WARWICK
THE UNIVERSITY OF WARWICK

Original citation:
Šehović, Annamarie Bindenagel. (2017) Identifying and addressing the Governance Accountability Problem (GAP). Global Public Health.

Permanent WRAP URL:
http://wrap.warwick.ac.uk/91558

Copyright and reuse:
The Warwick Research Archive Portal (WRAP) makes this work by researchers of the University of Warwick available open access under the following conditions. Copyright © and all moral rights to the version of the paper presented here belong to the individual author(s) and/or other copyright owners. To the extent reasonable and practicable the material made available in WRAP has been checked for eligibility before being made available.

Copies of full items can be used for personal research or study, educational, or not-for profit purposes without prior permission or charge. Provided that the authors, title and full bibliographic details are credited, a hyperlink and/or URL is given for the original metadata page and the content is not changed in any way.

Publisher's statement:
"This is an Accepted Manuscript of an article published by Taylor & Francis. International Feminist Journal of Politics on 13/09/2017 available online:
https://doi.org/10.1080/17441692.2017.1371203

A note on versions:
The version presented here may differ from the published version or, version of record, if you wish to cite this item you are advised to consult the publisher's version. Please see the 'permanent WRAP URL' above for details on accessing the published version and note that access may require a subscription.

For more information, please contact the WRAP Team at: wrap@warwick.ac.uk

warwick.ac.uk/lib-publications

Identifying and Addressing the Governance Accountability Problem (GAP)

Šehović, Annamarie Bindenagel[1]* (2017). 'Identifying and Addressing the Governance Accountability Problem (GAP)', *Global Public Health*.

Abstract

Successive global health crises – from HIV and AIDS to SARS and H5N1 to Ebola highlight one of the most pressing challenges to global health security: the GAP – the governance accountability problem. Introduced in 2014 in the book entitled, *HIV/AIDS and the South African State: The Responsibility to Respond*', this article takes up Alan Whiteside's challenges, in a book review in these pages, to offer a more comprehensive analysis of the GAP.

The Governance Accountability Problem, GAP,[2] posits that there is a disconnect between ad hoc, state and non-state (NSA) interventions to respond to an epidemic crisis, and the ultimate guarantee for health (security), which remains legally vested with the state. The existence and expansion of such ad hoc solutions results in a negligence: a failure of re-ordering of health rights and responsibilities for health between such actors and the accountable state. The GAP aims to highlight this disjunction.

This article first defines the GAP. Second, it asks two questions: First, what is the contribution of the GAP thesis to understanding the emerging health security landscape? Second, what can the GAP offer in terms of practical insight into viable solutions to the re-ordering of state / non-state-based responsibility and accountability for global health security?

Introduction

Health security embodies two impulses: first, a *right* to health that is guaranteed to be secured; and second, a *responsibility* or *obligation* to provide security of health. But for whom and by whom?[3] Health security it includes on the one hand, protection from threats to health, and on the other hand, guarantees of intervention to address health risks and vulnerabilities. If the right to health exists, then it must be provided for and protected. In the current geo-political context, where BREXIT was partly enabled by (false) promises of increased healthcare funding for citizens of the United Kingdom, and where U.S. President Trump is both spearheading the dismantling of the inaugural universal U.S.-healthcare program, the Affordable Care Act, denying millions of American citizens the means for attaining their right to health, and curtailing funding to global health programs, reviewing the relationship between that right to health and the provision of its security is timely and pertinent.

---

[1] Dr. Šehović is a Research Fellow, PAIS (Politics and International Studies), University of Warwick, UK. She is part of the EU Horizon2020 project, EL-CSID (European Leadership – Cultural, Science and Innovation Diplomacy), under Grant Agreement No 693799. In the norther hemisphere's Winter Term 2017/2018 she will be acting Professor of International Politics at the University of Potsdam, Germany. Special thanks to Alan Whiteside and Solly Benatar for their comments and encouragement, and the anonymous reviewers at *Global Health* for their constructive comments towards the publication of this article.

[2] Šehović, Annamarie Bindenagel. *HIV/AIDS and the South African State: The Responsibility to Respond.* (Ashgate, 2014).

[3] Šehović, Annamarie Bindenagel (2015). 'Where Are Rights? Where Is Responsibility? Who Acts for Global Public Health? *ASPJ Africa & Francophonie*, 3rd Quarter, pp. 35-48; and Rushton, Simon (2011). 'Security for Whom? Security from What? *Political Studies,* Vol. 59, Issue 4, pp. 779-796.

That precarious relationship presents one of the most pressing challenges to global health security. It is embodied in the GAP – the governance accountability problem. This article takes up Alan Whiteside's challenge in a book review in these pages,[4] to offer a more comprehensive analysis of the GAP.

The GAP[5], posits that there is a disconnect between state and (more) ad hoc non-state actors' (NSA) interventions in response to an epidemic crisis. While NSA, ad hoc solutions apply at the local but also at the global governance levels: from bilateral non-governmental organization (NGOs) interventions through to the ultimate guarantee for health (security), which remains legally vested with the state. The strengthened International Health Regulations (IHRs) at the World Health Organization (WHO), which rely upon Member States for their adoption and implementation, further underscore this point of the GAP. As a result, **the GAP emerges at the intersection health and human security. In doing so, it contends that the final responsibility and accountability for health security resides with the state.**

As such, the GAP is distinct from the scholarship of 'securitization.' Securitization prioritizes the security of the state, and is bolstered through that lens, whereas the GAP thesis emphasizes the human security in health security.[6] The responses to HIV and AIDS and Ebola illustrate the former: in both cases, fear for the stability and security of most-affected states elevated the international prioritization of interventions. While securitization itself does not necessarily preclude a human security focus, it has thus far reinforced the national security discourse at the border of state security. In contrast, the GAP explicitly puts the security focus on the human being, for whose health security accountability is a matter of life or death. On the one hand, this highlights the inextricable link between human security and that of the state, wherein lies the final onus of that security, and one the other hand makes room for the reality that the same human security is both threatened most critically and guaranteed most credibly by state (in)action. Acknowledging this duality enables the GAP to showcase the distance between the actions of non-state actors (NSAs) which contribute to health and human security, even holding themselves to account (Rights-Based-Accountability (RBA); Accountability for Health (A4H)), and the accountability for the ultimate **guarantee of accountability for such security, which remains with the State.**

---

[4] Whiteside, Alan (2015). *HIV/AIDS and the South African state: Sovereignty and the responsibility to respond*, Global Public Health, 10:5-6, 773-774, DOI: 10.1080/17441692.2015.1019908

[5] Šehović, Annamarie Bindenagel. (2014.) *HIV/AIDS and the South African State: The Responsibility to Respond.* (Ashgate Global Health).

[6] See Farmer, Paul (1999). *Infections and Inequalities* (); Farmer, Paul (2003). *Pathologies of Power* (); Nef, Jorge (1999). *Human Security and Mutual Vulnerability: The Global Policy Economy of Development and Underdevelopment*, 2nd edition (International Development Research Center); Nunes, João (2014). 'Questioning health security: Insecurity and domination in world politics,' Global Health in International Relations, Vol. 40, Issue 5, pp. 939-960; Šehović, 2014.

Recognizing this disjunction is critical. While NSAs play an invaluable role in providing provisions – notably treatment and care – of human and health security, they cannot and do not replace the guarantee function of states. The latter is embedded in the state-citizen relationship. These will not be dealt with in detail here except to note that accountability structures that circumvent this relationship by cannot by definition replace the ultimate guarantee of security promised, even if not enacted, therein. In order to make its case further, this article first defines the GAP and charts the course of its emergence. Second, it asks two questions: First, what is the contribution of the GAP thesis to understanding the emerging health security landscape? Second, what can the GAP offer in terms of practical insight into viable solutions to the re-ordering of state / non-state-based responsibility and accountability for global health security?

The GAP

The Governance Accountability Problem, GAP, first introduced in 2014,[7] highlights the critical link between states and their populations. The link referred to is the social contract that binds a state's population, via both its rights and responsibilities, to the state, and the state's responsibilities and accountability to its population in turn. This link makes it possible for a state population – citizens – to direct their demand for, in this instance, the right to health, to the state apparatus. Cementing this relationship is, furthermore, the entire international governance infrastructure, wherein the WHO, for example, renders its Member States responsible for the health of their population (citizenry). This reciprocal relationship is exclusive: (often) limited as it is to citizens of a state.

The GAP posits that states and NSAs have different allotments of accountability with regard to the protection and provision of health security. This is derived from the assumption that states harbor the ultimate responsibility for health security while NSAs operate in an ad hoc fashion whereby their contribution to the protection and provision of health security is accepted – invited, imposed – possibly even indispensable. However, whereas states are bound to fulfill their citizens' internationally articulated inalienable right to health and health security, NSAs are not. The latter may, of course, enter into voluntary accountability agreements, but these fall outside the remit of (inter)national jurisdiction and enforcement.

> *Governments have a **responsibility** for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be*

[7] *ibid*.

> *the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.*[8]

Allowing NSAs to assume some human and health security provision is not enough. Even including accountability loops between them and donors and / or funding states, does not close the gap in the GAP between rights and responsibilities still solely arranged between states and citizens.

National state actors, notably governments acting through their Treasuries, Finance and Health Ministries pertinent to this case, are capacitated as well as limited by their coffers and the capabilities of their citizens. They are also confronted by competing policy priorities. International and non-state actors tend to have deeper coffers and more substantial human resources on which to draw and to apply, for example, to one overriding policy focus: the World Health Organization (WHO) has as its sole aim the attainment of health. While health includes various facets, and its financial resources inadequate and unpredictable, the WHO does not have to compete within itself for policy prioritization of, for example, military, infrastructural or educational expenditure. In addition, national states can issue binding rules for whose compliance they are held to account. In contrast, international actors, whether institutions such as the WHO, composed of states, or non-state actors such as Médecins Sans Frontières (MSF), can merely issue recommendations and guidelines, for whose consequences they are not held to account.[9]

Yet as has often been argued, NSAs are invaluable. They perform tasks that states, particularly fragile or failing states, cannot or will not, including those which are impoverished, apathetic or openly hostile to particular treatment interventions,[10] such as for HIV and AIDS regimens.[11,12] Seen from this vantage point, it has been argued that such ad hoc relationship pose no (additional) threat or risk[13] to the securing of health (rights).

This illustrates empirically the theoretical argument above that NSAs remain outside of the purview of accountability that uniquely ties states to their populations – a relationship that, despite its

---

[8] WHO 1978.

[9] International institutions and organizations, as well as NSAs, can of course be held to account in the court of public opinion. Yet this paper is concerned with legal and structural accountability, outside of which these entities operate. Legal and structural accountability remains the purview of states, or Member States, as the case may be, though this is starting to change – as seen in the process of holding the UN to account for importing cholera into Haiti shows.

[10] This seems to be recurring as draconian anti-homosexuality laws are being discussed and passed in, for example, Kenya and Uganda. As the governments retract support for HIV and AIDS treatment and care, NSAs are (again) filling the void, sometimes under dangerous conditions.

[11] Such as when Zackie Achmet and the Treatment Action Campaign in South Africa illegally imported anti-retroviral drugs from Brazil to administer in the Cape townships to prove wrong the naysayers who argued that (poor) Africans could not tell time and therefore would be unable to stick to the strict treatment regimens.

[12] See also Davies, S., S. Elbe, and S. Rushton (2015), *Disease Diplomacy* (Johns Hopkins University Press).

[13] See Risse, Thomas (2012). 'Governance Configurations in Areas of Limited Statehood. Actors, Modes, Institutions, and Resources,' SFB-*Governance* Working Paper No. 32 (April), available at: http://www.sfb-governance.de/en/publikationen/working_papers/wp32/SFB-Governance-Working-Paper-32.pdf.

panoply of imperfect incarnations from democracy to dictatorship, exists in theory if not in enforceable practice, across the globe. Given this near-universality of state-population accountability, it becomes evident that there is a mismatch between state and NSA protection and provision of health security. That mismatch is explained by the GAP.

Furthermore, the GAP points to a functional as well as a normative schism. It highlights the lack of formal relationship between citizens' rights and states' responsibilities vis-à-vis NSAs. It also lays bare the normative oversight of non-citizens' rights: these go completely unaccounted for between the responsibility loops linking States-citizens and NSAs-donors. That particular problem is even more glaring when taking into account bilateral state (-citizen) relations which honor the rights of taxpayers in the giver-state but which likewise fail to account for the rights of recipient-States.

Health Security and the GAP

Health security is defined by a relationship of demand and supply directed at governance by the state. This is due to the fact that security, both 'traditional, territorial security,' as well as 'human security',[14] is and remains for the time being the purview of national states. While some scholars emphasize the 'securitization' of health,[15] wherein the security in question remains that of the state; others focus on the human security of health as their focal point.[16] Whereas the former sees health security as related to state defense, the latter draws on decades of research dating from the 1994 Human Development Report,[17] of the Commission on Human Security, *Human Security Now*,[18] to analyze health security as integral part of human security. The latter builds further upon centuries of development of the argument that state responsibility to promote and protect the rights of its citizens, not only in terms of territorial integrity, but also in terms of welfare – including health.[19] State-sponsored security has evolved to include the expectation of

[14] See UNDP (1994). *Human Security Now*.
[15] McInnes, Colin and Simon Rushton (2010) 'HIV, AIDS and Securitization,' Paper for 2010 International Studies Association Conference, New Orleans, USA; Elbe, Stefan (2010). *Security and Global Health*. (Polity).
[16] Farmer, Paul (1999). *Infections and Inequalities* (); Farmer, Paul (2003). *Pathologies of Power* (); Nef, Jorge (1999). *Human Security and Mutual Vulnerability: The Global Policy Economy of Development and Underdevelopment*, 2nd edition (International Development Research Center); Nunes, João (2014). 'Questioning health security: Insecurity and domination in world politics,' Global Health in International Relations, Vol. 40, Issue 5, pp. 939-960, Šehović, 2014.
[17] UNDP, (1994). *Human Security Now.*
[18] Benatar S R. 'Global leadership, ethics & global health: The search for new paradigms. *'Global Crises & the Crisis of Global Health*. Gill S (Ed) CUP 2011 pp 127-143; Gill, Stephen and Solomon Benatar (2016). 'Global Health Governance and Global Power: A Critical Commentary on the Lancet-University of Oslo Commission Report,' *International Journal of Health Services* Vol. 0, Issue 0, pp. 1-20.
[19] Benatar, in Gill, 2016.

1. Providing physical security to everyone living in its area of jurisdiction;
2. Building and maintaining legitimate political institutions to implement government programs and sustain the whole;
3. Providing sound and consistent economic management, as well as
4. Creating conditions for and providing mechanisms of social welfare to those who need them.[20]

This litany of *expected* securities showcases that "individual security, stemming from the liberal thought of the Enlightenment, was also considered both a unique and a collective good."[21] It is a public good dependent upon the state, whose own security was in turn contingent upon the security, including the health security, of its populace. In this iteration of human security, NSAs have a role to play: but, critically, they do not assume either the legal or the practical obligation to provide for the securities above. Despite norm evolution in terms of the expansion of individual human rights, and voluntary state and non-state intervention towards that end since Westphalia, the state-based system is still constrained by Westphalia's territorial dictation of citizen rights and state responsibilities.[22] As a consequence, states continue on the one hand to assume the obligations of health security, while on the other hand they face myriad constraints in the guise of concomitant and increasingly global challenges, as well as the limitations of their own willpower and capacity.

> *The challenge is that in a world of sovereign states, there is no hierarchical authority or world government to fill in the gaps. Rather, there is only a relatively weak system of multilateral institutions built on the shaky foundations of the consent of sovereign states.*[23]

Implementation can to an extent be divorced from the expectation that the State provide such securities. International Organizations (IOs), non-state actors (NSAs) and non-governmental organizations (NGOs) can and do enter the arena to provide securities. This occurs most notably individual physical security as by UN peacekeepers, who are on the one hand tasked with providing individual physical security within an enclave of territorial insecurity, who are, on the other hand, however, often ill-enabled by mandate or equipment to fulfill this task.[24] IO, NSA and NGO provision

---

[20] See Hösle, Vittorio. (2003.) *Morals and Politics* (University of Notre Dame Press); and Patrick 2006; Eisenstat, Porter & Weinstein. (2005), pp. 136 quoted in draft paper by Franklyn Lisk and Pieter Fourie, *AIDS & Security in their 21st Century.*

[21] Liotta, P.H. and Taylor Owen (2006). 'Why Human Security?' *The Whitehead Journal of Diplomacy and International Relations* (Winter/Spring), pp. 37-54.

[22] Matthews, Jessica (1997). 'Power Shift,' *Foreign Affairs*. Vol 76, Issue 1, pp. 50-66.

[23] See also Frenk, Julio, Gomez-Dantes, Octavio and Suerie Moon (2014). 'From sovereignty to solidarity: a renewed concept for global health for an era of complex interdependence,' *The Lancet* 383: 94-97.

[24] Reference Srebrenica, Bosnia and Herzegovina, for example.

of securities also takes place in spheres of social welfare, where they can and do provide healthcare services such as HIV and AIDS counselling, testing and treatment (VCT).

Yet the expectation that the state provide securities cannot be divorced from governance by the state. As a consequences, when and where states cannot or do not rise to the occasion of providing health security or security for health, the GAP arises. The GAP thus identifies the seminal reliance of governance on States; while at the same time illustrating that the government-ability of security involves states *and* additional actors. Make better sense of the latter necessitates a renewed look at the origins of the state security guarantee, which in turn, in the sections below, posits possible solutions for bridging the GAP.

Status

As human security is the purview of the state, so, too, is its component, health security. In this instance, security at the levels of territory and of social welfare is included. Significantly, within the evolutionary process sketched under 'origins' above, citizenship has emerged as a key defining characteristic used to differentiate within universal human rights. While the normative evolution of state responsibility includes physical protection to all living within the territory of the states, this has not translated into legal or functional provision of welfare, including of health security, to all. This latter, expansive norm is bound by the borders of citizenship.

This has created spaces for two sorts of gaps: first, a gap between what health securities states are able or willing to provide for their own citizens or populations within their borders; and second, a gap between the state *obligation* to provide health securities and the lack of such between states, their citizens and populations and the actors who do proffer health securities support. Terming health securities' interventions, such as VCT, 'supports' highlights the fact that these are voluntary measures, not obligatory implementations for the purpose of establishing and sustaining universal human security within a particular territory. This schism gap is revealed by the fact that in such an instance, the **demand** for health security knows no addressee. For that reason, it is the latter that concerns us most here, and which gets us to the GAP.

Getting to the GAP

In its first function, the GAP showcases the existent relationship between the (moral) obligation for individual human security and the state. In its second function, the GAP illustrates how the 'international community', comprised of such states, charged with holding the same accountable for

human security within their borders,[25] invokes, but does not govern, an even more precarious obligation for that selfsame human security.

Consequently, the GAP is a challenge bearing upon national and international actors. This includes States and IOs comprised of them, as well as NSAs and NGOs. From the normative perspective, the onus for response, for the acknowledgment of obligation, on the part of national states and international actors comprised of states, is attributable to the GAP itself; precisely because it is the schism between state jurisdiction and the void beyond. The onus for health security is simultaneously national and international due to the fact that health **in**security, its risks and vulnerabilities, can neither be confined to one territory nor rendered stationary in a world increasingly characterized by movement (which political instabilities threaten not to end but if anything to exacerbate).

The GAP in Health Security: revolutionizing the right to health through HIV/AIDS

This section introduces the illustrative example of the response to HIV and AIDS in South Africa to highlight the GAP. On the one hand it shows that while the norm of the right to health gained resonance, its translation into practice traction was made partly possible by NSAs. On the other hand, that same elevation of HIV and AIDS as a security threat at the global governance agenda reinforced the role of states in establishing and protecting that security. Finally, it argues that precisely the success of NSA action state action for HIV and NSA change of focus, reiterating the role of the state as the ultimate guarantor of, in this case, heath security.

In the aftermath of the Second World War, as the world was re-ordering in the wake of two devastating wars, the newly created World Health Organization (WHO) declared the universal right to health. The WHO defined that right as, "the highest attainable standard of physical and mental health."[26] Yet as the emerging global order relied on the principle of the equal status of national States, as reflected in the one State-one vote policies of the United Nations General Assembly and the WHO's governing body, the World Health Assembly, the enforcement of the right to health remained with states.

This governance model renders the first of the GAP functions visible. It iterates that "enforcing **rights** is another matter altogether, since it is often the signatory states themselves who are responsible for rights violations, from torture to neglect of the public sector."[27] The second gap becomes obvious over the course of the trajectory revealing that the 'international community' fails

[25] See also Hösle, Vittorio (2003). *Morals and Politics*. (University of Notre Dame Press).
[26] Constitution of the World Health Organization (WHO), 1948.
[27] Farmer, Paul, 1999 and 2003.

to hold states to account or to assist in enabling them to meet their health security obligations. Consequently, the right to health exists largely on paper but not in practice.

The HIV and AIDS epidemic, and the responses it spurred, challenged this course. First of all, by proving that HIV and AIDS could be treated,[28] activists teaming up with scientists turned the impossible into the possible. In the process, this unique transnational network, spanning from the U.S. to South Africa, with Brazil in between, rewrote the theory of the right to health into the practice of its realization.

On the one hand this led to a highly medicalized[29] and technical response. At the moment, this is culminating in a vaccine trial in South Africa. On the other hand, the revolutionary HIV and AIDS response served to expand the reach of the right to health. The current (2017) momentum around the proposed Framework Convention on Global Health (FCGH), which builds upon the Alma Ata agreement[30] and also crucially on the success of the rights'-realization experience with HIV and AIDS, is a further sign of this. Whether this push will prevail in the turbulent geopolitical times is one of the crucial tests of the right to health and its realization at this time.

Second, HIV and AIDS brought to the fore an ongoing debate around the right to health and the responsibility for realizing this right. It asks the question: "Health and human rights needs a legal framework to impose on national governments, true, but who is responsible?"[31] It straddles the arguably artificial divide between state and human security.

Initially, as noted above, the right to health was understood as the right of a national state to protect the integrity of its borders by 'securing' the (most) mobile trans-border population: the military. The military is also the crucial link between state territorial security and the human security of the population – it's economic and welfare protection and provision – within. In this discourse, the right to health became a security concern.

> *A security issue is posited (by a securitizing actor) as a threat to the survival of some referent object (nation, state, the liberal economic order, the rain forests), which is claimed to have a right to survive. Since a question of survival necessarily involves a point of no return at which it will be too late to act, it is not defensible to leave this issue to normal politics. The securitizing actor therefore claims a right to use extraordinary means or break normal rules, for the reasons of security.*[32]

---

[28] See Elbe, Stefan (2010). *Security and Global Health*, (Cambridge: Polity Press).
[29] *Ibid*.
[30] Declaration of Alma Ata, 1978.
[31] Farmer, Paul, 1999 and 2003.
[32] Eisenstat, Porter & Weinstein. (2005), pp. 136 quoted in draft paper by Franklyn Lisk and Pieter Fourie, *AIDS & Security in their 21st Century.*

This risk emphasizes the point that states themselves pose a threat to human and health security. As such, securitization, wielded to frame the health risk of HIV infection as a *state* security threat, is a double-edged sword. While it led to the public prioritization of response to HIV and AIDS, it also led to particular, vertical, national, international and NSA-driven interventions that promoted some health security. At the same time, this securitization and the ensuing treatments and care proved the effectiveness of (medical) responses to HIV and AIDS, in turn elevating the idea and possibility of health rights and human security.

This is aptly illustrated in the case of South Africa. In 1997, the South African Government passed an amended Medicines and Related Substances Control Act (originally of 1965) to thwart the rising costs of, among others drugs, ARVs. In response, 39 international pharmaceutical companies sued the government in its own Constitutional Court. At the end of a three-year legal battle, the pharmaceutical consortium ceded defeat, paving the way for South Africa to purchase patented – but not generic – medications from the lowest bidder. The subsequent assumption of responsibility for HIV response on the part of the South African Government rendered (some) NSA work redundant.

This highlights a trend: in the mid-to late 1990s, with the arrival of ARVs but a lack of infrastructure, NSAs took the lead in responding to health challenges, notably to the HIV and AIDS epidemics. These actors filled in for indifferent and / or overwhelmed states. In the wake of the South African court case with regard to State-sponsored intervention for health, a sea change occurred: in the mid-2000s, states re-emerged as the actor of and for health security. Now, in 2017, another shift is visible: that of the resurgence of NSAs as States attempt to cope not only with sustained and even burgeoning HIV and AIDS epidemics, but with the co-morbidities wrought of especially Zika in Brazil, and tuberculosis (TB), including multi-drug resistant (MDR) and extra-multi-drug resistant (XDR) TB. This trend leads back to the question of state vs. non-state rights and responsibility, to the GAP.

It is, however, a precarious prioritization. While HIV and AIDS has been on the international security – State and human – agenda for nearly three decades, neither its place there, nor that of health security more broadly, is ensured. National states have a securitization rationale to response to the risk posed by HIV and AIDS infection (at their borders). They also have a domestic security rationale for responding to the infectious threat; though research by Alex de Waal debunks the notion that the spread of HIV and AIDS (need to) result in state destabilization or dissolution. States also arguably have a human security reason to respond: based on a social contract of sovereignty wherein they are to provide protection to the population within their borders. Other responders, notably non-governmental organizations (NGOs) and non-state-actors (NSAs) have primarily a humanitarian response rationale. The debate over the location of the responsibility for that right to health realization has not taken place.

While states are theorized to be held accountable to both their citizen-populations and the international community, the arrangement lacks an inverse relationship. Despite whatever action or intervention the 'international community,' or NSAs, might take on behalf of, with or without the consent of states, for whatever period of time, this is not subject to the same ultimate guarantee. If the state is unable – or unwilling – to assume and assert this security guarantee, the GAP opens wide: reinforcing its salience on three counts. First, it emphasizes the lack of replacement of the state as the ultimate guarantor of (human) security. Second, it highlights anew the enduring tension between moral rights' demands on the state and states' corresponding responsibilities. Third, lacking legitimacy either due to lack of capacity or lack of will, states themselves cannot bridge it; neither can citizens, who must choose from whom to claim their demands. If the state is not an option, either NSAs fill the void it clarifies that minus the state guarantee, NSAs are an inadequate stopgap measure of human and health security. All three thus verify the existence of the GAP.

The GAP in Health Security: Revolutionizing Responsibilities – Getting over the GAP

The first step towards re-ordering – revolutionizing – health security responsibilities it to trace their origins and identify where and how to adapt. While states, also as Member States of the WHO, remain decision-makers, the 1969 International Covenant on Economic Social and Cultural Rights (ICESCR) and the 1978 Declaration of Alma Ata, among other entities, welcomes the participation of NSAs. For example, the ICESCR explicitly opened up the health security space to NSAs, while also reinforcing the role of states as the ultimate guarantor.

> *While only States are parties to the Covenant, and thus ultimately accountable for compliance with it, all members of society- individuals, including health professionals, families, local communities, intergovernmental and non-governmental organisations as well as the private business sector have responsibilities regarding the realisation of the right to health.*[33]

Recognizing that stronger mechanisms to safeguard increasingly global health security, the WHO adopted updated International Health Regulations (IHRs) in 2005, which went into effect in 2007. These, too, placed the final responsibility for health security with States.

> *Health is considered the sovereign responsibility of countries, however, the means to fulfil this responsibility are increasingly global. The International Health Regulations (2005) constitute the essential vehicle for this action. The International Health Regulations were revised a decade ago in order to better protect global health security – specifically, with the aim to*

[33] Committee on Economic, Social and Cultural Rights 2000.

> *prevent, protect against, control and respond to the international spread of disease while avoiding unnecessary interference with international traffic and trade.*[34]

Each of these treaty obligations continues to identify the state as the ultimate responder, reinforced by three realities of the current governance arrangement between states and NSAs. Bearing this in mind, this section offers initial ideas on how it might be possible to hold states and NSAs accountable – in a coordinated manner – to provide health security within the constraints of the current state-based order of international, global governance.

First, at present no mechanism exists to compel a NSA to continue or to sustain the provision of a particular good. For the NSA the good is private, even if, seen from the point of view of the recipient – and the recipient's state – it might (also) constitute a public good, such as a component of public health. The NSA can always argue that the state is ultimately responsible for the protection and provision of said good. Second, similarly, if a NSA changes its focus area, from health to water and sanitation,[35] there is no (internationally) recognized or automatic recourse at the state's disposal to compel the NSA to stay the course. In both instances, the consequence is that the state remains accountable for the protection and provision of its population's health, whether or not it controls the capacities to do so. Third, as in the case of HIV and AIDS, the initial provision and then the withdrawal of treatment and care, results in a death sentence for which only the state, with its responsibility links to its (citizen) population, can be held accountable. Although NSAs can be the (initial) difference between life and death, as has been argued here, the state retains the ultimate responsibility and accountability for the protection and provision of (health) security. This again highlights the importance of acknowledging and managing the GAP where it exists. Nonetheless, the GAP is not a foregone conclusion. It is feasible to re-order responsibility and accountability in a manner that gives an ultimate guarantee under, or over the level of state governance.

This could be amended through shared governance arrangements. Such governance (re)arrangement might take place on two levels. First, on the levels of states, which remain the ordering entity of the still existent (inter)national governing system. Second, a (re)arrangement is vital at the regional level, building bridges between states, NSAs and the individuals who reside within (porous) territories and with (tenuous) citizenship claims. At both levels, the aim must be to synchronize the primacy of individual human rights with the responsibility for their realization.

The former comes with the most serious caveat, visible also in the weakness of the United Nation's Security Council (UNSC) and the Responsibility to Protect (R2P), among others. That is,

---

[34] WHO Report of the Ebola Interim Assessment Panel - July 2015, available at: http://www.who.int/csr/resources/publications/ebola/report-by-panel.pdf?ua=1.

[35] The Bill and Melinda Gates Foundation did just this.

states policing themselves is a fraught exercise. Indeed, states themselves pose possibly the most serious threat to the security and health security of their populations.

> *We must be mindful, though, that a challenge to the sovereign authority of oppressive states is contingent on the sovereignty of states that are willing to intervene (politically or militarily) on behalf of oppressed people. This assessment suggests that as we sketch out permutations and transfigurations of sovereignty, we cannot stop thinking about the continued importance of statehood.*[36]

Here in the end, in a circular conundrum, States appear again to the arbiters of that same responsive accountability, whether directed towards the (human) security of the State's own population, to toward the population of another State, one incapable or unwilling to protects its populace.

With regard to the latter, history provides a possible inspiration for governance above the level of states. For example, in some medieval governance structures, states shared sovereign authority with a "host of other actors, including religious bodies and institutions." [37] These 'religious bodies and institutions' constitute the first NSAs. If NSAs were brought into a binding relationship with states to assume (sovereign) responsibilities for health security, this might represent a model to adapt. This could be done through sharing intervention tasks, by delegating these, or by allowing ad hoc procedures. Whereas the first two would allow the sharer – for instance the state – to revoke the arrangement and 'take back' full responsibility, the latter would not.[38]

A successful intervention would strengthen the argument for the possibility of the realization of the universality of the right to health: admitting a "universal ethic or regime of human rights (perhaps codified by international law) could delimit the sovereignty of states and **hold them accountable to a higher moral standard than a minimalist anarchic system would allow**."[39] While the European Union is in some ways an experiment that might move in this direction, its Brussels-issued directorates conform to the Westphalian system: they are up to individual Member States to implement, although in a possible sign of progress towards bridging the GAP, sanctions are attached to some.

Re-conceptualizing both state and human security, with the potential of reaching across borders, is all the more necessary in the current moment. Given the current challenges of cross-border (infectious) disease spread, also driven by climate change and migration, anticipating

---

[36] Carlson, and Owens, eds. *The Sacred and the Sovereign*: 10.
[37] Carlson, and Owens, eds. *The Sacred and the Sovereign,* pp. 17.
[38] See Šehović, Annamarie Bindenagel. (2014.) *HIV/AIDS and the South African State: The Responsibility to Respond.* (Ashgate Global Health) and Prah Ruger, Jennifer (2017). Health and Social Justice (Oxford University Press).
[39] Carlson, and Owens, eds. *The Sacred and the Sovereign,* pp. 17.

appropriate governance arrangements applicable above the level of states is invaluable. While some research is being done,[40] much more is necessary.

Conclusions

In the current order, States remain the ultimate and only legal entity responsible for the human, including health, security of their populace. NSAs, which might offer an ad hoc[41] modicum of human or health security, are not or cannot be held to account by the recipient population. Unless and until the relationship between states and citizens and is clarified, the threat of the GAP or the GAP itself will exist. The GAP thus reveals the vital necessity of re-thinking the provision and implementation of the State guarantee of human security, including health security, with (any) necessary accountability of NSAs. As such, getting over the GAP requires a re-ordered governance (re)arrangement[42] at the global level. Conceiving such solutions would go a long way toward getting over and bridging the GAP. Doing so is critical is part of a necessary response to increasingly interrelated and rising health, environmental and governmental insecurities.

The decision to bridge the GAP is fundamentally political.[43] Acknowledging and responding to demands for health rights along the spectrum of state and increasingly NSA accountability also constitute political acts with moral and practical inputs and implications for state and human security. Consequently, how states, as the ultimate guarantors of their own and their population's human security, conceptualize security within and beyond their bordered territories of space and citizenship represents the first input into any political decision to respond. How these states then act, and with whom, whether other states or NSAs, is the second decision phase. [44] Whether this response takes the form of shared, delegated or ad hoc governmentality is the third. Any successful human and health security intervention depends upon all three in an effort to bridge the GAP.

The GAP identifies a schism between individual human rights and the responsibility for their realization. While States remain the intended harbingers of territorial and human security, they are often far from achieving that ideal. Given the storm of insecurities converging on State and global governance at this time, bridging the GAP is critical to prepare, preserve and protect human and health security.

---

[40] Rushton, S. 2010; DiStefano M, Ruger JP. "Reflective Solidarity as to Provincial Globalism and Shared Health Governance," *Diametros*, 2015; 46: 151-158.

[41] See Keck, Margaret E. and Kathryn Sikkink. 1998. *Activists Beyond Borders: Advocacy Networks in International Politics* .Ithaca and London: Cornell University Press, on "boomerang effect" of actors working to influence states to act to meet their sovereign responsibilities – to protect, notably human rights' norms.

[42] See Rosenau, James N. 1992. 'Governance, order, and change in world politics.' In Rosenau, James and Ernst-Otto Czempiel, eds. *Governance without Government: Order and Change in World Politics*. Cambridge: Cambridge University Press. Re: 'regimes.'

[43] De Waal, Alex (2006). *AIDS and Power: Why there is no political crisis – yet*. (Cape Town: Zed Books): p. 123.

[44] Davies, Sara E., Adam Kamradt-Scott, and Simon Rushton. (2015). *Disease Diplomacy. International Norms and Global Health Security.* (Baltimore: Johns Hopkins University Press), pp. 122.

Bibliography

1. Benatar, S.R. (2011). 'Global leadership, ethics & global health: The search for new paradigms,' in *Global Crises & the Crisis of Global Health*, S. Gill (ed) (CUP), p. 217-143.
2. Benton, Adia. (2016). 'When Exceptions Become the Norm. HIV Exceptionalism Does More Harm than Good.' *Foreign Affairs*, (March 10).
4. Carlson, and Owens, eds. *The Sacred and the Sovereign*.
5. Committee on Economic, Social and Cultural Rights 2000.
6. Constitution of the World Health Organization (WHO), 1948.
7. Davies, Sara E., Adam Kamradt-Scott, and Simon Rushton. (2015). *Disease Diplomacy. International Norms and Global Health Security.* (Baltimore: Johns Hopkins University Press).
8. Declaration of Alma Ata, 1978.
9. De Waal, Alex (2006). *AIDS and Power: Why there is no political crisis – yet*. (Cape Town: Zed Books).
10. DiStefano M, Ruger JP. "Reflective Solidarity as to Provincial Globalism and Shared Health Governance," *Diametros*, 2015; 46: 151-158.
11. Ehlkes, Lutz und Jürgen May. (2015). ‚Seuchen – gestern, heute, morgen,' in Aus Politik und Zeitgeschichte (ApuZ), 65. Jahrgang, 20-21/2015.
12. Eisenstat, Porter & Weinstein. (2005), pp. 136 quoted in draft paper by Franklyn Lisk and Pieter Fourie, *AIDS & Security in their 21st Century.*
13. Elbe, Stefan. (2010). *Security and Global Health* (Cambridge: Polity Press).
14. Farmer, Paul (1999). *Infections and Inequalities: The Modern Plagues* (University of California Press).
15. Farmer, Paul (2003). *Pathologies of Power: Health, Human Rights, and the New War on the Poor* (University of California Press).
16. Frenk, Julio, Gomez-Dantes, Octavio and Suerie Moon (2014). 'From sovereignty to solidarity: a renewed concept for global health for an era of complex interdependence,' The Lancet 383: 94-97.
17. Garrett, Laurie. (2015). Notes November 13th. Council on Foreign Relations: New York. *Per email.*
18. Gill, Stephen and Solomon Benatar (2016). 'Global Health Governance and Global Power: A Critical Commentary on the Lancet-University of Oslo Commission Report,' *International Journal of Health Services* Vol. 0, Issue 0, pp. 1-20.
19. Garrett, Laurie. Global Health Update Council on Foreign Relations (13 April 2016).
20. Garrett, Laurie. Global Health Update Council on Foreign Relations (23 May 2016).
21. Gostin, Lawrence O. and Daniel Lucey (2016). 'The Emerging Zika Pandemic: Enhancing Preparedness,' *JAMA* (Online), (27 January).
22. Hanrieder, Tine (2015). 'Globale Seuchenbekämpfung: Kooperation zwischen Ungleichen,' in Aus Politik und Zeitgeschichte (ApuZ), 65. Jahrgang, 20-21/2015, p. 24.
23. Hansen, Lene. 'The little Mermaid's silent security dilemma and the absence of gender in the Copenhagen School,' *Millennium*, 29:2 (2000), pp. 285-306.
24. Hösle, Vittorio (2003). *Morals and Politics*. (University of Notre Dame Press.)
25. Horton, Richard (2015). 'Offline: An irreversible change in global health governance,' *The Lancet*, DOI: http://dx.doi.org/10.1016/S0140-6736(15)60997-7.
26. Howell, Alison (2014), 'The Global Politics of Medicine: Beyond global health, against securitization theory,' *Review of International Studies*, 40, pp. 961-987.
27. Interview with Dr. Maximilian Gertler, MSF / Institute of Tropical Medicine and International Health Berlin (8 June 2016).
28. Interview with Dr. Michael Edelstein (1 April 2016).
29. Interview with Dr. Rüdiger Krech, Director, Health Systems and Innovation, Office of the Assistance Director-General of the WHO (18 May 2016).
30. Kamradt-Scott, Adam and Colin McInnes (2012). 'The securitization of pandemic influenza: Framing, security and public policy,' *Global Public Health* Vol. 7, Issue supl. 2;

31. Keck, Margaret E. and Kathryn Sikkink. (1998). *Activists Beyond Borders: Advocacy Networks in International Politics*. (Ithaca and London: Cornell University Press).
32. Liotta, P.H. and Taylor Owen (2006). 'Why Human Security?' *The Whitehead Journal of Diplomacy and International Relations* (Winter/Spring), pp. 37-54.
33. Matthews, Jessica (1997). 'Power Shift,' *Foreign Affairs*. Vol 76, Issue 1, pp. 50-66.Moon, Suerie et al. (2015). 'Will Ebola change the game? Ten essential reforms before the next pandemic,' The report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola Health Policy, *The Lancet*, (November 22), available at: http://dx.doi.org/10.1016/S0140-6736(15)00946-0.
34. McInnes, Colin and Simon Rushton (2010). 'HIV, AIDs and Security: where are we now?' *International Affairs,* Vol. 86, Issue 1
35. McInnes, Colin and Simon Rushton (2010) 'HIV, AIDS and Securitization,' Paper for 2010 International Studies Association Conference, New Orleans, USA.
36. Nef, Jorge (1999). *Human Security and Mutual Vulnerability: The Global Policy Economy of Development and Underdevelopment*, 2nd edition (International Development Research Center).
37. 'No health workforce, no global health security,' (2016), *The Lancet*, Vol. 387, No. 10033, (21 May), p. 2063.
38. Nunes, João (2014). 'Questioning health security: Insecurity and domination in world politics,' Global Health in International Relations, Vol. 40, Issue 5, pp. 939-960.
39. Prah Ruger, Jennifer (2017). Health and Social Justice (Oxford University Press).
40. Philpott, Daniel. (2001). *Revolutions in Sovereignty: How Ideas Shaped Modern International Relations*. (Princeton: Princeton University Press).
41. Risse, Thomas (2012). 'Governance Configurations in Areas of Limited Statehood. Actors, Modes, Institutions, and Resources,' SFB-*Governance* Working Paper No. 32 (April), available at: http://www.sfb-governance.de/en/publikationen/working_papers/wp32/SFB-Governance-Working-Paper-32.pdf.
42. Rosenau, James N. (1992). 'Governance, order, and change in world politics,' in Rosenau, James and Ernst-Otto Czempiel, eds. *Governance without Government: Order and Change in World Politics*. (Cambridge: Cambridge University Press.)
43. Rushton, Simon (2011). 'Security for Whom? Security from What? *Political Studies,* Vol. 59, Issue 4, pp. 779-796.
44. Šehović, Annamarie Bindenagel. (2016.) *Coordinating Global Health Responses*, EL-CSID, Institute for European Studies (IES) Policy Brief Issue 2016/1 (October).
45. Šehović, Annamarie Bindenagel. (2014.) *HIV/AIDS and the South African State: The Responsibility to Respond.* (Ashgate Global Health).
46. Šehović, Annamarie Bindenagel (2015). 'Where Are Rights? Where Is Responsibility? Who Acts for Global Public Health? *ASPJ Africa & Francophonie*, 3rd Quarter, pp. 35-48.
47. Shah, Sonia. (2015). Snapshot. 'The Next Cholera Epidemic. How the Disease Could Spread from Syria,' *Foreign Affairs.* (10 November).
48. Thießen, Malte. (2015). 'Infizierte Gesellschaften: Sozial- und Kulturgeschichte von Seuchen,' in *Aus Politik und Zeitgeschichte* (ApuZ), 65. Jahrgang, 20-21/2015.
49. UN, 'Protecting Humanity from Future Health Crises,' Report of the High-level Panel on the Global Response to Health Crises, (25 January 2016).
50. UNDP, (1994). *Human Security Now.*
51. Whiteside, Alan. (2015). *HIV/AIDS and the South African state: Sovereignty and the responsibility to respond*, Global Public Health, 10:5-6, 773-774, DOI: 10.1080/17441692.2015.1019908
52. WHO Report of the Ebola Interim Assessment Panel - July 2015, available at: http://www.who.int/csr/resources/publications/ebola/report-by-panel.pdf?ua=1.