

**In Isolation No More:  
The Need for Human Rights-Based Frameworks for  
Global Health Emergencies**

Noelle Jaipaul

Graduate School of Public and International Affairs, University of Ottawa

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**ABSTRACT**

Ebola has taken the lives of over 11,000 people since the beginning of the outbreak in 2014. Observers including Médecins Sans Frontières have criticized the international community's sluggishness in addressing the outbreak. This paper argues that the reticence of the international community to address the Ebola crisis is a result of the dominant use of a securitization framework that compels states to neglect their legal and moral duties to the global community. The securitization framework obfuscates the innate right to health of every individual. I argue that a human rights-based framework should be employed to effectively motivate states to fulfill their duties to respond to global health emergencies and to devise strategies to prevent outbreaks from occurring. A human rights-based framework can successfully prompt states to fulfill their responsibility to secure the human right to health of citizens and non-citizens. Moreover, a human rights framework will work to address global power differentials that result in the inequitable distribution of resources that contributes to ill health and the spread of infectious disease.

*Keywords: human rights; securitization; infectious disease; Ebola epidemic; frameworks; global health; inequality*

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## **INTRODUCTION**

In 2014, the world saw the largest outbreak of Ebola since the discovery of the virus in 1976. While not the most deadly or far-reaching epidemic in the world's history, the outbreak nonetheless has proved fatal to over 11,000 people in the region of West Africa, along with one death in the United States (United States Centers for Disease Control and Prevention [US CDC] 2015). Guinea, Sierra Leone, and Liberia have experienced the worst of the epidemic with a significant toll on human life, the economy, and the stability of these nations. While the World Health Organization (WHO) declared Liberia Ebola-free on May 9, at the time of writing the infection rate has spiked yet again in Sierra Leone and Guinea, with several cases also emerging again in Liberia.

Many observers, including Médecins Sans Frontières (MSF), claim that the international response to the outbreak has been lacking in its timeliness and efficacy (Sun 2014; Médecins Sans Frontières [MSF] 2015). It is clear that a better system for responding to health emergencies such as the Ebola epidemic is needed; however, there must be impetus for states and non-state organizations to act, not only in response to a health emergency, but also to be proactive in developing systems that are able to contain or prevent outbreaks such as these.

The capacity of the disease to spread to other countries, and to other continents, demonstrates that communicable diseases such as Ebola do not respect the supposed sanctity of national borders. People are able to move more quickly than before across borders and around the world, and with them, they carry the risk of transporting infectious

diseases. The traditional response of governments has been to monitor and close borders, enforce quarantine, and restrict the movement of non-citizens into state territory. While these methods are widely employed, they are not the most effective way to prevent or halt the spread of infectious disease. These actions represent a securitization of global health, a reactionary response to health and illness that focuses on responding to health emergencies after outbreaks initially occur, rather than setting the stage for protecting and promoting health and health care infrastructure prior to an initiating incident. The securitization of health emphasizes disease as a threat to national security. While this is not seen on the surface as being detrimental to health, it neglects the human rights discourse intrinsic to global health. Additionally, the securitization of health works to support and sustain power imbalances on an international scale that in turn lead to ill health and poor management of disease outbreaks. Although national security has been widely employed as a framework for contextualizing and justifying state responses to global health emergencies, it has resulted in isolationist and insulated responses that deny the universality of the human right to health. In turn, this serves to absolve states of any associated moral imperative to ensure that the rights for citizens and non-citizens are safeguarded. By situating health within a human rights framework, we can instead shift to a broader conceptualization of health and wellness that protects health without the impetus of a disease outbreak and emphasizes the need for states to readjust structural forces to ensure that access to health is equitable and universal.

Health is a human right guaranteed to all people, entrenched in the Universal Declaration of Human Rights, the charter of the WHO, and the International Covenant on Economic, Social and Cultural Rights (ICESCR). In this paper, I will argue that by employing

a human rights framework to understand and address global health, the international community can better manage infectious disease outbreaks and emergencies. I will argue that through conceptualizing health within a human rights framework, states are able to recognize their legal obligations to uphold the human right to health, and are sufficiently compelled to assist in building the capacity of health infrastructure in developing nations in addition to contributing resources and knowledge to health missions in times of global health emergencies. Further, within a human rights framework, global inequalities that are ignored under the securitization framework can be scrutinized and altered in order to mitigate power imbalances in the global health arena.

In chapter one, the background of the Ebola outbreak will be outlined, highlighting the epidemiology, current course of the disease, and the ways in which globalization has allowed for Ebola to affect people beyond the borders of West Africa. The increased ability for diseases to traverse across continents has resulted in nation states everywhere being at risk for infectious disease, and has necessitated that states create public policy responses to disease outbreaks. Governments create public policy with the use of frameworks, in order to contextualize, explain, and legitimate their particular policies.

Chapter two will argue that a human rights framework can actually improve equitable and efficient outcomes of health policies within a state and on an international scale. I will outline the current international protocol that entrenches health as a human right as a formal legal convention. I will then explore the responsibility of the global community in safeguarding the right to health for those around the world, and the negative duties of states to desist from inequitable global institutions that contribute to ill health.

In chapter three, I will investigate the framework of securitization in the context of global health. I will begin with an analysis of the rationale for the securitization of disease. While the process has been over a century in the making, the current dominance of the security framework can be attributed to the quest for the reassertion of state sovereignty. Next, I will argue that the securitization framework has dire shortcomings that actually impede the ability for controlling infectious disease. Securitization compels states to focus inwards, enabling states to neglect their legal and moral obligations to protect the human right to health in a global context. This occurs at the cost of a broader vision, one which seeks to address the global inequality that underpins inadequate health infrastructure and resources. Additionally, the use of the securitization framework skews the attention paid to infectious disease to focus disproportionately on diseases that are deemed a security threat by, and for, the Global North. This results in the neglecting of infectious diseases that have a higher mortality and morbidity, serving to dictate global health priorities that run counter to the needs of countries in the Global South and to further cement inequitable power distributions. The securitization framework also leads to the potential for states to unduly implement restrictions that are antithetical to human rights, couched in the language of national security that prioritizes state concerns over the protection of rights. While travel restrictions and quarantines may be seen as necessary, they also facilitate a broader discourse of exclusion, discrimination, and xenophobia. For each of these shortcomings of the securitization framework, I will provide an analysis of how a human rights framework can mitigate these problems and serve to improve the response to infectious disease outbreaks and global health more generally.

## **CHAPTER 1: BACKGROUND OF THE EBOLA OUTBREAK**

### **The Characteristics of Ebola and the 2014 Outbreak**

The Ebola virus was first discovered in 1976 in the Sudan and present-day Democratic Republic of the Congo. During that year, the epidemic killed over 560 people before abating. After this occurrence, Ebola was not again seen until 1994. Between 1994 and 2012, outbreaks occurred in Gabon, Uganda, Cote d'Ivoire, and again in Democratic Republic of the Congo and the Sudan. Prior to the 2014 epidemic, there were 1590 documented deaths between 1976 and 2012 in over 20 different outbreaks across central Africa (UK Public Health England 2015). These past outbreaks were generally short in duration, confined to one state, and had a low death toll. The outbreak in 2014, however, proved to be much more severe, with higher human, economic, and health costs and causing significant alarm across the globe.

Ebola virus is classified into five species, three of which (Zaire, Sudan, and Bundibugyo) are associated with the Ebola hemorrhagic fever and a mortality rate of up to 90%. The Tai Forest species, also known as Cote d'Ivoire species, has been detected in only one case of infection with no casualty, and the Reston species has no identifiable symptoms in humans. For the purposes of this paper, the reference to Ebola Virus Disease (EVD) will refer to any case of Zaire, Sudan, or Bundibugyo species. The natural reservoir of Ebola is unknown, and both animals and humans face potential fatality when infected. Incubation period can range from 2 to 21 days, and the initial or prodromal phase of symptoms in humans includes the sudden onset of fever, headaches, joint and muscle pain, and intense weakness. The second phase is characterized by the malfunctioning of internal organs, and includes diarrhea, nausea, vomiting, loss of appetite, and other problems of the vascular,

neurological, and respiratory systems. Hemorrhagic symptoms develop in over 50% of patients and include internal and external bleeding and hemorrhaging. Ebola hemorrhagic fever will result in fatality in anywhere between 50-90% of cases (UK Public Health England 2015; European Centre for Disease Prevention and Control [ECDC] 2015).

The high fatality rate is even more alarming when considered in combination with the highly infectious nature of the disease. Ebola is transmitted by direct contact with the organs and bodily fluids of infected persons, as well as through handling infected animals. Family members or friends of infected persons are at risk through contact with both the living and deceased, including during burial procedures and handling contaminated clothing or linens. Healthcare professionals are especially at risk due to their close contact with patients, and the need to perform invasive procedures on those infected. Healthcare professionals are required to follow quarantine protocol, which includes wearing masks, gloves, and gowns. There is no cure for Ebola and there are currently no vaccines; however, there are vaccines currently in clinical trials and complementary treatments such as convalescent plasma trials underway (ECDC 2015). As such, without medical therapy as an option, states must seek to prevent initial infection of the disease and containment of any infections that do occur. While this can be done within a security framework, prevention is nonetheless better achieved within a human rights framework. Securitization views prevention myopically, focused on reducing prevalence and incidence in a state's own population. Within a human rights framework, prevention is more widely understood as requiring global effort, seeking to address those issues that contribute to outbreaks. This includes enhanced health infrastructure and resources, and a broad acknowledgement that global health is only as strong as its weakest link. Human rights shift the focus away from

preventing the death of citizens to instead focus on preventing the conditions in which infectious disease thrives. This will be discussed in more detail subsequently.

The first cases of the outbreak occurred in Guinea in December 2013. On March 22, 2014, the Ministry of Health in Guinea notified the WHO of an evolving Ebola outbreak, which by that point had caused 29 deaths out of 49 cases (WHO 2015a; ECDC 2015). In May 2014, cases were reported in Sierra Leone, indicating that the virus had spread, likely through the movement of infected people. The disease then spread further to Nigeria, Mali, Senegal, the United Kingdom, the United States, and Spain. By September 23, 2014, six months after the first cases were reported to the WHO, the doubling time of the epidemic in Guinea was estimated at 15.7 days (WHO Ebola Response Team 2014). By now, the epidemic was recognized as having far greater spread and fatalities than all of the previous Ebola epidemics combined. National governments undertook mandatory screenings of visitors at border crossings, quarantines of suspected infectious patients, and even travel bans on travellers coming from the affected regions. Liberia and Sierra Leone imposed curfews in an attempt to contain the disease and decrease the risk of contagion.

While the outbreak in Liberia was declared as terminated by May 9, 2015, as of May 17 a resurgence of the epidemic had occurred in Guinea and Sierra Leone, with a significantly increased caseload from the previous week. Dismayingly, new cases of Ebola occurred in Liberia in late June, causing concern of a new outbreak (BBC News 2015). As of July 19, there have been a total of 27,706 reported cases of EVD in Guinea, Sierra Leone, and Liberia, and 11,269 deaths (US CDC 2015). It is thought that this caseload is an underrepresentation, as there have almost certainly been occurrences of underreporting of

cases, misdiagnosis, or comorbidities that are inaccurately listed as the cause of death (MSF 2015).

### **The Movement of Disease**

In the case of EVD and other highly infectious diseases, the severity of an outbreak becomes amplified when the disease is able to move quickly, from rural to urban settings, across borders, and to distant continents. The increased movement of people, commodities and ideas that is resultant of globalization has had reverberating effects on health. This increased mobility has affected the existence and transmission of both health and disease in the world. In the context of the Ebola epidemic in particular, and its ability to spread rapidly, globalization is helpfully conceptualized as the “compression of time and space, the increased interconnectivity of human groups, [and] the increased volume of the exchange of commodities, people and ideas” (Turner 2010, 5). People are able to traverse large distances in a short period of time, come in contact with people beyond their own borders, and act as vehicles for disease to parts of the world that otherwise would not encounter a particular illness. In the case of Ebola, the virus had never before been reported in West Africa prior to the 2014 outbreak. While the reservoir of the initial case in Guinea is unknown, in a matter of four months, Ebola had travelled to Liberia and Sierra Leone via the relatively porous borders between the nations. By the end of July 2014, the first cases were reported in Nigeria, and were traced to a single man who had arrived in the country via air travel. The alacrity and indiscrimination with which infectious disease can penetrate borders has been recognized by the Institute of Medicine, which stated that, “in the context

of infectious diseases, there is nowhere in the world from which we are remote and no one from whom we are disconnected” (Institute of Medicine 1992, v).

Globalization has allowed for previously relatively secluded viruses to appear in populations that are geographically distant from disease reservoirs, with a subsequent increase in the global incidence. In addition to the ability of people, and thus disease, to travel around the world, globalization has also resulted in demographic changes that create proximity with which disease is easily transmitted, namely in the increased tempo of urbanization and the sustained density growth of urban environments. A large reason for the rapid spread of EVD in Guinea was due to initial cases occurring in urban centres, allowing for the transmission of the disease in public spaces frequented by many people.

Infectious disease is irreverent of geography and borders. Ebola is not unique in its inattention to claims of national territoriality, as dispersion of disease was also seen in the SARS crisis of 2003 that began in Hong Kong, spread to 29 countries, and killed more than 900 people (Pirages and Runci 2007; PubMed Health n.d.). HIV/AIDS is an epidemic that has left no country in the world untouched, and has infected around 75 million people worldwide since the beginning of the epidemic in the 1980s (UN Joint Programme on HIV/AIDS n.d.). While many biological, political, geographical, and economic factors affect the transmission of communicable disease, the increased mobility of people in particular has contributed to the presence of illnesses in states far away from initial outbreaks, and in many instances, with no previous record of those diseases. Communicable diseases cannot be stopped by national borders, and present a challenge to all national governments. The recognition by states that health and illness are no longer isolated within countries, but exist as transborder phenomena, has spurred cooperation between states on issues of

global health. Global health focuses on addressing these health burdens that are international and interconnected, and require responses that must involve a variety of actors, including national and international organizations.

### **Framing Disease in Public Policy**

Governments around the world must implement policy to respond timely and effectively to infectious disease that may imminently spread into their state. Yet, there is no singular prescription to prevent the spread of disease across porous borders. Policy makers within states are required to respond to pressing issues, and in order to do so, they must first identify the particular problem that necessitates a policy response. In order to engage with policy issues, policy makers routinely rely on the use of framing. Frameworks allow for the construction of a specific issue through particular ideational and constructed words, themes, and values in order to influence the ways in which the problem is understood, discussed, and resolved (McInnes et al. 2015). The policy issues and their accordant prescriptions are situated within a particular framework, selected implicitly or explicitly by policy makers. The framework can be a conscious choice by national legislators, but can also be the result of pressure from advocacy or lobby groups, international organizations, or a shifting of frameworks in discourse at regional, national, or international levels.

The use of framing in public policy ensures that certain elements of the issue are highlighted and memorable, while other elements are omitted, thereby increasing the salience and legitimacy of a particular policy position (Entman 1993; Edelman 1993). Framing policy arguments in a specific way allows decision makers to exert power over

those receiving information, through the inclusion and exclusion of particular policy positions. The frameworks used to present health issues can function to alter the way the problem is understood, and correspondingly, the policy responses that are deployed.

Common discourses of global health use a variety of frameworks in which to situate and discuss the issues, and in turn, to influence opinions. Most commonly, global health is discussed within the frameworks of security, economics, development, and human rights (Labonté 2014; Bustreo and Doebbler 2010; McInnes et al. 2015). While each of these frameworks operates under the imperative to solve a policy dilemma, it is outside the scope of this paper to discuss all of them in detail. Instead, I will focus on the emphasis that is currently placed on the security framing of health, despite the inability of a securitization framework to effectively provide long-term solutions to global health dilemmas. While the security framing of global health, and specifically, the Ebola crisis, has been widely employed, it is nonetheless a lacking discourse. As will be discussed, security frameworks necessitate isolationist policy responses that focus on a nation's internal security, rather than addressing a global problem that requires global action and cooperation. The security framework becomes problematic when nations and international organizations tend towards policies that insulate national populations within borders, overemphasize the risk level of particular diseases, and unduly call for the suspension of other rights in the name of national security.

Indeed, the current discourse surrounding the Ebola crisis is an example of the ways in which infectious disease has been securitized and conceptualized as a demonstrable 'threat' against citizens of a particular nation-state, against which defensive measures must be taken. To use a comparison, Ebola and influenza have both been subjectively framed as

security risks, resulting in national governments implementing policies and solutions that are also situated within a security framework. The securitization of Ebola can be likened to the cases of pandemic influenza and SARS due to the way in which “preparedness, planning and policies [are] driven by national priorities and not the need for a coherent global public health response” (Kamradt-Scott and McInnes 2015, 25). Kamradt-Scott and McInnes (2015) argue that pandemic influenza has, over the past two decades, shifted from being framed as a health hazard to being framed instead as a security threat. The authors contend that influenza and other infectious diseases are not inherently threats to security, but rather, that they become security threats through the act of framing them as such.

The influenza pandemic of 1918 was a defining moment in the conceptualization of disease and illness in the contemporary narrative of security. Partially, this was due to the pandemic’s extensive toll on human life, which caused many to consider infectious disease to be as fatal as war itself. The creation of specialized research divisions for vaccination and curatives following the First World War saw a continuation of post-war discourse of influenza as a threat, and helped to cement the ideas of disease prevention as “fundamentally related to national security and wellbeing” (Mudd qtd. in Kamradt-Scott and McInnes 2015, 16). Following the outbreaks of influenza pandemics throughout the second half of the 20<sup>th</sup> century, there was a resurgence in the construction of infectious disease as a threat to security. Amidst a climate of Cold War politics and the threat of nuclear war, security was a widely employed framework, and was able to pervade other fields of policy, including health policy. During the 1997 H5N1 outbreak and the 2003 SARS outbreak, the security framework gained additional gravity, with notable policy elites, health practitioners, academics, and even institutions adopting and reinforcing the

ideational frameworks of securitization. By the 21<sup>st</sup> century, the narrative framework of infectious disease as a threat to security was widespread and commonplace.

In the case of pandemic influenza, and as is being seen in the case of Ebola, the disease was framed “as an existential threat requiring emergency action” (Kamradt-Scott and McInnes 2015, 17). Yet, the use of the security framework is not the only context within which to conceptualize global health issues and infectious disease. A human rights framework can be used to more effectively respond to pressing contemporary health issues, and finds its justification in the duty of states not only to their citizens, but also to the broader global community. The next chapter will explore health as a human right, and argue that the international community does in fact have a duty to ensure the human rights of others if a state itself cannot provide the appropriate environment for individuals to actualize their human right to health.

## **CHAPTER TWO: EMPLOYING A HUMAN RIGHTS-BASED FRAMEWORK**

### **Health as a Human Right: International Protocol**

The Ebola outbreak remains ongoing, with surges in the number of cases having recently occurred in Sierra Leone and Guinea, and a reappearance of the disease in Liberia. Médecins Sans Frontières and other observers have contended that if a similar outbreak were to occur again, the world would be no better prepared to handle it (MSF 2015; Woolf 2014). It is clear that a more robust and effective system is needed in order to respond to infectious disease outbreaks such as Ebola. Further, states and the international community must develop a strategy for proactively establishing strong health infrastructure in order to prevent outbreaks from turning into global pandemics in the first place. By using a human rights framework, both of these objectives can be achieved. This chapter will begin with an exploration of the international statutes that provide the legal basis for the human right to health. Secondly, I will describe the moral importance of good health in a population and its influence on individual and societal wellbeing. I will then discuss the ethical and moral obligations of states to those beyond their borders, in line with the state's negative duties to refrain from harming others, particularly in the context of inequitable distributions of power at the international level.

Human rights and their various instruments and doctrines are aimed at promoting human wellbeing, the dignity and equality of all people, and social progress towards better standards of life. The Universal Declaration of Human Rights (UDHR) is the most well-recognized formal codification of human rights, and national governments around the world have adopted tenets of the UDHR within their national constitutions, as well as signed and ratified numerous treaties, covenants, and conventions that uphold human

rights. Specifically in the context of health, the UDHR affirms the right of individuals to good health, in that “everyone has the right to a standard of living adequate for the health and wellbeing of [themselves], including food, clothing, housing and medical care and necessary social services” (United Nations General Assembly 1948, Article 25). Further, the WHO’s constitution conforms to the assertion of health as a human right, stating, “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition” (WHO 1946, Preamble).

These two international statutes were drafted over 60 years ago, yet the commitment of the international community to health as a human right has been reiterated time and again. Moreover, the fairly ambiguous call for health as a human right within the UDHR was clarified in no uncertain terms within both the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR), and the 1978 Declaration of Alma-Ata. Article 12 of the ICESCR affirms that “the States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health... [including] the prevention, treatment and control of epidemic [and] endemic... diseases” (United Nations Economic and Social Council 2000, Article 12). Importantly, in addition to reaffirming health as a human right, the Declaration of Alma-Ata defined health as “a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity” (WHO 1978, Article 1). The Declaration of Alma-Ata saw health as a worldwide social goal that, like illness, must be of concern to all nations and requires commitment and cooperation on a global scale.

It is important to note that these assertions that humans have an inalienable right to the highest attainable standard of health are not absolutely legally guaranteed. The UDHR is not legally binding, and likewise, the WHO constitution is not enforceable by law. However, it remains that states have indeed ratified or become signatories to these statutes, and in doing so, have conferred legitimacy onto them. Through this legitimacy, states have signaled their agreement with the content of the UDHR and the WHO's mandate. Further, national governments have used the UDHR as a basic guide for drafting their own national constitutions, within them entrenching political, social, and economic rights (International Federation of the Red Cross and Crescent Societies and François-Xavier Bagnoud Center for Health and Human Rights). For instance, the Canadian Charter of Rights and Freedoms (1982) guarantees the "right to life, liberty and security of the person" (Article 7). The right to security of the person includes the right of a Canadian citizen to be free from serious physical or psychological harm, and moreover, the right to physical and psychological wellbeing. Again, the right to health indicates not only being free from disease or illness, but also being entitled to health and wellbeing, as was affirmed in the Declaration of Alma-Ata.

### **The Moral Importance of Good Health**

While the UDHR and the WHO constitution do not serve as legal constraints on nations, the ICESCR, as a covenant, is legally binding to all 164 states that are signatories. The ICESCR is therefore a legal instrument that, at least in theory, compels states to commit to guaranteeing the rights contained within the ICESCR (Wolff 2012b). Indeed, research has shown that signatories to ICESCR are more likely to incorporate rights to health into their

constitutions, especially in developing countries (Cole 2013). Yet, it would be imprudent to contend that simply being a signatory to the ICESCR necessarily results in the immediate and unwavering upholding of those rights. Indeed, the same research by Cole (2013) indicates that within national constitutions, social and economic rights, including the right to health, “are formulated in purely aspirational [that is,] non-enforceable, terms”, and that the promise of these rights does not in fact lead to their provision (166). Moreover, pursuing litigation to assure the right to health is hardly a practical option for most citizens, and health care professionals and policy makers themselves either are unaware of the legal gravitas of the covenant, or are unwilling to hold themselves accountable (Wolff 2012b; Bustreo and Doebbler 2010). It is clear that we cannot rely solely on juridical tools like the ICESCR as the only way to compel states to protect the right to health.

Rather, there must be a deeper emphasis on the moral importance of health. This includes recognizing the ways in which health is innately valuable and the imperative to secure health as a human right in order to promote social progress and equality of people. An emphasis on the moral importance of health reflects the value that health lays “the foundation for realizing physical, mental, and social wellbeing”, transcending into other facets of life and society (Mann et al. 1999, 16). The underlying vision of the right to health is to create systems and structures that promote the wellbeing of individuals, and by doing so, contribute to functioning, healthy societies in the broadest sense.

Barriers to achieving one’s optimal functioning can be easily observed in the linkages between health and human rights. In a very linear illustration, the abuse of human rights through torture, incarceration, or wartime trauma can have ill effects on health. This can be expanded to include examples such as occupational hazards associated with

unfavorable or unjust workplace conditions (Mann et al. 1999). Yet, there are more subtle conditions and circumstances under which human rights and health are intrinsically linked. Institutions or structures that give rise to inequity and disparity can result in the ill health of populations that traditionally wield less power. In a milestone example, the ability of corporations to patent life-saving medications has come under fire as antithetical to the human right to health. The Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) guarantees patent rights to corporations on the medicines they create to treat communicable and non-communicable diseases. The right to patent the medicines can lead to a corporation marking up the price to the extent that it ends up being too expensive for patients to afford, particularly in the Global South (Pogge 2012). The patent laws prevent cheaper, more accessible generic medicines to be available to those who need these life-saving medicines. It is estimated that one-third of the world's population is unable to afford or access basic drugs, and approximately only 10% of people living with HIV/AIDS in the Global South are able to access antiretroviral therapy (Cullet 2003). The TRIPS patent laws illustrate a broader structure that disenfranchises certain segments of the population, and inhibits people from achieving their optimal functioning through the inaccessibility of essential medicines. Indeed, after a significant amount of campaigning by governments of low and middle-income countries, health advocates, and non-governmental organizations, the Decision on the Interpretation of Paragraph 6 of the Doha Declaration conceded provisions for protecting public health by maintaining flexible patent laws. These provisions acknowledged that the patent laws were infringing upon the basic necessities for life, contributing to ill health and death, and thus violating the human right to health.

Ensuring good health, and by extension, the human right to health, is a moral imperative and it is a matter of justice. As stated by Daniels (2008), “failing to promote health in a population, that is, failing to promote normal functioning in it, fails to protect the opportunity or capability of people to function as free and equal citizens. Failing to protect that opportunity... is a failure to provide us with what we owe each other. It is unjust” (14). By promoting physical and mental wellbeing, the right to health ensures that individuals do indeed enjoy equality of opportunity. First conceived of by Rawls, this theorization posits that, “members of a just society should benefit from fair equality of opportunity”, and that a just society would strive to neutralize circumstances in which, despite formal equality of opportunity, inequalities still manifest (Weinstock 2010, 110). Structures within a just society should ensure that all citizens have an ability to achieve their highest potential, such that inequalities do not serve as barriers that disproportionately disadvantage one citizen or group of citizens. Poor health and illness present significant barriers to achieving one’s highest potential.

That ill health poses an obstacle to achieving one’s potential is illustrated very clearly in the case of Ebola. The diagnosis of the disease, which in the outbreak had a mortality rate of between 50% and 90%, greatly impeded the ability of the infected person to live their life fully. Especially given the highly contagious nature of the disease, the illness does not just prevent a person from achieving her or his highest potential, it even prevents one from the simple daily activities of life, such as going to work and caring for loved ones. Further, even those unaffected by the disease but living within affected areas are not capable of fulfilling their highest potential. Limited health resources are diverted away from more common, yet still urgent, public health concerns such as pregnancy and

labour, chronic diseases, and other illnesses that require immediate medical attention such as tuberculosis and malaria (MSF 2015).

The role of states in providing their citizens with the appropriate health policies and tools for equality of opportunity is rooted in the tenets of justice and an inalienable right to health. Yet, despite the inherence of this right, thousands of people died, and continue to die, during the Ebola outbreak. In the next section, I will argue that while this is a failure on the part of the states themselves to contain the disease within their borders, it also constitutes a failure on the part of the international community.

### **The Duty of the Global Community**

Human rights, by their definition, are not confined to a particular citizenship. Nor are they limited to a specific race, gender, or ethnicity, and they make no differentiation between abilities, religions, or class. Human rights are universal – they are guaranteed to everyone, and as such, this predicates the need for an agent to uphold rights, with the state normally acting as that guarantor. Yet, it is clear that not all states uphold rights in a manner that corresponds to the universality of that right. Part of the power of human rights, though, lies in the ability for an individual or group to lay claim to their rights by appealing to the broader global community if his or her state is unable to uphold them to a universal standard. Human rights in a global schema protect against the ability of a state to control or exert force over their own citizens. As Wolff (2012a) states, human rights provide a type of security in which “a citizen can appeal to the world community in disputes with his or her government” (219). Thus, global health requires a commitment not

only from a national government to its citizens, but from governments to the broader global citizenry. As stated by Charles Malik, a drafter of the UDHR, a person “can agitate against [their] government, and if she does not fulfill her pledge, [one] shall have and feel the moral support of the world” (as qtd. in Wolff 2012b, 17).

In the case of Ebola, the worst-affected countries of Liberia, Sierra Leone, and Guinea lack the necessary resources to contain the disease on their own. Medical personnel are lacking, as are skilled personnel to assist with engaging the community in infection control practices. There is insufficient infrastructure such as laboratories and surveillance systems (WHO 2014). In addition to these immediately observable shortcomings of the state to protect the right to health, the inability of these states to secure a standard of health is also apparent in more embedded and latent ways. The inability of these states to successfully control the virus on their own has been linked back to lacking health care infrastructure that is a coalescence of the effects of poverty and civil war (Buseh, Stevens, Bromberg, and Kelber 2015). As an example, Beyrer (2003) argues that Charles Taylor’s bloody presidency in Liberia (1997-2003), and his stoking of civil unrest in Sierra Leone, is evidence that “the health and wellbeing of the citizenry was not of primary concern to the state” (29). In the aftermath of Taylor’s rule, health care infrastructure, including health care workers, research capacity, and hospitals and clinics, remained hollow and decimated and had not yet recovered to cope with the Ebola outbreak in 2014. Within the affected West African countries, the extant health infrastructure was, and remains, woefully inadequate to attend to not only the demands of an EVD outbreak, but also to the broader health needs of the population. This represents the states’ incapacity to provide their

citizens with equality of opportunity within the context of the highest attainable standard of health.

The inability of the state to provide an environment within which the health of its citizens could be guaranteed constitutes a failure on the state's part to secure the human right to health. It is in this situation that the responsibility of the international community becomes apparent. The duty of the international community to act in instances where a state neglects the health of its citizens has been clearly articulated by the Committee on Economic, Social, and Cultural Rights in General Comment 14. The Committee formally recognized the international obligations associated with the human right to health. Very clearly stated, the Committee acknowledged that,

*“State parties should recognize the essential role of international cooperation and comply with their commitment to take joint and separate action to achieve the full realization of the right to health. In this regard, States parties are referred to the Alma-Ata Declaration which proclaims that the existing gross inequality in the health status of the people, particularly between developed and developing countries, as well as within countries, is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.”* (United Nations Economic and Social Council 2000, Article 38).

Within a rights-based idea of justice, states have both positive and negative duties to one another in order to adhere to the protection of human rights. Negative duties require the actor to refrain from action that would cause harm to another, while positive duties

require the actor to ensure that they do not actively engage in circumstances where human rights abuses occur (Pogge 2005). For Pogge (2005), imposing or tacitly abiding by an institutional order that puts others in a worse off position, that is, harms others, is a violation of negative duties. Further, he argues that, “by shaping and enforcing the social conditions that foreseeably and avoidably cause the monumental suffering of global poverty, we are harming the global poor” (33). Pogge argues that a common historical process has resulted in international inequality and power imbalances. Stronger powers in the international sphere have perpetuated these imbalances through the destruction of political institutions and cultures within weaker powers. This has had reverberating effects into health care and infrastructure, as well as education, legal systems, and political organization (Pogge 2005, 38). This has also resulted in the continual and coercive exclusion of the global poor from accessing resources that would provide restitution, or assist in rebuilding infrastructure that would contribute to rebalancing equality of opportunity on a global scale.

The international systems and historical processes that have resulted in poverty and inadequate state resources and infrastructure have played a large role in contributing to the harm associated with the deprivation of the right to health. We can consider the social determinants of health as markers of the ability of a population to achieve good health (Birn 2011). These are the social, economic, and political factors that overlap and interact in order to contribute to and affect health outcomes. A lack of resources at the state level leads to a deficiency of state-provided infrastructure that confers good health through meeting requirements for social determinants of health. This includes education, child and maternal health programs, clean water and sanitation, appropriate housing, food security,

and employment security. Many of the determinants that are underprovided or denied have been in part due to the economic and political interests of richer nations (Benatar, Daar, and Singer 2003). In the context of global justice, these determinants have been altered and negatively impacted by imbalanced power structures that exist internationally. Yet, while poverty leads to the weakness and ineptness of health infrastructure, to merely increase the funding to poorer nations to improve population health is oversimplified. This would neglect the historical and structural underpinnings of the global system, and would leave intact the imbalances in power at the international level (Birn 2011; Wolff 2012b). Instead, in order to address the poverty that in turn fosters human rights abuses, including the violation of the right to health, it is “essential to modify the upstream forces, including the rules [of] global governance that fail to alleviate poverty and improve institutional capacity in poor nations” (Benatar, Lister, and Thacker 2010, 148). Included in this is the institutional capacity for a functioning and responsive health system that requires technical assistance, equitable distribution of resources, and a reimagining of global power structures as opposed to simply development aid and financing.

At the beginning of the Ebola outbreak, states were not necessarily breaking their positive duties, as they were not actively contributing to the spread of the outbreak. However, the inability of the health care infrastructure in West Africa to attend to the dire needs during the outbreak has been attributed to global poverty and those institutions that perpetuate disparities between rich and poor nations. Further, it can be argued that after the initial outbreak occurred, states did not act to secure the human right to health of those living in the affected regions, thus violating their positive duty to protect human rights. MSF (2015) stated that despite their warning that the epidemic was burgeoning and

they were unable to control it on their own, the warning was dismissed by national governments as well as the WHO. MSF contends that when the warning was given to the international community in June 2014, the outbreak could have been controlled had action been taken immediately, yet no support was provided. The WHO Ebola Interim Assessment Panel (2015b) has admitted to this misstep, albeit with no justification or explanation, stating, “it is still unclear to the Panel why early warnings... did not result in an effective and adequate response” (4). The continual reticence of the global community to dedicate resources led MSF to label the response a “global coalition for inaction” (MSF 2015, 8). Upon learning of the severity of the outbreak, the global community had a duty to safeguard the health of those affected, yet violated that duty through neglecting to take action.

Countries that suffer from weak governance or lack of resources, and as a result, insubstantial health infrastructure, are unable to respond with the necessary resources and expertise to an outbreak like Ebola. In wealthier nations, the capacity exists to monitor and respond to new cases of Ebola, thus eliminating a real threat of a disastrous outbreak occurring in a country like Canada to the same extent that it has occurred in Guinea, Sierra Leone, or Liberia (Price-Smith 1999; Elbe 2010). Within the post-civil war environment of Liberia and Sierra Leone, poverty and weak governance and infrastructure led to the spreading of the disease much faster and easier than in a country with strong health systems and extensive resources. This inequality of opportunity, when extended to global justice, requires that wealthier and more powerful nations have a duty to the citizens of other states when their human rights are violated, which is at least partially the result of processes for which wealthy nations are largely responsible.

The human right to health denotes a universal standard, applicable to all people, regardless of their residence in a poor or rich country. In other words, there exists a “universal moral standing for all humans regardless of where they live, and the demands of justice apply at the global, national, and local level” (Ruger 2009, 264). Human rights are not goals, but are mandatory norms, justified for implementation around the world. As such, they apply regardless of a nation’s gross domestic product or ability of implementation at the present time. Nickel (2007) contends that national governments do have a responsibility to, in good faith, do their best to provide for the environments in which the human rights of their populations can be secured. Yet, if they are genuinely unable to do so, they are temporarily excused from their duty. In these cases, rather than the rights being rendered irrelevant, the international community has the secondary responsibility to provide meaningful assistance. Simply because there are limited enforcement mechanisms to ensure that states uphold the rights of non-citizens is not reason enough to deny the duty of the international community. Further, Nickel (2007) argues that citizens share in the duties of their government, especially in the case of democratic countries in which citizens are the principal source of political authority. Just as governments must guarantee human rights, so too do citizens have a duty to promote or act in compliance with human rights. Thus, Nickel argues that citizens share the responsibility for ensuring that the actions of their own government do not encroach on the rights of non-citizens, and moreover, that they do not tacitly support structures that violate those rights. In essence, states have a legal and moral responsibility to ensure the health of their own citizens. Yet, a state’s inability to ensure the health of its own citizens does not inevitably lead to the eradication of those citizens’ claim to health. Wealthy

nations have a secondary responsibility to assist in promoting the health of non-citizens, as historical and structural forces have put them in a position of privilege such that they have a negative duty to disrupt these forces of inequality. Moreover, citizens of these wealthier nations must act as a compass for their governments, individually taking responsibility and holding their leaders to account in an appeal for the recognition of human rights across borders.

### CHAPTER 3: EMPLOYING A SECURITY FRAMEWORK FOR DISEASE

The 2014 Ebola outbreak was surely devastating, and remains so for many in West Africa, as the virus has not yet, at the time of writing, been contained in Sierra Leone and Guinea, and several new cases have surfaced in Liberia, even after the country had been declared Ebola free (BBC News 2015). The outbreak has taken over 11,000 lives and generated ample confusion and fear both in West Africa and abroad. Much of the mainstream media's portrayal of the outbreak did little to allay fears or contribute to a feeling of calm. Headlines like "Horror in Sierra Leone"<sup>1</sup> and "Ebola Outbreak 2014: The Terrifying Statistics You Need to See"<sup>2</sup> and even "Jihadists Send 'Vial of Ebola' to Newspaper"<sup>3</sup> insisted that Ebola was a very real, very harmful threat. While it is not in the scope of this paper to analyze the media involvement or influence on the common perceptions of the disease, it can be said that it reflected a broader international discourse of Ebola as a significant threat. The outbreak, along with the response measures taken by states, has been situated within a security framework.

The question remains of why states continue to use a security framework. This chapter will begin with an exploration of the rationale behind the use of a security framework for global health issues. Next, I will argue that despite the alleged advantages, it nonetheless remains that it is not a sufficient framework for effectively addressing global health emergencies. A focus on security leads to isolationist policies that do not work to inhibit the spread of disease, but rather cause states to ignore their legal obligations and their moral duties to the international community. Further, the security framework

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<sup>1</sup> From NBC News, written by Maggie Fox, December 2014.

<sup>2</sup> From news.com.au, October 2014

<sup>3</sup> From New York Post, written by Charis Chang, November 2014

disproportionately focuses on 'dreaded' diseases, while largely ignoring more common diseases that inflict more harm. The disease agenda is set by powerful nations with little regard for the diseases that are more likely to occur in countries in the Global South. Consequently, securitization of disease does little to upset the existing power structures in the international sphere or help to strengthen the health care infrastructure of other nations. Finally, the use of the security framework can compel states to implement policies that further restrict human rights, such as migration control or forced quarantine. This works to normalize harsh state responses, contribute to increased discrimination in segments of the population, and divert resources away from stopping the spread of disease in the Global South.

### **The Rationale for the Securitization of Health**

The current state of global health security can be understood along a continuum of regimes that has seen states interacting on matters of health policy since the mid-1800s. During the period from 1851 to 1892, a number of states attended International Sanitary Conferences, prompted by a series of cholera outbreaks (Hoffman 2010). These conferences set the stage for international health collaboration, as they generated a common discourse on the presence of contagious disease and the common problems affecting states across the world. It is important to note that during this time, states' collaboration was predicated on the inability of any individual state to successfully contain infectious disease, as there was a lack of "political and institutional public health architecture that could deal with the spread of infectious diseases across borders" (Elbe 2012, 81). Following this regime, the period from 1892-1946 ushered in a new and even

stronger internationalism within which to discuss and engage with global health. This regime brought with it legal conventions, international structures, and formal diplomacy to address contagious disease. This period was a time in which infectious disease was a very pressing and existential threat to livelihood. In an era with limited medical capacities for preventing or treating infectious disease, and very rudimentary surveillance and monitoring systems, any sort of contagion could eliminate a large portion of a state's population. This was clearly illustrated in the 1918 Spanish influenza epidemic. Occurring amidst the backdrop of World War I, the pandemic is said to have contributed to the defeat of Austria and Germany, as the disease decimated their troops and citizens (Elbe 2010; Kamradt-Scott and McInnes 2015). The stark reality of the disease being able to kill as effectively as the war itself promoted the discourse that contagious disease could be equated to violent wartime peril. This era set the stage for the contemporary framing of the securitization of health.

Later on, HIV/AIDS played an important role in reinvigorating the discourse of pandemics as security threats. As the HIV/AIDS pandemic rapidly grew and gained more recognition through the 1980s and 1990s, it was seen that the disease had a high prevalence rate in armed forces and populations affected by violence, and more generally an effect on the stability of fragile states (Elbe 2011). HIV/AIDS infection was seen as a threat as real as the approach of an army, able to contribute to the mortality of a nation, and as a destabilizing force that could affect key facets of the state, including the economy and military. The primary global health governing bodies, the UN and the WHO, both played a role in normalizing and mainstreaming the discourse of securitization of health. In 2000, the UN Security Council declared HIV/AIDS a threat to international peace and

security, thus making it the first disease to ever be qualified in such a way (Selgelid and Enemark 2012). In 2001, the WHO passed a resolution entitled 'Global Health Security: Epidemic Alert and Response'. Since that time, numerous resolutions, initiatives, and policies at the state and global level have adopted the terminology of securitization in the context of health issues.

Another important factor in the appeal of framing health within a broader security mandate is tied to sovereignty. This argument is two-pronged. Firstly, issues of state identity in the post-Cold War era must be investigated, and secondly, the slow waning of the inviolability of state sovereignty has played a role. Following the Cold War and the collapse of the bipolar power balance, states no longer had to focus on the acute threat of nuclear war. States were able to shift focus to those non-military, and thus, non-traditional, threats (Heymann 2003; Abraham 2011; Schell 1997). More attention was paid to internal stability and the factors that could threaten it, including infectious disease, migration, and economic stagnancy. The ability of a state to contend with these often invisible enemies was a testament to the strength of a state, as well as crucial to the credibility of a state to defend its citizens, and in turn, maintain its identity (Campbell 1992; Abraham 2011).

States find identity in their sovereignty, that is, their exclusive claim to territory and the people therein. Increasingly porous borders, the rise of transnational groups, and the emergence of global issues that transcend political borders have led to a transition and attenuation of sovereignty (Cusimano Love 2007). While it is not the intent to debate the current form or strength of sovereignty, it must be acknowledged that changing sovereignty has resulted in changes to the traditional ways in which a state enforces its power and holds exclusive claim over its population and territory. By constructing a

common enemy, be it a non-state terrorist group or the spread of an infectious virus, the state is able to assert its power and authority in protecting its populace. Sovereignty maintains that the state should hold exclusive control over the protection of its people, and infectious disease creates a useful, powerful, and poignant common enemy against which a state can rally. Security threats can be conceptualized relatively clearly with distinctive response measures. Infectious disease in particular can be conceptualized as a clearly defined problem with physical manifestations, and there are definitive steps that political officials can take to control the spread of disease, such as implementing quarantines, border controls, and research and development of vaccinations and remedies (Kamradt-Scott and McInnes 2015). The ability of a state to take actions to defend its borders and territories from the external threat of infectious disease is an assertion of a state's sovereignty.

Indeed, during George W. Bush's presidency, the securitization of infectious disease was made clear through various presidential speeches. Bush deemed the spread of avian and pandemic influenza as a danger to the state, and consequently established both domestic and foreign policy measures to detect, respond to, and monitor outbreaks. The securitization of disease led to the ability of the administration to then implement measures that were well beyond the scope of public health, but rather "were similar to the response to a terrorist attack, or any other national emergency" (Abraham 2011, 800). Thus, by appropriating a securitization framework to respond to infectious disease, the state is able to strategically reassert its authority and power.

State sovereignty and authority, however, is dependent upon a state's ability to execute its duties to its populace. The evolution of sovereignty has seen the redefinition of

state sovereignty informed by “a renewed and spreading consciousness of individual rights”, which places the state at the service of its people, rather than the people at the service of the state (Annan 1999, n.p.) A state must function to protect the individual rights and freedoms of its citizens, and in failing to do so, it foregoes its claim to sovereignty (Steinberg 2013). When a state is unable to protect its citizens, and is unable or unwilling to provide the necessary instruments and institutions to uphold rights and freedoms, a state loses its claim to sovereignty (Mott 2013). In this case, the international community has the ability and responsibility to intervene, such that individual freedoms and rights are upheld. This corresponds to Nickel’s (2007) argument that the international community has a secondary responsibility to ensure the rights of non-citizens. The securitization framework, however, remains ineffective in assuring the human right to health of non-citizens and across borders. The next section will explore the ways in which it is unable to promote health as a human right, and provide examples of how a human rights-based framework can help individual states and the international community mitigate some of these shortcomings in order to better fulfill their duty to protect the human right to health.

### **The Shortcomings of the Securitization Framework**

The framing of infectious disease as a threat to national security has gained it prominence on national and international policy agendas, and at the same time, substantial increased political momentum. National health ministries, research institutes, and health advocacy groups are enlisted in policy planning and are able to provide guidance to political officials on the nature of transmission, symptoms, and sequelae of disease (Abraham 2011; Peterson 2002). In turn, informed by this medical knowledge, policy

makers are able to create policies that seek to contain or prevent the spread of disease within their borders. Medical professionals and advocacy groups have been able to capitalize on the broader discourse of health as an issue of national security. The presence of existential health threats, and the corresponding attention paid by policy makers and political elites, means that a substantial amount of resources are poured into addressing those threats. The essentiality of having non-government stakeholders at the policy table has been elucidated by Yuk-Ping and Thomas (2010), who state that “business groups, civil society organizations and individuals all need to be mobilized to deal with health threats. The omission of any one cohort or the failure of any one cohort to reallocate resources... jeopardizes the effective securitization of the health threat” (450). The prioritization of infectious disease as a key risk to national security has certainly resulted in the mobilization of resources, providing ample opportunities for those involved in global health to gain access to funding, research opportunities, and elite positions, which can be considered the “securitization bonus” of being able to get a particular issue on the national security agenda (Prins 2004, 940). As an example, in 2005 George W. Bush insisted that avian and pandemic influenza posed an imminent danger, and requested US \$7 billion from Congress for pandemic preparedness (Abraham 2011). Yet, despite the increased salience and import of those in the global health field and the increased funding available to respond to pressing health concerns, the securitization of disease has in fact led to many problems that undermine the longer-term project of preventing, containing, and eradicating infectious disease. The effects of securitizing infectious disease are numerous, however in this paper the focus remains on shifting away from a security framework and instead to a human rights framework. Thus, the negative effects of securitization will be

contrasted with the ways in which a human rights framework can minimize or alleviate those negative outcomes.

### **State Insulation and Isolation**

The emphasis placed on infectious disease as a national security risk pushes the focus of states towards a myopic view that takes into account only the threat of infectious disease within their own borders. By securitizing infectious diseases, states are able to locate it within a “state-centric framework, where states are primarily concerned with maximizing power and security, rather than addressing wider humanitarian concerns” (Elbe 2006 129). Any impetus to monitor or contain an outbreak in other areas of the world is seen as secondary to ensuring that a state’s own borders are secured or that appropriate surveillance measures are in place within their own territory. This was clearly the case in the Ebola outbreak, with states being extremely reticent to respond to urgent requests for help from the governments in West Africa (MSF 2015). Not only were states slow to take action by providing resources, they were also slow to even communicate with each other on the true scope and spread of Ebola as it was occurring.

This sort of insulation against the request from other states runs counter to the duty that states have to ensure the human right to health of the global community. States may abnegate their commitments to ensuring global health, with “the appeal to national security [relieving] states without major public health threats of any moral obligation to respond to health crises of monumental proportions in the developing world” (Peterson 2002, 80). States focus on protecting their own populations without due concern for the populations of other countries, namely, those in the developing world. However, as stated

in the Alma Ata declaration, and reaffirmed in the ICESCR, states do have an international legal obligation, as well as a moral duty, to the developing world and to ensuring that global health emergencies are given due attention. This would necessitate not only securing a state's own borders, but also ensuring that states in the Global South are able to effectively contain infectious disease outbreaks. It is important to note that this has a significant 'trickle up' effect. By ensuring the human right to health in the Global South through enabling those states to contain the spread of disease, Global North countries are also safeguarding the human right to health of their own populations. As stated by Heymann (2005), strengthening health institutions "benefit[s] developing countries by ensuring early identification and containment of outbreaks.... At the same time, industrialized countries benefit from decreasing risk that these diseases will spread internationally" (171). By instituting a human rights framework with which to view health emergencies, states would be better able to implement policy that is effective in responding to these needs. By moving away from a state-centric, securitization framework, disease emergency responses can be viewed for the broader humanitarian issues that they are, extending beyond narrow self-interest of security, and instead as health issues that are worth addressing in their own right (Peterson 2002). Situated within a human rights framework, states are capable of viewing responses to disease outbreaks as their duty and responsibility, and garner the support and resources to act in accordance with their international legal and moral obligations. Further, this appeal to human rights successfully justifies an investment in both short-term remedies to contain infectious disease, and long-term strategies to improve the health infrastructure of poorer states. In turn, wealthier nations are able to

actualize their duty to the international community, as well as protect the human right to health of their own citizens.

The use of a human rights framework will allow for more effective prevention of future disease outbreaks through the bolstering of health infrastructure worldwide that is better able to avert diseases from reaching the level of epidemics or pandemics. The securitization framework fails to sufficiently address prevention of infectious diseases precisely because it focuses instead on the insulation of a state, rather than pragmatic and preemptive strategies. By focusing only on the best ways in which to secure a state once an outbreak occurs, the securitization framework neglects the importance of prevention in promoting the health of a population. Yet a human rights framework can work to pull the attention of states away from their own territory in order to assess the capacity of other states to guarantee the human right to health. By framing health as a human right, a state will be judged against its ability to ensure the basic right to health to its population, similar to the adjudication of a state's ability to protect their citizens from war or torture, for example. Political leaders would be able to assess whether their foreign counterparts are able to, in good faith, promote the health of their citizens. In this way, "human rights provide standards against which government performance is measured", and in turn, "human rights principles... can be used by advocates and authorities to help diagnose the effectiveness of current health policies" (Robinson 2007, 241). When a state is adjudicated to be failing in their duty to provide the necessary resources and infrastructure for the good health of its citizens, the international community is compelled to respond. This would mean assisting with and providing the appropriate tools to guarantee the right to

health, and in turn, prevent isolated infectious disease outbreaks from turning into devastating epidemics like the recent Ebola outbreak.

Framing infectious disease outbreaks within the context of human rights shifts the attention away from the insulation of states against disease, and instead to the broader context in which infectious disease spreads. Part of this is the acknowledgement of the ways in which disease transmission has societal, rather than solely biological, factors (Mann 1999; Birn 2011). This includes those structural factors, such as poverty and global power imbalances, which play a large role in perpetuating disease. In a human rights framework, the focus moves from keeping disease out to instead preventing those conditions under which infectious disease is able to thrive. The human rights framework is premised on the understanding that the protection of human wellbeing is an ultimate goal and mandatory norm, and as such, promoting health calls for “analysis and action on the societal root causes of vulnerability” of infectious disease (Mann 1999, 223).

### **‘Dreaded Diseases’ and the Ignorance of Disease Burden**

A second shortcoming of the securitization of disease is that it is effective in garnering interest and resources to stop only certain diseases. These diseases tend to be those that are sensationalized and conceived as a genuine threat to people in developed nations. This results in three important phenomena. First, the ‘genuine threats’ tend not to be assessed strictly on the basis of morbidity and mortality. Rather, they are assessed in part by widespread ‘dread’ (Selgelid and Enemark 2012). Dreaded diseases are those that are able to “touch the security nerve of people and politicians in ways that set them apart

from other health issues” (Selgelid and Enemark 2012, 48). These diseases excite fear for different reasons, including the *way* in which they kill in addition to their ability to kill. Ebola hemorrhagic fever has been framed as a disease that instills dread, with the common grotesque images of bleeding from the eyes, ears, and nose, and the depictions of dead bodies being transported by alien-like workers dressed head-to-toe in isolation gowns, masks, boots, and gloves. While states attend to these ‘dreaded’ diseases, they shift focus away from less dreaded, but much more deadly, diseases. In 2013, malaria killed 584,000 people and tuberculosis (TB) killed approximately 1.5 million worldwide, compared to fewer than 11,300 EVD deaths from December 2013 to July 2015 (World Malaria Day 2014; TBfacts 2015; The Economist 2015). Ebola is certainly a concern due to its infectiousness and high mortality rate, however the problem remains that securitization leads to a focus on Ebola as an easily sensationalized disease, while at the same time diverting global attention and resources away from the diseases that have a greater impact (Abraham 2011; McInnes and Lee 2006). The human right to health is thus not conceptualized as the wellbeing and physical health of the broad global community, but rather overemphasizes the potential transmission of dreaded diseases to privileged populations within the global community.

However, by shifting from a securitization to a human rights framework, this effect can be reversed. By acknowledging the human right to health, the emphasis is placed on those diseases that claim lives and rob individuals of the right to health and life, rather than those that illicit a disproportionate amount of fear and panic. For those countries and regions which battle diseases like malaria and TB, a human rights framework would recognize the huge burden these diseases place on the resources and infrastructure of

developing nations, as well as the detriment to health, and by extension, human rights. The lack of a functioning health system not only negates the ability of a state to support the prevention of these diseases, but it also diverts resources away from the surveillance, reporting, and response protocol of other infectious diseases – including those that are more likely to be transmitted across the globe, such as Ebola (Smith, Woodward, Acharya, Beaglehole and Drager 2005). By using a human rights framework, the measuring stick of health disasters would be those that are genuine threats, that are deleterious to human rights on the broadest scale, and affect the most people, as opposed to the emphasis on those which can evoke a security response cultivated in fear.

The second phenomenon represents a flipside to the discourse of dreaded diseases. Those states that deal with the largest burden of infectious disease find their greatest caseloads in contagions such as HIV/AIDS, malaria and TB. Primarily sub-Saharan African states, these countries have an extensive burden on their health care systems posed by these diseases alone (Peterson 2002). While HIV/AIDS has been widely touted as a security threat, it does not instill the same panic as do more dreaded diseases. This is in part due to the availability of antiretroviral therapy, advances in education and awareness, and HIV/AIDS no longer being an ‘exotic’ disease with many unknowns. Global South countries are forced to shift their limited resources away from these more ‘common place’ infectious diseases, despite them being much bigger killers, and instead focus on dreaded diseases at the behest of international pressure. As stated by Abraham (2011), the dreaded diseases are conceptualized by “dominant countries in the global political system”, which results in “countries lower down in the global and economic pecking order [being] compelled to devote extraordinary attention and resources to issues that might not pose a grave threat

to them” (809). While it is clear that Ebola certainly does pose a grave threat to sub-Saharan African countries, it remains true that limited resources must be deflected. MSF (2015) found that a great tragedy during the Ebola crisis was the number of deaths from diseases such as malaria and tuberculosis, as well as maternal complications and newborn and infant illness. This happened simply due to the fact that the EVD-affected countries had limited resources to deal with myriad and complex health problems. Ebola was suddenly at the top of the global agenda, and other diseases and health issues were simply not conceived of as genuine, pressing threats.

The third phenomenon is an extension of this, and leads to the exclusion of particular states in setting the agenda for addressing infectious disease. The diseases that are given attention are those that “appear to be slanted towards the priorities of the western nations” (Brown 2011, 324). This speaks to a broader global power imbalance in which the priorities of the world are set by dominant powers, namely, the West. A securitized international response that results in calculative steps taken by states will disproportionately benefit those players who have more power at the global level, leading to winners and losers in terms of access to health technologies, infrastructure, and capacity to deal with disease (Elbe 2010). This can lead to the decline of international health cooperation on issues of great importance, as lesser powers feel left out of the bargaining process. This also leads to the absence of crucial and expert voices from developing nations on matters of global health.

However, by reframing infectious disease through the lens of human rights, these phenomena can be alleviated, at least in part. Firstly, by using a human rights framework, emphasis is placed not only on the response to emerging infectious diseases, but also on

the process of building and attaining effective and functioning health care systems. By ensuring that all countries have appropriate health care infrastructure to respond to the health needs of their citizens, states will have the ability and autonomy to address those diseases that are most exigent in their own health context.

Further, a human rights framework for health recognizes the importance of building not only health infrastructure, but also mitigating the imbalance of power within global institutions and inequitable global structures (Labonté 2014). From a human rights framework, these inequalities are acknowledged, as well as the negative duty of the international community to impose no harm, and to forego implicit participation in global institutions that cause harm. A human rights framework that takes this into consideration can help to find systemic changes to address this imbalance, and in turn, give a stronger voice to those states that are not traditional power brokers on the world stage. By doing so, these states will be able to have input on global public health agendas, and will not feel the same degree of pressure to respond to diseases that they feel are disproportionately characterized as a security risk (Abraham 2011). In doing so, global health can be meaningfully inclusive not only of the expertise of the Global South, but also incorporate the experiences of individuals in the developing world in order to create more equitable health care infrastructure and promote broader global equality.

### **‘In the Name of Security’: The Encroachment on Human Rights**

Lastly, the use of a securitization framework can actually compel states to implement measures that restrict and renege on protecting other political and social rights of their citizens and the citizens of other nations. This is apparent in cases of quarantine

and travel bans. A distinction must be made between the rights of an individual in relation to the rights of the greater community. By implementing quarantine and travel ban protocol, states are seeking to protect the population, by temporarily and provisionally restricting the rights of an infected or supposedly infected person. Yet, simply by framing the infectious disease as a national security threat, it is imbued with a sense of urgency and ascendancy that it would not otherwise have. With it comes the potential that by framing an infectious disease in security terms, a state “can remove it from exposure to the normal bargaining process of public politics” (Selgelid and Enemark 2012, 50).

These travel bans may be a reasonable method to prevent the spread of infection within a state. However, it is a problem inherent in the securitization of disease that the emphasis is placed on national security instead of the basic human rights intrinsic to human beings. As argued by Elbe (2012), these bans show “how a genuinely securitized response to infectious diseases can lead to the curtailment of the civil liberties of individuals in a way that... is deeply problematic” (84). With securitization comes a legitimization of human rights restrictions, as they are couched in the language of national security and protection against threats. This also serves to generate a discourse of fear. The imposition of travel bans and quarantine triggers a more general sense of xenophobia and fear in the public. This can result in the further violation of human rights and civil liberties, as particular individuals or segments of the population are discriminated against by others, or even the state itself. Anecdotally, this has manifested itself throughout the Ebola crisis. According to a journalist with *The Guardian*, two Rwandan children were denied entry into their school in New Jersey, and a teacher was forced to resign from her teaching position in Kentucky after a trip to Kenya (Smith 2014). These episodes resulted in the unnecessary

violation of human rights – restricting the ability for these individuals to seek education and employment, respectively. In a less injurious yet more absurd turn, a restaurant in Minnesota that offered African cuisine removed Liberian food from the menu, as people feared contamination with Ebola (Smith 2014). That certain sects of the population face discrimination has also been expounded by Brown (2011), who argues that infectious disease is commonly framed not as a problem that is a universal concern for all peoples, requiring universal commitment to alleviate. Rather, infectious disease is viewed through a lens of ‘third worldification’, in which disease outbreaks that occur in the developed world are considered the fault of those who are believed to have connections with impoverished sub-regions in which disease is endemic.

Under a securitization framework, when restrictive health measures such as travel bans, quarantine, and mandatory screening take precedence over the provision of rights, the effect can be counterproductive. For instance, Annas (2003) argues that selective screening and travel bans have the effect of frightening those who may be infected, such that the epidemic is driven underground, and potential carriers are more likely to avoid public health officials. The fear of being ostracized, discriminated against, or having one’s civil liberties and rights withheld can work to discourage people from seeking help. Annas (2003) also argues that travel bans and “involuntary quarantine [are] generally unnecessary and almost always ineffective”, as they have the effect of diminishing trust in the government (65). This can further contribute to a state’s inability to control transmission of disease as citizens lose faith that the government is acting in their best interests, and they may then refuse to follow the restrictive orders of the government (Annas 2003; Selgelid 2012, Carney and Bennett 2012).

However, by viewing infectious disease within a human rights framework, this can be somewhat mitigated. By couching the spread of infectious disease in the language of human rights, the state can stress to its citizens that they have a right to health, but also a negative duty to assure the rights of others. This includes a negative duty to refrain from engaging in activities or practices that put the human right to health of other citizens at risk. In this way, voluntary quarantine and screening can ensure that individuals autonomously take responsibility for their own health, as well as contribute to the broader community's right to health. Research has shown that voluntary quarantine has proven to be more effective than mandatory quarantine, as it emphasizes the precedence of individual human rights – one of which is the right to health (Annas 2003; Smith, Bensimon, Perez, Sahni, and Upshur 2012). Further, it shifts the discourse from one of blaming or shaming those who may have fallen ill to one of respect for the individual who willingly does their duty to ensure the human rights of their compatriots.

Even when travel bans, quarantines, and screenings are used judiciously by the state, their effectiveness is not always obvious. In the United States, enhanced screening was implemented for all travellers coming from Sierra Leone, Liberia, and Guinea between October 11 and November 10, 2014. During this time, 1,993 travellers were screened at 5 different airports (US CDC 2014). Of these, 86 people were referred to the CDC, and only 7 of those were given subsequent evaluation. None of these 7 developed EVD, and it was found that those who presented with symptoms were more likely to be infected with malaria, endemic to the region (Gostin, Hodge, and Burris 2014). There were 4 Ebola cases in total in the United States, 2 of which were individuals who had travelled abroad. Both individuals were asymptomatic at the time of travel to and landing in the United States,

developing the disease almost a full week after arrival. Furthermore, it has been noted that in the case of Thomas E. Duncan, the Liberian man who died from EVD infection in the US, he was sent home from the hospital when he presented with Ebola-like symptoms and alerted the staff that he had recently travelled from Liberia. Even though he had been screened upon arrival into the country, he infected 2 nurses on his treatment team due to a series of public health missteps, which included the lack of personal protective equipment worn by the emergency medical service personnel and hospital staff (Gostin et al. 2014). It is not the intention to assert that these specific missteps in public health would never have happened had the Ebola outbreak been framed as a human rights issue as opposed to a security issue. However, it can be said that the securitization framework contrasts security with insecurity, and in the case of Duncan, the presence of Ebola in the United States was portrayed as an instance of insecurity. Problematically, within a security framework, this is identified as insecurity existing within the body of an individual (Elbe 2010). This results in the erasure of the individual from the analysis, seeing him or her as merely a security breach, and thus also removing the individual's claim to human rights. By situating infectious disease within a human rights framework, a state may not be able to prevent every instance of a disease outbreak, but those instances that do occur do not result in the automatic labeling of each individual as a breach to security. Instead, the instance of disease is seen more broadly as an affront to that individual's right to health, and any attempts to control the disease are grounded in an analysis that sees the disease occurrence as an infringement on human rights.

Restrictive measures such as screening and quarantine only work when used in conjunction with rigorous and precise infection control protocol at every step. While the

airport screening that was employed during the Ebola outbreak may have been necessary, and may be required in a future event of a global disease emergency, it remains that the most effective method of preventing the international spread of disease is by controlling it at the source. This is best achieved when global health responses are situated within a human right to health discourse, acknowledging that when the health of distant others is secured, the risk of infectious disease is lessened both for developing and developed nations. The resources that are poured into border controls, mandatory screening, and migration bans may be better put towards providing solutions for longer term infrastructure solutions. If, however, these restrictions are implemented, it must be done in conjunction with broad-scale national public health measures that effectuate containment of the disease, rather than just as a response of fear and panic in the face of 'dreaded' diseases. Further, the framework of human rights better allows for the management of infectious diseases that cross borders and disregard sovereignty. The spread of infectious disease represents a challenge to all countries, and "under such a system there is a moral imperative towards human and health security irrespective of state borders which supersedes national interests" (Yuk-ping and Thomas 2010, 451). A human right to health framework allows for the understanding of emergencies not solely as threats to which borders must be closed, but rather a deeper acknowledgement of the internationalization and interconnectedness of these threats.

Moreover, the act of reframing infectious disease in the context of human rights as opposed to security can change the discourse through the language used, and in turn can have an effect on the ensuing implementation of policy at the state level. By shifting towards a language of human rights, it can imbue state responses with a level of attention

to human rights that the securitization framework obfuscates. This occurs as a framework “can also be constitutive of meaning – that is, they may move beyond being merely a presentational artifice to become a means of shaping the way in which a health issue is understood” (McInnes et al. 2015, 3). The ways in which global health is constructed has an effect on the material ways that policy is able to play out. By using a human rights framework, global health emergencies can be formulated as detrimental to human health and wellbeing and thus a compromise of the individual right to health. In turn, this can propel the global community to implement policies that not only abate health emergencies, but also safeguard human rights in coexisting facets of life.

When infectious disease is situated within a security framework, states are unwilling to take the steps necessary to respond to disease if they do not anticipate their own populations will be affected. Yet, this exemplifies the shortsightedness of the securitization framework. Infectious disease is not constrained by territoriality and does not discriminate against rich or poor nations. The ability to monitor, prevent, and treat infectious disease is dependent upon the infrastructure and resources of states. By using a human rights framework to address global health emergencies such as Ebola, countries in both the Global North and the Global South can work towards equitable distributions of resources. In turn, this serves to produce functioning and capable health care infrastructure that can reduce the occurrence of infectious disease at the source, such that outbreaks do not occur or spread on a dangerous scale.

## CONCLUSION

While the Ebola epidemic may have faded from the forefront of the news, it nonetheless remains a looming concern, not only for West Africa, but the international community at large. The epidemic has forced states to consider both their ability to control the environment within their borders, and also their vulnerability in a world that is increasingly more interconnected. The Ebola outbreak signaled a devastating loss of life, with MSF (2015) attesting that many lives could have been saved with more expeditious and effective intervention by the international community. While the WHO Ebola Interim Assessment Panel has refrained from providing an explanation for the lack of action in the first few months of the outbreak, MSF has been more blunt. The organization contends that it was only when the disease had become a threat to security at home, rather than a distant concern affecting poor countries, that states became mobilized to act (MSF 2015). This is indicative of the broad securitization of global health emergencies, in which states are disinclined to take action unless there is an imminent threat to their own narrow interests.

Yet, health is a human right and as such, the protection of health on a global scale warrants not only a strong response in the face of a global health emergency, but also the consistent commitment to the realization of that right for all people. States have a responsibility to protect the rights of their citizens, and in the context of health, this includes ensuring the presence of necessary resources and infrastructure. However, historical and structural imbalances in power, in addition to poor governance and enduring poverty, render some states incapable of providing the necessary instruments to promote the health of its citizens. When states are unable to guarantee human rights for its citizens, the international community has a secondary responsibility to act.

In this paper, I have argued that this international responsibility is predicated on both legal and moral imperatives. Documents such as the Universal Declaration of Human Rights and the World Health Organization's charter establish a normative basis for the entrenchment of the human right to health. Covenants such as the International Covenant on Economic, Social and Cultural Rights are legally binding to signatories, and set a precedent for adoption into national constitutions. Beyond legislative tools, there is a moral imperative that calls for states to justly address health inequalities, share societal burdens, and redistribute power and resources. As the beneficiaries of an inequitable global system, wealthy nations must cease their implicit support and reproduction of these power differentials. The historic and structural power dynamics that have disproportionately disadvantaged certain groups must be addressed, and wealthy states must fulfill their negative duties to disrupt imbalances that enable ongoing unjust power and privilege. Citizens of wealthy states have a responsibility too. In democratic nations, as the agents of political authority, they must hold their governments to account, to level the international playing field and shape a world that allows for the equality of opportunity of all people. By framing health as a human right, intrinsic and fundamental to all human beings, the international community can begin to redress those factors which lead to ill health, and in doing so, will create better systems for responding to, and preventing, infectious disease outbreaks such as Ebola.

Instead of focusing on the inherence of health as a human right, the securitization framework situates health as an issue on the national security agenda. This forces states to look inward, tending towards isolation from other states in the face of global health emergencies, attempting to secure their own borders rather than acknowledge the human

rights concerns of non-citizens. This isolation eschews the legal and moral responsibility of states to respond to global health emergencies, and moreover, impacts the ability of states to build the necessary infrastructure to prevent further disease outbreaks from occurring. Additionally, the securitization framework funnels attention away from the most common infectious diseases that affect a great portion of the Global South, instead focusing on 'dreaded diseases'. The imbalance of power in the international sphere allows for the Global North to set the health agenda, serving to both ignore the diseases that are most deleterious in poorer nations, and to cement the existing power dynamics. Lastly, within the context of a securitization framework, states may implement restrictive measures under the guise of security that actually result in the restriction of human rights. This can produce highly problematic outcomes, including the promotion of fear, discrimination, and xenophobia within populations, as well as state justification of suspending the human rights of citizens who are deemed to be threats to security.

While securitization frameworks are widely and commonly employed in the context of global health, this is by no means an inevitability. The discourse at the global and state level can, and must, shift towards a human rights-based framework. It is within a human rights analysis that effective, proactive, and lasting solutions to the pressing issues of global health can be found. Globalization has contributed to the spread of infectious disease, and will continue to do so, but it can also be a means for improved coordination and the sharing of techniques to bolster health infrastructure across the world. Improved information technology can assist in monitoring and surveillance, and the coordination of resources and expertise. Social media can garner resources and support in record time, as well as transmit information about impending or breaking health emergencies. Improved research

and technical skills must be shared broadly to empower nations in the Global South to adopt those techniques that are relevant and useful in their own contexts. Further, the lessons learned from the Ebola outbreak, as well as previous outbreaks like SARS or H5N1, must be implemented not only for those states most directly affected, but also as a matter of international collective action. Within a human rights framework, this is an achievable goal. Human rights are universal, and speak to the shared values of humankind. By contextualizing health as a human right, the international community can address the burden of disease as an issue that affects all states, not only narrowly as threats to national security, but as a worldwide challenge to human wellbeing. Health is a necessary requirement for functioning societies and flourishing communities, and as such, of paramount importance to a stable global environment.

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