yet, infectious diseases are not declared to be a security risk, in specific. Health is also not addressed, particularly regarding the importance of public/ global health. Furthermore, there is no reference to the 2014 Ebola outbreak.

Only minimal changes are noticeable in the 2016 EU document compared to the previous one. For example, the occasional reference to health; even though not linked with infectious diseases being a threat to security. Therefore, the 2014 Ebola outbreak did not change the EU's evaluation of infectious diseases as a security risk.

Infectious diseases are not discussed as a security risk in the 2016 strategy. However, it states: “We will invest in African peace and development as an investment in our own security and prosperity.”⁵³⁵ To achieve this, it adds: “We will build stronger links between our trade, development and security policies in Africa, and blend development efforts with work on migration, health, education, energy and climate, science and technology.”⁵³⁶ While it can be hypothesised that the reference to the health sector in connection to security in Africa and Europe is a hint to the securitisation of health, the threat of infectious diseases is not pointed out in particular. Therefore, the hypothesis is not supported for the EU.

10.5 African Union

During its meeting on Ebola in August 2014, the AU Peace and Security Council “authorize[d] the immediate deployment of an AU-led Military and Civilian Humanitarian Mission, comprising medical doctors, nurses and other medical and paramedical personnel, as well as military

534. EU, “Shared Vision, Common Action,” 41 & 43.

535. EU, “Shared Vision, Common Action,” 36.

536. EU, “Shared Vision, Common Action,” 36.

personnel, as required for the effectiveness and protection of the Mission.”⁵³⁷ The “African Union Support to Ebola Outbreak in West Africa (ASEOWA)” was the first humanitarian mission in the AU’s history and was established on 20 August 2014. The AU Executive Council supported the establishment in its extraordinary session on Ebola in September 2014, as did the AU Assembly in its ordinary session in January 2015. The AU Executive Council also recognised the implementation of travel and trade restrictions and requested the AU Commission to demand that member states lift them. The AU Assembly also demanded the lifting of previously implemented restrictions in January 2015, as did the UN Security Council.⁵³⁸ In its extraordinary session, the AU Executive Council demanded the AU Commission to “take all the necessary steps for the rapid establishment of an African Centre for Disease Control and Prevention (ACDCP)⁵³⁹ [...] together with the establishment of regional centres by mid-2015.”^{540 541} In January 2015, the AU Assembly supported the creation of the ACDCP.⁵⁴² Further, it requested the establishment of “mechanisms of the operationalization of existing regional centers for mounting rapid response to emergency public health crisis such as the Ebola outbreak.”⁵⁴³ In the 2014 session, the AU Executive Council encouraged member states to share information on infected persons to assure their medical treatment and to provide better health security at all levels; from national to global. In June 2015, the AU Assembly requested the AU Commission to create an African Volunteer Health Corps (AVOHC) to operate in health emergencies. It has already been established and its first service was the observation of the 2017 Ebola outbreak in the Democratic Republic of Congo.⁵⁴⁴

537. AU, “PSC/PR/COMM.(CDL). Communiqué,” <http://www.peaceau.org/uploads/psc-com-450-ebola-outbreak-19-8-2014.pdf>, 1, (Accessed: 2 December 2017).

538. Institute for Security Studies Africa, “AU to deploy a humanitarian mission to fight Ebola in West Africa,” <https://issafrica.org/pscreport/addis-insights/au-to-deploy-a-humanitarian-mission-to-fight-ebola-in-west-africa>, (Accessed: 8 January 2018); AU, “Timeline of AU Response to the Ebola Outbreak,” https://au.int/sites/default/files/newsevents/workingdocuments/26997-wd-timeline_au_revised.pdf, (Accessed: 6 January 2018); AU, “Ext/EX.CL/Dec.1(XVI): Decision on the Ebola Virus Disease (EVD) Outbreak,” https://au.int/sites/default/files/decisions/9663-final_ebola_decisionI_e.pdf, 1–2, (Accessed: 2 December 2017); AU, “Assembly/AU/Dec.553(XXIV): Decision on Ebola Virus Disease (EVD) Outbreak,” https://au.int/web/sites/default/files/decisions/9665-assembly_au_dec_546_-_568_xxiv_e.pdf, 15, (Accessed: 2 December 2017); UN, “S/RES/2177(2014),” 4.

539. Also referred to as “Africa CDC”.

540. AU, “Ext/EX.CL/Dec.1(XVI),” 3.

541. The regional centres will be located in Egypt, Nigeria, Gabon, Zambia and Kenya. Nellie Peyton, “New Africa disease agency aims to prevent fresh Ebola crisis,” (Reuters), 15 February. <http://www.reuters.com/article/us-africa-health-ebola/new-africa-disease-agency-aims-to-prevent-fresh-ebola-crisis-idUSKBN15U227>, (Accessed: 13 December 2017).

542. AU, “Assembly/AU/Dec.554(XXIV): Decision on the Establishment of the African Centre of Disease Control and Prevention (African CDC),” https://au.int/web/sites/default/files/decisions/9665-assembly_au_dec_546_-_568_xxiv_e.pdf, 17, (Accessed: 2 December 2017).

543. AU, “Assembly/AU/Dec.554(XXIV),” 17.

544. AU, “Ext/EX.CL/Dec.1(XVI),” 4; AU, “Assembly/AU/Dec.570(XXV): Assembly Decision on Ebola Virus Disease (EVD) Outbreak,” https://au.int/web/sites/default/files/decisions/9664-assembly_au_dec_569_-_587_xxiv_e.pdf, 7, (Accessed: 2 December 2017); Panapress, “Ethiopia: Africa volunteer corps deployed to DRC to monitor Ebola,” <http://www.panapress.com/Ethiopia--Africa-volunteer-corps-deployed-to-DRC-to-monitor-Ebola--12-630518118-20-lang2-index.html>, (Accessed: 17 February 2018).

10.5.1 Conclusions African Union

The AU Executive Council, which selects topics for the AU Assembly, dealt with the 2014 Ebola outbreak to a lesser extent than the AU Assembly. It is striking that both did not address the outbreak in their sessions in June 2014, when the outbreak was already ongoing for six months. In addition, the two institutions did not attend to the outbreak after January 2016. It is also noticeable that the AU Assembly adopted, with one exception, only decisions on the outbreak. The single resolution dealt with the cancellation of debts of Ebola-affected states. The establishment of ASEOWA was unprecedented for the AU. The 2014 Ebola outbreak also confirmed the demand for an African CDC. Its necessity was already determined in July 2013 and adopted by the AU Assembly in January 2014.⁵⁴⁵ Therefore, the outbreak did not initiate the establishment. However, as previously explained, the AU Executive Council requested the AU Commission to “take all the necessary steps for the rapid establishment of an African Centre for Disease Control and Prevention (ACDCP).”⁵⁴⁶ This statement is quoted in the preamble of the ACDCP’s statute. Therefore, it is concluded that the 2014 Ebola outbreak was an accelerator in the establishment of the Africa CDC. It was officially launched on 31 January 2017 and was first employed in the observation of the 2017 Ebola outbreak in the Democratic Republic of Congo. In addition, the requested establishment of AVOHC occurred and it is currently operational.⁵⁴⁷

The AU Executive Council and the AU Assembly discussed the risk Ebola posed. Yet, it is striking that neither institution addressed the general threat of infectious diseases between January 2014 and May 2017. However, the AU Executive Council asked for the cooperation of member states to assure better health security at all levels.⁵⁴⁸ The AU Peace and Security Council declared in 2014 that it “recognizes the seriousness of the security implications of the current Ebola outbreak, and notes with concern that three of affected countries are in a post-conflict situation, and that the epidemic has the potential of undermining the tremendous progress made.”⁵⁴⁹ This underscores that the AU takes the topic of infectious diseases more serious now; at least concerning health security. Therefore, the 2014 Ebola outbreak changed the AU’s evaluation of infectious diseases as a security risk.

545. AU, “Assembly/AU/Res.1(XXIV): Resolution on Debt Cancellation of Countries Affected by Ebola Virus Disease,” https://au.int/web/sites/default/files/decisions/9665-assembly_au_dec_546_-_568_xxiv_e.pdf, 71, (Accessed: 2 December 2017); Institute for Security Studies Africa, “AU to deploy a humanitarian mission”; AU, “Statute of the Africa Centres for Disease Control and Prevention (Africa CDC),” https://au.int/web/sites/default/files/documents/30730-doc-africa_centre_for_disease_control_validated_and_clean.pdf, 2, (Accessed: 16 February 2018).

546. AU, “Ext/EX.CL/Dec.1(XVI),” 3.

547. AU, “Statute,” 2; AU, “Africa CDC,” <https://au.int/en/africacdc>, (Accessed: 4 December 2017); AU, “Africa Centres for Disease Control and Prevention activates the Emergency Operational Centre to monitor the Ebola Outbreak in the Democratic Republic of Congo. Team of experts on standby for deployment to respond to the emergency,” <https://au.int/en/pressreleases/20170514/africa-centres-disease-control-and-prevention-activates-emergency-operational>, (Accessed: 16 February 2018); Panapress, “Africa volunteer corps deployed”.

548. AU, “Ext/EX.CL/Dec.1(XVI),” 4.

549. AU, “PSC/PR/COMM.(CDL),” 2.

Even though the AU did not deal with the 2014 Ebola outbreak as extensively as other organisations, effects of securitisation (e.g. mobilisation, increase of awareness) were visible during and after the outbreak. For instance, the establishment of the AU's first humanitarian mission ASEOWA, the accelerated establishment of the Africa CDC and the establishment of AVOHC. In addition, the AU Peace and Security Council stated that "military personnel [...] [was] required for the effectiveness and protection of the [ASEOWA] Mission."⁵⁵⁰ The use of military forces for humanitarian interventions is not novel, but does not qualify as a form of emergency action as Buzan/ Waever/ de Wilde point out.⁵⁵¹ As ASEOWA's goal was to tackle the outbreak, one can say that the military was necessary to protect the public/ health personnel (referent object) from the infectious disease (existential threat). The AU Peace and Security Council also recognised "the seriousness of the security implications of the current Ebola outbreak."⁵⁵² Furthermore, the AU Assembly declared in January 2016, that "violent conflicts, terrorism and other destabilizing factors, including disease outbreaks and climate change, continue to pose a serious threat to the socio-economic and political equilibrium" of Africa.⁵⁵³ This statement illustrates that the AU also connects the securitisation of infectious diseases with the economic and political sector; as did the WHO and the UN. Even though the AU Executive Council and the AU Assembly did not discuss the risk of infectious diseases, the AU Peace and Security Council did. Therefore, and because of the cited examples illustrating the effects of securitisation, the hypothesis is supported for the African Union. Although, not as clearly as for the other organisations.

This chapter analysed the security strategies/ resolutions of the WHO, the UN, the EU and the AU. The objectives were to answer the research question and support or refute the hypothesis. This was conducted separately for each organisation. The following chapter focusses on the analysis of national security strategies/ white papers of selected states.

550. AU, "PSC/PR/COMM.(CDL)," 2.

551. Buzan, Wæver and Wilde, *Security*, 22.

552. AU, "PSC/PR/COMM.(CDL)," 1.

553. AU, "Assembly/AU/Dec.598(XXVI): Decision on the Activities of the Peace and Security Council and the State of Peace and Security in Africa," https://au.int/web/sites/default/files/decisions/29514-assembly_au_dec_588_-_604_xxvi_e.pdf, 24, (Accessed: 2 December 2017).

11. Analysis of national security strategies/ white papers

The previous chapter reviewed the security strategies/ resolutions of selected organisations. In the following, the national security strategies/ white papers of selected states are analysed, as including infectious diseases in these documents is one option for states to address the topic. Subsequently, the documents are compared, based on pre-defined questions, to identify similarities and differences.

11.1 The analysis

In the following analysis, the focus is on the middle level; namely states. A detailed explanation of how the analysis is conducted exactly is described in chapter 5. However, a quick repetition of the most important parameters is illustrated in the following.⁵⁵⁴

The national security strategies/ white papers of ten states (Canada, France, Germany, Italy, Japan, UK, US, Sierra Leone, Guinea and Liberia) are examined. This is accomplished in two steps. The first step is the screening of the sources based on pre-selected keywords and the second step is the review itself. The latter, is undertaken on the basis of pre-defined questions to identify changes between the previous and the current document regarding the evaluation of infectious diseases as a security risk. The timeframe determined for the analysis is January 2014 until May 2017.

The first of three objectives is to answer the second research question: Which changes did the 2014 Ebola outbreak cause in the evaluation of infectious diseases as a security risk in national security strategies/ white papers? The second objective is to support or refute the hypothesis: “The 2014 Ebola outbreak led to a further securitisation of infectious diseases.” This is done by implementing the securitisation theory into the review. The third objective is the identification of similarities and differences between the national security strategies/ white papers.

The analysis starts with the G7 member states (in alphabetical order), followed by the African states. The study of each state is completed in three parts. Firstly, by a conclusion, which consists of the main differences between the previous and the current document. Secondly, the answer of the research question. Thirdly, the support or refutation of the hypothesis. Subsequently, the national security strategies/ white papers of all states are compared based on pre-defined questions (chapter 5) to identify similarities and differences. For those states, which either published only one document or which did not update it in the determined timeframe, the research question cannot be answered and the hypothesis cannot be supported or refuted. However, the analysis is still conducted to enable a comparison.

554. The reasons why the states were selected are described in chapter 3.

11.2 Canada

Canada's 2004 national security policy contains 52 pages and health is integrated into the majority of chapters. In "Public Health Emergencies" the importance of health and how to tackle risks, which affect public health on the national and international level, is debated.⁵⁵⁵

The document points out that Canada faced a variety of threats throughout its history up to the present. Terrorism and infectious disease outbreaks (e.g. 1918 influenza, 2003 SARS outbreak) are named as some examples. In the "excursus to the 1918 influenza pandemic" (chapter 7.4) it was described why it was the most significant pandemic in modern history. The policy states that the 2003 SARS outbreak is an illustration of an accidental, worldwide spread of a risk. The role of international travel in the transmission of infectious diseases and the fact that outbreaks can severely affect the Canadian society is also mentioned. Further, it is warned that pandemics can impact Canada's economy and the health of its citizens. The threat of an intentional dissemination of biological agents is also addressed. This topic was discussed in a quick excursus in chapter 6.2. Other reasons why infectious diseases are a security risk and what contributes to their (re-)emergence and spread (travel, economy, etc.) were illustrated in chapters 1.1 and 8. The document explains that threats like terrorism, proliferation, failed states and pandemics do not respect borders. It is also declared that incidents ranging from the attacks of 11 September 2001 to infectious disease incidents (e.g. SARS, BSE, avian influenza) highlight the necessity to adapt the emergency management to meet these challenges.⁵⁵⁶

11.2.1 Conclusions Canada

The importance of public health is debated several times throughout Canada's national security policy. For example, in "Public Health Emergencies", in which infectious disease outbreaks are named among other risks affecting public health. As the document was published in 2004, the research question cannot be answered and the hypothesis cannot be supported or refuted.

11.3 France

The 2008 French white paper is 336 pages long and does not contain a separate chapter that discusses infectious diseases. Although, the topic is briefly debated in the chapters "Consequences for France and Europe" and "Prevention". In the latter with reference to pandemics. In addition, the topics health, epidemics and pandemics are mentioned several times throughout the document.

555. Canada Privy Council Office, "Securing an Open Society. Canada's National Security Policy," <http://publications.gc.ca/collections/Collection/CP22-77-2004E.pdf>, 29–33, (Accessed: 14 June 2017).

556. Canada Privy Council Office, "Securing an Open Society," Preface, 1, 6, 8, 16 & 21.

The white paper addresses health threats (e.g. risk of pandemics) in connection to globalisation and names the SARS outbreak as an example. Infectious diseases are illustrated in more detail in the chapter “Consequences for France and Europe”. Firstly, in connection to Sub-Saharan Africa, where the possibility of epidemics and inadequate health systems are named as some of the consequences resulting from poverty. Secondly, the paper points out that health threats can result in disadvantages for the economic sector and disrupt social stability. Thirdly, it adds that the (re-)emergence and spread of infectious diseases is accelerated by globalisation. In addition, the possibility of a pandemic is rated, on a scale, as medium and the magnitude between medium and severe. In the chapter “Protection” the document states that France needs to be protected from unintentional (e.g. health crises) and intentional risks (terrorism, release of biological agents, etc.). In the section “New Frameworks for Global Security Challenges” it is declared that joint efforts of states and international organisations are necessary to protect public health and to tackle threats (e.g. pandemics). In the chapter “Prevention” the white paper claims that a pandemic within the next 15 years is probable and that its prevention has highest priority. In the case of a pandemic, the focus would lie on the prevention of severe effects on various sectors (e.g. economy, security).⁵⁵⁷ The assumption of a pandemic within the next 15 years has proven true, as the H1N1 pandemic occurred in 2009.

The 2013 French white paper is 135 pages long and also does not contain a chapter that discusses infectious diseases. However, the topics health and pandemics are mentioned multiple times throughout it.

In the preface it is explained that several threats (terrorism, pandemics, etc.) have become more urgent since the previous document. In the chapter “The State of the World”, the advances of biotechnology for public health are pointed out, yet it warns of potential malicious exploitation of these new technologies. In the sections “Risk of weakness” and “Threats and risks intensified by globalisation”, the disadvantages of globalisation are debated and the fact that an epidemic can rapidly develop into a pandemic is described. In addition, accelerated transportation is also named as a contributor to faster dissemination, which results in (infectious) diseases affecting more people.⁵⁵⁸ Further, it is declared that, besides other factors, failed states are interconnected with health as “the destruction of infrastructure and the absence of basic levels of healthcare means that the slightest disease can be fatal.”⁵⁵⁹ The document adds: “We face the risk [...] of a new highly pathogenic and lethal pandemic caused, for instance, by the emergence of a new virus that crosses the species barrier, or by the escape of a virus from a biocontainment laboratory.”⁵⁶⁰ In

557. République Française, *The French White Paper on Defence and National Security*, 1st ed. (New York: Odile Jacob, 2008), 13-15, 20-25, 44, 53-54, 66, 109, 113, 154 & 156.

558. République Française, “French White Paper. Defence and National Security 2013,” <http://www.defense.gouv.fr/english/content/download/215253/2394121/White%20paper%20on%20defense%20%202013.pdf>, 7, 37-45, (Accessed: 17 June 2017).

559. République Française, “French White Paper,” 39.

560. République Française, “French White Paper,” 44.

chapters 6.2 and 8.1 to 8.2.6 it was illustrated how the named examples contribute to the (re-)emergence and spread of infectious diseases. In the chapter “The strategic priorities”, a major health crisis is named alongside several other issues that pose a risk to France, its citizens and the state’s essential functions.⁵⁶¹ In “The resources required to implement the strategy”, the white paper addresses the importance of France’s forces: “Our forces [...] must have the capacity to react rapidly to protect the country and the infrastructure or institutions essential to its economic and social life, against global threats (cyber-threats, terrorism, [...] natural, health or technological risks).”⁵⁶² The document adds that international cooperation is crucial to France’s national security.⁵⁶³

11.3.1 Conclusions France

The importance of global health is pointed out several times throughout the 2013 white paper. While the risk of a pandemic is explained repeatedly, the term “infectious disease” is not named once. A noticeable difference to the previous document is that certain keywords (defined in chapter 5.1) are used half as often. This is suggestive of a decreased focus on the topic of health. Both white papers have in common that they do not contain a chapter that deals with health security. The topics pandemics and health are mentioned throughout the 2013 document. Yet, it does not include a paragraph, which exclusively addresses the topic. This is a noticeable decline compared to the white paper of 2008, in which the topic of health threats was briefly debated several times. As the document has not been updated since the 2014 Ebola outbreak, the research question cannot be answered and the hypothesis cannot be supported or refuted.

11.4 Germany

Germany’s 2006 white paper contains 126 pages and infectious diseases are discussed in the chapter “The Strategic Context- Global Challenges, Opportunities, Risks and Dangers”.

There, diseases are listed in connection to globalisation and named among other factors

that provide a breeding ground for illegal migration and secular as well as religious extremism. [...] These risks not only have an influence on their immediate environment but also affect the security of the international community as a whole in various ways.⁵⁶⁴

Infectious diseases are mentioned briefly again later when the document states that the spread of infectious diseases is accelerated by migration, travel and trade. It also declares that infectious diseases can cause poverty and social instability.⁵⁶⁵ These examples illustrate reasons why

561. République Française, “French White Paper,” 47 & 49.

562. République Française, “French White Paper,” 85.

563. République Française, “French White Paper,” 125–26.

564. Federal Ministry of Defence Germany, “White Paper 2006 on German Security Policy and the Future of the Bundeswehr,” 17, (Accessed: 19 April 2018).

565. Federal Ministry of Defence Germany, “White Paper 2006,” 20.

infectious diseases are a security risk and what contributes to their (re-)emergence and spread. This was also explained in chapters 1.1 and 8.1 to 8.2.6. The white paper also warns: “Epidemics and pandemics can develop into a serious threat to stability and peace.”⁵⁶⁶ This statement proved true in 2014 when the UN Security Council declared the Ebola outbreak a “threat to international peace and security.”⁵⁶⁷ Regarding Germany’s international cooperation, the UN, along with other organisations, is named and its “outstanding role in dealing with a multitude of issues relating to a wider concept of security” such as tackling pandemics and diseases is pointed out.⁵⁶⁸ The narrow and the wider view of security was debated in chapter 9.1.1.

The white papers of 2006 and 2016 differ for three reasons. One, with 144 pages it is longer than the prior one. This is suggestive that more topics are now on the German agenda. Two, the section “Epidemics and Pandemics” was expanded to half a page as compared to a short paragraph in the previous document. The expansion is visible for the entire chapter “Challenges for German Security Policy” as the challenges are now discussed on 13 pages. Three, keywords linked with health and infectious diseases are used more often in the 2016 white paper. Globalisation is named as a cause for transformation in “The International Order in Transition”: “Globalisation is also promoting the interconnection and spread of risks as well as their repercussions. These include epidemics, the possibility of cyber attacks and information operations, and transnational terrorism.”⁵⁶⁹ In the section “Epidemics and Pandemics”, the growing population and worldwide mobility are listed as causes for the emergence and spread of infectious diseases.⁵⁷⁰ It is explained:

Even locally confined outbreaks of particularly contagious diseases can overwhelm public and other services and precipitate a collapse of healthcare systems and public order. This can result in regional destabilisation. At the same time, there is a risk that disease could spread regionally or globally.⁵⁷¹

Further, it is stated that aside from disease outbreaks being a threat to human life, they also pose systemic risks.⁵⁷² These risks can appear “as a result of stress on national and international healthcare systems, severe disruptions of transnational traffic and economic systems, as well as the de facto quarantining of affected regions.”⁵⁷³ It is indicated that a dissemination to Germany would be a threat to the German population, could lead to a stressed national healthcare system and have drastic effects on the economic sector. Terrorism, collapsed health systems, morbidity, travel and trade as well as economic disruptions are all reasons why and how infectious diseases

566. Federal Ministry of Defence Germany, “White Paper 2006,” 20.

567. UN, “S/RES/2177(2014),” 1.

568. Federal Ministry of Defence Germany, “White Paper 2006,” 43.

569. The Federal Government Germany, “White Paper 2016 on German Security Policy and the Future of the Bundeswehr,” 28, (Accessed: 19 April 2018).

570. The Federal Government Germany, “White Paper 2016,” 44.

571. The Federal Government Germany, “White Paper 2016,” 44.

572. The Federal Government Germany, “White Paper 2016,” 44.

573. The Federal Government Germany, “White Paper 2016,” 44.

can be a risk to security and how these factors contribute to their (re-)emergence and spread. This was illustrated in chapters 1.1 and 8.2 to 8.2.6. The document also addresses the challenges that emerge when equipment and specialists need to be deployed in areas difficult to access. In addition, it is pointed out that Germany supports the work of international organisations (e.g. WHO, UN) and it contributes to European instruments to establish a body of specialists able to be quickly deployed in affected regions.⁵⁷⁴

11.4.1 Conclusions Germany

The 2016 white paper points out the importance of health several times- primarily in the section “Epidemics and Pandemics”. There, it is explained how disease outbreaks can affect health and the health sector. In contrast to the 2006 document, the topic of health is mentioned slightly more often and one chapter is dedicated to disease outbreaks. The 2014 Ebola outbreak is not named in the 2016 white paper. However, the previously addressed challenges posed by the deployment of equipment and specialists to difficult accessible areas can be understood as a reference to the Ebola outbreak. Therefore, and because of the illustrations provided, the 2014 Ebola outbreak intensified Germany’s evaluation of infectious diseases as a security risk.

Securitisation, as illustrated in chapter 9.2.1, focuses mainly on the middle level (e.g. states) as it is the most active one and actors are easier to identify. It is also pointed out that securitisation is an intersubjective practice. Furthermore, it is a political selection whether a topic is securitised or to accept a securitisation move. Germany’s 2016 document states that infectious disease outbreaks are not only a risk to life, but also to the system. This can be linked to Behnke, who describes that framing an issue or a protagonist as a threat to the state or society creates a national identity.⁵⁷⁵ In addition, Buzan/ Wæver declare that all states and people “share a universal physical threat perception against themselves as referent objects, from nuclear weapons [...] through disease [among others].”⁵⁷⁶ The white paper illustrates that the mentioned systemic risks may appear “as a result of stress on national and international healthcare systems, severe disruptions of transnational traffic and economic systems, as well as the de facto quarantining of affected regions.”⁵⁷⁷ With reference to economic effects, it is observed by various researchers that the securitisation of infectious diseases is often not focused on the health sector, but on the economy and social stability. In addition, quarantining of affected areas is one of several possibilities to tackle an infectious disease outbreak. The use of emergency actions (quarantine, traveller screening, travel and trade restrictions etc.) are part of the third step of the

574. The Federal Government Germany, “White Paper 2016,” 44-45 & 62-63.

575. Buzan and Wæver, “Macrosecuritisation and security constellations,” 253–54; Buzan, Wæver and Wilde, *Security*, 29–30; The Federal Government Germany, “White Paper 2016,” 44; Behnke, “No way out,” 65.

576. Buzan and Wæver, “Macrosecuritisation and security constellations,” 264.

577. The Federal Government Germany, “White Paper 2016,” 44.

securitisation process, just after the audience accepted a securitisation move and before the topic is under control and moves to the desecuritisation phase. Mobilisation, which includes the release of resources (financially or personnel) is one possible effect of securitisation. The German document also explains that the state contributes to European instruments to establish a body of specialists able to be deployed quickly in affected regions.⁵⁷⁸ Compared to the 2006 white paper, securitisation is more visible in the 2016 one. Therefore, the hypothesis is supported for Germany.

11.5 Italy

Italy's 2015 white paper is 123 pages long and does not contain a chapter that discusses infectious diseases, epidemics or pandemics.

In "Why a white paper?", it is illustrated that risks such as "the destabilization of important neighbouring regions for social, economic, health or religious reasons, as well as the more traditional politics of power, require us to look at these events with concern."⁵⁷⁹ The document points out that prediction, prevention and crisis management (e.g. migration, pandemics, terrorism, crime) are necessary.⁵⁸⁰ In the chapter "Strategic Framework", it is addressed that "the consequences arising from the possession of chemical, bacteriological, radiological or nuclear offensive tools" are even higher in weak states.⁵⁸¹ Further, it is explained that in states where structures are very weak, the risk of migration, illegal trafficking, terrorism and the emergence/ transmission of infectious diseases is increased. This connection was also indicated in chapters 8.2.1 to 8.2.6. The white paper describes in "Human Resources" that health and safety are two key elements for personnel associated with Italy's military/ defence as they are at higher risk.⁵⁸² It declares: "Ensuring employment conditions that prevent potential risks to personnel, reducing as far as possible, the consequences of ill health that could arise from operating in harsh and complex environments."⁵⁸³

11.5.1 Conclusions Italy

Defence is the focus of Italy's white paper. The topic of health is pointed out several times throughout it, yet is linked only twice to the risk of pandemics. Infectious diseases are not mentioned and neither is the importance of public/ global health or health security debated. Further, there is no reference to the 2014 Ebola outbreak. As there is no previous document

578. Sands, Mundaca-Shah and Dzau, "Neglected Dimension"; Kamradt-Scott and McInnes, "Securitisation"; Lo Yuk-ping and Thomas, "Health"; Elbe, "Pandemics"; Buzan, Wæver and Wilde, *Security*, 29; The Federal Government Germany, "White Paper 2016," 44-45 & 62-63.

579. The Ministry of Defence Italy, "White Paper for international security and defence," 2015, 14, https://www.difesa.it/Primo_Piano/Documents/2015/07_Luglio/White%20book.pdf, (Accessed: 27 August 2017).

580. The Ministry of Defence Italy, "White Paper," 14.

581. The Ministry of Defence Italy, "White Paper," 25.

582. The Ministry of Defence Italy, "White Paper," 25-30 & 97.

583. The Ministry of Defence Italy, "White Paper," 97.

available to compare the current one with, the research question cannot be answered and the hypothesis cannot be supported or refuted.

11.6 Japan

Japan's 2013 national security strategy is 39 pages long and does not contain a chapter that discusses health or infectious diseases.

The document warns in "Global Security Environment and Challenges" of the possible disadvantages of globalisation and technology. Further, it explains that Japan is threatened by the proliferation of weapons, including biological weapons.⁵⁸⁴ In the section "Challenges to Human Security", the risk of infectious diseases is briefly mentioned: "Global issues that cannot be dealt with by a single country- namely, poverty, widening inequality, global health challenges including infectious diseases, climate change and other environmental issues, food security, and humanitarian crises caused by civil wars and natural disasters."⁵⁸⁵ How climate change can be a cause for the spread of infectious diseases was illustrated in chapter 8.2.3. The strategy refers to health again in "Strengthening Cooperation Based on Universal Values to Resolve Global Issues", where it is declared that Japan will increase efforts to achieve the Millennium Development Goals in the area of global health, among others.⁵⁸⁶ It adds: "Japan will take the lead in international cooperation on disaster management and ensure that communities around the world have a high degree of resilience to disasters."⁵⁸⁷

11.6.1 Conclusions Japan

The 2013 document is Japan's first national security strategy.⁵⁸⁸ It does not contain a chapter that debates public/ global health. Even a paragraph addressing the topic is absent. In addition, infectious diseases are only mentioned once and global health twice. Other, in chapter 5.1 pre-defined, keywords are not used in the document. As the strategy was published in 2013, the research question cannot be answered and the hypothesis cannot be supported or refuted.

584. Government of Japan, "National Security Strategy," http://japan.kantei.go.jp/96_abe/documents/2013/___icsFiles/afieldfile/2013/12/17/NSS.pdf, 7, (Accessed: 19 June 2017).

585. Government of Japan, "National Security Strategy," 10.

586. Government of Japan, "National Security Strategy," 32–33.

587. Government of Japan, "National Security Strategy," 33.

588. Elena Atanassova-Cornelis, "Japan's new approach to national security," https://www.iss.europa.eu/sites/default/files/EUISSFiles/Brief_2_Japan_s_national_security.pdf, 1, (Accessed: 19 June 2017).

11.7 United Kingdom

The UK's 2010 national security strategy is 38 pages long and does not contain a chapter that discusses infectious diseases. However, they are referred to throughout the document.

The advances in the field of biological sciences are debated in "Part One: The Strategic Context". While the disadvantages include a potential misuse (purposely or accidentally), the advantages comprise advancements in drug-production procedures, which can be a key element in the fight of infectious diseases and their transmission. "Part Two: Britain's Distinctive Role" points out that today's globalised world also includes the risk of a spread of infectious diseases to the UK.⁵⁸⁹ In "Part Three: Risks to Our Security", "a major accident or natural hazard" (e.g. pandemics) is named among three other "Tier One" risks, which have the highest priority for the UK's national security.⁵⁹⁰ The document declares: "The risk of human pandemic disease remains one of the highest we face. [...] Pandemics have global human health consequences."⁵⁹¹ The pandemics of 1918 and 2009 are listed as cases for influenza pandemics. Canada's security policy also named the 1918 influenza pandemic as an example for a threat, which the state faced in history.⁵⁹² The pandemic was also illustrated in an excursus in chapter 7.4. The UK's strategy continues to explain:

There is a high probability of another influenza pandemic occurring and, based on a range of data, possible impacts of a future pandemic could be that up to one half of the UK population becomes infected, resulting in between 50,000 and 750,000 deaths in the UK.⁵⁹³

This statement can be linked with the research of Taubenberger/ Morens research, which was described in chapter 7.4. They claim: "Even with modern antiviral and antibacterial drugs, vaccines, and prevention knowledge, the return of a pandemic virus equivalent in pathogenicity to the virus of 1918 would likely kill >100 million people worldwide."⁵⁹⁴ This potentially high mortality rate underscores why infectious diseases are a security risk. The previously mentioned disadvantage of globalisation would play a crucial role in the spread. Both, mortality rate and globalisation, were debated in chapters 1.1 and 8.1.

Even though the 2015 UK national security strategy, also, does not contain a chapter that discusses infectious diseases, they are referred to throughout it.⁵⁹⁵ In addition, global health security (linked with infectious diseases) is illustrated twice. There are two noticeable differences

589. HM Government, "A Strong Britain in an Age of Uncertainty: The National Security Strategy," https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/61936/national-security-strategy.pdf, 17 & 22, (Accessed: 19 June 2017).

590. HM Government, "Strong Britain," 27.

591. HM Government, "Strong Britain," 30–31.

592. HM Government, "Strong Britain," 31; Canada Privy Council Office, "Securing an Open Society," Preface.

593. HM Government, "Strong Britain," 31.

594. Taubenberger and Morens, "1918 Influenza," 21.

595. HM Government, "National Security Strategy and Strategic Defence and Security Review 2015. A Secure and Prosperous United Kingdom," https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/555607/2015_Strategic_Defence_and_Security_Review.pdf, 3, (Accessed: 19 June 2017).

between the 2010 and the 2015 documents. The first one is its length, as it encompasses 95 pages, compared to 38 pages of the previous one. This is suggestive that the threats, which pose a risk to the UK's national security, grew and broadened in their extent. This impression is supported by this statement: "From the rise of ISIL⁵⁹⁶ and greater instability in the Middle East, to the crisis in Ukraine, the threat of cyber attacks and the risk of pandemics, the world is more dangerous and uncertain today than five years ago."⁵⁹⁷ The second striking difference is the declaration of public health being a "Tier One" risk as compared to the 2010 strategy, in which the threat of a pandemic was integrated into the category "major accident or natural hazard". The 2015 document states that some risks have a higher possibility of occurrence or greater long-term effects. Antimicrobial resistance and the emergence of infectious diseases are named among other examples (cyber threats, chemical/ biological weapons attacks, proliferation, etc.).⁵⁹⁸

In the chapter "The National Security Context" the role of globalisation in the rise of risks threatening the nation and its territories as well as global health security is pointed out. There, it is explained that especially states with fragile health systems are more vulnerable. The 2014 Ebola outbreak is named as an example. Further, it is described that the outbreak did not only lead to deaths, it also disturbed stability-building efforts. As another threat to health security, agents with the potential to develop into pandemics and drug-resistant pathogens are named. The strategy declares that international cooperation is key to tackling all these risks to health security. The Ebola outbreak is mentioned again in the chapter "Protect Our People", in which it is stated that the UK's Armed Forces will engage in various kinds of operations (e.g. assistance during the Ebola outbreak). The section "Crisis response and resilience" of the document illustrates that the UK learned its lessons from infectious disease outbreaks in other states. Later, it is pointed out that the UK cooperates with African states to achieve the same for them. Resulting from the 2014 Ebola outbreak in West Africa, the UK is working on a "national bio-security strategy", which will deal with the risk of unintentional (e.g. infectious disease outbreaks) and intentional (e.g. bioterrorism) spread. The national security strategy describes in the chapter "Project Our Global Influence" that the UK will assist other states to be resilient and prepared for threats that affect health security. The necessity of international cooperation, as numerous risks are global, is addressed again.⁵⁹⁹ It is added: "Tackling poverty and instability overseas means tackling the root causes of many of the global challenges that we face including disease, migration and terrorism."⁶⁰⁰ One statement regarding health (section "Building international resilience") needs to be pointed out: "We have chosen to invest in and lead international work on two major areas of global risk which threaten stability overseas and the UK's long-term security: climate

596. Islamic State of Iraq and the Levant.

597. HM Government, "National Security Strategy," 5.

598. HM Government, "National Security Strategy," 85–87.

599. HM Government, "National Security Strategy," 15, 17-18, 30, 43, 47, 50 & 57.

600. HM Government, "National Security Strategy," 48.

change and health security.”⁶⁰¹ This statement is striking as two topics of wider security are referred to as global risks. In chapter 9.1.1, the narrow and the wider view of security was illustrated. The section “Global health security” discusses the topic on a half-page.⁶⁰² Here, it is explained: “Health crises can have regional and international impact. Diseases can spread rapidly, including across borders. The emergence of drug-resistant disease is an increasing global threat.”⁶⁰³ The UK aims to bolster global health security with the increase of their international activities. To fight drug-resistance they cooperate with international partners. The UK also created the “Fleming Fund” to assist developing states. In addition, the “UK Vaccines Network” was established as a platform for experts in various fields to develop and test new vaccines to fight infectious diseases more effectively. Plus, the UK will make investments in research and development to tackle infectious diseases with epidemic potential and those which affect people living in developing states.⁶⁰⁴ Further, the UK will create “a new rapid response team of technical experts to deploy to help countries to investigate and control disease outbreaks. This team will include epidemiologists, infection control specialists and researchers and will be on permanent standby.”⁶⁰⁵ Reasons why infectious diseases are a security risk and what contributes to their (re-)emergence and spread (e.g. globalisation, weak states/ systems, biological agents, migration) are given throughout the document. These examples are also described in this thesis, in particular in chapters 1.1, 6.2 and 8.1 to 8.2.6.

11.7.1 Conclusions United Kingdom

The UK’s 2015 national security strategy points out the importance of global health several times. In addition, the effects of infectious diseases on national and international security are illustrated. Global health security is discussed in more detail in the chapters “The National Security Context” and “Project Our Global Influence”. The focus on the risk of (infectious) diseases on public/ global health and on (global) health security intensified in the 2015 document. This is affirmed in the increased use of some, in chapter 5.1 pre-defined, keywords and in the frequent reference to the risk infectious diseases pose. The most noticeable difference between the 2010 and 2015 strategies is the declaration of public health as a “Tier One” risk in the one of 2015. Further, the 2014 Ebola outbreak is mentioned several times. This is in contrast to the previous document, in which the 2009 H1N1 pandemic was only referred to twice. The detailed explanations in the 2015 national security strategy underscore that the UK takes the threat of infectious diseases even more serious as compared to the 2010 strategy. Therefore, the 2014 Ebola outbreak intensified the UK’s evaluation of infectious diseases as a security risk.

601. HM Government, “National Security Strategy,” 65.

602. HM Government, “National Security Strategy,” 66.

603. HM Government, “National Security Strategy,” 66.

604. HM Government, “National Security Strategy,” 66.

605. HM Government, “National Security Strategy,” 66.

The securitisation of infectious diseases was already visible in the 2010 national security strategy. Several, previously, named examples underscore this. One, the inclusion of pandemics in the category “major accident or natural hazard” (one of three “Tier One” risks, which have highest priority for the UK). Two, advances in drug-production procedures, which can be key in the fight against infectious diseases. Three, focus on economic effects and social stability. In the 2015 strategy, public health has been “levelled up” to a “Tier One” risk for the UK. Furthermore, the document points out that some threats are more likely to happen or have greater long term effects (antimicrobial resistance, emergence of infectious diseases, cyber threats, chemical/ biological weapons attacks, proliferation etc.).⁶⁰⁶ This can be connected to Buzan/ Waever’s statement that all states and people “share a universal physical threat perception against themselves as referent objects, from nuclear weapons [...] through disease [among others].”⁶⁰⁷ The 2015 strategy declares, referring to the 2014 Ebola outbreak, that it disturbed stability-building efforts.⁶⁰⁸ It also announces: “We have chosen to invest in and lead international work on two major areas of global risk which threaten stability overseas and the UK’s long-term security: climate change and health security.”⁶⁰⁹ Both statements underscore the findings of several researchers that the securitisation of infectious diseases is often focused on the economic sector and social stability. The second declaration also highlights how seriously the UK takes health, as it is categorised as a risk with the potential to affect security continuously. This can be connected to Behnke as, according to him, framing an issue as a threat to the state/ society creates a national identity. The UK’s work on a “national bio-security strategy”, the establishment of the “Fleming Fund”, the “UK Vaccines Network” and “a rapid response team” as well as investments in research and development emphasise securitisation in two ways. One, they illustrate how the UK aims to fight infectious diseases. The use of securitisation is, according to Waever, a possibility to gain control over an issue. He also explains that with “security” the response to a threat is that a form of action is taken. In contrast, with “insecurity” there is no response to the security problem. Two, all examples provided are effects of the securitisation (mobilisation, attention) of infectious diseases.⁶¹⁰ In short: two significant changes between the 2010 and the 2015 national security strategy are identified. One, the declaration of public health as a “Tier One” risk. Two, the increased focus on infectious diseases and how to tackle them. These shifts, and the illustrations provided, emphasise that the hypothesis is supported for the UK.

606. HM Government, “Strong Britain,” 27 & 30-31; HM Government, “National Security Strategy,” 85–87.

607. Buzan and Wæver, “Macrosecritisation and security constellations,” 264.

608. HM Government, “National Security Strategy,” 17.

609. HM Government, “National Security Strategy,” 65.

610. Sands, Mundaca-Shah and Dzau, “Neglected Dimension”; Kamradt-Scott and McInnes, “Securitisation”; Lo Yuk-ping and Thomas, “Health”; Elbe, “Pandemics”; Behnke, “No way out,” 65; HM Government, “National Security Strategy,” 43 & 66; Wæver, “Securitization and Desecritization,” 54 & 56; Buzan, Wæver and Wilde, *Security*, 29.

11.8 United States

The 2010 US national security strategy is 52 pages long and does not contain a chapter that deals with health security. Infectious diseases are mentioned several times, albeit briefly, among other threats and challenges. For example, to fight infectious diseases to promote public health, to keep regions safe as well as to build and/ or strengthen resilient systems to minimise the risk of spread and the aftermath).

The document points out that infectious diseases can be a threat when released on purpose or by accident.⁶¹¹ Other reasons why infectious diseases are a risk are also explained:

An epidemic that begins in a single community can quickly evolve into a multinational health crisis that causes millions to suffer, as well as spark major disruptions to travel and trade. [...] We seek to mitigate other problem areas, including limited global vaccine production capacity, and the threat of emergent and reemergent disease in poorly governed states.⁶¹²

In the 2015 national security strategy, three changes are noticeable. One, with 29 pages it is shorter than the previous one. Two, a chapter ("Increase Global Health Security") is dedicated to health. Three, the topic of infectious diseases has been "levelled up" from being referred to as a "key global challenge"⁶¹³ in the previous document, to being placed into part two ("Security") of the 2015 one. There, infectious diseases are placed alongside traditional (e.g. terrorism, national defence) and wider risks (e.g. climate change) of security.⁶¹⁴ The narrow and the wider view of security were discussed in chapter 9.1.1. The US' increased focus on health is noticeable as it is declared that massive worldwide outbreaks of infectious diseases are a "top strategic risk".⁶¹⁵ The strategy also points out that certain developments (e.g. interdependence of globalised economy, swift advancements in technology) can impact the field of security. While globalisation has advantages, its disadvantages include the exposure of societies/ sectors to threats like infectious diseases.⁶¹⁶ Further, it is stated that the US "will also continue to enhance pandemic preparedness at home and address the threat arising from new drug-resistant microbes and biological agents."⁶¹⁷ The section "Increase Global Health Security" explains that the 2014 Ebola outbreak underscored the risk of infectious diseases. It is also illustrated that the spread of infectious diseases, the increase of drug-resistance and the intentional release of biological agents are intensified by globalisation (e.g. travel, trade, technology). The document declares that the majority of states are inadequately prepared for outbreaks of infectious diseases and that the US leads the fight against infectious diseases and in the increasing of global health security. This

611. The White House, "National Security Strategy 2010," <http://nssarchive.us/NSSR/2010.pdf>, 5–24, (Accessed: 19 June 2017).

612. The White House, "National Security Strategy 2010," 49.

613. The White House, "National Security Strategy 2010," 47–49.

614. The White House, "National Security Strategy 2015," <http://nssarchive.us/wp-content/uploads/2015/02/2015.pdf>, (Accessed: 19 June 2017).

615. The White House, "National Security Strategy 2015," 2.

616. The White House, "National Security Strategy 2015," 4.

617. The White House, "National Security Strategy 2015," 9.

will be accomplished by bolstering regulatory frameworks, establishing structures to restrain preventable epidemics and boosting the communication and reaction to them.⁶¹⁸ Like the UK's national security strategy that of the US also cites examples of why infectious disease are a security risk and what contributes to their (re-)emergence and spread (e.g. technology, biological agents, globalisation, travel/ trade).

11.8.1 Conclusions United States

The importance of global health is pointed out several times in the 2015 national security strategy. In addition, the effects of infectious diseases on national and international security are illustrated. The 2014 Ebola outbreak is mentioned a few times. This is in contrast to that of 2010, in which the 2009 H1N1 pandemic was only referred to once as an example. Compared to the previous document, the 2015 strategy increased its focus on health security. Another difference is the integration of health into part two "Security" and naming it a "top strategic risk." The US already classified infectious diseases as a security risk before the 2014 Ebola outbreak. Yet, the illustrations and changes between the two documents highlight that the US takes the topic even more seriously. Therefore, the outbreak intensified the evaluation of infectious diseases as a security risk.

The 2010 national security strategy discusses infectious diseases only briefly and mainly in connection to why they are a risk to security. However, this changes in the 2015 document. Firstly, this is demonstrated in the integration of infectious diseases in part two "Security". The topic has been "levelled up" from being identified a "key global challenge" to being named alongside traditional (e.g. terrorism, national defence) and wider risks (e.g. climate change). Secondly, the change is visible in the declaration of worldwide outbreaks of infectious diseases as a "top strategic risk". In the same manner as for Germany and the UK, Behnke's statement, that framing an issue as a threat to the state/ society creates a national identity, can be linked here as well. Thirdly, the strategy explains how a globalised economy impacts the field of security (e.g. exposure of society/ sectors to infectious diseases).⁶¹⁹ This can be linked to Elbe, who states that when focussing securitisation on national security, it is mainly concentrated "on the threat posed by naturally emerging and re-emerging infectious diseases in the context of an increasingly globalised and interdependent world economy."⁶²⁰ It can also be connected to the observation of various researchers that the securitisation of infectious diseases focusses more on the economic sector and stability than on the health sector. Other possible threats stemming from infectious

618. The White House, "National Security Strategy 2015," 13–14.

619. The White House, "National Security Strategy 2010," 47–49; The White House, "National Security Strategy 2015," Introduction, 2 & 4; Behnke, "No way out," 65.

620. Elbe, "Should health professionals play the global health security card?," 220.

diseases are drug-resistance and the deliberate or accidental release of biological agents.⁶²¹ Here, Buzan/ Wæver's statement that, in general, all states and people "share a universal physical threat perception against themselves as referent objects, from nuclear weapons [...] through disease [among others]" can be linked to highlight the securitisation of infectious diseases.⁶²² Effects of securitisation are "focus, attention, and mobilization."⁶²³ The US aims to boost health security by bolstering regulatory frameworks, establishing structures to restrain preventable epidemics and boosting the communication and reaction to them.⁶²⁴ The increase of awareness and mobilisation is also visible in the following statements: "We will keep working with partners to reduce deaths from Ebola, HIV/ AIDS, malaria, and tuberculosis."⁶²⁵ As well as: "American leadership has proven essential to bringing to bear the international community to contain recent crises while building public health capacity to prevent future ones."⁶²⁶ Wæver explains that securitisation can be used as a possibility to gain control over an issue and that with "security", as compared to "insecurity", the response to a risk is that a form of action is taken.⁶²⁷ The integration of health into the chapter "Security" and the given illustrations emphasise that the securitisation of infectious diseases has increased. Therefore, the hypothesis is supported for the US.

11.9 Africa

National security strategies focus mainly on external threats (terrorism, infectious disease outbreaks etc.). Yet, in numerous African states the threats affecting the state are internal.⁶²⁸ As Buzan already described in 1998: "Little of Africa [...] has the typical security complex type of threats in which one state threatens another. Military threats occur more often within states (over competition for state power) than between them (where capability for military power projection is low)."⁶²⁹ He adds: "The main societal referent objects are a mix of premodern- the extended family, village, clan, and tribe- and modern, the "state nation".⁶³⁰ In addition to these factors, security is often linked to the survival of a regime as compared to the protection of the nation. The, usually, transparent process of developing a national security strategy often does not take place in African states. The reason why is the focus on the survival of the regime. These circumstances make it difficult to develop a comprehensive national security strategy/ white

621. Sands, Mundaca-Shah and Dzau, "Neglected Dimension"; Kamradt-Scott and McInnes, "Securitisation"; Lo Yuk-ping and Thomas, "Health"; Elbe, "Pandemics"; The White House, "National Security Strategy 2015," 9.

622. Buzan and Wæver, "Macrosecritisation and security constellations," 264.

623. Buzan, Wæver and Wilde, *Security*, 29.

624. The White House, "National Security Strategy 2015," 14.

625. The White House, "National Security Strategy 2015," 27.

626. The White House, "National Security Strategy 2015," 27.

627. Wæver, "Securitization and Desecritization," 54 & 56.

628. Africa Center for Strategic Studies, "Q&A: Developing Inclusive National Security Strategies in Africa," <https://africacenter.org/spotlight/qa-developing-inclusive-national-security-strategies-africa-malaquias/>, (Accessed: 15 April 2017).

629. Buzan, Wæver and Wilde, *Security*, 127.

630. Buzan, Wæver and Wilde, *Security*, 126.

paper. Many African states do not have one; the few exceptions include Sierra Leone and Liberia.⁶³¹ For the latter, its 2008 document is not publicly available and, therefore, cannot be reviewed. For Guinea, no national security strategy/ white paper is available for analysis.

11.9.1 Sierra Leone

Sierra Leone's defence white paper was published in 2003 and is 23 pages long. It does not contain a chapter that discusses health or infectious diseases. However, the importance of health is mentioned several times in the document and is addressed in more detail in chapter six.

In the section "threats and challenges", it is explained that Sierra Leone's security can be threatened by risks from within, outside or a mixture of both. Further, it is pointed out that the population is mainly threatened by socio-economic challenges, which can lead to instability and include poverty, unemployment and deficiencies in the education and health system. Several listed factors, which can contribute to the (re-)emergence and spread of infectious diseases, were also illustrated in chapters 8.2.1 to 8.2.6. In the section "the defence budget" it is disclosed that Sierra Leone's highest expenses are those for health, education and defence. It is added that national security is of primary importance for the states' government. Health is debated in the sections "health and welfare support" and "RSLAF⁶³² and HIV/ Aids". The white paper describes that the health of the Armed Forces is necessary for operational achievements. Their health should be attained and maintained through various actions (e.g. increasing the number of doctors, development of a policy with focus on health and welfare, investment in health education, establishment of independent healthcare). In the section "RSLAF and HIV/ Aids", the document states that HIV/ AIDS is a risk for the Armed Forces as it threatens to deprive the military of valuable and effective personnel. Further, it is declared that the establishment of several policies (e.g. HIV/ AIDS policy, AIDS prevention programme), the cooperation with agencies (e.g. National Aids Council, Ministry of Health), NGO's and donors will help in the fight against HIV/ AIDS.⁶³³

11.9.1.1 Conclusions Sierra Leone

The 2003 defence white paper is Sierra Leone's first and only one.⁶³⁴ It does not contain a chapter that discusses public/ global health. However, it refers to the topic of health. While certain, in chapter 5.1 pre-defined, keywords (e.g. health, disease, epidemic, pandemic) are mentioned, others (e.g. health security, public/ global health) are not. It is noteworthy that the topic and

631. Africa Center for Strategic Studies, "Q&A".

632. Republic of Sierra Leone Armed Forces.

633. Ministry of Defence, "Defence White Paper Sierra Leone," <http://www.mod.gov.sl/docs/MODDefenceWhitePaperSierraLeone.pdf>, 5, 18 & 21-22, (Accessed: 19 June 2017).

634. Ministry of Defence Sierra Leone, "Mod/ RSLAF Publications," <http://www.mod.gov.sl/resources-publications.html>, (Accessed: 15 May 2018).

importance of health is addressed in the document, as many African states do not even have a national security strategy/ white paper. As the document was published in 2003, the research question cannot be answered and the hypothesis cannot be supported or refuted.

11.10 Comparison of national security strategies/ white papers

In the following section, the similarities and differences between the national security strategies/ white papers of Canada, France, Germany, Italy, Japan, the UK, the US and Sierra Leone are identified. This is accomplished by answering the majority of the pre-defined questions laid out in chapter 5.1.

Are infectious diseases evaluated a (national) security risk?

The national security strategies/ white papers of Canada, France, Germany, Japan, the UK and the US classify infectious diseases/ pandemics as a security risk or at least name them as a global issue/ challenge. Infectious diseases/ pandemics are also named as being as much of a risk as terrorism and other challenges (which varies among the states). Italy's document is vaguer and names pandemics alongside other threats that potentially harm the state. Sierra Leone's white paper does not refer to infectious diseases as a security risk.

Is public/ global health discussed?

All analysed documents evaluate public/ global health as an important topic. The exception is Italy, whose white paper only focusses on the importance of health to their Armed Forces. Sierra Leone's white paper also points out the significance of health. Mainly regarding their Armed Forces and mentions health with reference to its citizens once. The documents of the US and France focus on global health, whereas Germany directs its attention to public health. Canada's and the UK's security strategy concentrate on public and global health to the same degree. Compared to the other reviewed documents, that of the UK debates public health in more detail. It also provides specific explanations of how the health of its citizens will be provided for and maintained (specific funds, programmes, research etc.).

Is the 2014 Ebola outbreak mentioned?

The 2014 Ebola outbreak is not mentioned in the majority of the analysed national security strategies/ white papers. The reason why is that most documents were not updated during or since the outbreak. Italy, the UK and the US published their (updated) documents in 2015 and Germany did so in 2016. Italy and Germany do not refer to the 2014 Ebola outbreak. Only the UK and the US debate it.

Is international cooperation evaluated as a necessity in the fight of infectious diseases?

The national security strategies/ white papers of Germany, France, Japan, the UK and the US all point out the necessity of international cooperation during outbreaks and in the fight against the spread of infectious diseases. Italy's white paper addresses the importance of international cooperation, yet not with reference to infectious diseases. Sierra Leone's document does not mention the topic.

Is globalisation named as a factor for the emergence and spread of infectious diseases?

Even though globalisation has numerous advantages, one disadvantage is the possibility of a more rapid transmission of infectious diseases. Aside from Sierra Leone's document, all reviewed national security strategies/ white papers name globalisation as a factor for the spread of infectious diseases.

Are biological agents/ weapons evaluated as a security risk?

The intentional release of biological agents or their use as a biological weapon is classified as a risk in all analysed documents, except for that of Sierra Leone, which does not discuss the topic.

In this chapter, the national security strategies/ white papers of Canada, France, Germany, Italy, Japan, the UK, the US and Sierra Leone were analysed. The objectives were to answer the research question and to support or refute the hypothesis. This was conducted separately for each state. Subsequently, the documents of all states were compared based on pre-defined questions to identify similarities and differences. The next and last chapter of this master's thesis is the conclusion.

12. Conclusions

Infectious diseases have impacted humankind throughout history; some have even eradicated parts of the world population (e.g. 1918 influenza pandemic). The discussion about infectious diseases as a security risk is not novel and their securitisation is not either. While there is no agreement about the starting point (e.g. 1918 influenza, HIV/ AIDS) of securitising infectious diseases, examples of the recent history include SARS, H5N1 and the H1N1 pandemic. The 2014 Ebola outbreak in West Africa is one of the latest cases that illustrated and emphasised the risk of infectious diseases. The outbreak also revealed the deficiencies of regional and international organisations as well as of states.

The knowledge void this master's thesis has aimed to fill was the identification of changes the 2014 Ebola outbreak caused in the evaluation of infectious diseases as a security risk in (national) security strategies/ white papers and resolutions. In addition, it was hypothesised that the outbreak led to a further securitisation of infectious diseases.

Therefore, the security strategies/ resolutions of selected regional and international organisations (WHO, UN, EU, AU) as well as the national security strategies/ white papers of ten states (G7 member states plus Sierra Leone, Guinea, Liberia) were analysed. The timeframe determined was January 2014 until May 2017. The security strategies were reviewed based on pre-defined questions to identify changes between the current and the previous document. The resolutions were first screened for pre-defined keywords to filter out the relevant ones. The objectives were: one, to answer the research questions and two, to support or refute the hypothesis. For the states, the third objective was to identify similarities and differences among the documents.

Regarding the research question the analysis revealed that the 2014 Ebola outbreak intensified the evaluation of infectious diseases as a security risk for three organisations (WHO, UN, AU). As a result of the outbreak, the WHO has initiated the most profound reform in its history. The UN now places even more emphasis on infectious diseases than prior to the outbreak. The AU also takes the topic more serious now- at least concerning health security. Yet, identifying the intensification for the AU was not as obvious as for the WHO and the UN. The EU did not change its evaluation of infectious diseases as a security risk as the changes in the 2016 strategy are minimal compared to the previous one. This result was unexpected and striking as several cases of Ebola were confirmed in the EU.

For the states analysed an unanticipated restriction was exposed. Only three states (Germany, UK, US) updated their documents during the set timeframe. However, the 2014 Ebola outbreak intensified their evaluation regarding infectious diseases as a security risk. This is emphasised with the following examples: an extension of the discussion of health (Germany), the elevation of

public health to a “Tier One” risk (UK), the integration of health into the section “Security” and its categorisation as a “top strategic risk” (US).

Another objective of the analysis of national security strategies/ white papers was the identification of similarities and differences among them. This was done for all states, regardless of the timeliness of their documents. Canada, France, Germany, Japan, the UK and the US all declared infectious diseases/ pandemics a security risk or a global challenge. Italy was vaguer in its definition and Sierra Leone did not mention the topic. Aside from Italy and Sierra Leone, which focused on their Armed Forces, all other reviewed documents evaluated public and/ or global health as being of importance. Except for Sierra Leone, biological agents were addressed by all states and categorised as a security risk. Even though Germany, Italy, the UK and the US published national security strategies/ white papers during the Ebola outbreak, only the latter two discussed it. International cooperation was highlighted in all documents, except for that of Sierra Leone. While Italy only referred to the topic in general, the other states agreed on its significance to fight infectious diseases.

The securitisation theory was chosen as the theoretical basis of this master’s thesis. In short: the first step of securitisation is the identification of an existential threat to a referent object, which differs among sectors and levels. This is followed by the acceptance of a threat by an audience. The next step is the implementation of emergency action to tackle it. Finally, when the threat is under control, the issue moves to the desecuritisation phase; namely back into a normal mode (of politics). If the audience does not accept the existential threat, it is called a securitisation move. As a result, there will be no emergency action or desecuritisation.

When securitisation occurs on the international level (macrosecuritisation) it means a topic is so existential and relevant that it needs to be handled by top leaders and has priority over other subjects (e.g. precedents within the UN during the 2014 Ebola outbreak: resolution 2177, UNMEER). However, securitisation on the system level is complicated due to political factors and as the referent object is in a way all of humankind. Possible advantages of securitisation include increased awareness and mobilisation. This was visible for the WHO, the UN and the AU during and after the 2014 Ebola outbreak. For example, the establishment of programmes/ funds as part of the WHO’s reform, UNMEER, the PEF, ASEOWA, the Africa CDC and AVOHC. Further, securitisation is a possibility for powerholders to attain control over an issue (e.g. establishment of UNMEER and ASEOWA). Based on the analysis, the hypothesis was supported for the WHO, the UN and the AU. Although for the latter, not as clearly as for the other organisations. The hypothesis was refuted for the EU.

In general, securitisation focusses mainly on the middle level (e.g. states), as it is the most active one and actors are easier to identify. Further, all states and people have a threat perception in common where they are the referent object. For instance: Germany’s statement that infectious disease outbreaks are a risk to life, the UK’s declaration that the state faces long-term effects

resulting from infectious diseases and other health risks as well as the US' integration of health into the topic of security and the categorisation of infectious diseases as a primary risk for the state. These examples illustrate that infectious diseases are evaluated as an existential threat as they are integrated into national security strategies/ white papers. For states, possible advantages of securitisation also include the increased awareness and mobilisation (e.g. contributions to the establishment of a body of specialists for emergencies (Germany), work on a "national bio-security strategy", the establishment of the "Fleming Fund", the "UK Vaccines Network", a "fast response team", investments in research and development (UK), declaration to bolster regulatory frameworks, establishment of structures to restrain preventable epidemics, boost of communication and reaction to infectious disease outbreaks (US)). Therefore, the hypothesis was supported for Germany, the UK and the US.

12.1 Main findings and contributions

The following section presents the main findings and contributions of this master's thesis.

One, most of the illustrated reasons why and factors, which can contribute to the (re-)emergence and spread of infectious diseases, played a role during the 2014 Ebola outbreak.

Two, during the discussion of the Copenhagen School's definition of sectors, it emerged that it lacks the health sector. While the widening of security studies was still debated and ongoing during the 1990s and the world was not as globalised as it is today, the circumstances are much different nowadays.

Three, Lo/ Thomas and Buzan/ Waever explained that securitisation on the system level is difficult to achieve due to political factors and as the referent object is in a way all of humankind. However, the analysis demonstrated that securitisation in regional and international organisations is possible.

Four, several researchers (e.g. Sands/ Mundaca-Shah/ Dzau, Kamradt-Scott/ McInnes, Lo/ Thomas, Elbe) observed that the securitisation of health is often not focused on the health sector, but on the economy and social stability. The review of documents confirmed this observation. The WHO, the UN, the AU and the UK, all linked the threats of the 2014 Ebola outbreak mainly to the economy and/ or social stability. Germany and the US also generally linked infectious diseases/ health with the economy.

Five, researchers (e.g. Evans, Brachman, Elbe, Satcher, Sands/ Mundaca-Shah/ Dzau, Chan/ Store/ Kouchner) are not in agreement whether infectious diseases constitute a risk to national or global security or to both. The points illustrated in this thesis clearly emphasised that infectious diseases (can) pose a risk to both.

Six, the 2014 Ebola outbreak is indeed comparable to the 1918 influenza pandemic, which was one of the deadliest diseases in modern history. The existing literature, the explanations

throughout this thesis and the WHO's declaration that the outbreak was "the most severe acute public health emergency seen in modern times", further underscore this.

Seven, the analysis revealed that all the steps of a securitisation were passed through during the 2014 Ebola outbreak. The actor (governments/ organisations) identified an existential threat (the Ebola virus) to a referent object (citizens/ humankind). The securitisation move was accepted by the audience (citizens/ states) and emergency action was implemented to tackle the threat. For states the examples included: the closing of borders, schools/ universities, travel and trade restrictions, traveller screening, movement limitations/ curfews, quarantine and mass vaccinations. For the organisations the establishment of UNMEER and ASEOWA, can among several others, be named as examples. After the threat was under control, the desecuritisation phase began.

12.2 Recommendations and implications

Based on the reviewed literature and the analysis conducted, four recommendations can be made:

One, the frequent (re-)emergence and spread of infectious diseases, in general, and more specifically the deficiencies the 2014 Ebola outbreak exposed, emphasise that the discussion of infectious diseases being a security risk should be continued.

Two, the outbreak demonstrated the global ill-preparedness for a severe infectious disease outbreak as developed states also had difficulties treating infected people. Therefore, investments in health (e.g. research) should be maintained.

Three, the extension of the Copenhagen School's definition of sectors with that of the health sector should be debated. In general, the repeated (re-)emergence and spread of infectious diseases, persistent infectious diseases and the rise of drug-resistance illustrate that the importance of health should not be underestimated. Specifically, the 2014 Ebola outbreak itself (mortality, economic impact, partial breakdown of public health measures etc.), but also the Ebola-initiated WHO reform, the precedents within the UN (resolution 2177, UNMEER) and other examples confirmed the necessity of a discussion.

Four, the analysis revealed that the majority of national security strategies/ white papers have not been updated in up to 15 years. In addition, some states revise them only every ten years. Hence, it is recommended to consider a more frequent revision of these documents as well as of pandemic plans so as to adapt them to current circumstances. Further, international organisations should debate the development of security strategies.

Based on the topic of this thesis, two recommendations are made for further research. One, an investigation of how the backgrounds of states (e.g. historical, political, societal) affect the incorporation of the emphasis on health into their national security strategies/ white papers. Two,

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an analysis of the dynamics among states and their influence on the inclusion/ exclusion of health on the agenda of regional and international organisations. These suggestions are proposed as understanding these aspects could further the process to make/ keep (global) health security a priority.

In the introduction of this master's thesis it was assumed that when the question: "What incidents pose a risk to security?" is raised, infectious diseases were not among the first topics that came to mind. It was intended that when the question is asked again at this point in the thesis, the answer would be a different one. Namely, that one immediately thinks of them as a security risk.

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Die Debatte ob Infektionskrankheiten eine Sicherheitsbedrohung darstellen sowie deren Versicherheitlichung (z.B.: HIV/ AIDS, SARS, H5N1, H1N1) ist nicht neu. Heutzutage sind Infektionskrankheiten oftmals in (nationalen) Sicherheitsstrategien integriert.

Im Fokus dieser Masterarbeit liegt der Ebola-Ausbruch in Westafrika im Jahr 2014. Die Fragestellungen lauten, ob der Ausbruch die Einschätzung von Infektionskrankheiten als Sicherheitsbedrohung in (nationalen) Sicherheitsstrategien/ Weißbüchern/ Resolutionen von regionalen und internationalen Organisationen (WHO, UN, EU, AU) und von Staaten (G7-Mitgliedsstaaten, Sierra Leone, Guinea, Liberia) verändert hat. Weiters wird die Hypothese aufgestellt, dass der Ausbruch zu einer weiteren Versicherheitlichung von Infektionskrankheiten geführt hat.

Um die Fragestellungen zu beantworten und die Hypothese zu bestätigen oder zu widerlegen, wurden die (nationalen) Sicherheitsstrategien/ Weißbücher/ Resolutionen auf Basis vordefinierter Schlagwörter und Fragen gefiltert und ausgewertet. In Bezug auf die untersuchten Staaten war ein weiteres Ziel, Gemeinsamkeiten sowie Unterschiede der Dokumente zu identifizieren. Die Analyse hat gezeigt, dass der Ausbruch die Einschätzung von Infektionskrankheiten als Sicherheitsrisiko für drei Organisationen (WHO, UN, AU) und für drei Staaten (Deutschland, GB, USA) verstärkt hat. Die EU hat ihre Einschätzung nicht geändert. Die Hypothese wurde für die genannten Organisationen und Staaten bestätigt, aber für die EU widerlegt.

Die Hauptergebnisse umfassen: erstens, es wurde aufgezeigt, dass Infektionskrankheiten ein Sicherheitsrisiko sowohl für die nationale und internationale Sicherheit darstellen (können). Zweitens, Makro-Versicherheitlichung ist erreichbar. Drittens, die Integration von Infektionskrankheiten in viele der ausgewerteten Dokumente zeigt, dass sie als existenzielle Bedrohung eingestuft werden. Viertens, alle Schritte einer Versicherheitlichung wurden während des Ebola-Ausbruchs im Jahr 2014 durchlaufen. Fünftens, der Definition von Sektoren der Kopenhagener Schule fehlt der Gesundheitssektor.

Abstract

The discussion about infectious diseases as a security risk is not novel and their securitisation (e.g. HIV/ AIDS, SARS, H5N1, H1N1) is not either. Nowadays, infectious diseases are often integrated in (national) security strategies.

This master's thesis focusses on the 2014 Ebola outbreak in West Africa. The research questions are whether the outbreak changed the evaluation of infectious diseases as a security risk in (national) security strategies/ white papers/ resolutions of regional and international organisations (WHO, UN, EU, AU) and of states (G7 member states, Sierra Leone, Guinea, Liberia). Further, it is hypothesised that the outbreak led to a further securitisation of infectious diseases.

To answer the research questions and to support or refute the hypothesis, the (national) security strategies/ white papers/ resolutions were screened and analysed based on pre-defined keywords and questions. For the reviewed states, a further objective was to identify similarities and differences among the documents. The analysis revealed that the outbreak intensified the evaluation of infectious diseases as a security risk for three organisations (WHO, UN, AU) and for three states (Germany, UK, US). The EU did not change its evaluation. The hypothesis was supported for the same organisations and states, but was refuted for the EU.

The main findings encompass: one, it was emphasised that infectious diseases (can) pose a risk to national and global security. Two, macrosecuritisation is achievable. Three, the integration of infectious diseases into many of the reviewed documents indicates that they are evaluated as an existential threat. Four, all the steps of a securitisation were passed through during the 2014 Ebola outbreak. Five, the Copenhagen School's definition of sectors lacks the health sector.