Concluding Remarks

Achieving good health is a constant struggle and, as this book's survey of the WHO's activities reveals, it is made no less difficult at the global level. Since the organization's creation in 1948 the WHO secretariat has adopted a number of methods and approaches to fulfil its overriding mandate to assist the attainment of the highest possible level of health for all peoples. The eradication of disease – particularly the infectious kind – is fundamental to that objective, existing as the precondition to the WHO's definition of health. Further reflecting the importance of this central mission, the IO's founders imbued the organization with considerable authority and autonomy to affect its disease eradication mandate. Over the years the WHO secretariat has sought to accomplish this assigned task by instituting a series of global disease eradication campaigns and establishing multiple disease eradication and/or control programmes. The lessons that the IO – and particularly its senior leadership – learned from these campaigns subsequently informed the organization's classical approach to disease eradication. Yet as the world continued to change and globalize, and member states continued to shirk their responsibilities in reporting disease outbreaks, the WHO was forced to adapt its methods and approach.

It is in this regard that the WHO's utilization of the health security discourse to reframe its public health mandate reflects yet another step in the IO's attempts to fulfil its delegated responsibilities. Like the organization's previous endeavours to use human rights, economic, and development arguments before it, the WHO secretariat has arguably used the concept of security to great effect, not only in securing new political attention and resources but also in obtaining additional powers. Following the WHO's successful management of the 2003 SARS outbreak, the IO also witnessed the further expansion of its authority,

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with several policies and procedures that had proved so effective in containing and eliminating the pathogen enshrined in another core element of the organization's delegation contract – the IHR (2005). Importantly, however, member states also revealed that they held concerns about the level and extent of IO autonomy that the organization had wielded throughout the SARS crisis, and so, using the vehicle of the IHR revision process, instituted several new legal and procedural mechanisms of control.

It took a number of years, but criticisms of the WHO secretariat's decision to securitize its public health mandate did also eventually emerge. While the IO could, and predictably has, largely ignored the denunciations arising from one group of detractors (namely elements of the academic community), as an intergovernmental organization answerable to its principals, the WHO has not been able to side-step the concerns raised by a small sub-set of member states quite so readily. In response to this latter group's concerns, the IO's secretariat has chosen to progressively desecuritize its disease eradication responsibilities by intentionally removing security-related language and concepts from policy documents, reports, and speeches. Somewhat surprisingly, the WHO secretariat has taken these actions despite the fact that, when collectively viewed, member states have continued to display considerable preference heterogeneity over this matter.

It therefore does not appear that the WHO can – at least in this instance – be accused of agency slack per se. In fact rather the opposite may be true. For while some governments that have been strong supporters of the health-as-security discourse may be tempted to suggest that the IO is currently engaging in a form of slippage, it could well be argued on the converse side that by removing virtually all reference to global health security the WHO secretariat's actions reflect significant sensitivity to its principals, even those who perhaps might otherwise be described as some of its more distal members. Importantly, however, in perpetrating this action, the WHO secretariat is also enacting a particular form of desecuritization.

According to the Copenhagen School's founders, securitization actually represents a breakdown of normal public policy processes to adequately deal with issues. Security, as Buzan et al. (1998, p. 29) observe, 'should be seen as negative, as a failure to deal with issues as normal politics'. This is principally because security 'works to silence opposition and has given power holders many opportunities to exploit "threats" for domestic purposes, to claim a right to handle something with less democratic control and constraint' (ibid.). In practice, therefore, Buzan

and his colleagues contend that securitizing an issue elevates it and places it above standard political contestation and debate – what is described as 'hyper-politicization' – primarily as solutions are required as soon as possible to deal with the imminent 'threat'. Buzan et al. accept that some issues warrant this hyper-politicization, but maintain that ultimately the preferred option should be to reintegrate securitized issues into mainstream political bargaining processes and policy contestation. This process has been described as desecuritization, and remains at the normative heart of the Copenhagen School project.

Despite the fact that desecuritization serves as the definitive, preferred endpoint, to date very little of the security studies literature has actually attempted to engage with this concept, let alone how to achieve it. Generations of scholars have instead sought to dissect in ever-diminishing circles the core elements and minutiae of securitization theory, ranging from those fascinated with the process or outcomes of securitization and the roles and performativity of actors, moves, and audiences (Vuori 2008, Léonard and Kaunert 2011, Roe 2012), to those seeking to draw distinctions between 'internalist' and 'externalist' readings (Stritzel 2007), while yet others interrogate the theoretical, philosophical, sociological, or emancipatory potentialities of the theory (Williams 2003, Aradau 2004, Balzacq 2011, Nunes 2014). By way of comparison, very few scholars have engaged with how to affect desecuritization.

Having said this, the field is not completely devoid (see, for example, Wæver 1995, Knudsen 2001, Williams 2003, Aradau 2004, Roe 2004, MacKenzie 2009, McDonald 2011). In her work, Hansen (2012) has traced the existing theoretical and empirical pathways that actors have used to desecuritize certain issues, identifying that there have been four forms or categories that have been deployed to date. These categories have been described as: *change through stablilization*, which is when an issue is reframed as something other than a security threat even though some form of menace or conflict may still be present; *replacement*, which is when one issue is diminished in significance while being replaced by another; *rearticulation*, which occurs when an issue is recast as a non-security issue due to a resolution of the underlying conditions that warranted its initial securitization; and *silencing*, which occurs when an issue is depoliticized but also side-lines potentially insecure referents (ibid., p. 529).

It is in this regard that by actively reframing its disease eradication responsibilities using alternative language and concepts more akin to conventional public health, the WHO secretariat's actions potentially align most closely with desecuritization via rearticulation. Said another

way, by intentionally extracting the health-as-security discourse from its communications with member states and replacing it with health-related technocratic language, the IO is seeking to fundamentally transform the debate surrounding how best to deal with the problem of infectious disease outbreaks. The solution offered to address this issue is to strengthen the disease surveillance and response technical capacity under the IHR (2005) which, while once associated as essential to global health security, has now been reframed as a procedural state-building initiative (see Cassels et al. 2014, WHO 2014b). These measures, as Hansen (2012, p. 543) has observed, thereby seek to extract the rearticulated issue (infectious diseases) out of the Schmittian 'friend-enemy' distinction that would otherwise necessitate emergency measures and re-insert it into a forum whereby political contestation and debate over how best to deal with the problem (e.g. economic investment) resumes.

It is here, however, that the WHO secretariat may yet also confront one of its most significant and potentially insurmountable challenges. More precisely, given that the IO's securitization of health issues has proven to be so effective – as evidenced by such developments as the massive increases in funding to strengthen global preparedness, member states' almost universal development of pandemic preparedness plans, the passage of new legislation designed to facilitate intergovernmental (and intrastate) cooperation to combat infectious disease, and efforts to enable greater access to medicines via the creation of new global health partnerships – serious questions can be raised whether in fact the correlations that have now been drawn between health and security can be persuasively 'un-made'. This is a challenge that is best encapsulated by Jeff Huysmans (2002), so much so that it has since become known as 'the Huysmans dilemma' (Wæver 2011).

In short, Huysmans' dilemma recognizes the difficulty associated with successfully desecuritizing an issue without simultaneously making reference to – and thereby further reinforcing – the original securitization. Put more simply, how do you convincingly argue that an issue is no longer a security issue when in uttering those very words you have drawn attention to its pre-existing status and identification as a security threat? At a more fundamental level, what this dilemma highlights is the problematic nature of 'un-making' a speech act once it has been uttered/performed/acted and has entered the social world. For the WHO, which willingly co-opted the efforts of a number of high-income countries in drawing the world's attention to the physical, economic, social, and political dangers arising from fast-moving acute health hazards such as infectious diseases and bioweapons, and which persuasively

argued that such 'threats' warrant emergency measures to mitigate, the problem now becomes how to encourage governments (and the leaders, policy-makers, and general public contained within) to forget these initial associations and re-imagine these issues in an alternative light.

For the WHO secretariat the problem is further compounded by the fact that even if the IO was able to effectively engender this new understanding, the unpredictability of events like disease outbreaks or bioterrorist attacks, combined with their impact on human physical and mental well-being, inhibits the normalization of these incidents. The randomness and the existential and psychological impact automatically disrupts customary social patterns, which in turn necessitates the prioritization of response. The very nature of such events thus demands that they receive priority, and as Buzan et al. (1998, p. 24) have noted, an issue is usually designated as a security issue 'because it can be argued that this issue is more important than other issues and should take absolute priority'. The current outbreak of Ebola in West Africa thus serves as a manifest example, for in a world-first this latest outbreak has even warranted the deployment of thousands of military personnel to help contain the virus. As such, it is at least plausible that were the WHO now to successfully reframe its disease eradication mandate, locating it within a more traditional public health framework, the new frame will collapse as soon as another event materializes which exhibits the characteristics previously described as constituting a security threat. The risk to the WHO secretariat then transforms to one in which questions are raised about its performance, continued relevance, and whether the IO has been doing its job 'properly' or rather shirking its delegated duty.

For the moment, the above scenario remains purely hypothetical. What is clear, however, is that the WHO secretariat has currently set on a path to desecuritize its disease eradication delegation contract and return it to its former 'health-for-security' status, albeit while performing specific roles that have proved intrinsic to its health-as-security mandate. Presumably, these actions are being taken with the full knowledge and consent of the IO's leadership, and especially of the WHO director-general. As this book has demonstrated, the personal and professional experiences of those in leadership positions within the WHO have played a key role in shaping the direction of the organization – sometimes to the benefit and at times to the detriment of the IO's reputation. These findings are consistent with the work of others exploring IO independence, and as Oestreich (2012, p. 265) has observed, the importance of 'visionary leaders' at the helm of IOs cannot be overstated, principally because 'these are human institutions, run by people

who are key variables in themselves'. Whether the WHO secretariat's latest decision to extricate itself from the health security discourse proves to be the latter or the former of these outcomes is yet to be revealed, but as the current director-general has no doubt shaped the policies and direction of the WHO, so too will the next person who assumes that role. It is also in this regard that securitization may return as a viable frame for the organization's activities at some point in the future – either in response to an internal change in policy focus, political pressure from member states, or in response to external events – but in the long run only time will tell.

It is also in this regard that the book has additionally attempted to reveal how rationalist and constructivist approaches can in fact be complementary. By using the PA theory model and examining the various shifts and turns in the WHO's approach to eradicating disease (and, importantly, the context in which they occurred), the book has been able to interrogate how a collective agent has attempted to shirk, slip, or address the stated collective preferences of its principals at various junctures. In blending this rationalist model with constructivism though, it has also revealed how both principals' and the agent's preferences have changed in response to events external to the IO as well as internal developments. Perhaps most importantly, it has also revealed how the WHO secretariat has collectively exercised discretion at times (Johnson and Urpelainen 2014), even when the opportunity arguably arose for the IO to engage in agency slack when confronted with considerable preference heterogeneity amongst its principals.

Ultimately, however, what this book has sought to highlight is the vitally important role that the WHO fulfils. Given that the IO was the first specialized UN agency ever to be created, it is somewhat surprising that the organization has attracted so little attention over the years. Of course, like any major bureaucracy, the WHO is subject to inefficiencies and failures. Opportunities have been squandered and resources have been wasted, much to the irritation of its member states – both the wealthy and the less so. The WHO and its secretariat are thus far from perfect. Equally though, the WHO secretariat – like many secretariats of intergovernmental organizations – faces a daunting task in attempting to meet the needs of almost 200 masters, all of which hold divergent views and differing opinions on what the organization should do and how it should do it. Programmes are commenced and staff are employed, but under the current funding arrangements where three quarters of the IO's budget is comprised of voluntary contributions, both can be terminated at a moment's notice if member states' priorities change.

The fact that the WHO has been able to accomplish so much within these arrangements should therefore perhaps be cautiously applauded.

It is also within this context that the WHO secretariat's forswearing of the global health security discourse is somewhat lamentable. Indeed, for all the criticisms and negative consequences that have been attributed to the securitization of a certain sub-set of health issues, it conceivably could still prove to be a very valuable political tool for improving the health outcomes of people all over the world due to the simple fact that security, like sex, sells. It should never be forgotten, for instance, that for decades wealthier countries willingly neglected a host of infectious diseases because they had been largely eliminated from within their respective territories. Globalization and the realization that these diseases are no longer geographically constrained, combined with the framing of these pathogens as 'threats', re-ignited the international community's attention and spurred considerable financial investment into strengthening disease surveillance and health systems around the world. That this investment had a distorting impact should not be overlooked, but as Hoffman (2010, p. 516) has optimistically noted, 'this situation may be improving over time. Certain redistributional consequences, for example, are likely to emerge as the health security interests of wealthier countries increasingly align with the social and economic goals of less developed countries'. Rather than discard the health-as-security discourse and disengage from diplomatic discussions that utilize this frame, therefore, perhaps the more appropriate, ethical course of action, as Hwenda et al. (2011, p. 21) have argued, is to ensure that low-income countries use such opportunities 'in order to advance their health security interests'. Fortunately, a forum already exists through which such arguments can be actively prosecuted – the WHA.

Moreover, as noted above, now that the connections have been drawn so successfully, it remains highly problematic for the IO to fully reverse course by discarding the health-as-security discourse without consequences ensuing. Instead, a far more productive use of both the IO's and member states' time would be to re-focus collective efforts on resolving the definitional problems surrounding the concept of global health security. It is clear, for instance, from WHA deliberations that even some of those member states that have previously railed against the IO's use of the phrase 'health security' in relation to the organization's work have periodically exploited the terminology for their own domestic and international objectives. From this it may be ascertained that the assumed preference heterogeneity over global health security may be more reflective of intermittent political posturing for domestic political

gain rather than resolute, outright hostility, and as such, definitional consensus may in fact be attainable. The question thus becomes whether the political will to tackle this problem exists within the WHO secretariat, or whether it is far easier to move on to other issues.

In this book, the position explicitly adopted has been to support a narrow definition – one that embraces fast-moving, acute hazards to human health such as infectious diseases while excluding others. Such a narrow definition aligns with the WHO's founding raison d'être and delegation contract. It also parallels the PHEIC concept that has been articulated and enshrined within the revised IHR (2005), as well as the WHO's customary practice that has emerged since the turn of the century. Perhaps most compelling, however, is that a narrow definition of global health security that focuses on the control and elimination of infectious diseases coincides with the majority view of policy-makers and academics (Rushton 2011; see also DeLaet 2015, Stevenson and Moran 2015, Weir 2015 for examples). Alternative definitions, of course, have emerged at the margins and are likely to continue to do so (see Aldis 2008, McInnes 2015 for summaries). But as Rushton (2011, 2012) has articulated, there is the sense that we do already have a clear understanding of what the concept pertains to and that is, ultimately, the control (and wherever possible eradication) of infectious diseases.

Agreeing on a narrow definition does not preference either a state-centric or human security paradigm though, as Rushton (2011, pp. 787–793) suggests. Indeed, given the ongoing level of human suffering, morbidity, and mortality arising from infectious diseases as well as the potential for damage to national economies and social functioning, health security is arguably one instance where government and individual security interests fuse. It is conceivably for these reasons that even some of the staunchest detractors of the WHO's adoption of the concept have used health security for their own purposes, as outlined earlier. Therefore, rather than seeking to perpetuate an unhelpful debate as to which worldview of security should dominate, in this instance the international community would be better served by addressing the continuing technical capacity gaps that reside at the domestic and international levels and that preclude the WHO from fulfilling its mandate.

Technical and human resource capacity gaps linger as the international community's most pressing inhibitor for improving global health. These cavities also continue to thwart full compliance with the revised IHR (2005) (Davies et al. 2015). Disturbingly, these gaps were well known prior to the 2003 SARS outbreak and provided a powerful motivation for the WHO secretariat to issue travel advisories in an attempt to prevent

the pathogen gaining a foothold in low-income countries, particularly Africa (Heymann 2005). Multiple resource-poor countries also went to considerable effort to stress during the IHR IGWG that in agreeing to the revised framework deemed so critical to ensuring global health, security was an expectation that the world's wealthier countries would assist their less wealthy counterparts develop the requisite core capacities in disease surveillance and outbreak response. Yet throughout the intervening years between the adoption of the revised IHR (2005) and the deadline for full compliance, the majority of high-income countries offered very little in the way of assistance. For a time it may have appeared that the lack of action was justifiable, especially in the wake of the global financial crisis that the 'threat' narrative was overblown. As the most recent outbreak of Ebola in West Africa has profoundly demonstrated again though, the level of physical, temporal, and cognitive interconnectedness that now permeates our world cannot be easily discarded, and the same measures that facilitate global trade also enable worldwide microbial dissemination. The perennial challenge for improving health systems to combat the spread of infectious diseases thus remains, and it behoves the international community to arrive at innovative solutions.

In this respect, one of the more interesting features of the current response to Ebola in West Africa has been the deployment of thousands of military personnel to help contain the outbreak. Military intervention in global health has been a topic of fierce debate over the years, with the overwhelming majority of commentators from non-governmental, public health, and even military disciplines arguing against such measures (Elbe 2006, Feldbaum et al. 2006, Bernard 2013). Some have even postulated that the comingling of health and security has resulted in a medicalization of security policy (Elbe 2010b). Despite this, however, military forces have a long-established interest in mitigating the spread of infectious diseases and considerable logistical and medical expertise that can substantially aid civilian efforts (Smith 1992, Owens et al. 2009, Kronmen et al. 2013). Encouraging greater civil-military cooperation in health security may provide an innovative and sustainable pathway to addressing capacity gaps in light of the financial constraints and the reduction in health-related ODA that have emerged in recent years, and yet the conventional position adopted by most health advocates and policy entrepreneurs decries such notions. If capacity gaps are to be addressed, however, pioneering measures are required and civil-military cooperation may offer one avenue of possibility.

Of course, capacity building will take years to accomplish. In the meantime it may be tempting for member states – given the self-acknowledged

dysfunction of the WHO's latest efforts to prevent the spread of a highly lethal contagion in the form of Ebola – to move swiftly to impose yet further mechanisms of control on the IO to prevent further agency slack. Without addressing the budgetary issues though, any such moves would be short-sighted to say the least. Plainly there is need for further administrative and programmatic reform, but simply reducing the WHO's voluntary contributions and curtailing its staff is hardly the way to achieve this. Here the organization's proximal principals have the greatest responsibility to ensure that the reforms that are implemented will result in a leaner, more effective IO as opposed to applying measures that will cause additional dysfunction. The WHO is, ultimately, the sum of its parts and due to the limitations enshrined within its delegation contract, the IO's autonomy remains appropriately limited.

The fight against infectious diseases is far from over. Indeed aside from the periodic appearance of new zoonotic diseases that have successfully managed to cross the species barrier to infect humans (such as Ebola, SARS, and MERS-CoV), the emergence and progressive spread of AMR that the international community is presently witnessing reveals how limited modern medicine – for all our medical advances – really is at present. When viewed against the technological advances that are permitting humans to travel further and faster than ever before, the prospect of a disease-free future does not look particularly promising at the moment. The WHO's central mission and mandate have thus never been more important, and yet while the organization is in need of further reform to ensure greater efficiencies, equally the IO arguably needs the financial and political backing of its principals now more than ever. It is, after all, those governments and the people they represent that the WHO exists to serve.