CHAPTER 6

Health and Human Security

Abstract This chapter focuses on health and how it can be reimagined through the lens of human security. It builds on Chap. 5's exploration of human security, including of health, beyond borders. It delves more deeply into the nuts and bolts of delivering the right to health by reallocating the responsibility for it across State border as well as between States and NSAs. Antecedent to its analysis is the acknowledgment of the tension between the morality of a universal human right to health and the claim to health care conferred by citizenship, focusing on the continued (r)evolution of the human right to health as part and parcel of human security, and of its practical feasibility beyond State borders.

Keywords Human security • Health security • Borders • States • Non-State actors

This chapter focuses on health and how it can be reimagined through the lens of human security. It builds on Chap. 5's exploration of human security, including of health, beyond borders. It delves more deeply into the nuts and bolts of delivering the right to health by reallocating the responsibility for it across State border as well as between States and NSAs. Antecedent to its analysis is the acknowledgment of the tension between the morality of a universal human right to health and the claim to health

A. Bindenagel Šehović, *Reimagining State and Human Security Beyond Borders*, https://doi.org/10.1007/978-3-319-72068-5_6

care conferred by citizenship (Linklater 2007). This is evidenced on the one hand in France's extension of health care to all those ill within its territory and on the other hand Spain's curtailment of the same in the wake of the 2007–2008 global financial crisis. The introductory Chaps. 1 and 2 traced this competition to the division between church and State (Hösle 2003), which will not be repeated here.

Instead, the focus of this chapter is on the continued (r)evolution of the human right to health as part and parcel of human security, and of its practical feasibility beyond State borders (Benatar 2011). As such, it follows from the previous chapters' focus on borders and relates to the migration not only of people, but also of disease (potential). Throughout, State security, human security, self-interest, knowledge and knowledge transfer, acknowledgment and adaptation, culture and fear intermingle (also Šehović, *Policy Paper* 2017; Stone 2016), and Nunes 2014; and Singer and Baer 2011).

The chapter first situates the human right to health within the framework of human security. Second, it traces the responses to the HIV and AIDS and Ebola epidemics to illustrate the political and security acceptance of the right to health and to elevate the rationale for securing health beyond borders. While not absolute, the chapter argues that the right to have has arrived in the discourse on State responsibility vis-à-vis its citizens. This does not resolve the conundrum around whether health security can be used for predominately State security reasons (see McInnes and Rushton 2012; Nunes 2014; Howell 2014; Mcinnes and Lee 2006; Kevany 2016). Nor does it absolve NSAs either of their liability in undermining State sovereign capacity (see Matthews 1997; Šehović 2015) or of their predetermined focus on select disease threats. Nonetheless, health security can arguably be said to have arrived on the international agenda (see UNSC; Trilateral Commission; G7; G20). The examples below offer more detail on this evolution. Third, and finally, the chapter introduces ideas reimagining health security beyond borders.

6.1 The Right to Health

Since the initial incorporation of the right to health in the post–World War II period, its prioritization on the international policy agenda and in practice has steadily progressed. However, its realization has remained tied to the sovereign responsibility of States for their citizens. This relationship, as seen throughout this book, has become too limited in a world increasingly defined and beset by cross-border challenges and opportunities.

In 1948, the newly founded WHO defined the right to health as "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being" (WHO 1948). As the decades since have passed, this has come to conceptually incorporate access not only to preventive, notably vaccines, and primary care, particularly maternal and newborn care, but also to tertiary care and treatment for communicable infectious diseases such as HIV and Ebola, and chronic conditions such as cardiovascular disease and mental health. The delivery of these promised rights has been hampered by the State's citizen-centric allocation of responsibility and accountability.

Numerous agreements codify the right to health and human security. These all allocate the attendant responsibility to States. The ICESCR's Article 12 states that the right to health requires *States* to recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The remit is limited to States' obligation to respect, protect, and fulfill the right to health for *citizens* within their borders (ICESCR 2000, General Comment 14).

> *Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.* (Declaration of Alma-Ata 1978, paragraph V)

This allocation of responsibility is repeated in the Millennium Development Goals (MDGs) and the Sustainable Development Goals (SDGs). It is also reiterated in the UN Security Council (UNSC) resolutions and UN General Assembly (UNGA) declarations pertaining to the international responses to the HIV and AIDS and Ebola epidemics (UNSC 2000; UNGA 2006, 2011; UNSC 2014). This trajectory highlights three points: first, that health is increasingly accepted as a universal right; second, that the international order as currently conceived and practiced holds national States responsible for the provision and protection of health security; and third, that non-citizens and cross-border coverage, prevention measures and eventually necessary intervention are not codified (see also Davies 2010; Davies et al. 2015).

As Frenk et al. (2014) among others have written, "increased interdependence has eroded the capacity of states" to meet their health security obligations to their own populations, to say nothing about non-citizens. As the GAP also noted,

> *The challenge is that in a world of sovereign states, there is no hierarchical authority or world government to fill in the gaps. Rather, there is only a relatively weak system of multilateral institutions built on the shaky foundations of the consent of sovereign states.* (Frenk et al. 2014)

Adding a further complication is the fact that these multilateral institutions, notably the WHO and its IHR (updated 2007), lack mandatory and effective implementation measures to ensure health security provisions if and when States fail to do so. Thus while States continue to assume the obligations of health security, they face constraints of both willpower—including their own—and capacity. Anyone who falls outside of the jurisdiction of State responsibility for health security[1] is left vulnerable—a vulnerability which can easily spread even to those who are 'secure' (Liotta and Owens 2006).[2]

The case of South Africa offers one illustration of this. South Africa espouses an ardent commitment to human rights and assumes the corresponding responsibilities in delivering these explicitly as per the Constitution.

> *Everyone has the right to have access to health care services, including reproductive health care…. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. No one may be refused emergency medical treatment.* (Constitution of the Republic of South Africa 1996, Paragraph 27, Chap. 2, Bill of Rights)

Yet the State arguably became caught in the conundrum between universalism and practice in its woefully short initial HIV and AIDS response. It was also not always aided by external State or NSA intervention.

In July 1989, long before HIV surfaced as an epidemiological and possible existential threat to the South African State, now former president Thabo Mbeki observed that to govern, "you have to be in office" (Gevisser 2007, 540). Upon assuming office in 1994, the newly elected African National Congress inherited a nearly depleted treasury. Bowing to the strictures of the global capital market, the democratic government aimed

to work for 'broader public interest,' whose priorities included HIV/AIDS (Skinner 2010, 46). However, the exorbitant costs of HIV treatments that entered the market in 1996 made such a pledge prohibitive: other policy priorities also had to be addressed.

As the government stalled on HIV and AIDS, shirking its responsibility for that specific aspect of health rights and health security, NSAs entered the void, yet, as indicated by Frenk et al., exacerbated it further, confirming the GAP. "In using business, NGOs, and international organizations to address problems they cannot or do not want to take on, States will, more often than not, inadvertently weaken themselves further" (Mathews 1997). When these NSAs shifted their focus on water security (see Gates Foundation), the ability of the State to respond to HIV and AIDS threatened to recede further.

South Africa has been able to rise to the occasion to provide (some) HIV and AIDS treatment to the largest number of its citizen HIV patients of any country in the world. This reflects its status as the nation with the highest infection rate. Yet its success is being tested by the high numbers of migrants and refugees from across the African continent and the rise of concommitant diseases, notably tuberculosis. At the current imprecise count, South Africa is host to upwards of 3 million refugees out of a population of 55 million.[3] Especially alarming are also increasing rates of TB, including multidrug- and extensively drug-resistant strains; the future of its health security provisions and protections is in doubt: "U.S. experts agree that the disease that currently poses the greatest risk, both to the border crossers themselves and the public at large, is tuberculosis (TB)" (Kamel 2009; Kassalow 2001). TB, as opposed to either HIV or Ebola, is airborne, adding a particular menace to an overburdened health-care system. The examples below illustrate this further.

6.2 HIV and AIDS and Ebola: Evidencing the Right to Health/Evaluating Responsibilities

The prescient case of the national, international, and global HIV and AIDS response illustrates at once an unprecedented success and a possibly equally unparalleled failure. In terms of success, it can be argued that HIV and AIDS both put health rights and health security on the international agenda. In terms of failure, the enormous success of that rights campaign, and the tremendous financial flows that followed in its wake, can be held partially responsible for the current fatigue for health issues.

6.2.1 HIV and AIDS

Epidemiologists, scientists, political scientists, and international security experts, notably at the US National Security Agency, predicted a crisis with the onset and spread of HIV and AIDS. They foretold of peacekeepers bringing the virus with their deployments, of war (Singer 2002), and of already fragile States failing. This was the premise of UNSC 1308 (2000) which called for an unprecedented global response to an infectious disease also considered a security threat.

This threat was not borne out in reality. However, lacking a baseline comparison, it is impossible to evaluate what 'would have' happened without the ensuing global mobilization to fight HIV and AIDS. Beyond the militarized security threat, scholars, notably again political scientists, predicted a 'hollowing out' (Poku and Whiteside 2004) of State bureaucratic and service delivery capacity. Sociologists anticipated unparalleled numbers of orphans (Demographic Information Bureau, Southern African Development Bank) whom they feared would become street urchins prone to violence. Economists estimated that South Africa's economy alone would shrink by an estimated 17% of GDP in 2000 (Arndt and Lewis 2000) due to the effects of the epidemic. None of these predictions have come to pass—at least not in the ways anticipated (Barnett and Prins 2006).

Health practitioners swarmed to the most affected regions, and while they did not 'see' the destabilizing effects of HIV and AIDS on peacekeeping forces, military forces were among the first groups to benefit from interventions against the epidemic, including treatment. While military interventions remained firmly under the remit of the State, other interventions, such as those established bilaterally (US PEPFAR) or by NGOs, helped staunch the tide of HIV and AIDS infections, but had two adverse consequences: first, they 'brain-drained' public sector staff with the lure of better salaries and conditions into effectively parallel health structures, and second, as a result, undermined other health services, such as maternity care and internal medicine, depriving the public health system and, however inadvertently, undermining the right to health (services).[4]

Such an ad hoc arrangement saw—and continues to see—HIV and AIDS health-care provision prioritized over other health demands, and the line(s) of allocation and assumption of responsibility and accountability between government and non-State actors remains unclear. South Africa's experience confirms that the global response to HIV and AIDS scattered among assorted State and non-State actors and interventions.

The State continues to bear ultimate responsibility and accountability for the health and welfare of all of its citizens, even as its capability to enact that guarantee is effectively outsourced to unaccountable NSAs.

Similar interventions and accompanying consequences would be mirrored in the response to Ebola—with one important difference: the first responders to HIV and AIDS had to establish the right of infected and affected people to receive a response; that right was taken (mostly) as a given in the response to Ebola, and to Zika. Liberia 'solved' this citizenship claim for the right to health during the Ebola epidemic by actively outsourcing Ebola response to bilateral actors; the Zika response in Brazil consisted of a military intervention that heeded immediate citizenship claims but possibly imperiled civil liberties in the longer term.

6.2.2 Ebola to Zika

In the case of Ebola, it seems clear that the States most affected were indeed aware of the expectation of responsibility and accountability that accrued to them for the health of their populations. Owing an enormous debt to the African HIV and AIDS experience, little international resistance met the desperate cry for help. Admittedly, however, no medications were or have been forthcoming.[5]

Nonetheless, Guinea, Sierra Leone, and Liberia accepted the theoretical responsibility for the health of their populations and took differing practical routes toward devising responses to their epidemics. Guinea, despite the presence and early warning of MSF, assumed responsibility for the epidemic response itself. Sierra Leone benefited from the external aid of the UK, and an influx of Cuban doctors, though it lost (too) many of its doctors and its one and only infectious disease expert. Liberia made headlines when President Sirleaf Johnson pleaded for assistance in an open letter. Her plea resulted not only in financial and NSA aid but, most controversially, in military deployments by a number of countries (the US, the UK, and Germany were involved), to build clinics and stem the spread of the Ebola epidemic. Whether these effects worked, or whether they were deployed as the tide of the epidemic was already turning, remains debated (Price-Smith 2009).

What seems clear is that, as both the epicenter, the first point (Iliffe 2006), of the outbreak and the country which asked for no outside assistance, and evinced difficult relations with internal helpers (MSF), Guinea suffered the highest Ebola mortality (60%). Sierra Leone and Liberia

benefited both by being the secondary victims of the epidemic and from aid, though much of its impact is in dispute. Notably, it remains that first, the accountability for the given aid rests with the giver, not with the recipients: in other words, US (citizen) taxpayers can demand an accounting of the funds spent in West Africa since these are theirs, but West Africans cannot do the same although they were (to be) the beneficiaries of the monies, reinforcing the gap between the theory of sovereignty and citizenship divorced from the practical responsibility for health delivery; and second, notably given the uncertainty of the timing and effectiveness of the aid, it remains unclear what role such diplomatic and military aid had versus local interventions to end the Ebola epidemics.

With regard to Zika, the Brazilian government mounted the largest joint military-civilian operation in Brazil's history, mobilizing 315,000 people into a mosquito-elimination campaign (Garrett, 13 April 2016). Then, a number of regions of Brazil "proactively declared a public health emergency with regard to Zika in November 2015" (Gostin and Lucey 2016). If and when the expanded political, and military, powers granted under the emergency are not revoked, these could lead to serious infringement of biological and civil liberties. As the Zika epidemic slumbers for the duration of the winter in the southern and now northern hemisphere, the time is ripe to consider the lessons it, alongside the Ebola and HIV and AIDS epidemics, continues to offer vis-à-vis the role of health diplomacy at the interregnum between citizenship and States.

Indeed, this present moment showcases a liberal international order confronted by innumerable challenges—including unprecedented migration and (re)emerging infectious diseases (EIDs) (Brower and Chalk 2003, xiii). However, it is especially constitutional crises of democracy and governance writ large which imperil the right to health and real commitment to human security for citizens as well as non-citizens. Consequently, the urgency of reimagining such security beyond borders grows.

6.3 Health Security *at* Borders

As the post–World War II liberal order faces constraints, health security has not lost its resonance. In spite of some 'AIDS fatigue' and the crowding out of health security on some international agendas, the issue retains its salience and importance for human security. Indeed, health security is indisputably present on the international agenda (see UNSC; Trilateral Commission; G7; G20; European Council 2003).

> *The international discourse (at the UN, ICC, G7/G8) is beginning to effect change on the institutions and practice of global governance. …Synergies between issues and the new coalitions that result have produced new forms of diplomatic action. Coalition building among like-minded states and non-state actors is one dynamic element of this "new diplomacy."* (Axworthy 2001, 20)

This diplomacy operates at the traditional, bilateral level of State-to-State relations wherein the security of population health is evaluated in the service of the security of the State. Yet it also involves NSAs and NGOs in efforts to elevate health on the international agenda in what Luk van Langenhove (2016) calls 'science for diplomacy'. Altogether, these trends and attendant initiatives have resulted in a proliferation of health security initiatives, spanning the whole range of State and human security definitions (Nunes 2014; Howell 2014; Mcinnes and Lee 2006; Kevany 2016; Kickbusch 2007). These reinforce the embeddedness of health security within human security, though their relationship(s) with State responsibility remain contested (Der Derian 1995, 28).

Yet States remain the decision-makers on health security. As such, more often than not, it still stops at borders. The right to health without the right to migrant health cannot be guaranteed. The provision and protection of any such right without the delineation of attendant responsibilities, of States and NSAs (please see Fig. 4.1 in Chap. 4), can likewise not be guaranteed. Yet little movement has taken place to rearrange responsibility for health security beyond State borders.

> *While disease, migration and borders are present in the EU variant of the new security discourse, the nature of concrete policy responses is determined by the differential development of EU powers. The centrality of health policy to electoral politics in all European countries has meant that control has largely been retained by states, and authority within European institutions is consequently relatively weak.* (Bashford 2006, 164)

Furthermore, EU Decision No 1082/2013 calls for only 'coordination' between Member States (European Commission 2013). It also calls for the extension of notification of threats as per Decision No 2119/98 to human health security at the EU level. Toward this end, the EU has set up the Health Security Committee (2001) on the basis of the Presidency Conclusions of 15 November on bioterrorism. However, the group, composed of high-level representatives from Member States, is informal.

The EU established (Regulation [EC] No 851/2004) the European Centre for Disease Prevention and Control (ECDC). Its mandate includes "surveillance, detection and risk-assessment of threats to human health from communicable diseases and outbreaks of unknown origin" (European Commission 2013). The ECDC began working in May 2005. It is much smaller than its equivalent in the US. The EU also launched the European Medical Corps in February 2016, but participation is voluntary. Meanwhile, the Africa CDC, inaugurated 31 January 2017, in Addis Ababa, Ethiopia, the seat of the AU, is just getting off the ground. Each of these also complements and ideally coordinates with the WHO's "Global Outbreak, Alert and Outbreak Network" (GOARN), which collects disease surveillance data and contributes to the coordination of outbreak responses.

The US, the EU and all of its Member States are also signatories of the WHO's IHR of 2005, which went into effect in July 2007. The IHR are designed to limit and stop the spread of infectious diseases across borders. They prescribe capacities that countries should development to enable and reinforce disease outbreak response, and foster coordination among States toward "the preparedness for, and response to, a public health emergency of international concern" (WHO 2005; European Commission 2013). However, far from all countries around the world have established even one 'core capacity': the African IHR website is currently unavailable (5 September 2017). Further crippling their effect is the IHR' lack of implementation tools, including sanction options if and when countries fail to comply and contribute. This endangers health security beyond their borders—as when an outbreak becomes an epidemic which becomes a pandemic as in the case of the 2014–2015 Ebola outbreak in West Africa. The only incentive the IHR have is reputational: a country which complies with the requirements to notify the WHO of a suspected outbreak is spared public shaming and instead (ideally) rewarded with international acclaim for its forthright actions to protect international health security. When China failed to do so during the 2003 SARS epidemic, it was internationally condemned. When it did adhere to IHR guidelines during the H5N1 outbreak of 2005 and beyond, it was internationally lauded. Yet the IHR, like the EU decisions, rely on States to provide for health within their borders, and to enable other States to do the same in instances of cross-border penetration of disease outbreaks. None of these provisions present adequate measures to protect and provide for health security, for sedentary and/or migrant populations, beyond borders.

6.4 Health Security Beyond Borders

As argued throughout this book, State-based security alone is inadequate in the face of the cross-border impacts on health and human security. As Brower and Chalk argue, "statecentric models of security are ineffective at coping with issues, such as the spread of diseases that originate within sovereign borders, but have effects that are felt regionally and globally. Human security reflects the new challenges facing society in the twenty-first century" (Brower and Chalk 2003, 161). Even the State-based entities of the EU and the WHO illustrate the limitations of State-based responses to health security.

NSAs alone are not up to the task either. Though they have a role to play, they retain their liability both in their capacity undermining State sovereign capacity (see Matthews, 1997; Šehović 2015) and in their predetermined focus on select disease threats. They can, however, play an important role in highlighting emerging health security threats. They seem, for instance, to work anti-cyclically: when a State cannot or refuses to engage against a particular disease threat, NSAs might fill the void (Risse 2012; Keck and Sikkink 1998). When the State assumes its responsibility, NSAs might dissipate. The risk remains in the (un)avoidable gap: when NSAs shift their focus onto other risks or threats and States fail to step in and take over their security guarantee (Šehović 2014). For example, as the HIV epidemic burgeoned in South Africa in the late 1990s to early 2000s, any response lay mostly in the hands of NSAs, including NGOs, civil society, and the business community and private industry (Šehović 2014). As the State assumed greater responsibility for treatment and care, many of these NSAs shifted their focus elsewhere. This worked as long as not another massive (health) demand overburdened the State's capacity to respond. Now, in 2017, South Africa faces a skyrocketing number of TB, including MDR and XDR, cases, as well as a surge in drug-resistant HIV infections.[6] As during the early days of HIV, NSAs are providing much of the care and support.[7] This time, however, there is little likelihood of the South African State stepping in, let alone to the extent that it did with HIV, again.[8] That TB is airborne and therefore able to cross borders even more readily than HIV, affecting sedentary and migratory populations alike, should elevate the argument that removing myopia on borders and disease is all the more critical to imagining health security beyond borders.

Some imagining is being done and put into practice. Adding to GOARN, the Global Public Health Intelligence Network (GPHIN) is expanding the net of disease outbreak inputs to include NSAs. By ignoring geographical lines and circumventing governmental border surveillance, it is able to garner more precise data. However, as seen above, most of these initiatives hit a State-backed wall with regard to either information access or decision-making procedure. Furthermore, the boundaries between citizen and non-citizen plague equitable access to protections and provisions of health security which would benefit all persons and parties, including States. Yet without implementation, authorizations, and capabilities similarly across borders, the information falls on deaf ears of closed decision-making rooms whose access is restricted to disinterested or disinclined States, despite an eventual reputational cost (see also Weir and Mykhalovskiy, in Bashford 2006; Davies et al. 2015).

Despite such obstacles, movement beyond such State-centric, vertical responsiveness is taking place. The Framework Convention on Global Health (FCGH) represents one example. The FCGH is a proposed global treaty based on the right to health and aimed at national and global health equity. The treaty would reform global governance for health to enhance accountability, transparency, and civil society participation and protect the right to health in trade, investment, climate change, and other international regimes, while catalyzing governments to institutionalize the right to health at community through to national levels. It, too, relies on States as the ultimate guarantor of health security. Yet, by being a treaty agreement, the FCGH does two things: (1) incorporates the possibility of sanctions in the event that a State does not provide for health security, including through trade and investment provisions, among others; and (2) it thereby legalizes the possibility of external State intervention if and when the (internal) States fails to meet its treaty commitments. Such interventions might include (imposed) bilateral or multilateral aid, or the imposition of decision-making around health investment. They might also provide for options for the use of military intervention—with caution.

Military intervention, especially in the aftermath of its deployment during the Ebola outbreak in West Africa, albeit late, represents the second option. In this instance, it might be to have national States, as Member States of the UNSC and the WHO, sign preemptive agreements which foresee military intervention in the event that civilian actors, both national and non-State, invoke the need. The trouble with the WHO is that it is politically constrained; it must obtain governments' permission to work in

their territory, as in Liberia. Therefore, such preliminary agreements directly between States and, for instance, a coalition of signatories to the FCGH might be useful on two counts in securing health and human security: first, to accelerate investment in civilian capacity could forestall the need for such an intervention having to be invoked; second, by establishing *a priori* which foreign militaries might come to the aid of which nations, for how long, and under what conditions. This might also prevent the national or international abuse of States of emergency or uninvited military intervention in the name of 'security' (Šehović 2016).

In the end,

> *Each disease outbreak is potentially different, with varied epidemiology, infection, morbidity, and mortality rates and requiring diverse control measures, means that each outbreak obliges governments to be flexible in how they respond.* (Davies et al. 2015)

In order for any of these strategies to be successful, however, not only action but also accountability is required. As States remain the entities at which both human security per se and its provision and protection rest, the onus is on them to respond. This ups the ante for any response, for States to be seen 'doing something' (Davies et al. 2015, 123). The challenge then is not to equate 'doing something' as opposed to nothing with doing anything, but to customize the response to render it timely and effective. Such effectiveness is in turn predicated upon coordination, at the national, international, and global levels.

On the national and international levels in Europe, a European global health strategy could present a first step (Speakman et al. 2017). Supplementing the European Medical Corps and the ECDC, this could tie into the German Foreign Ministry's Global Health Security Office, established in 2015. Such a strategy would also enable the European and German offices to link with others, such as the US Global Health Security Initiative and the State Department's health diplomacy desk, both launched in 2009, at the bilateral level. This could be critical in terms of both additional coordination and deployment capacities, but also as a buffer should any one national State pull out.

On the global level, the Global Health Program of the WHO, inaugurated in 2012, holds true to its Status as a Member State organization. As such, it focuses mostly on inter-State coordination. As argued above, this has two shortcomings based on the assumption that States are the final

guarantor of human and thus of health security. First, States may or may not be able to meet their obligations toward human security. Second, they may actively neglect or even pursue aims contrary to the provision of human and health security. Particularly at risk are non-citizens. The ensuring gap cannot be filled by NSAs alone. Likewise, military intervention without prior coordination is a risky strategy with unproven (long-term) repercussions for the health and human security of both sedentary and migrant populations on all sides of borders to which it remains unaccountable. Consequently, a new global ordering of health and human security responsibilities premised on State but capturing non-State actions toward its realization is vitally necessary.

6.5 Conclusion

Since the International Sanitary Regulations were adopted in 1851, the precursors for the IHR of 2005 (2007), health security has gained national, international, and global attention. States and, increasingly, NSAs have engaged with one another through traditional as well as newer forms of diplomacy in order to stem the tide of various initially infectious diseases, from cholera to HIV and AIDS, to noncommunicable diseases (NCDs) within and across borders. This has resulted in the IHR of 1969, updated in 2005 (2007), as well as the Framework Convention on Tobacco Control. An FCGH, focusing on universal health coverage (UHC), is being negotiated. In the interim, the UNSC and, among others, the US National Security Council, the WHO, and the German Foreign Office (AA) have identified particular diseases as health security threats, propelling health security to the heights of the international and global political and policy agendas and keeping it there—so far.

At this juncture, newly or reemerging diseases present the latest challenge to be addressed by health security. Their proliferation is exacerbated by the unprecedented movement of people likewise within and across borders. A particular challenge is posed by and to the human security of those who can(not) claim health rights as a function of citizenry.

As this chapter has striven by analyzing the attendant challenges thereof through the lens of human security, there is an urgent need to reimagine health and human security beyond borders. The chapter offered initial ideas toward approaching disease and population movements across (always) fluid borders to provide for and protect the health security of both mobile and sedentary populations. It emphasized that each conceptual

level of political theory and each organizational level of health, the choice can be made to prioritize State or human security. The following and final chapter makes this choice and offers a number of more concrete solutions to high- and low-ordering human security beyond borders.

Notes

1. This includes non-citizen residents who might not have access to heath care within a State and cross-border migrants who cannot claim citizenship or access within any border.
2. In this case 'secure' refers to those who can claim, through their citizenship, access to heatlh security provision and protection.
3. Conversational interview with Adrienne Blignaut, Pretoria, South Africa, 4 April 2017.
4. Of the most affected countries in Africa, notably East and Southern Africa, Rwanda might be an exception here. Emerging from its 1994 genocide just in time for anti-retrovirals to enter the market in 1996, Rwanda kept tighter reins on its international aid than did most countries, integrating donors' aid into budget support aligned to national priorities, largely successfully. Also, author's interviews at Kalafong Hospital 2004.
5. Experimental treatments, such as with donated plasma, often went to Westerners medevacked out of the region, or were tried ad hoc in local settings.
6. Interviews with Dr. Webber, Pretoria, 4 April 2017; S. Nawab, Johannesburg, 5 April 2017; S. Timol, Cape Town, 9 April 2017; K. Grosvender, Durban, 10 April 2017.
7. Interviews with S. Nawab, Johannesburg, 5 April 2017; at Centre for Sexualities, AIDS and Gender, Pretoria, 4 April 2017.
8. Interview with M. Boddenberg, DIHK, Johannesburg, 3 April 2017; Dr. C. Panter, Daimler, Centurion, 4 April 2017; Dr. Webber, Pretoria, 4 April 2017, Centre for Sexualities, AIDS and Gender, Pretoria, 4 April 2017.

References

Air and Space Power Journal – Africa and Francophonie (ASPJ-A&F) 3rd Quarter 2015, Vol. 6, No. 3, pp. 35–48.

Arndt, C., and J.D. Lewis. 2000. The Macro Implications of HIV/AIDs in South Africa: A Preliminary Assessment. *South African Journal of Economics* 68 (5): 380–392.

Axworthy, L. 2001. Human Security and Global Governance: Putting People First. *Global Governance* 7: 19–23.

Barnett, Tony, and Gwyn Prins. 2006. HIV/AIDS and Security: Fact, Fiction and Evidence—A Report to UNAIDS. *International Affairs* 82 (2): 931–952.
Bashford, A., ed. 2006. *Medicine at the Border*. London: Palgrave Macmillan.
Benatar, S.R. 2011. Global Leadership, Ethics & Global Health: The Search for New Paradigms. In *Global Crises & the Crisis of Global Health*, ed. S. Gill, 217–143. CUP.
Brower, J., and P. Chalk. 2003. *The Global Threat of New and Reemerging Infectious Diseases: Reconciling U.S. National Security and Public Health Policy*, xiii. Washington, DC: Rand Corporation.
"Constitution of the Republic of South Africa, Act 108 of 1996," Paragraph 27, Chapter 2, Bill of Rights. http://www.justice.gov.za/legislation/constitution/SAConstitution-web-eng.pdf
Davies, Sara E. 2010. *Global Politics of Health*. Cambridge: Polity.
Davies, S., A. Kamradt-Scott, and S. Rushton. 2015. *Disease Diplomacy*. Baltimore: Johns Hopkins University Press.
Declaration of Alma-Ata. 1978. International Conference on Primary Health Care, Alma-Ata, USSR, September 6–12. http://www.who.int/publications/almaata_declaration_en.pdf, paragraph V.
Demographic Information Bureau (DIB). Southern African Development Bank.
Der Derian, J. 1995. The Value of Security. In *On Security*, ed. D. Lipschutz, 28. New York: Columbia University Press.
European Commission. 2013. Decision No 1082/2013: (1) Article 168 of the Treaty on the Functioning of the European Union (TFEU) states.
European Council. 2003. *European Security Strategy*. https://europa.eu/global-strategy/en/european-security-strategy-secure-europe-better-world
Frenk, J., O. Gomez-Dantes, and S. Moon. 2014. From Sovereignty to Solidarity: A Renewed Concept of Global Health for an Era of Complex Interdependence. *The Lancet* 383 (9911): 94–97.
Garrett, L. 2016. Global Health Update from Laurie Garrett, April 13, per email.
Gevisser, M. 2007. *Thabo Mbeki: The Dream Deferred*. Jonathan Ball Publishers.
Group of Seven (G7). 2017. *See Group of Seven, Council on Foreign Relations*. https://www.cfr.org/backgrounder/group-seven-g7
Group of Twenty (G20). See G20 Members, Available Through Heinrich Böll Stiftung. https://www.boell.de/en/2016/10/06/group-20-g20-nutshell
Hösle, Vittorio. 2003. *Morals and Politics*. University of Notre Dame Press.
Howell, Alison. 2014. The Global Politics of Medicine: Beyond Global Health, Against Securitization Theory. *Review of International Studies* 40 (5): 961–987.
Iliffe, J. 2006. *The African AIDS Epidemic: A History*. Oxford: James Currey.
International Covenant on Economic, Social and Cultural Rights. 2000. General Comment 14, "The Right to the Highest Attainable Standard of Health," ICESCR, August 11.

Kamel, Wadie Wanies. 2009. Health in Border Areas. *Global Perspectives in Health*, II. Encyclopedia of Life Support Systems (EOLSS).

Kassalow, J.S. 2001. *Why Health Is Important to U.S. Foreign Policy*. New York: Milbank Memorial Fund. http://www.milbank.org/reports/Foreignpolicy.html

Keck, M., and K. Sikkink. 1998. *Activists Beyond Borders: Advocacy Networks in International Politics*. Cornell University Press.

Kevany, S. 2016. New Roles for Global Health: Diplomatic, Security, and Foreign Policy Responsiveness. *Lancet Glob Health* 4 (2): e83–e84.

Kickbusch, I. 2007. Health Governance: The Health Society. In *Health and Modernity: The Role of Theory in Health Promotion*, ed. D. McQueen and I. Kickbusch. Springer.

Kickbusch, I., G. Silberschmidt, and P. Buss. 2007. Global Health Diplomacy: The Need for New Perspectives, Strategic Approaches and Skills in Global Health. *Bull World Health Organ* 85 (3): 230–232.

Linklater, Andrew. 2007. *Critical Theory and World Politics: Citizenship, Sovereignty and Humanity*. London: Routledge.

Liotta, P.H., and Taylor Owen. 2006. Why Human Security? *The Whitehead Journal of Diplomacy and International Relations* Winter/Spring: 37–54.

Lucey, D.R., and L.O. Gostin. 2016. The Emerging Zika Pandemic: Enhancing Preparedness. *JAMA* 315 (9): 865–866.

Mathews, Jessica T. 1997. Power Shift. *Foreign Affairs* 76 (1). https://www.foreignaffairs.com/articles/1997-01-01/power-shift

McInnes, C., and K. Lee. 2006. Health, Security and Foreign Policy. *Review of International Studies* 32 (1): 5–23.

McInnes, Colin, and Simon Rushton. 2012. HIV/AIDS and Securitization Theory. *European Journal of International Relations* 19 (1): 115–138.

Nunes, João. 2014. Questioning Health Security: Insecurity and Domination in World Politics. *Global Health an International Relations* 40 (5): 939–960.

Poku, N., and A. Whiteside, eds. 2004. *Global Health and Governance HIV/AIDS*. Basingstoke: Palgrave Macmillan.

Price-Smith, A. 2009. Infectious Disease, Governance, and Security: Contagion and Chaos: Disease, Ecology, and National Security in the Era of Globalization. *International Studies Review* 11 (4): 773–775.

Risse, T. 2007. Paradoxien der Souveränität: Die konstituive Norm, auf der die heutige Staatenwelt gründet—dass nämlich Staaten souverän sind—gilt uneingeschränkt nicht mehr. Was heisst das? *Internationale Politik* July/August: 40–47.

Risse, Thomas. 2012. *Governance Configurations in Areas of Limited Statehood. Actors, Modes, Institutions, and Resources*. SFB-Governance Working Paper No

32, April. http://www.sfb-governance.de/en/publikationen/working_papers/wp32/SFB-Governance-Working-Paper-32.pdf
Šehović, Annamarie Bindenagel. 2014. *HIV and the South African State: The Responsibility to Respond*, 38–39. Aldershot: Ashgate Global Health.
Šehović, Annamarie B. 2015. *Where Rights, Where Responsibility? Who Acts for Global Public Health?*
———. 2016. *Coordinating Global Health Responses.* EL-CSID Policy Brief, Issue 2016/1, October.
———. 2017. *Securing Global Health through Diplomacy: From One-Way Transfer to Multi-directional Knowledge Exchange*. EL-CSID Policy Paper, Issue 2017/3, forthcoming.
Singer, Merrill, and Hans Baer. 2011. *Introducing Medical Anthropology: A Discipline in Action*. AltaMira Press.
Singer, P.W. 2002. AIDS and International Security. *Survival* 44 (1): 145–158.
Speakman, E.M., M. McKee, and R. Coker. 2017. If Not Now, When? Time for the European Union to Define a Global Health Strategy. *Lancet Global Health* 5 (4): e392–e393.
Stone, Diane. 2016. Understanding the Transfer of Policy Failure: Bricolage, Experimentalism and Translation. *Policy & Politics* (Polity Press).
Trilateral Commission. http://trilateral.org/
United Nations' General Assembly (UNGA). 2006. Political Declaration on HIV/AIDS, June 15.
———. 2011. Political Declaration on HIV/AIDS, June 10.
United Nations' Millennium Development Project, Millennium Development Goals (MDGs). http://www.unmillenniumproject.org/goals/
United Nations' Security Council (UNSC). 2000. UNSC Resolution 1308, July 17.
———. 2014. *UNSC Resolution 2177*, September 18.
United Nations' Sustainable Development Goals (SDGs). http://www.un.org/sustainabledevelopment/sustainable-development-goals/
Van Langenhove, Luk. 2016. Global Science Diplomacy as a New Tool for Global Governance. *Focir pensement* (United National University/Vrije Universiteit Brussel).
Weir, L., and E. Mykhalovskiy. 2006. *Medicine at the Border*. Ed. Bashford, A., pp. 159–176. London: Palgrave Macmillan.
WHO. 2006. World Health Organization (WHO) (1948, 45th edition, 2006). *Constitution of the World Health Organization*. http://www.who.int/governance/eb/who_constitution_en.pdf