Processes of Securitization of Infectious Diseases and Western Hegemonic Power: A Historical-Political Analysis

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There is a generalized consensus today that major infectious diseases became global security issues. David Fidler considers it a recent, "revolutionary"[1] process intimately connected to post-September 11 and post-2003 SARS[2] outbreaks. In this article I introduce a perspective aimed at deepening Fidler's view. Drawing from Michel Foucault's analytics of power, I review the ramifications between epidemics' securitization and reinforcement of Western hegemonic liberal power after the Cold War through the human security paradigm. Rather than recent, this securitization proceeds from the colonial dominance system to which epidemiological surveillance and public hygiene were instrumental.

INTRODUCTION[3]

Arguably starting as a Western-led activist strategy to obtain more attention and therefore more funding,[4] the health-security nexus discourse resulted in the lifting of international health concerns to the high ranks of security and defense strategic policies. The deadliest epidemics (HIV/AIDS[5], tuberculosis, and malaria) and those more directly menacing the West (food- and migrant birds-related diseases, such as brucellosis, SARS and avian influenza) have already been inserted in the strategic documents of the United States[6] and the European Union.[7] Usually they are articulated with a range of other preoccupations: terrorism, civil wars and economic globalization's many interrelated phenomena (urbanization, migration, energy access, etc.).

Assuming that the process of securitization of infectious diseases is far from being a new phenomenon, this paper seeks to trace the genealogy of it back to the 18th century, drawing mostly from historical studies on the British Empire. The paper is organized in three parts. The first part reviews the concept of infectious disease and its inclusion in the post-Cold War human security paradigm. Human security is particularly emphasized with the aim of reinforcing the current importance of non-military issues (pandemics, migrations, state failure, etc.) to the strategic concepts of the West. The second part focuses on the juridical-institutional approach drawn from David Fidler's scholarship on global health governance and law regimes and the way they have been reshaped by current processes of securitization in health. Finally, the third section introduces another approach, a historical-political one, with an aim to discuss Fidler's proposals. Here I adopt a lens to securitization as constructed around Western historical-political elements, informed by Michel Foucault's study of hygiene in European rising liberal societies. Rather than recent and juridically regulated, securitization is presented here as rooted in around three hundred years of Western public health intervention as a global securitizing practice under an assemblage of dispersed and multifaceted, yet hierarchized, liberal powers.

EPIDEMICS AND HUMAN SECURITY

Historically, public health intervention has primarily relied, at the national scale, on health departments, and, at the international level, on the World Health Organization (WHO). Yet, health also became important in the development aid and military agendas during the Third World post-independence waves and the bipolar West-East confrontation.

The Western victory of the Cold War and the perspective of global human rights promotion have promised the accomplishment of an international health agenda based on the 1978 'Health for All' Alma-Ata Declaration. At the same time, due to the change of threat perception in the West – from overt attacks against national territorial integrity by an inimical state or alliance of states to "new threats" of a deterritorialized and multiform nature – health and other human-related dimensions were growingly inserted in Western defense agendas too. Both dimensions – human rights and security – coexist in the 'human security' paradigm, as I will describe.

Infectious diseases are caused by an organism that penetrates the body, grows and multiples in cells, tissues and body cavities, and constitute the main cause of death in the world.[8] They tend to emerge and remerge according to the conditions of the ecosystems where human beings live in. Diseases that have been receiving more attention are, on the one hand, HIV/AIDS, tuberculosis and malaria, and, on the other hand, avian influenza, SARS and brucellosis (also known as "mad cow disease"). The response to the former group has been mostly under the auspices of grand funding schemes of the World Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the United States (mainly the President's Emergency Plan for AIDS Relief – PEPFAR), in conjunction with other public and private initiatives. These programs were established to prevent and treat the most lethal diseases in the world, especially in Southern and Eastern Africa, but with an increased focus in other countries/regions: India, China and South-eastern Asia, the Caribbean, Russia and Eastern Europe. Those diseases are transmitted sexually, from mother to child and through drug injection and needle sharing. Lack of sanitation, food and water is also decisive. Often diseases such as tuberculosis appear and disseminate opportunistically in people living with AIDS. These diseases account for the greatest cause of death in the world, and their effects are felt at the family and community levels. As far as the latter sort of diseases goes, they are animal-transmitted, and as they enter the food chain, they pose a direct threat to the populations. Despite its (still) low score in inflicted deaths, Western and international authorities often compare their potential effects with the 1918 Spanish Flu's experience. Whereas the high number of AIDS, tuberculosis and malaria deaths justifies their policy relevance, the case of avian flu and others are considered major threats given the imminent direct threat they pose to the West. I argue that such direct threat status *vis-à-vis* the West explains the extraordinary attention they have been receiving, especially when compared to "neglected" ones. Diseases such as buruli ulcer, dengue/dengue haemorrhagic fever, dracunculiasis (guinea-worm disease), fascioliasis, human African trypanosomiasis, leishmaniasis, leprosy, lymphatic filariasis, neglected zoonoses, onchocerciasis, schistosomiasis, soil transmitted, elminthiasis, trachoma, and yaws have their

incidence in the Third World and, coincidently or not, were long eradicated in the West. The rare cases emerging in the richest societies happen generically due to travel or immigration.

The topic of infectious diseases has been inserted in the most recent Western strategic concepts. The United States's National Strategy states that "new flows of trade, investment, information, and technology are transforming national security. Globalization has exposed us to new challenges and changed the way old challenges touch our interests and values, while also greatly enhancing our capacity to respond. Examples include: *Public health challenges like pandemics (HIV/AIDS, avian influenza) that recognize no borders.* The risks to social order are so great that traditional public health approaches may be inadequate, necessitating new strategies and responses."[9] In turn, the European Union's view is that "in much of the developing world, poverty and disease cause untold suffering and give rise to pressing security concerns. (...) New diseases can spread rapidly and become global threats."[10]

The end of the Cold War and the global expansion of the neo-liberal model brought about changes more in terms of nature of threat than subject of threat. States as sovereign units are not bound to cause so much preoccupation from a security viewpoint as "non-traditional threats" do: environmental imbalances, religious fanaticism and terrorism, ethnic wars, refugees and other 'irregular' migrations, urban insecurities, reductions in energy resources, etc. Often these "new threats" were regarded as risks Western societies had to take for the sake of their own middle-class lifestyle, which one would describe as Western "ontological security."[11] They are described by Anthony Giddens as "dark side" of globalization, drawing from what Ulrich Beck has called "risk society."[12] One such risk turned out as actual hazard in September 11, 2001 was global terrorism. With regard to epidemics, risks and effective hazards have pronouncedly been associated with the deterioration of many populations' living standards in developing countries, particularly in Africa. Phenomena such as "new wars,"[13] i.e. post-Cold War civil wars, and "failed states,"[14] that is, states "unable or unwilling" to offer the residents basic public goods such as food, access to health or public security, have strongly potentiated that negative trend. These phenomena appear as both cause and effect of the threats mentioned above.

The human security paradigm emerged in the early 1990s as a political and instrumental response to the problems that "new wars" and "failed states" have posed throughout the post-Cold War era. It embodies the early 1980s ambition of several authors in Security Studies (Homer-Dixon, Ullman, etc.) of enlarging the concept of security in which threat builds less in function of states and more of populations and their well-being. Informing the nascent European defense and foreign security policies and the Middle Powers Initiative, human security has been embedded since the early 1990s in the United Nation's conflict prevention, peacekeeping and post-conflict reconstruction missions. It was so defined by the United Nations Development Program (UNDP): "human security can be said to have two main aspects. It means, first, safety from such chronic diseases as hunger, disease and repression. And second, it means protection from sudden and hurtful disruptions in the patterns of daily life – whether in homes, in jobs or in communities."[15]

According to this definition, the concept of human security presents itself as an eminently emancipating, pacifist and human rights-centered doctrine. It is in that vein that I believe that it is widely promoted by the activist community, as, for instance, the panel "Human Security and HIV," coordinated by Alex de Waal, at the 2008 International AIDS Conference in Mexico City confirmed. Yet, Mark Duffield warns us on human security's two interconnected problems.[16]

One problem with the human security paradigm is its ambivalence, since, as one suggested above, it incorporates two rather conflicting agendas, i.e. human rights and security. Duffield argues that "in a single concept the idea of human security [...] contains the optimism of sustainable development while, at the same time, it draws attention to the conditions that menace international stability."[17] Writing about HIV/AIDS, human rights and security, Laurie Garret expresses such tension in these terms: "As vital as the human rights agenda is in the HIV pandemic, however, it ought not to be permitted to befuddle attention to security."[18] The second problem meets the ethical issue emerging from the induction of a state of exception for a non-military issue.[19] Following 1930s scholarship by Carl Schmitt on the establishment of a state of exception,[20] securitization may jeopardize civil liberties, democratic order and therefore the emancipating horizon of human security.

It is relevant to clarify that pathogenic agents only appear as menacing human beings when they, first, infiltrate human ecology and afterwards penetrate and develop themselves within the human body. Thus, those agents as such do not pose any threat. What is actually convertible to a threat status are peoples, societies and, in the last analysis, states. If one perceives detection, prevention, care and eventual cure of populations as the major measures against disease, one defines as security objective the contention, if not the abolition, of the multiplication of the number of people carrying the agent. It also accounts for the social impact that such multiplication feeds and probably provokes. The securitized people are depicted as those "at risk," "vulnerable," if not making up "dangerous classes."[21] In Southern and Eastern Africa they are, among the general population, "orphans and vulnerable children." In China, India, Russia, and the West, they are drug injectors, migrants, homosexuals and the general mass of "marginalized ones." Conversely, the securitizing agents tend to be most influent groups in society, where power, according to Williams, is more "'sedimented' (rhetorically and discursively, culturally, and institutionally) and structured in ways that make securitizations somewhat predictable and thus subject to probabilistic analysis."[22]

Usually those agents correspond to the political and economic elites and the military. However, dominant civil society groups, such as large international nongovernmental organizations (INGO) and other transnational networks led by companies, charities and celebrities, achieve their voice opportunity. As part of a global assemblage of dispersed liberal powers, they exert their strong influence globally as well. A good example, which has been recently analyzed by Marco Vieira, relates to the process of politicization of HIV/AIDS.[23] From the mid-1980s to the late 1990s HIV/AIDS politicization occurred through the establishment of WHO Global Program for AIDS in 1986 and UNAIDS in 1996 and was followed by the effective adoption of a security

discourse in the late 1990s, mostly among "a growing circle of high-profile politicians, transnational activists and academics."[24]

The securitization of diseases narrative is elaborated in articulation with other issues. The main five topics are: "war on terror;" "failed states," "new wars," and "uncontrolled migrations;" globalization; current medical practices; and social and behavioral changes. The response to the terrorist attacks against the United States in September 11, 2001, inaugurated an era of asymmetric, global and apparently endless war. The war on terror aims to identify and combat the means of dissemination of terror through a merge of a various governance sectors, including health. The so-called "Amerithrax" case, i.e. the distribution of letters containing anthrax to several media offices and two U.S. senators, starting on September 18, 2001 and for several weeks, fatally materialized the inscription of health-related sectors in the strategy of counterterrorism and international stabilization. Andrew Price-Smith has produced an exhaustive work on the relation between health indicators and state capacity, pursuing an investigative avenue for research on epidemics' impact on several societal fields.[25] Authors writing on epidemic incidence in the population allude to the mutual direct reinforcement of disease proliferation and disruption of the socio-economic tissue, collapse and war feeding.[26] Other authors have established linkages between HIV-orphaned and "vulnerable" children and delinquency. The perspective of many children and youths finding themselves without a family, so the argument goes, might lead to the formation of pockets of delinquency that provoke instability, even politically, with potential extremist associations.[27] Lyman and Morrison have suggested that countries like Nigeria and South Africa offer safe havens for recruitment of children and youths for jihadist, anti-Western activities home and abroad.[28] U.S. army official Charlene Jefferson's summarizes this complexity: "Simply put, a disturbing new formula may be emerging; AIDS creates economic devastation. Economic devastation creates an atmosphere where stable governments cannot function. When stable governments cannot effectively function, terrorism thrives by exploiting the underlying conditions that promote the despair and the destructive visions of political change. (...) ...AIDS has created a steady stream of orphans who can be exploited and used for terrorist activities."[29]

Yet it should be remarked that attention paid to children and AIDS is prior to September 11. It was first elaborated by Richard Holbrooke, former United States ambassador to the United Nations, in 2000 after visiting some African countries. Irregular migratory movements have been added to the triangle epidemics/state capacity/conflict too. Apart from being considered themselves object of security, migrants pose a threat to public health in the countries they enter, since they generally have quite limited or inexistent access to health care for detection and care. Migrations are, furthermore, phenomena that economic globalization has been pushing as markets merge through circulation of people and goods. One should then enumerate the following eco-social determinants of health: crossborder trade, climate change, fast urbanization and intercontinental tourism. Brower and Chalk included the relevant dimension of excessive use of antibiotics, which contributed for the emergence of more resistant strains of viruses.[30] Reflecting the moralist debate present particularly in the domain of sex-related diseases, those authors found another set of causes in "the higher

acceptance of multiple sexual partners and *permissive* homosexuality particularly in the Western countries (...) the Asian strong sex industries, and the growing prevalence of intravenous drug use."[31]

Several authors have pointed out with regard to HIV/AIDS global preventive instruments, securitization of specific scenarios, namely the catastrophic ones on the nexus orphanage-social disruption-state collapse-violence, are highly speculative,[32] and therefore paving the way for the creation of a "truth effect" informing non-evidenced policies.

SECURITIZATION: JURIDICAL-INSTITUTIONAL APPROACH

Legal scholar David Fidler considers that September 11 terrorist attacks, the "Amerithrax," and 2003 SARS outbreaks have led to a reconfiguration of global health governance's "constitutionalism."[33] Yet, the historiography of such "constitutionalism" goes back to the first international hygienist conference that took place as a response to a cholera epidemic in Europe in the 1830s. This conference was followed by others throughout the 19th and early 20th century, which paved the way for the League of Nations' office of health affairs and WHO. Founded in 1948, WHO has gained reputation for inculcating an international cooperation regime based on the 1969 International Health Regulations (IHR), consolidating what Fidler has called *Microbialpolitik*, that is, an international agenda fundamentally guided by allied fight against disease.[34]

Fidler perceives the events above and their corresponding structuring responses of contingency as a turning point in the understanding of epidemics as object of national and international security. One might therefore realize that security concerns were arguably not as influent as they have been since the early 21st century. 2003 furthermore inaugurates "the new world order in public health," in which global health governance adopts the United States federal model in the context of crisis in health at the global scale. The functions of that model are: provision of national security; regulation of international trade; preparedness support and response to epidemic crisis; and protection of human rights.[35] Fidler holds that such "new order" reflects the post-September 11 counterterrorist response. Thus, he confirms the merging of all areas of governance in the United States towards a more efficient and engaged reaction. Finally, Fidler affirms that the 2005 revision of the IHR reoriented WHO's mandate, since it may be specifically serving national and international policies: "less clear is whether the new IHR might embroil WHO in the politics of national and international security to the detriment of its core public health functions. Although it makes some experts uncomfortable, the potential for terrorism involving weapons of mass destruction connects public health to security concerns."[36]

The 2005 IHR revision calls for the necessity to establish partnerships with other "interested" sectors, notably the armed forces. Moreover, it has to be stressed the actual paradigm change in the whole philosophy of the revised IHR. A striking case relates to the possibility of "containment at the source," beyond the typical border controls for people and goods.[37] Such situation allows foreign interventions to be triggered regardless of state sovereignty, namely with military means, for the sake of epidemic contention.

Fidler's legalist analysis appears limited *vis-à-vis* a profounder discussion on who is composing the global health governance's constitution. Conversely, a critical political approach to this topic credits many other influent agents beyond major states and international organizations – private companies, non-governmental organizations, networks and partnerships and even Hollywood "celebrities."[38] Likewise, they hold intense power agendas and regulating capacities. Perplexingly, models relying on states as sovereign units (independently of the power relations they maintain) do not take into due account the realization that sovereignty itself is under jeopardy according to the premises of the 2005 IHR and the aforementioned possibility of "containment at the source." This framework of reduced national sovereignty, namely in the post-colonial world, is exacerbated by the presence of those governance actors. Sovereignty, as argued below, is understood as a political component of the globality of the international system – described as an assemblage of dispersed, multifaceted liberal powers – rather than a mosaic of states in an anarchic system. Fidler's constitutionalism seems to overestimate the role of epidemic crisis and response as contextual facts, i.e. the outbreak event and the demanded quarantine measure. Conversely, this approach seems to reduce the importance of structural elements in the machinery of public health, such as surveillance and hygiene mechanisms administered by national and international agents. Started nationally in Western settings, they were increasingly implemented in the colonies, and helped to consolidate a system of security that one recognizes today.

SECURITIZATION: HISTORICAL-POLITICAL APPROACH

Instead of stressing events such as September 11 or the 2003 SARS outbreaks I am rather more attentive to another important happening that took place a couple of years before them and the specific context which led to it, i.e. the first session of the United Nations' Security Council dedicated to a health issue (HIV/AIDS), in January 10, 2000. This session, which was followed by others under the auspices of the Security Council and the United Nations' General-Assembly, resulted in a financial reinforcement of the United Nations Joint Program for AIDS (UNAIDS). Two years later, in 2002, the Global Fund for the Fight against HIV/AIDS, Tuberculosis and Malaria was launched. In 2003 the United States President Emergency Plan for AIDS Relief (PEPFAR) was finally established.

It is remarkable that the first grand HIV/AIDS international momentum at the political level took place in the Security Council, and moreover introduced by the Clinton Administration. Contrarily to what would somehow be expected, it was neither discussed in the General-Assembly, nor brought to the fore by some hard-hit country in Southern Africa. As such, this event is revealing for the complex chain of developments that it provoked, a set of energetic responses to the contemplation of a disturbing "dark side" of globalization. United States Ambassador to the United Nations at the time, Richard Holbrooke, expressed that contemplation finely. "Watching kids sleep in the gutters in Lusaka, [Zambia], knowing that they will become either prostitutes or rape victims, either getting or spreading the disease, because there's no shelter for them, and that the government is doing nothing about it, makes a powerful impression on you. (...) I said: 'Look at the facts; it's not

simply a humanitarian issue. If a country loses so many of its resources in fighting a disease which takes down a third of its population, it's going to be destabilized, so it is a security issue.' (...) Anyway, that was years ago. That issue is over. Everyone now accepts our definition of AIDS as a security issue – it's self-evident."[39]

The genealogy of securitization of infectious disease can be considered as old as the rise of liberal political regime in Europe since the 17th century, and whose global expansion and consolidation were favored by international public hygienist surveillance as of the 1830s.[40] Given this structure, it is relevant to briefly review French historian-sociologist-philosopher Michel Foucault's work on the analytics of power.

Inverting the principle put forward by Clausewitz that "war is nothing but a continuation of political intercourse, with a mixture of other means,"[41] Foucault maintains that modern societies in Europe, with the end of religious wars and rise of nation-states since the 17th century, started to be managed in function of the eminence of war, even in times of formal peace. Hence, according to Foucault, "politics is the continuation of war by other means."[42] As a result, there is a change in the idea of sovereignty, which is based less on juridical and territorial premises and more on political terms. This means that sovereignty, and its agency, is to be found, not only in the institutional body of the state as the national Leviathan, but in an insidious, comprehensive web of institutions and practices, governmental and non-governmental, local and international, yet commonly affiliated to ideals of liberal democracy and free trade. Foucault argues that "in opposition to the philosophical-juridical discourse, which builds on the problem of sovereignty and law, this discourse [analyzed by Foucault] is essentially a historical-political discourse, a discourse in which the truth works as a weapon for a partisan victory, a discourse soberly critical and, at the same time, intensively mythic."[43]

Unlike in the *Ancien Regime*, the nature of the power exerted by the sovereign agent as an assemblage of dispersed liberal powers reformulates itself towards a smaller capacity of exterminating lives. On the contrary, power is conceived to both foster life and impede it to the point of death. The object of such power consists on human beings at the aggregate level, as well as life in general. Designated as "biopower," it expresses the 18th century scientific effort of measuring and regulating all dimensions of life, such as birth, mortality, schooling, employment, criminality, etc. This change has implied thinking the human being as an "*être biologique*," a natural species, yet with political life and power. Biopower is therefore 'totalitarian' in the way that it is aimed at the totality of the population. Yet, its design is tremendously ambivalent, which allows it to manage surplus populations *vis-à-vis* the sovereign agent's survival and expansionist objectives. Holding society under control, biopower guarantees in the last analysis the prevalence of the superior 'race,' in which the concentration camp is not just a symbol of the regime and an institutional practice under a state of exception, but also a *locus* of scientific efficiency. Therefore, two major case-studies are the Nazi genocides and at the time of writing the unlawful imprisonments at Guantanamo Bay detention centre.[44] From an ethical point of view, the essential problem with biopower as securitization of bodies and societies is that it works towards the establishment of normalizing political objectives, discriminating what is superfluous, unnecessary and impure. In his study of

leper in Europe, Foucault has focused on how systems of quarantine institutionalized a "line of hygiene" based on "a practice of rejection, of exile-enclosure [where the patient] was left to his doom in a mass among which it was useless to differentiate."[45] Inspired by the Foucauldian approach, in his discussion of HIV/AIDS securitization, Stefan Elbe warns about the potential for implementation of public measures which might further an already very stigmatizing status for people living with AIDS.[46]

Contrarily to previous absolutist regimes, biopower, or biopolitics as it was later reformulated, necessitates to be rationalized, justified. "It was no longer considered that this power of the sovereign over his subjects could be exercised in an absolute and unconditional way, but only in cases where the sovereign's very existence was on jeopardy: a sort of right of rejoinder. If he was threatened by external enemies who sought to overthrow him or contest his rights, he could then legitimately wage war, and require his subjects to take part in the defense of the state; without "directly proposing their death," he was empowered to "expose their life" [...] But if someone dared to rise up against him and transgress his laws, then he could exercise a power over the offender's life: as punishment, the latter could be put to death."[47]

Foucault's later concept of governamentality embodies that necessity. It accounts for a discursive-material device (*dispositif*) of security embodying rationalities and technologies of government. They comprise "discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic propositions."[48] These technologies do not necessarily use violence to force people do what the sovereign likes.[49] In liberal societies that would indeed be very complicated to manage for the sake of the system's own sustainability. Frequently control is displayed through "ideological manipulation or rational argumentation, moral advice or economic exploitation."[50] The target is, nevertheless, the anatomic body in its most comprehensive political sense and at very different scales, from the professional setting to the dietary/beauty regime.[51]

A major manifestation of the sovereign power's governamentality is found in the "medical police."[52] First, one should stress the centrality of the police more as a "science" than a corporation within the apparatus of liberal governance. Foucault has associated the development of the police and its mission with the implementation of liberal regimes in Europe in the last three centuries. In fact, governamentality as rationalities and technologies of government largely corresponds to a general idea of police activity: "practices of inspection and surveillance, information and intelligence gathering, and direct intervention (to the point of deadly force) in private, familial and commercial matters."[53] Writing about the British case, Patrick E. Carroll argues that the medical police did not resort to deadly force; yet it pursued a variety of sanitary techniques in order to guarantee "health and safety" among the population.[54] Alison Bashford's article on the 1881 smallpox epidemic in Sydney, Australia, illustrates the more administrative facet of such medical policing through the establishment of the local health authority, i.e. the Board of Health in the British Colony of New South Wales.[55] Although smallpox epidemics were not "uncommon" in the 19th century, that one precipitated key bureaucratic changes. An analysis of medical police intervention in its early decades should not indeed be misguided by today's understandings of police

as a public uniformed authority structure.[56] Policing was primarily about carrying out activities animated by socio-political concerns rather than exhibiting state presence. Thus, one should mention the police role that charities pursued, as Carroll shows in the case of colonial Dublin, Ireland, hygienic activities in the 18th century.[57] The ultimate function of health policing was to potentiate the general health status of the populations, not just for the sake of political economy, but also to prevent scarring contagions and epidemics that could undermine the body politic.

The conceptualization started by Foucault on liberal power as driven by political economy ideology and not institutions leads to an image of an assemblage of various entities. "*Nébuleuse*" is an apt alternative word to assemblage that one borrows from Robert W. Cox to model the "constitutionalism" in global (health) governance, contrasting with Fidler's adoption of the United States federal model.[58] The end of the Cold War and the rise of global neo-liberal agendas performed by an enlarged quantity of institutions in many different sectors of activity (trade, development, humanitarian, etc.) and at different scales (local, national, regional, global) confirmed the reformulation of the state as sovereign political unit and accelerated the networking of biopolitical-like modes of power. This "*nébuleuse*" builds on strong political density, where many networks of governmental and non-governmental agents interact formal and informally at a global level. Global public health constitutes a quite solid domain for the analysis of those phenomena and the power relations they embody. They feature grand public-private, bilateral and multilateral funding, managing and implementing programs, initiatives and entities: WHO, PEPFAR, Global Fund, World Bank, UNAIDS, Clinton Initiative, Bill and Melinda Gates Foundation, and a vast range of INGO in the field.

Once inserted in the broader global governance, the health system as a regime of global surveillance consolidates the supremacy of an international arena dominated, not by anarchical relations of individual units of sovereignty in the form of states, as put by the realist tradition of International Relations,[59] but by a hegemonic world system of liberal sovereignty.[60] If it is true that this explanation is not fully applicable to the whole world, namely in terms of the "modern world" of powerful states of regional prominence, such as India, China and Russia,[61] this is particularly compelling with regard to the post-colonial world.

Alison Bashford reports that, in function of the establishment of border epidemical check-ups and quarantine systems, surveillance mechanisms were installed at the global scale uniting metropolises and colonies.[62] National surveillance and hygienist measures moved beyond from the national sphere on to the rest of the world, cementing Western power territorially and biologically, as the 1881 smallpox epidemic in Sydney above illustrated. As mentioned, a cholera epidemic affecting the European powers in the 1830s paved the way for the several international hygienist conferences during the 19th century that led to establishment of the international sanitary institutions in the two world wars' interval. Yet, it should be stressed that in that period, health issues were essentially taken as technical matters by the League of Nations' health office. According to Bashford, its mission was to collect information from the national administrations, in order to control diseases such as malaria, smallpox and sleeping sickness, in close collaboration with

the Economics Office of the organization. General population-related dossiers tended to be studied in its migratory and trade dimensions, excluding issues such as birth control, and sexual and reproductive health. The author provides several examples on how, despite direct enquiry, those latter matters were untouched by the League of Nations under the basis of not being part of the organization's mandate.

An important role in the systems of information on populations between colonies and metropolises was played by the educational transnational institutions of tropical medicine of the British Empire. Founded in the late 19th century, the schools of Tropical Medicine in London and Liverpool were instrumental in the research and dissemination of epidemiological facts and practices at the field level. Supported by different agents – the Rockefeller Foundation, the Red Cross, the business community of Liverpool (with vested interests in the Caribbean, West Africa and Latin America) – their agendas ranged "from the medical concerns of a fading Empire to a national and international school of public health, moving towards integration of domestic and global health concerns."[63]

The cultural history of medical intervention in the colonial world is quite informative with regard to a profounder comprehension of the meaning and practices of the structures of global health. Tropical medicine as a distinctive discipline in the curricula of medical studies was born with the objective of facilitating the settlement of Britons and other Europeans in threatening environments characterized by pests such as smallpox, malaria or yellow fever.[64] But it also held the mission of improving the lives of natives engaged in the colonial businesses, therefore pursuing the "benevolent" task assigned to imperialism. Nevertheless, in his revision of British and Australian literature in the imperial period, Cameron-Smith identifies tropical medicine "as a discourse that constructed the space of the tropics as Other and thus as racially pathological."[65] Building upon perceptions of higher mortality overseas as compared to the metropolis, and of climate-conditioned "native laziness" *vis-à-vis* the superiority of the Northern European spirit, physicians in the 18th century came to the conclusion that "foreign countries were simply unhealthy."[66] In any case, the economic profits from colonial enterprise outweighed the mortality risk, and so the Empire prolonged its mission of civilization and exploitation.

In his article on medicine in Somaliland during the first half of the 20th century, Mohamed shows how colonial rule benefited from health interventions, vaccination namely, as it improved public health. The medical mission was therefore "popularizing the Government, and identifying the administration with the people's welfare."[67] The integration of tropical medicine's culture and history when linked to the rise of "medical police" is particularly illustrative of both the character of this early securitization of infectious diseases and the apparatus of biopolitical instrumentalization at the global level. Beyond international and national political institutions, culture, science and medical practice informatively contribute to the historical power regime.

Hygienism has been notably instrumental with regard to the implementation of powerful white-supremacist regimes such as the one South African experienced during the Apartheid period.[68] According to Youde, the legacy of public health intervention as historically anti-black population

transpires from the 2000 conflict between South African government, notably President Thabo Mbeki, and the international AIDS community. Mbeki claimed that the international community's AIDS discourse was a Western neo-colonialist discourse expressing Africans' inferiority as a race to tackle their own problems. This episode was particularly dramatic since South Africa was holding, as it still does, the highest rate of HIV infections in the world.

CONCLUSION

David Fidler is quite right when affirming that major global health concerns are "revolutionizing" the way International Relations researchers observe them, from an "uninteresting" topic to a relatively prominent one as part of post-Cold War human security paradigm. The general issue of Western securitization of infectious diseases is mostly, and hierarchically, connected to scenarios of biological agents spread for terrorist purposes, outbreaks of diseases transmitted within the food chain, and extensive impact of major diseases such as HIV/AIDS, tuberculosis and malaria in Southern and Eastern African weak states.

The adoption of a historical-political lens *vis-à-vis* a juridical-institutional one allows us to come to, not only denser, but also, perhaps, surprising conclusions about the intimate function of disease in the whole Western global security project. First, the historical-political approach takes governance's constitution as an assemblage of dispersed, though hierarchized, liberal powers. Second, it permits an appreciation of the power role played by a larger range of actors, namely INGOs, apart from the states and multilateral organizations. As the HIV-security nexus case shows, INGOs played an essential role in the early politicization of the issue of HIV. Third, this approach emphasizes the idea of structure as the major securitization driver. Even though context remains important (e.g. September 11, 2003 SARS outbreaks, etc.), structural governance elements, i.e. surveillance mechanisms of epidemic control, preparedness and response, strongly contributed to Western security. They helped in the expansion and consolidation of the world system of dominance over the colonial world in function of a rising global liberal economy. Post-September 11 'new order' in global health and the security agenda emerging from it unfolds continuities of the colonial legacy. Such continuities appear as tantamount to the post-Cold War reduction of state sovereignty in the international arena, proportionately to the hegemonization of the assemblage of dispersed, multifaceted liberal powers. Table 1 summarizes the main characteristics.

Table 1. Characteristics of the Juridical-Institutional and Historical-Political Approaches to Securitization of Infectious Diseases

	Juridical-Institutional Approach	Historical-Political Approach
Constitutional Type of Global Health Governance	United States federal model	"*Nébuleuse*" of liberal powers
Main Actors in Governance	States and international organizations	States, international organizations, private companies, INGOs, "celebrities," academics

Securitization Driver	Contextual events (e.g. 1830s cholera epidemic; September 11, 2001; September 18, 2001; 2003 SARS outbreaks)	Structural continuities of colonial health governance: surveillance mechanisms, hygiene intervention and tropical medicine culture

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[3] Earlier versions of this article were presented at the IV Congress of the Portuguese Association of Political Science (Lisbon, March 6-7, 2008) and WISC 2008 – Second World International Studies Committee Conference (Ljubljana, July 23-26, 2008). I acknowledge support from the Foundation for Science and Technology, which is funding my doctoral project. I very much appreciate feedback through the e-mail: pereirarjr@yahoo.com.
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