THE POLITICS OF GLOBAL HEALTH SECURITY: PROBLEMETIZING A SOCIAL EVIDENCE

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Abstract: Why have states, in a somewhat short period of time (1995-2005), suddenly decided to "cooperate" regarding global infectious disease surveillance? What kind of "cooperation" is it? Why did states apparently surrender part of their sovereign power to the WHO by giving it the power to declare pandemic at the global scale without state consent? These questions appear especially relevant in the context where issues of health and diseases at the global scale have been explicitly linked with the concepts of "risk", "security", "emergency", "crisis", "intelligence", and "terrorism". The objective of this article is to start answering these questions by first of all looking at the problems and paradoxes of the practices of Global Health Security through an analysis of the microbial space, capitalistic cooperation, and the production of information and data about health security. Secondly, the article draws the attention to the politics behind the structuration of Global Health Security as a social evidence by looking at contested concepts that represent promising research avenues.

Keywords: global health security, disease outbreak, risk management, WHO, social evidence.

INTRODUCTION: PROBLEMATIZING GLOBAL HEALTH SECURITY

In 1970, and for the first time in its history, the World Health Organization (WHO) internationally reported a disease outbreak without its member countries consent (Fidler 2004a; Weir and Mykhalovskiy 2010). The WHO internationally and openly reported a cholera outbreak in Guinea without official confirmation and validation by Guinean state authority. We were at that time under a newly adopted set of international regulations for the management of infection diseases at the global scale, known as the 1969 International Health Regulations (IHR 1969)[1]. The consequences of WHO actions were disastrous, as much for the international organization as for

member countries, and included, among others: major economic, political and diplomatic impacts on the targeted country, fear and mistrust of WHO by other countries, lack of subsequent diseases reporting by the vast majority of WHO members and an enduring credibility crisis at the WHO. This unilateral action, which was highly criticised by countries members, the international community and other UN institutions, forced the international organization to never report again disease cases without state consent. This event strongly reminded that state sovereignty, especially with regards with Global Health Security[2], was inalienable. Global health governance and infectious diseases surveillance at the WHO level lost almost all its substance and credibility. It would be like that for twenty-five years.

Then a new set of International Health Regulations was approved in 2005 (IHR 2005). Under this new IHR, adopted by 194 parties in 2005, but in practice and trial since 1995, everything became suddenly radically different: the WHO has now the recognized and accepted legally-binding power and technological capacity to declare global pandemic alerts and identify disease cases *without* state consent, approval and/or validation. Through those new 2005 IHR, the WHO is also authorized to use and share unofficial sources of information (Internet, news, rumours, drug sales, etc.) in order to evaluate global health security issues, emergencies and risks. And finally, not only the new IHR is not anymore limited to a specific list of diseases (what is was under the previous IHR), but non-intentional events (naturally occurring diseases, environmental disasters, etc.) *as well as* intentional ones, such as bio-terrorism, emergency and deliberate spread of diseases, can now be subject of surveillance and monitoring by the WHO. As the recent Ebola epidemic demonstrated, where the WHO played a central, and powerful role, sometime against (some) state interests, this new IHR represents a major change in the scope of action and the power given to the WHO under the generic umbrella of Global Health Security, something that was never experienced before in the history of public health.

These international regulations, which were rapidly approved and applied by member countries in a context of a growing fear of emerging and re-emerging infectious diseases as well as new health risks

posed by globalization (foodborne diseases, drug resistance, etc.), pro-
voked a radical shift from global health governance (Dogson Lee and
Drager 2002; Kickbusch 2003 2005) to Global Health Security,
where specific connections with risks, military interventions, surveil-
lance, bio-terrorism, deliberate spread of viruses etc. are now part of
the new normal (see for example WHO 2001). In this context, and as
shown amply by WHO discourses during the recent Ebola epidemic,
a strengthened infectious diseases surveillance structure at the WHO
level, and managed by the WHO, is presented as the best way to deal
with infectious diseases at the global scale. Global Health Security: it
is today what we can call a "social evidence", something that is rarely,
if not at all, called into questions.

From this impressive historical reversal, a series of questions arise:
Why have states, in a somewhat short period of time (1995-2005),
suddenly decided to "cooperate" regarding infectious disease surveil-
lance? What kind of "cooperation" is this? Why did states accepted to
surrender part of their sovereign power to the WHO? What are the
consequences and implications of such changes?

These questions are especially relevant in the context where issues
of health and diseases at the global scale have been explicitly linked
with the concepts of "risk", "security", "emergency", "crisis", "intelli-
gence", "terrorism", etc., which are usually indicators of higher state
priorities. To summarize the overall questioning of this article: why is
that that the emergence of Global Health Security, trough, for exam-
ple, the new 2005 IHR, did, in appearance at least, showed a some-
what retreat of state's sovereignty regarding this central security issue?

Since the new 2005 IHR is quite new (implemented between
1995-2005), few studies have been directly dedicated to its under-
standing. The most up-to-date and accurate study is the one made by
Lorna Weir and Eric Mykhalovskiy (2010). Even if this study is quite
elaborated and documented, it is at the same time very broad and
dedicated to a general understanding of the legal changes introduced
by the 2005 IHR. This useful overview is however made at the ex-
pense of a lack of specific understanding, theorizing and conceptualiz-
ing of the practice of Global Health Security and risk management.
Filling this gap would requiring, among other things, a detailed analy-

sis of the technical functioning of Global Health Security apparatus, which is almost free from any academic investigation (Weir and Mykhalovskiy 2010). Moreover, this study, alongside others (Bashford 2006a, 2006b; Baker and Fidler 2006; Dry 2008, etc.), did not ask the question of why and how this system took place, something that needs a more sophisticated and elaborated answer than those provided so far by some scholars. These answers include: the WHO as a form of supra-sovereign power (Weir & Mykhalovskiy 2010), a post-westphalian order (Fidler 2003a; 2004a; 2004b), imperialism and neo-colonialism (Aginam 2003; Bashford 2006a). These answers, while arising from highly documented and elaborated studies made by respected scholars, are however somewhat unsatisfactory. This kind of answer does not explain why states agreed to such legally binding apparatus, or how this system took place, under which conditions, through which struggles, by which choices. It neither shows its consequences nor its implications, and it does not detail what this apparatus excludes from Global Health Security as both a theoretical/conceptual and practical object. It only represents a form of categorization without giving any understanding of how the system works and lack any critical perspectives[3]. Put shortly, it does not reveal the *politics* of Global Health Security.

In order to bring back the politics of Global Health Security, this article proceeds in three folds. First of all, it underlines the problems and paradoxes of the practices of Global Health Security through an analysis of 1) the microbial space, 2) capitalistic cooperation and joint risk management, and 3) the production of information and data about health security. Secondly, it draws the attention to the politics behind the structuration of Global Health Security as a social evidence by looking at contested concepts that represent promising research avenues.

LOSING SOVEREIGNTY, GAINING SECURITY: THE PARA-DOXICAL PRACTICE OF GLOBAL HEALTH SECURITY

A questing strikes anyone who wants to research about contemporary Global Health Security practices: Why WHO member states

accepted to surrender part of their sovereignty and joined an interna-
tional body of regulations (the 2005 IHR) that seems, at first at least,
to limit their ability to identify, act on and communicate about health
threats? Answering this question first requires understanding what
exactly the Global Health Security context is. But rather than provid-
ing specific definitions of Global Health Security, a concept that is, as
stated previously, highly contested and characterised by many differ-
ent (and sometimes opposed) definitions (Aldis 2008), we think it is
more useful to underline its practices, performances and changes. To
show what actors do with and throughout this concept, rather than
limiting the analysis to a specific definition. This "practice" of Global
Health Security informs and structures its contentious and contested
meaning(s), ultimately pointing to the rational behind states agree-
ment to embark in contemporary Global Health Security apparatus so
avidly, as it was the case with the new 2005 IHR.

The first section of this article is thus dedicated to the problems
and paradoxes of the practice of Global Health Security. Three aspects
bring particular questionings and interrogation: 1) the actual meaning
of health in a "global" context; 2) the practical aspects of the 2005
IHR managed by the WHO; and 3) the role of technologies and net-
works in Global Health Security, such as the Global Outbreak and
Alert Response Network[4] (GOARN). Each of these paradoxes and
problems with the practice of Global Health Security answer part of
the question why 194 states agreed so avidly to the new 2005 IHR.

VIRUSES IN A GLOBAL CONTEXT: SOVEREIGNTY AND
THE MICROBIAL (POLITICAL) SPACE

How state sovereignty interacts with global health security? At the
supranational level, the first international sanitary conference, held in
the mid-nineteen century, initiated a discursively new scale of collabo-
rative interventions – at least between major Europeans powers – to-
wards diseases, viruses and outbreaks. What was at the beginning con-
sidered to be a limited international structure, with an emphasis on
Europe and a few other countries, undergone rapid growth and changes,

to be now considered as a "global" set of regulations (Brown Cueto & Fee 2006: 76; King 2004: 65; Fidler 2004b 2004c 2004d 1996), involving both new institutions (*Office International d'Hygiène Publique*; the League of Nations Health Organization; PAHO; WHO; private foundations, etc.) and new practices (treaties, wars, foreign interventions, drug discoveries, R&D, etc.). These institutional practices produced, and where sustained by, a particular understanding of the microbial world, in which the space of action of these institutions was linked with the space of action of viruses, germs and pathogens themselves: global actions/institutions for global threats. This is what we call the global microbial space.

It is possible to find the first explicit narrative and discursive representation of disease management as being "global" in the works of the American immunologist Stephen Morse, a later popularized by Milton Roemer with the idea that "diseases know no border" (Roemer 1994). The global scale of infectious diseases is conceived in terms of a unified microbial world in which there is no place that can be out of reach of infections and pathologies. In a global epidemiological world, there is no place to hide. This popular and generalized conception of epidemic and diseases, known as the "*emerging diseases worldview*", was acknowledged in the 1990s as alluding to the idea that biomedical threats can be linked to a de-territorialized and globalized world (Calain 2007: 4). In this perspective, the modern conception of territoriality-based states was no longer seen as sufficient and adequate regarding health regulations, laying the groundwork for the inclusion of transnational, and later, global actors. The narrative itself of the microbial space is thus infused with the idea that there is a prefund inadequacy between political (i.e. state) borders and epidemiology. Sovereignty and viruses were presented as evolving in two separate and conflicting words. The global microbial space interacts incoherently with the sovereign space.

What kind of shift in health and security policies does this global microbial world involves? Surveillance played here a central role, by being the main tool for providing security and guarantees in a now conceived as "borderless"[5] world, at least in terms of epidemiology and virus spread. In what is represented as a global and fluid world, global

surveillance and intelligence began consequently to be seen as the most effective ways to control disease propagation and contagion (Brownstein and al. 2008: 1019). The mobile and volatile conception of diseases in a globalized and borderless world (Heymann and Rodier 2001: 348), along with the emphasis put on risk and emergency rather than long term intervention (Calain 2007), became identify as the main pillars of today's global health practices, the new 2005 IHR being an examples of these new policies. The best strategy is thus seen to be a "good intelligence, on a global scale, gleaned through sensitive surveillance on a national and international basis" (Twisselmann 2002: 1).

But here appears one the major change in the rationally of public health intervention and Global Health Security in a borderless world: surveillance cannot be performed by states, as there is a supposedly strong incentive to hide epidemiological information and data to the rest of the global community, fearing a kind of blame and shame boomerang effect. This phenomenon is link to the evolution of health surveillance itself. At its origin, surveillance was usually conflated with epidemiology (Declich and Carter 1994: 285) and, as pointed out by Thacker (2000), until the fifties, surveillance focused on human contacts in order to rapidly identify single case outbreak of disease and implement isolation or quarantine strategies. The state played a central role here. It was both the main foci *and* actors of intervention. The importance was thus put on *intervention* through small scale, direct and individual surveillance by state/national actors. But with the successive association of health and security/risks issues (Weir and Mykhalovskiy 2006: 253; Calain 2007), and the development of technologies that have the potential to be global in scope, the ongoing apparatus of health surveillance underwent a major transformation in its rationality and practices, moving to a global[6] perspective through *managerial* practices, risk analysis and security referents: global health surveillance.

Its actors themselves define this kind of surveillance apparatus as "the ongoing systematic collection, analysis, and interpretation of outcome-specific data for use in the planning, implementation, and evaluation of public health practice" (Thacker 2000: 1). This implies a

new mode of surveillance called "*systematic pre-detection*" (Castell 1991: 288), which rests on four types of action: collecting, interpreting, disseminating and acting on health information (Weir and Mykhalovskiy 2006: 242). It represents a fundamental shift from resolving health issues through intervention to managing and communication through information and data, a shift that involves a transition from traditional sovereign actions/actors (border closure, national emergency plans, internal drug policy, etc.) to a form of communicative and information-based power. This power is not anymore the sole capability of state actors. In fact, states are somewhat seem as counter productive to this global surveillance system, where they are expected to lie about disease cases, hide information or provide out-of-date data. Global actors revealed themselves, in this narrative account of Global Health Security, as the objective and neutral force: they are seen as the only one that can adequately perform and implement global surveillance and security. And the WHO, with the new 2005 IHR performatically inscribed itself as the cornerstone of this global apparatus.

Noteworthy, the WHO is represented[7], at the global scale as the most important and effective actor in the functioning and execution of global health surveillance mechanisms (Woodall 2001) through its communication/information based power (its ability to act on and communicate health information globally through networks and online-based tools). As it argues itself, its main objectives regarding infectious diseases is to "improve international preparedness for epidemic response [and] actively collect information on ongoing outbreaks or rumors of outbreaks worldwide"[8]. Data collection, information and communication, networks represent the new reality of global health surveillance by the WHO, a reality that states do not, and cannot, control anymore due to the very nature of the task: acting on information that they don't possess. Health information, in a borderless world, are own by individuals, interest groups, private actors, technologies, virtual spaces, social media data, big tech corporation, etc. This is the space of health surveillance and security. And this explain partly why states where so inclined to stretch their sovereignty regarding global health security and surveillance, as it gives them ac-

cess to information for which they are seen as irrelevant, even counter-productive. Being part of this global apparatus was seen as advantage in terms of information and communication access. The global comes at the extent of information access. And the cost of sovereignty losses appears as a tradeoff for better information into, and about, the global space of diseases and viruses.

And here comes a new way the "global" must be understood in global health security and surveillance. Following Bruno Latour's conception of the "global", such scale of intervention should not be understood exclusively as a macro structure or as an overall space opposed to a local one "here". The "global" can rather be conceived of in terms of "connected, blind, local, mediated, related" space (Latour 1999: 18), that is, the summing up of relations, the production of a space of articulations/interconnections that, ultimately, may or may not be effectively and/or geographically global, but global in it's potentiality. Global Health Security is information, and states wanted to enter this informational space. Their main tool to do so was the new 2005 IHR.

CAPITALISTIC COOPERATION AMONG RISKS AND UNCERTAINTIES: THE 2005 INTERNATIONAL HEALTH REGULATIONS

What kind of cooperation the new 2005 IHR involves? What kind of practices and actions structured its functioning and implementation? The specific understanding of the "global" as being information is profoundly linked with the effective functioning of Global Health Security through the 2005 IHR. A new sort of "cooperation" now enlisted countries members: capitalistic cooperation among risks and uncertainties.

This new form of cooperation involves a profound modification in the scope and range of practices of global health governance, surveillance and security. These modifications, centered around risk, uncertainties in (what is presented as) a borderless world coalesced in the 2005 IHR, but also integrated, as we argue later, the importance

of trade, or rather the ability of health security *not to disrupt* global trade and the routes of globalization. The nature of these modifications helps comprehend the type of state cooperation and interaction with global actors (WHO, global health foundations, pharmaceutical companies, etc.) witnessed with the new IHR by underlining the role of risks and uncertainties for global cooperation.

The main modifications of the 1969 IHR, introduced between 1995 and 2005, and which profoundly impacted on the social production of contemporary Global Health Security, are: *a*) the transition of the surveillance focus from a specific list of diseases[9] to an all-risk approach (Fidler and Gostin 2006: 86) encompassing all infectious diseases without regard to their sources or origins, including all types of health emergencies, even those made with *intentional purpose* (e.g., bio-terrorism, biological weapons, etc.); *b*) the integration of the concept of public health emergency of international concern (PHEIC) to identify what has to be under scrutiny by the global health security and surveillance structure (IHR 2005; Backer and Fidler 2006: 1059; Fidler and Gostin 2006: 88); *c*) the use of official and unofficial sources of information (such as coming from the media, Internet, NGOs, social media, forum, corporations, etc.) to identify PHEIC; *d*) Diseases surveillance centered on event rather than case (Weir and Mykhalovskiy 2010); *e*) the integration of the Emerging Infectious Diseases (EID) concept originally forged in the US; *f*) real-time surveillance and global mapping of health emergencies and risks; *g*) the use of algorithms to identify PHEIC and implement responses; *h*) the power to announce pandemic alert without state consent given to the WHO.

Surprisingly, 194 states accepted to be legally banded by these new practices and rules regarding Global Health Security. But what exactly is the main goal of this new global mechanism? According to the article 2 of the 2005 IHR, the main objectives 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" (WHO 2005). What appears significant is that under the 2005 IHR, the WHO is granted

with a noteworthy form of power. The international institution can openly report disease events and PHEIC *without* state approval, which is why some argued that the new 2005 IHR goes against state sovereignty or represented a supra-sovereign form of power (Weir and Mykhalovskiy 2010; Fidler 2004a 2005).

However, the definition of what is a PHEIC is highly controlled and requires following specific identification and evaluation processes that are still controlled and shapes by some actors, including, as we will underline later, some major Western powers. What has to be subject of surveillance coverage, scrutiny, real time mapping and alert, the core of global health security practices (Backer and Fidler 2006: 1059; Fidler and Gostin 2006: 88), still represent a byproduct of institutional settings and/or power relationships centered on some state. The definition itself of what constitutes a PPHEIC by the WHO shows how contested and conflicting the politics of Global Health Security is. According, for example, to the article 1.1 of the 2005 IHR, "'public health emergency of international concern' means an extraordinary event which is determined, as provided in these Regulations: (i) to constitute a public health risk to other States through the international spread of disease and (ii) to potentially require a coordinated international response" (IHR 2005). There are 4 criteria – on a form of a question to be answered and called criteria algorithm[10] – for a disease outbreak to be considered as PHEIC, and then reported to the WHO and be subject to global surveillance mechanisms and alert: 1) Is the public health impact of the event serious? 2) Is the event unusual or unexpected? 3) Is there a significant risk for international spread? 4) Is there a significant risk for international travel or trade restrictions? (IHR 2005).

Two elements are noteworthy here regarding state's acceptance of this new global health security apparatus and the new "cooperation" involved: 1) the importance put on trade, as well as 2) the central role played by risks and uncertainties. First, trade and international commerce play a key role as being the disruptive channel through which the importance of a global health issue will be judged and evaluated. During the IHR revision process, the importance of the World Trade Organization (WTO) in global health policy was for example explicit-

ly acknowledged. A 1999 report by the WHO secretariat stated that "the objective of the Regulations is therefore fully consistent with WTO's purpose in reducing barriers to international trade" (1999, 3). States accepted this new set of rules, as they are part of the overall neoliberal approach to global politics. Capitalistic cooperation characterizes the 2005 IHR: the use the language of health to protect and secure global trade against regulations. Second, the all-risk approach (Fidler and Gostin 2006: 86) behind the IHR favored the inclusion of bio-terrorism, which appeared, during the IHR negotiation process, as a bandwagon for some states, inclusion the US and GB. This second aspect underlines the interest shown by major states in the new IHR.

The practical consequences of such linkage between health and security are enormous and underline the fact that the type of cooperation at stake, even if presented as global and endorsed by 194 actors, (re)produced inequalities at the global scale. In the disaster-oriented perspective that usually characterized Global Health Security, "terrorism, bioterrorism and epidemic disease became conflated" (Bashford 2006b: 13), fostering and re-producing the connection between health and security (King, 2002). The intermingling of global public health and security issues also leads to a prioritization process among health issues that follows military and political interests (McInnes and Lee 2006), not health issues and event themselves. According to Calain (2007), in such context, the "core argument over global surveillance has moved from public health concerns toward foreign and security policies, and economic interests" (pp. 1-3). States saw this potential for mixing health and security as one more reason to accept the new 2005 IHR, even if these instruments seemed at first to reduce and affect negatively their power. Ultimately, those who can define the health threat and danger, even if implemented by an international organization such as the WHO, will benefit in terms of interest and power. Understanding the process through which health threats and dangers information/data are produced requires going inside the global health security apparatus.

PRODUCING DANGERS AND THREATS: THE GLOBAL OUT-
BREAK AND ALERT RESPONSE NETWORK

How do we identify global health threats information and what
impacts does it have on health policies? Answering this question re-
quires to look at the Global Outbreak and Alert Response Network
(GOARN), the branch of the WHO responsible of the supervision
and management of health surveillance and risk enacted by the 2005
IHR. Created in 1998 and in function in 2000, the GOARN is a
network of various actors supervised by the WHO and for which the
objective is to provide, coordinate, manage and act on information
about infectious diseases and health risks at the global scale. The
GOARN is a special structure in the international system. It is fi-
nanced both by the WHO and private donors: 5 per cent of its annual
budget of about US$ 200 millions is financed by the WHO and the
rest comes from other international institutions, individual states,
private corporations, national health institutions and initiatives – the
WHO also grants the GOARN with a small administrative staff and
bureaucratic resources (Weir and Mykhalovskiy 2010: 94-5). Its main
goal is "to investigate and characterize events and assess risks of rapidly
emerging epidemic disease threats"[11]. It is based on information shar-
ing and transmission through a networked organization of public and
private actors (Formenty and al. 2006). The GOARN is self-defined
as: "a technical collaboration of existing institutions and networks who
pool human and technical resources for the rapid identification, con-
firmation and response to outbreaks of international importance. The
network provides an operational framework to link this expertise and
skill to keep the international community constantly alert to the threat
of outbreaks and ready to respond"[12]. One of the main purposes of the
GOARN is thus to ensure that outbreaks of international concern,
according to the IHR standards and PHEIC definition, are rapidly
verified and shared among the international community in order to
coordinate international and state responses. The GOARN thus pro-
duces the information/data that is communicated and shared, the
foundation of Global Health Security.

The GOARN is in this perspective structured around six key functions: *a*) epidemic intelligence and systematic; *b*) event verification; *c*) information management and dissemination; *d*) real time alert; *e*) coordinated rapid outbreak response; *f*) outbreak response logistics.

Interestingly, this system of health surveillance represents a transition from direct response and intervention to preparedness and prevention in the action against infectious disease at the global scale (WHO 2000: 31). This represents a crucial shift toward managing infectious diseases instead of trying to resolve them. This shift explains why states where so inclined to accept the new 2005 IHR: because it management and not intervention, states saw this mechanism as an opportunity to transfer responsibilities and accountability for identification of health risks at the global scale, but still keeping their own prerogatives for internal intervention.

As stated at the preparatory conference to the implementation of the GOARN held in Geneva in April 2000:

Whereas traditional approaches to containing outbreaks were defensive, trying to secure borders from the entry of infectious diseases, modern solutions, in addition to the development of new anti-infective drugs and vaccines, are built on a combination of early warning surveillance systems, epidemic preparedness plans, stockpiles of essential materials, speedy communications and information sharing through networks to rapidly contain epidemic threats. (WHO 2000)

As stated previously, such system of information and communication is based on unofficial sources of information (Dry 2008: 10; Grein and al. 2000; Brownstein and others 2008: 1020-1021). This is one of the major differences introduced by the 2005 IHR (Fidler and Gostin 2006). According to Fidler, the integration of information technologies in health surveillance has made it more "dynamic, flexible and forward-looking" and allows a better implication of non-state actors (Fidler 2005: 362). The impacts of information technologies and the reporting from unofficial sources in an almost instantaneous manner have had however profound impacts on the way global health is managed and the natures of information (i.e. health threats and

dangers), especially with regard to the information validity and legitimacy (Heymann and Rodier 1998; 2001; Grein et al 2000; Dry 2008). In this sense, there is a formal process of assessment of the validity of outbreak information through which it is decided if the information will be reported as a case of international concern. This process is based on an outbreak verification team based in Geneva that evaluates the different outbreak reports from the various informal sources (Dry 2008: 12). In this perspective, "raw intelligence gleaned from all formal and informal sources is converted into meaningful intelligence by the WHO Outbreak Verification Team" (Heymann and Rodier 2001: 349). This is, we argue, where the politics of global infectious disease surveillance lies through a mix of technological and state's inputs.

The current functioning of the GOARN is consequently based on an already existing networks, but uses "several new mechanisms and a computer driven tool for real-time gathering of disease intelligence. The network interlinks 110 existing networks that together possess much of the data, expertise, and skills needed to keep the international community constantly alert and ready to respond" (Twisselmann 2002: 1). This is representative of the multiplication of actors implicated in global health surveillance and risk management, a phenomenon that nevertheless hides the fact that some states, through this multiple and networked form of organization, still play a key role in global health security.

One of the most important contributors of information to the GOARN is for example the Global Public Health Intelligence Network (GPHIN), from which 60 per cent of the information analyzed at the GOARN comes from[13] (Zacher 2007). The GPHIN is a good example of state hidden interventionism in this so-called supra-sovereign Global Health Security apparatus. The GPHIN is a Canadian based (in partnership with the WHO) health surveillance "initiative that draws on the capacity of the Internet and newly available 24/7 global news coverage of health events to create a unique form of early warning outbreak detection" (Weir and Mykhalovskiy 2006: 42). The GPHIN is "continuously crawling websites, newswires, local online newspapers, public health email services, and electronic discus-

sion groups" for potential information about outbreaks rumors and information (Twisselmann 2002: 1). Information about outbreaks rumors in the GPHIN is only provided to subscribers and for a certain fee, (re)producing a form if privatization and state control of global spaces. Weir and Mykhlovskiy also pointed out that the GPHIN have been used by the US for counter-terrorism intervention (Weir & Mykhalovskiy 2006). States interventions thus still structure and frame global healthy security definition, information, and practices.

GLOBAL HEALTH SECURITY: THE POLITICS OF A SOCIAL EVIDENCE

Why states accepted to surrender some of their sovereignty regarding the new 2005 IHR? Without giving a definitive answer, the previous sections underlined some of the rarely questioned key aspects structuring the rationality behind contemporary Global Health Security. These key aspects include: *a*) the structural of a global microbial space where states appear as irrelevant; *b*) The role of information and communication controller/centralizer played by the WHO in a – presented as – borderless world; *c*) The 2005 IHR as the centerpiece of informational and communicative governance laws, rules and regulations; *d*) The practical focus on uncertainties and risks that jeopardy global trade, structuring a form of capitalistic cooperation both for health and trade governance; *e*) The connection between health and security, and especially terrorism, that favored state's acceptability of the new 2005 IHR; *f*) The persistent role of (some) states in the multidimensional and networked organization of global health security; *g*) The production of health threats information/data as power in Global Health Security.

As mentioned previously, these elements are far from a definitive answer regarding global health security reasoning and rationality. However, they do bring to the attention the fact that social sciences somewhat lack the theoretical and conceptual tools to adequately question and analyse global health security, most notably because of its social evidence status. The spatial exclusion of the sick, the leprosy,

the sanitary cordon, the lazaretto, the urban mapping and surveillance of diseases or the quarantine strategies[14] show how diverse and multiple the social interactions with diseases can be. While those interactions with diseases are clearly motivated by different functions, logics, modes of action or rationalities, a similarity seems to persist at the same time: they emerge, at one moment or another, as social evidence, as the obvious and rational *political* response to a recognized problem. The political process through which global health security became the obvious response to a specific problematic is thus deeply embedded into micro sites of actions and power disseminated at the global scale.

Challenging this social evidence status requires to grasp the complexity of global health politics – complex not as complicated, but as intertwined with other practices, issues, knowledge, etc.[15] The inscription of global health security and risk management into everyday life practices (such as those underlined previously) has provoked a shift towards information, communication and management involving micro practices (risk management, computerized practices, digitalization, surveillance, etc.) that reproduce the evidence status of Global Health Security.

The problem, in terms of social analyses of these practices and sites of (inter)actions, is that we forgot that these sites of power they are deeply political. Recognizing global health security practices *as* politics inscribed into everyday life performances has been rarely done, which creates and structures the misunderstanding regarding the reason why states accepted the new IHR, which, in appearance, reduced their sovereign powers. Four concepts specifically need, we argue, to be challenged: 1) The assumed non-political aspect of global health itself; 2) the spatial tension of global health security; 3) the productive nature of global health security; and 4) its link with the nation building process. These four concepts and assumptions represent the main research avenues that must be investigated deeper to challenge the social evidence status of global health security.

Global health as politics

Global health as politics means to show that it is not as self-
evident that global infectious disease surveillance is the right and obvi-
ous way to promote and manage global health, and that this evidence
in fact results from political choices, contexts and decisions. We need
to recognize that the consequences and implications of Global Health
Security practices and surveillance, which still need to be identified,
are also deeply political. The argument made here is that this kind of
answer to global health "problems" is rather dependent on social con-
texts, power relations, institutions, knowledge, etc. Indeed, we need to
underline this historical construction of Global Health Security as an
evidence, a research agenda still to be undertaken, by showing the
political and social process through which diseases surveillance and
risk management became the central loci of contemporary Global
Health Security.

The spatial tension of global health

Global health, as a social concept, brings with it a deep and in-
herent tension: the spatial dimension of the object at stake and its
interaction with geo-localized identities. Space, territory and identity
play here a central role in the identification of health threats, dangers
and risks, which is usually set aside in the analysis of Global Health
Security. Many studies have shown, for example that, historically,
diseases were thought to be brought or developed by marginalised
groups, abnormal behaviours, foreigners or immigrants (King 2002;
2003: 41; Bashford 2006: 71; Elbe 2005: 414). They also pointed out
that the origin and source of infectious diseases had been linked with
undermined identities (Ingram 2008a; 2008b: 78; Zylberman 2006:
22-25; Strange 2006: 234). For instance, according to Weir and
Mykhalovskiy (2006: 245), the origins of diseases in the post-World
War II era have been associated with what is represented as Third
World countries, which were identified as reservoirs of disease (Agi-
nam 2004: 298). A cultural imaginary of the world geography of dis-

eases, in which some spaces are represented as containers of pathogens and others as receivers is, in this sense, fashioned, creating what Zerner called an "emerging cartography of danger" (Zerner 2005: 168) or what Schell called the foreign viral geography[16] (Schell 1997: 133). This conception of the pathological spacialization is linked with "the long history of the geopolitics of disease [where] people [are] being considered properly in their place, or improperly out of place" (Bashford 2006a: 10). This geo-cultural tension is however absent of the current Global Health Security "problem". Global Health Security analysis assumes that no cultural, identity based and spatial factors shaped the identification of health threats and danger. These analyses are in complete rupture with the social history of health policies. The geo-cultural tension of health has to be bringing back into the analysis.

The productive nature of Global Health Security

In a somewhat antagonistic perspective with was underlined previously, Global Health Security practices must be understood not only for their exclusionary and oppressive properties (through its deep connection with security), but also for their productive nature. As a reminder, it is still cooperation rather oppression that predominates regarding Global Health Security. By focusing on the "dark" side of health politics (exclusion, oppression, violence, etc.), the analytical purpose lost its capacities to understand and analyze a situation in which actors are in fact implicated in a highly complex system of cooperation, collaboration and coordination that produces meaning and knowledge. This system includes and incorporates, rather that excludes. It is this precise process of incorporation that needs to be investigated. Global Health Security must be understood as a system, as a network that attract, modify, translate and transfer information and meaning. At the analytical level, we are still stuck in a form of domination-based type of analysis in which those who are identified as "victims" lose all agency power. At best, the analysis we have limits the problematization to two types of actors, the oppressed and the oppressor, the good and the bad. This dichotomous analysis distorts the

reality of Global Health Security where multiple actors are involved through a collaborative process. Global health security works without direct oppressive power. The specific functioning of such a productive system must be included in future analysis.

Global Health Security and the nation state building process

Lastly, the connection between heath and the nation state building process is not as clear at the global scale as it is for national health, thus necessitating further analysis and inquiries. Post-1800 public health practices have been identified as having deeply constitutive implications on the modern racialized nation-building process through the issues of space, territory and identity (Bashford 2006a: 66-7; 2002; Bashford and Nugent 2001; Manawi 2006: 144-5). However, this interaction with the nation building process and legislation has somewhat being lost in the translation form national health to global health. Not only the states appeared to be irrelevant, but in some sense it completely disappeared form the analysis. Fuzzy categorization such as post-westphalian order, supra-sovereign form of power, imperial and neo-colonial domination, etc. are ultimately unsatisfactory in their ability to show and specify the role of states in Global Health Security. Among other things, we lack empirical sources and evidences regarding states intervention and actions in Global Health Security . We still have very few ideas how this system took place and was initiated; how some states were involved in the structuration process of Global Health Security ; how it helps also so-called emerging states to legitimize their action at the international scale through the work, for example, of the WHO.

CONCLUDING REMARKS: GLOBAL HEALTH POLICIES AS RANDOMNESS

The study politics of Global Health Security, as a social science analytical object, should be oriented towards one objective: to under-

stand and evaluate the consequences and implications of a structure that is rarely questioned and problematized. Global Health Security implies consequences and effects (hierarchization process regarding health priorities, resources allocation, power relationship, new roles for both international organizations and sates, capitalistic management, private actors, new space of action, new role for information and communication, etc.) that are obliterated by its status of evidence and its incorporation in everyday life practices. Highlighting those consequences and implications that are erased by the current political, academic and public discussions regarding Global Health Security would be especially important for our understanding of contemporary Global Health Security apparatus.

This should be made both by acknowledging the fundamental political nature of Global Health Security, by recognizing that it results directly from political choices and decisions. Those political actions have important consequences on what is, and what is not, Global Health Security. This question has never been addressed fully, which, in the end, reproduces confusion and misunderstanding about its modalities of operation, target, practices and rules (such as the new 2005 IHR). Our ability to understand and comprehend the reason why states agreed to the new 2005 IHR depends on our capacity to analyze Global Health Security as a political object; to analyze it as resulting from political decision making processes that, rather than (re)producing an social evidence status, shows the irregularities, discrepancies and the randomness of Global Health Security practices.

APPENDIX

2005 IHR ALGORITHM TO IDENTIFY PHEIC

**DECISION INSTRUMENT FOR THE ASSESSMENT AND NOTIFICATION
OF EVENTS THAT MAY CONSTITUTE A PUBLIC HEALTH EMERGENCY
OF INTERNATIONAL CONCERN**

Events detected by national surveillance system (see Annex 1)

A case of the following diseases is unusual or unexpected and may have serious public health impact, and thus shall be notified[1,2]:
- Smallpox
- Poliomyelitis due to wild-type poliovirus
- Human influenza caused by a new subtype
- Severe acute respiratory syndrome (SARS).

OR

Any event of potential international public health concern, including those of unknown causes or sources and those involving other events or diseases than those listed in the box on the left and the box on the right shall lead to utilization of the algorithm.

OR

An event involving the following diseases shall always lead to utilization of the algorithm, because they have demonstrated the ability to cause serious public health impact and to spread rapidly internationally[2]:
- Cholera
- Pneumonic plague
- Yellow fever
- Viral haemorrhagic fevers (Ebola, Lassa, Marburg)
- West Nile fever
- Other diseases that are of special national or regional concern, e.g. dengue fever, Rift Valley fever, and meningococcal disease.

Is the public health impact of the event serious?

Yes → **Is the event unusual or unexpected?**
No → **Is the event unusual or unexpected?**

Is the event unusual or unexpected?
- Yes
- No → **Is there a significant risk of international spread?**

Is the event unusual or unexpected?
- Yes → **Is there a significant risk of international spread?**
- No

Is there a significant risk of international spread?
- Yes
- No → **Is there a significant risk of international travel or trade restrictions?**

Is there a significant risk of international spread?
- Yes
- No

Is there a significant risk of international travel or trade restrictions?
- Yes
- No → Not notified at this stage. Reassess when more information becomes available.

EVENT SHALL BE NOTIFIED TO WHO UNDER THE INTERNATIONAL HEALTH REGULATIONS

Source: 2005 IHR, annex 2, p. 43.

NOTES

[1] The regulation of international health governance was originally shaped through the International Sanitary Regulations in the 19th century, renamed IHR in 1969 (Baker and Fidler 2006). The IHR represent the main rules through which global health policies are practiced today. The main purpose of the IHR is to establish the objects and modalities of disease regulations beyond and between states, using surveillance as the main tool for transnational health governance (Fidler 2005). Adopted for the first time in 1851, the IHR were amended several times (WHO, 2003: 1). The adoption of a new version of the IHR in 2005 completed revision process initiated in 1995.

[2] There is no definition of Global Health Security on which States and international actors agreed. However, as reminded by Abraham, "the WHO began using the term global health security in 2001 to describe the global public health measures required to protect the world from trans-border infectious disease threats, marking a step in the securitisation of diseases (WHO 2001)" (Abraham 2011). Throughout this article, when using the concept of Global Health Security, we specifically refer to this understanding.

[3] The use of the term critical in IR and elsewhere is subjected to a lot of… "critique". The term is sometimes used in a hierarchical manner, such as in the critical/uncritical dichotomy (i.e. good/bad distinction). To avoid this misunderstanding, we rather follow Gerard Holden here and use critical "to identify what is happening when an argument challenges or objects to a certain phenomenon or argument" (Holden 2006: 806).

[4] As mentioned by Weir and Mykhalovskiy, GOARN is one of the main research and empirical sites that remains unaddressed by social scientists (2010: 177).

[5] The argument made here is not that we effectively live in a borderless world, but that through the work and action of international and global health actors, the epidemiological world is presented at such.

[6] This is not to say the diseases surveillance is effectively global, but that in practices and discourses, it is represented as such.

[7] Again, this not to say that the WHO is the only or the main actor in GHS, but only that it is represented as such; this ultimately participates in the institutionalization of GHS as evidence.

[8] http://www.who.int/csr/labepidemiology/projects/diseasesurv/en/, consulted on October June 15th 2015.

[9] Under the 1969 IHR, disease surveillance was limited to cholera, plague, and yellow fever.

[10] See appendix 1 for an overview of the algorithm provided by the 2005 IHR to identify a PHEIC.

[11] http://www.who.int/csr/outbreaknetwork/en/, consulted on June 12th 2015.

[12] http://www.who.int/csr/outbreaknetwork/en/, consulted on June 12th 2015.

[13] Other networks include the Pro-med system, the Health map project, the GeoSentinel, the EuroSurveillance, etc.

[14] The point made here is not that those different practices are mutually exclusive or that they took place one after the other in a linear and mechanical manner. Those practices in fact overlap, merge, conflate, and mix with one another. They can be found in the present, retraced in the past. The idea is that while those practices present discrepancies and ruptures over time as well as continuity and persistency, they appear as social evidence and constitute the everyday life.

[15] The term complexity is used here not in the sense of being "difficult to understand" or complicated, but in the sense of the interaction between different objects, themes, spaces that are represented as being distinct, but that, in fact, produce order and meaning (Morin and Le Moigne 1999; Morim, 2004).

[16] In these studies, space and territory get the function of a line of hygiene where the separation/distinction between the healthy and the pathological can be made (Hooker 2006: 189; Bashford 2001, 2004; Convery, Welshman and Bashford 2006: 97). When associated with the modern conception of the border, it is its biological aspect that is revealed, providing it with a "hygienic containment" role (Shildrick 2001).

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