

PANDEMIC PEACE?

When bird flu broke out in the Middle East, Israeli, Palestinian, and Jordanian health officials worked side by side sharing information to prevent its spread. Networked cooperation among health professionals in the three locations in detecting, identifying, and monitoring infectious diseases made this successful response to a potential emergency possible.¹ Close collaboration continued even during the outbreaks of violence in the region in 2006 and 2009, so that when swine flu was reported in Israel in May 2009, health officials from the three jurisdictions met immediately at the Allenby Bridge, which links Jordan and Jerusalem, to implement a plan they had developed over the previous three years.² Likewise, the six countries of the Mekong River Basin—a region of numerous interstate wars in the recent past—have worked together quietly for more than a decade to coordinate surveillance and response to air- and waterborne diseases, including the deadly avian influenza.³ Countries in conflict-prone or resource-poor regions such as East Africa,⁴ Southern

1. Cooperation among the three entities occurs under the auspices of the Middle East Consortium on Infectious Disease Surveillance (MECIDS).

2. Louise Gresham et al., “Trust Across Borders: Responding to the H1N1 Influenza in the Middle East,” *Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science* 7, no. 4 (2009): 399–404; Dale Gavlak, “Catching Outbreaks Wherever They Occur,” *World Health Organization Bulletin* 87, no. 10 (October 2009): 741–42, who.int/bulletin/volumes/87/10/09-031009/en/.

3. The six countries are Cambodia, China, Laos, Myanmar, Thailand, and Vietnam and the organization is known as the Mekong Basin Disease Surveillance network (MDBS).

4. The East African Integrated Disease Surveillance Network (EAIDSNet) is a collaborative effort of the Ministries of Health of Kenya, Tanzania, and Uganda established under the auspices of the East African Community in 2003. Rwanda and Burundi joined the Community in 2007 and the Health Sub-Sector in 2009.

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Africa,⁵ and the Balkans⁶ also are beginning to cooperate on infectious disease surveillance and response.

Although largely unnoticed, this form of international cooperation has immense practical and theoretical significance. Theoretically, these sub-regional initiatives present intriguing anomalies to the classic problem of interstate cooperation in providing a global or transnational public good⁷ (health) in “anarchy.”⁸ In parts of the world with difficult histories, where trust is low and misunderstanding and recrimination high among countries, cooperation in an area of national vulnerability is especially provocative. It raises the question of why public health cooperation is occurring there. To answer this question, this book uses three unlikely cases—the Mekong Basin, the Middle East, and East Africa—to explore empirically and comparatively several contending but untested hypotheses suggested by the global health diplomacy literature.⁹ In so doing, it develops an empirically grounded theoretical explanation that illustrates exactly how interests, institutions, and ideas together enable international cooperation. This explanation helps clarify the potential and problems of fostering transnational cooperation in international affairs in this and potentially a host of other important areas, such as counterterrorism, environmental challenges, resource management, human rights protection, and economic assistance.

Some might argue that cooperation in health is a lesser form of international cooperation and hence less relevant to understanding cooperation in

5. The Southern African Center for Infectious Disease (SACIDS) is an emerging network of national institutions and research organizations involved in infectious disease surveillance. SACIDS brings together human, animal, and plant health sector experts from five countries—Democratic Republic of Congo, Mozambique, Tanzania, Zambia, and South Africa. SACIDS began operations in January 2008.

6. The signatories of the Dubrovnik Pledge of 2001 conceived the South-Eastern Europe Health Network (SEEHN). Members of SEEHN include Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Romania, Serbia and Montenegro, and the former Yugoslav Republic of Macedonia. A year later, cooperation was extended to Moldova and three regional donors: Greece, Hungary, and Slovenia. The primary aims of SEEHN are to increase the integration of regional health services, strengthen disease surveillance and control, and establish networks for information collection and sharing.

7. Global public goods are benefits that are both nonexcludable and nonrival, and, though immensely desirable, they are chronically underprovided. See Scott Barrett, *Why Cooperate? The Incentive to Supply Global Public Goods* (New York: Oxford University Press, 2007).

8. For a discussion of this term in international relations theory, see Alexander Wendt, “Anarchy Is What States Make of It: The Social Construction of Power Politics,” *International Organization* 46, no. 2 (Spring 1992): 391–425.

9. See, for example, Ilona Kickbusch, Gaudenz Silberschmidt, and Paulo Buss, “Global Health Diplomacy: The Need for New Perspectives, Strategic Approaches and Skills in Global Health,” *World Health Organization Bulletin* 85, no. 3 (March 1987): 161–244, www.who.int/bulletin/volumes/85/3/06-039222/en/; Martin McKee, Paul Garner, and Robin Scott, eds., *International Cooperation and Health* (Oxford: Oxford University Press, 2001); Graeme MacQueen and Joanna Santa-Barbara, “Peacebuilding Through Health Initiatives,” *British Medical Journal* 321 (2000): 293–96.

the most critical areas of international relations. I disagree. For example, in discussing new forms of transnational politics, Edgar Grande and Louis Pauly use the term *meso-politics* to refer to welfare-related issues (such as health) that follow security and foreign policy in importance but precede technical standardization.¹⁰ As I argue in the next section of this chapter and later in chapter 5, infectious disease threat is now a first-order problem affecting both the security and welfare of states and the international system.¹¹

Such is the conclusion of the World Health Organization (WHO), the U.S. government, and most scholars and policy practitioners. Moved by the severity of the threat to human and national security, in 2005 the 193 members states of the World Health Assembly (WHA) concluded a decade-long effort to overhaul its requirements for disease surveillance reporting and response, and set a strict timetable for implementation by its members. These requirements, discussed in chapter 2, greatly expanded both the number of diseases and threats that must be monitored and the responsibility of every state to meet these threats through national policies and participation in regional and global efforts. These changes are the first significant revision of the international health regulations in fifty years and the first expansion of the disease coverage since international agreements began in 1851. This comprehensive response to the spread of infectious disease, compared with the failed one to global warming, for example, attests to the consensus that states see this issue as a fundamental threat to their interests and are willing to devote substantial diplomatic and material resources to fighting it and to urging other states and regional organizations to fight it too.

Combating infectious disease has also become a top security concern of national policymakers and analysts. The 2000 U.S. National Intelligence Estimate, for example, classified infectious disease for the first time as a threat to national security: “new and reemerging infectious diseases will pose a rising global health threat and will complicate US and global security.”¹² The

10. Edgar Grande and Louis W. Pauly, “Complex Sovereignty and the Emergence of Transnational Authority,” in *Complex Sovereignty: Reconstituting Political Authority in the Twenty-First Century*, eds. Edgar Grande and Louis W. Pauly (Toronto: University of Toronto Press, 2005), 292–93. Regional cooperation in infectious disease control is a mid-level problem in the sense of falling between bilateral and fully multilateral cooperation and in the sense that the actors involved, though state agents, often do not attract the same level of public scrutiny as officials whose sole function is to represent state interests in matters of traditional security and foreign affairs.

11. See Harley Feldbaum et al., “Global Health and National Security: The Need for Critical Engagement” (unpublished manuscript, Center on Global Change and Health, London School of Hygiene and Tropical Medicine, 2004).

12. National Intelligence Council, “The Global Infectious Disease Threat and its Implications for the United States,” NIE 99-17D (Washington, DC: National Intelligence Council, 2000), www.dni.gov/nic/special_globalinfectious.html.

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2010 National Security Strategy reaffirms this concern.¹³ Leading military and security policy experts have reached the same conclusions,¹⁴ and in his recent book Andrew Price-Smith captures the academic consensus that epidemic disease “presents a direct threat to the power of the state, as it erodes prosperity, destabilizing the relations between state and society, renders institutions sclerotic, foments intrastate violence, and ultimately diminishes the power and cohesion of the state.”¹⁵

Because the key participants in each of these transnational networks include public actors (states and international organizations) and private actors (nongovernmental organizations, transnational corporations, and philanthropies), this study also offers an opportunity to examine crucial questions in the field of public-private transnational governance.¹⁶ Specifically, this book responds to two fundamental questions in the nascent literature: Are these new forms of governance effective in delivering transnational public goods and what factors contribute to or impede their effectiveness? Do these hybrid (public-private) international actors exercise political authority legitimately—that is, are they democratically accountable—and what factors enhance or detract from their legitimacy? The answers to these questions will generate working hypotheses on transnational networked governance for further investigation by scholars of global governance, and offer a plausible framework for practitioners and policymakers engaged in safeguarding this particular dimension of national and international security and welfare. Furthermore, these cases afford an occasion to examine the origins of transnational networks and to consider how they relate to states and international governmental organizations operating in the same policy arenas.

13. The White House, *National Security Strategy of the United States of America, May 2010* (Washington, DC: Executive Office of the President, 2010), 48–49, www.whitehouse.gov/sites/default/files/rss_view/national_security_strategy.pdf.

14. See, for example, Susan Peterson, “Epidemic Disease and National Security,” *Security Studies* 12, no. 2 (2002): 43–81; Jennifer Brower and Peter Chalk, *The Global Threat of New and Reemerging Infectious Diseases: Reconciling U.S. National Security and Public Health Policy* (Santa Monica, CA: RAND Corporation, 2003); Michael Moodie and William J. Taylor Jr., “Contagion and Conflict: Health as a Global Security Challenge,” Report of the Chemical and Biological Arms Control Institute and the Center for Strategic and International Studies, International Security Programs (Washington, DC: Center for Strategic and International Studies, 2000).

15. Andrew T. Price-Smith, *Contagion and Chaos: Disease Ecology and National Security in the Era of Globalization* (Cambridge, MA: MIT Press, 2009), 2.

16. Transnationalism refers to “regular interactions across national boundaries when at least one actor is a non-state agent.” Networks are “forms of organization characterized by voluntary, reciprocal, and horizontal patterns of communication.” See Robert Keohane and Joseph Nye, Jr., “Transnational Relations and World Politics: An Introduction,” in *Transnational Relations and World Politics*, eds. Robert Keohane and Joseph Nye Jr., xi–xvi (Cambridge, MA: Harvard University Press, 1971).

Challenges and Opportunities Posed by Infectious Disease

The spread of avian influenza and other naturally occurring or man-made biological threats presents a grave security and humanitarian threat regionally and globally.¹⁷ Dramatic increases in the worldwide movement of people, animals, and goods; growing population density; and uneven public health systems worldwide are the driving forces behind heightened vulnerability to the spread of both old and new infectious diseases.¹⁸ Since the global spread of the human immunodeficiency virus (HIV) began in the early 1980s, twenty-nine new bacteria or viruses have been identified, many of which are capable of global reach.¹⁹ Commenting on this trend in 2007, the United Nations' World Health Organization warned, "Since the 1970s, newly emerging diseases have been identified at the unprecedented rate of one or more per year. . . . It would be extremely naïve and complacent to assume that there will not be another disease like AIDS, another Ebola, or another SARS, sooner or later."²⁰ Senior World Health officials have noted that "inadequate surveillance and response capacity in a single country can endanger national populations and public health security of the entire world."²¹

With more than a million travelers flying across national boundaries every day, it is not an exaggeration to say that a health problem in any part of the world can rapidly become a health threat to many or all²²—what one author calls the microbial unification of the world.²³ The outbreak of severe acute respiratory syndrome (SARS) in 2002 and 2003 demonstrated how a previously unknown but lethal virus could spread by modern air transport, traveling from Hong Kong to Toronto in fifteen hours and eventually

17. For an early discussion of this emerging threat, see Laurie Garrett, *The Coming Plague: Newly Emerging Diseases in a World out of Balance* (New York: Penguin, 1995). For a skeptical view, see the comments of Dr. Peter Palese in "Science," panel session at CFR Symposium on Pandemic Influenza: Science, Economics, and Foreign Policy, Council on Foreign Relations, New York, October 16, 2009, www.cfr.org/project/1442/cfr_symposium_on_pandemic_influenza.html.

18. "Neither globalization nor the potential [health] threat posed by globalization is new," citing the European discovery of the Americas that led to a devastating loss of life among indigenous people. See Sarah Payne, "Globalization, Governance, and Health," in *Governance, Globalization and Public Policy*, eds. Patricia Kennett (Cheltenham, UK: Edward Elgar, 2008), 153. By some estimates, 90 percent of those deaths were attributed to contagious diseases for which native populations had no immunity.

19. Lincoln Chen, Tim Evans, and Richard Cash, "Health as a Global Public Good," in *Global Public Goods: International Cooperation in the 21st Century*, eds. Inge Kaul, Isabelle Grunberg, and Mark A. Sterns (New York: Oxford University Press, 1999), 288.

20. WHO, *World Health Report 2007* (Geneva: World Health Organization, 2007).

21. David Heymann and Guenael Rodier, "Global Surveillance, National Surveillance, and SARS," *Emerging Infectious Diseases* 10, no. 2 (2004), www.medscape.com/viewarticle/467371.

22. Kelley Lee, *Globalization and Health* (New York: Palgrave, 2003); Maureen T. Upton, "Global Public Health Trumps the Nation-State," *World Policy Journal* (Fall 2004): 73–78.

23. Giovanni Berlinguer, "Health and Equity as a Primary Global Goal," *Development* 42, no. 2 (1999): 12–16.

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reaching twenty-seven countries.²⁴ The increased speed of transmission also means that contagion is likely to be well established before governments and international organizations are aware of the presence of the disease.²⁵

SARS, in turn, focused attention on the ability of public health systems worldwide to cope with an anticipated pandemic associated with the next major antigenic shift in the influenza A virus. Although the influenza A virus mutates regularly (antigenic drift), every decade or so the virus undergoes a major change, or shift, for which most people have little or no protection. The threat is magnified today by the ability of such diseases to spread worldwide very rapidly.²⁶ For example, since emerging in 1997, avian influenza—which to date has infected more than 400 people and killed more than 200—could create, if it becomes capable of human-to-human transmission as a new influenza A virus, a global pandemic of unprecedented lethality. Avian influenza could, if it becomes capable of human-to-human transmission as SARS did in 2002, kill somewhere between 200,000 to 16 million Americans. Countries with less robust public health systems would lose an even larger percentage of their population to such a disease.²⁷ The relatively benign H1N1, or swine flu, outbreak provides a harbinger of this future danger.

Global economic and political stability could fall victim to a pandemic too. Today, nations must provide for their citizens' health and well-being and protect them from disease. Health provision has become a primary public good and part of the social contract between a people and its government.²⁸ Accelerating transnational flows, especially pathogens, can stress and could overwhelm a state's capacity to meet this essential function. Weak states could fail economically or politically, thereby creating regional instability and a breeding ground for terrorism or human rights violations.²⁹ Statistical studies reveal that declining public health substantially increases the probability

24. Kelley Lee and Derek Yach, "Globalization and Health," in *International Public Health: Disease, Programs, Systems and Policies*, eds. Michael H. Merson, Robert E. Black, and Anne J. Mills (Sudbury, MA: Jones and Bartlett Publishers, 2006), 690.

25. Payne, "Globalization, Governance, and Health," 164.

26. Lee and Yach, "Globalization and Health," 689.

27. Global Alert and Response, "Pandemic Preparedness," World Health Organization, www.who.int/csr/disease/influenza/pandemic/en.

28. See Andrew Price-Smith, *The Health of Nations: Infectious Diseases, Environmental Change, and Their Effects on National Security* (Cambridge, MA: MIT Press, 2002). This state responsibility is not new. Historically, one of the first functions of the emerging trading states in the late Middle Ages was the development of maritime quarantine systems to protect their populations from importing diseases. See Kelley Lee, Susan Fustukian, and Kent Buse, "An Introduction to Global Health Policy," in *Health Policy in a Globalising World*, eds. Kelley Lee, Susan Fustukian, and Kent Buse (Cambridge: Cambridge University Press, 2002) 3–17.

29. Commission on Macroeconomics and Health, *Investing in Health* (Geneva: World Health Organization, 2003).

of state failure,³⁰ and historical examples of the correlation between disease outbreak and political instability and violence extend from the fall of ancient Athens to recent violence in Zimbabwe. Even in the strongest states, leaders must be prepared, in an integrated way, to respond to the full spectrum of biological threats that could impede essential social functions such as food supply, transportation, education, and workforce operation and result in huge economic costs.³¹

Reducing the danger of influenza or other infectious diseases requires a focus on preparedness and monitoring. Rapidly identifying the problem, sharing information, and coordinating response are each critical to limiting the perils of pathogenic threats. Although the peril is great, so too is the promise of building cooperation through regional disease surveillance, detection, and response.

Here is the positive potential of globalization: it can facilitate the rapid response to health challenges by quickly mobilizing health professionals, medicines, and supplies, and by deploying information technology for disease surveillance and sharing best health practices across nations.³² These exchanges, between neighboring states and even between traditional adversaries, could contribute to reducing disparities in health and help improve regional relations. Armed with a theoretical understanding of the basis for such cooperation, the regional and international practitioner and policy communities can respond more effectively to this critical transnational security and humanitarian concern.³³

30. See Gary King and Langche Zang, "Improving Forecasts of State Failure," *World Politics* 53, no. 4 (July 2001): 623–58, doi:10.1353/wp.2001.0018.

31. K. C. Decker and Keith Holtermann, "The Role for Exercises in Senior Policy Pandemic Influenza Preparedness," *Journal of Homeland Security and Emergency Management* 6, no. 1 (2009): 1–15, doi:10.2202/1547-7355.1521. The cost of an influenza pandemic in the United States has been estimated to be somewhere between \$71.3 to \$166.5 billion. Martin I. Meltzer, Nancy J. Cox, and Keiji Fukuda, "The Economic Impact of Pandemic Influenza in the United States: Priorities for Intervention," *Emerging Infectious Diseases* 5, no. 5 (1999): 659–71.

32. See Kelley Lee, "Globalization: A New Agenda for Health," in *International Cooperation in Health*, eds. Martin McKee, Paul Garner, and Robin Stott (Oxford: Oxford University Press, 2001), 13–30; Mark W. Zacher, "The Transformation in Global Health Collaboration since the 1990s," in *Governing Global Health: Challenge, Response, Innovation*, eds. Andrew Fenton Cooper, John J. Kirton, and Ted Schrecker (Burlington, VT: Ashgate Publishing, 2007) 15–27.

33. According to the UNDP's human-centric definition, security involves protection from a range of threats including "disease, hunger, unemployment, crime, social conflict, political repression, and environmental hazards." See United Nations Development Program, *Human Development Report 1994* (New York: Oxford University Press, 1995), 22. This broader notion of security has become increasingly meaningful in practice, including state practice. See Armed Forces Health Surveillance Center, "Global Emerging Infectious Surveillance and Response Systems," (Washington, DC: U.S. Department of Defense), www.afhsc.nhl.gov/geisPartners. Many states, including the United States, consider the defense against infectious disease to be a part of their national security policy. See Feldbaum et al., "Global Health and National Security."

This chapter outlines general theories of interstate cooperation and how, to date, health practitioners, policymakers, and analysts have attempted to account for international cooperation in the global public health domain more particularly. These hypotheses provide pathways into the empirical investigation in chapter 2. Chapter 3 returns to the question of cooperation and develops a unique theoretical explanation for this anomaly that blends elements of our general understandings of the prospects and problems of international cooperation into an integrated and more specified theory of cooperation in health and potentially other arenas of international affairs.

Attempts to Explain International Cooperation in Public Health

Because states remain indispensable actors in these cases, international relations theory is a useful framework for thinking about international and transnational cooperation in public health and disease surveillance and response.³⁴ This literature is vast. In a nutshell, though political realism in its many forms emphasizes the enduring propensity for conflict among self-interested states seeking their security in an anarchic environment, that is, one where there is no central authority to protect states from each other or to guarantee their security. Hence international cooperation is thought to be rare, fleeting, and tenuous—limited by enforcement problems and each state's preferences for relative gains in their relationships because of their systemic vulnerability.³⁵ Liberal approaches are particularly interested in identifying several ways to mitigate the conflictive tendencies of international relations, particularly through shared economic interests and norms and institutions (e.g., democracy). Liberals argue that these factors can help ameliorate the enforcement problem in anarchy and permit states to focus more on mutual gain defined in absolute rather than relative terms.³⁶ More recently, constructivist approaches emphasize that nonmaterial, ideational factors, not just state interests and national and international institutions, are critical to understanding the formation of interests and the possibility

34. Transnationalism, as distinct from internationalism, implies that though states remain important or even indispensable actors, they find themselves drawn increasingly into nonhierarchical modes of governance involving both public and private actors. See Grande and Pauly, "Complex Sovereignty," 3–21.

35. Contemporary classics of political realism in its traditional and structural variants include Hans J. Morgenthau, *Politics among Nations: The Struggle for Power and Peace*, 3rd ed. (New York: Alfred A. Knopf, 1960); Kenneth N. Waltz, *Theory of International Politics* (Reading, MA: Addison-Wesley, 1979).

36. See, for example, Robert Keohane and Joseph Nye Jr., *Power and Interdependence*, 3rd ed. (New York: Longman, 2000).

of cooperation. As the name implies, for constructivists, the interests and identities of states are highly malleable and context-specific and the anarchic structure of the international system does not, in itself, dictate that conflict is the norm and cooperation the exception. Rather, the process of interaction between and among actors shapes how political actors (not just states) define themselves and their interests: “self-help and power politics do not follow logically or causally from anarchy. . . . Anarchy is what states make of it.”³⁷ Because identities and interests are not dictated by structure, a state’s purely egoistic interests can be transformed under anarchy to create collective identities and interests by intentional efforts and positive interaction.

Moving away from concerns about whether theory should focus primarily on interests, institutions, or ideas as the key causal variable in understanding cooperation (or the lack thereof), the theory of cooperation that emerges in chapter 3 blends elements of these and other approaches, often cast as alternatives, to demonstrate precisely the processes by which interests, institutions, and ideas (particularly about identity) can combine to shape cooperation in this, and arguably other, areas of international relations. In so doing, it demonstrates the organic interrelationship among the causal forces of cooperation and specifies the characteristics and dimensions of interests, institutions, and ideas about identity that facilitate cooperation.³⁸

Most explanations for international cooperation in the area of public health come from practitioners, policymakers, and analysts, not international relations scholars.³⁹ To account for cooperation in matters of international public health, the practitioner and analyst literature offers several contending, but largely untested, proto-hypotheses that draw from various social science approaches:

- An interest-based argument derived from the forces of globalization and the social nature of the problem, that the global benefits from controlling the transnational spread of disease necessitate cooperation and that “enlightened self-interest and altruism will converge in the increasingly interdependent world being shaped by the process

37. Wendt, “Anarchy Is What States Make of It,” 394–95.

38. On the value of blended explanations for understanding complex international dynamics see Richard Deeg and Mary O’Sullivan, “The Political Economy of Global Financial Capital,” *World Politics* 61, no. 4 (October 2009): 731–63, doi:10.2202/1547-7355.1521.

39. Recently, scholars of international relations have begun to focus on issues in global health, some applying an explicitly theoretical perspective. See, for example, Mark W. Zacher and Tania J. Keefe, *The Politics of Global Health Governance: United by Contagion* (New York: Palgrave MacMillan, 2008); Price-Smith, *Contagion and Chaos*.

of globalization.”⁴⁰ Infectious diseases know no physical borders and present particularly compelling superordinate problems that transcend the interests of contending parties, are shared by all of them, and require joint efforts for effective response.⁴¹ This explanation identifies the potential basis for interest-based cooperation in infectious disease surveillance and response, but fails to address how the difficulties inherent in providing an international public good such as disease control are overcome.

- A psychosocial, identity hypothesis that health initiatives promote an environment that emphasizes human well-being. The aim of reducing pain and disease is relatively undisputed. Health initiatives thus help overcome other, more divisive sources of identity by shifting the focus away from questions of national or ethnic security to human security, and allowing for an evocation and extension of altruism.⁴² How such identities are formed and reformed is not addressed, however.
- A scientism or epistemic community hypothesis that health cooperation creates a realm of objectivity and much-needed expertise in areas where propaganda, suspicion, and recrimination often dominate relations.⁴³ Medical experts can phrase the causes and the responses to health threats in scientific terms. Health workers, in turn, have greater credibility as unbiased professionals, thereby encouraging greater trust and reliance among actors from different states. For example, Martin McKee, Paul Garner, and Robin Stott assert that “health professionals thus have a unique combination of competence in communication, trust of civil society, intimate contact with most of the members thereof, and the capacity to influence individuals whatever their role in society.”⁴⁴ These observations draw our attention to the critical issue of trust and how to establish and maintain it across borders.

40. Derek Yach and Douglas Bettcher, “The Globalization of Public Health, I: Threats and Opportunities,” *American Journal of Public Health* 88, no. 5 (1998): 735–44.

41. See Ronald J. Fisher, *The Social Psychology of Intergroup and International Conflict Resolution* (New York: Springer-Verlag, 1990).

42. See Harvey Skinner et al., “Promoting Arab and Israeli Cooperation: Peacebuilding through Health Initiatives,” *The Lancet* 365 (April 2, 2005): 1247–77.

43. Scientism suggests that certain socially beneficial, technical tasks should be handed over to experts. See Craig Murphy, “Global Governance: Poorly Done and Poorly Understood,” in *The Global Governance Reader*, ed. Rorden Wilkinson, 90–104 (New York: Routledge, 2005). Epistemic community is a network among professionals with an authoritative claim to policy-relevant knowledge. See Peter M. Hass, “Knowledge, Power and International Policy Coordination,” *International Organization* 46, no. 1 (1992): 1–35.

44. See Martin McKee, Paul Gardner, and Robin Scott, “Introduction,” in *International Cooperation in Health* (Oxford: Oxford University Press, 2001), 10.

- A domestic politics, rational choice⁴⁵ hypothesis that health cooperation provides an essential national public good⁴⁶ (physical security) that redounds to a participating government's credit, thus enhancing state capacity and legitimacy and improving regional stability. This approach highlights the domestic, state-level, variables that might help account for cooperation. Furthermore, positive results in health can be observed and measured by epidemiological statistics on mortality and morbidity, have powerful impacts on citizens, and thus are attractive investments for governmental and nongovernmental actors.⁴⁷
- A negotiation and signaling hypothesis that health initiatives, as voluntary, novel, and consequential projects, are reliable signals for improving communication, reducing threats, and breaking patterns of conflict among traditional rivals or antagonists.⁴⁸ For example, Thomas Novotny and Vincanne Adams maintain that "health and scientific interactions can serve as core diplomatic gestures to improve communication, reduce mutual or bilateral threats, and address health problems of mutual importance."⁴⁹ This observation suggests that health initiatives can be a top-down strategy as part of national statecraft.

Furthermore, drawing from functionalist and neofunctionalist theory, the public health diplomacy literature suggests that health sector cooperation can spillover into other technical areas (natural disaster planning, for example) or even sensitive political and security arenas (mitigating man-made biological threats, for instance).⁵⁰ Is this so, and what would explain health as the leading edge of wider cooperation?

45. Assumptions of rational decision making are as follows: actors pursue goals; these goals reflect the actor's perceived interests; behavior results from a process that involves, or functions as if it entails, conscious choice; the individual is the basic agent in society; actors have preferences that are consistent and stable; if given options, actors will choose the alternative with the highest expected utility; and actors possess extensive information on both the available alternatives and the likely consequences of their choices. These assumptions apply with equal force for all persons.

46. Unlike international public goods, national public goods are more likely to be provided through the use of governmental coercion. See Barrett, *Why Cooperate?* This issue is addressed in detail in chapter 3.

47. Judith Richter, "Public-Private Partnerships for Health: A Trend with No Alternatives?" *Development* 47, no. 2 (2004): 43–48.

48. See James D. Fearon, "Domestic Political Audiences and the Escalation of International Disputes," *American Political Science Review* 88 (1994): 577–92.

49. Vincanne Adams and Thomas Novotny, "Global Health Diplomacy" (working paper, Global Health Sciences, University of California, San Francisco, January 16, 2007), 1–10.

50. According to David Mitrany, technological issues confronting modern industrialized nations in the twentieth century require international cooperation along functional lines. He suggests that organizations for functional cooperation will eventually eclipse the political institutions of the past such as the national state. See David Mitrany, *A Working Peace System. An Argument for the Functional Development of International Organization* (Chicago: University of Chicago Press, 1943, 1966). Arguing from a neofunctionalist perspective, Ernst Hass maintained that rational behavior led not only to transnational

Using evidence from the cases of the Mekong Basin Disease Surveillance Network (MBDS), the Middle East Consortium on Infectious Disease Surveillance (MECIDS), and the East Africa Integrated Disease Surveillance Network (EAIDNet), this book investigates whether there is support for any of these notions or some elements of them, and determines how these instances of cooperation fit within and speak to our understanding of broad theories of international cooperation.

Transnational Governance: Examining Public-Private Partnerships

Governments acting alone cannot meet the challenge of infectious disease spread. Diseases cross and even ignore the geopolitical boundaries of the state. The six countries of the Mekong Basin share thousands of miles of borderlands and waterways crossed by more than a million people a year. Eighty miles separate the capitals of Jordan, Israel, and the Palestine Authority, and the five nations of the East African Integrated Disease Surveillance Network are similarly intertwined. Effective disease surveillance and response must also cross borders and requires not just governments, but governance.⁵¹ *Governance* can be defined as the “ability to promote collective action and deliver collective decisions”⁵² and, as distinct from government, can be fulfilled by a wide range of individuals and institutions including the public sector, private companies, nongovernmental organizations, professional bodies, and civil society.⁵³ An investigation into regional or global governance cannot slight the interests of traditional national actors or the distribution of power in a given policy arena, but must also consider other actors that might facilitate cooperation and the role that knowledge and norms play in managing a particular problem.

In health, power has shifted from vertically organized governments and international agencies to horizontally linked coalitions or networks that also include private actors such as nongovernmental organizations, businesses, and philanthropies; a process of institutional pluralism driven by changing ideological and institutional preferences, technological advances, new sources

interdependence, but also to the creation of supranational institutions, such as the European Community, which contribute to international peace. See *The Uniting of Europe: Political, Social, and Economic Sources 1950–1957* (Stanford, CA: Stanford University Press, 1958).

51. McKee, Gardner, and Scott, “Introduction,” 21.

52. Richard Dodgson, Kelley Lee, and Nick Drager, “Global Health Governance: A Conceptual Review,” in *Global Health Governance: Key Issues*, ed. Kelley Lee (Westport, CT: Greenwood Press, 2000), 6.

53. McKee, Gardner, and Scott, “Introduction.”

of funding; and lower barriers to entry.⁵⁴ These new amalgamations have been labeled global health alliances, global health partnerships, and global public-private partnerships.⁵⁵ The three examples of public-private governance initiatives in infectious disease control examined in this study provide a basis for systematically exploring key questions regarding global health governance, and transnational problem-solving networks.⁵⁶ Specifically, we want to know whether these experiments in transnational governance can collectively solve problems and effectively deliver the (public) goods. If so, we need to identify the factors that either are necessary or facilitate effective governance. In addition, we want to use these cases both to consider whether the authority wielded by these transnational networks is legitimate, defined in terms of democratic accountability, and specify the factors that enhance or impede their legitimacy.

Detailed comparative analysis of the governance process in these three cases will generate useful insights for practitioners and researchable hypotheses for scholars. For practitioners and policymakers, generic insights can be tailored to their specific circumstances. For scholars and students, these cases may contribute to a better understanding of global governance, private-public partnerships, and transnational problem-solving networks by generating plausible hypotheses about the effectiveness, legitimacy, and origins of transnational networks for further inquiry.

54. Rene Loewenson, "Civil Society Influence on Global Health Policy" (online report, Geneva: World Health Organization, 2003), www.tarsc.org/WHOCESI/globalhealth.php. See also Marco Schäferhoff, Sabine Campe, and Christopher Kaan, "Transnational Public-Private Partnerships in International Relations: Making Sense of Concepts, Research Frameworks, and Results," *International Studies Review* 11 (2009): 451–74; Nirmala Ravishankar et al., "Financing Global Health: Tracking Development Assistance for Health from 1990 to 2007," *The Lancet* 373 (June 20, 2009): 2113–24.

55. See also Zacher and Keefe, *Politics of Global Health Governance*, 7; Kent Buse and Gill Walt, "Global Public-Private Partnerships: Part II, What Are the Health Issues for Global Governance," *Bulletin of the World Health Organization* 78, no. 5 (2005), [www.who.int/bulletin/archives/78\(5\)699.pdf](http://www.who.int/bulletin/archives/78(5)699.pdf).

56. Global health governance is defined as collective action to deliver cooperative solutions in the pursuit of common goals in health. See Richard Doggson, Kelley Lee, and Nick Drager, "Global Health Governance: A Conceptual Review" (Geneva: World Health Organization and London School of Hygiene and Tropical Medicine, 2002); David P. Fidler, "Architecture amidst Anarchy: Global Health's Quest for Governance," *Global Health Governance* 1, no. 1 (January 2007). Transnational problem-solving networks are defined as relevant actors working internationally on an issue, bound together by shared values, a common discourse, and dense exchanges of information. See Margaret Keck and Kathryn Sikkink, *Activists beyond Borders: Advocacy Networks in International Politics* (Ithaca, NY: Cornell University Press, 1998). Jean-François Rischard has argued that networked governance has two generic features that rectify limitations of the current international system: they have a minimum of bureaucracy with a maximum of knowledge; and relatedly, their start up and delivery time are fast-aiming for global action, not global legislation. See Jean-François Rischard, "Global Issue Networks: Desperate Times Deserve Innovative Measures," *The Washington Quarterly* 26, no. 1 (2003): 17–33.

Thoughts on Policy and Practice

As noted, the fight against infectious disease spread occurs on many levels: global, pan-regional, subregional, and national and these initiatives are interdependent. Chapter 2 introduces the global and pan-regional frameworks for fighting infectious disease and analyzes in-depth the working of three intriguing subregional infectious disease control networks. National policies are also critical in infectious disease control and, as discussed at length in chapter 5, no nation is more important than the United States in this respect. The United States, as a leader in both medical and information technology, is well situated to strengthen public health systems abroad and indirectly support regional health cooperation as a peaceful and positive dimension of its global health diplomacy and a frontline defense of its own population from the threat of infectious diseases, outbreaks of which typically begin in the developing world. Beyond terrorism, disease surveillance and response provides the United States an opportunity to address a critical national and transnational problem. Indeed, because it is largely apolitical and nonreligious, combating pandemics, more than counterterrorism, may offer a basis on which to build better bilateral relations and lay a foundation for regional cooperation. The U.S. government could, by helping prevent the political and social discord and the personal suffering wrought by pandemic disease, win the good will of both foreign governments and peoples.

To date, some domestic actors—notably the U.S. Centers for Disease Control and Prevention (CDC), the U.S. Department of Defense (DOD), and the United States Agency for International Development (USAID)—have participated indirectly in support of some of these subregional networks by their assistance to infectious disease surveillance and response capacity abroad. Chapter 5 analyzes in detail the programs of the U.S. government explicitly designed to bolster foreign capacity in infectious disease control within the larger context of America's global health diplomacy. It asks whether the policies and the institutional arrangements of the U.S. government are enough to fully meet the challenge that infectious disease spread poses to national and international security and whether the United States is doing all it should to maximize the potential diplomatic benefits to be had from its policies.

Method and Design

This study, using a detailed, theoretically informed, comparative case design, considers why cooperation is occurring and what factors facilitate or impede

the success of transnational organizations. An in-depth study of a few cases provides an opportunity to explore these questions contextually yet systematically. Although less parsimonious than some approaches, case method can lead to plausible statements of causality regarding why and how health-based cooperation is occurring in complicated regions when many variables are involved.⁵⁷ A situated approach yields an added advantage: insights that may prove helpful to policymakers and practitioners accustomed to wrestling with real world complexities and ambiguities.⁵⁸

This methodology presents certain challenges, of course. The most significant is the problem of complex, multiple determinants of social phenomena and the risk of spurious or invalid inferences being drawn from a few cases in which many causal factors may be at play—in short, overdeterminacy.⁵⁹ To control for this, the investigation is defined by systematic use of the hypotheses about the possible reasons for health policy cooperation and the central debates on transnational public-private governance and a within-case process-tracing procedure.

In terms of data collection, multiple sources of evidence are used to strengthen construct validity. Data sources include semistructured interviews, field and participant observations, and document and archival analysis.

Regarding case selection, each of the disease surveillance networks studied is an important policy initiative, and two of the three are dramatic examples of subregional cooperation. In general, the cases are what we call least-likely instances, given the absence of favorable factors such as existing institutions, regimes, or normative consensus, and because infectious disease control requires that states share sensitive information about the vulnerability of their populations and the weaknesses of their institutions. These cases may thus tell us something unique and important about the possibilities and mechanisms for international cooperation generally. For controlled comparison and to reduce selection bias, some significant variance exists along the dependent variables (cooperation and governance effectiveness and legitimacy): MBDS as the most established institutionally, MECIDS as less codified but highly effective, and EAIDSNet as much less successful in sustaining cooperation in infectious disease monitoring and response. The fieldwork for the cases was

57. Gary King, Robert Keohane, and Sidney Verba, *Designing Social Inquiry* (Princeton, NJ: Princeton University Press, 1994).

58. Alexander L. George, *Bridging the Gap: Theory and Practice in Foreign Policy* (Washington, DC: U.S. Institute of Peace, 2003); Alexander George and Andrew Bennett, *Case Studies and Theory Development in the Social Sciences* (Cambridge, MA: Massachusetts Institute of Technology, 2005).

59. Robert K. Yin, *Case Study Research: Design and Methods* (Beverly Hills, CA: Sage Publications, 1989).

conducted sequentially with the first—MBDS—establishing the theoretical boundaries of the study and related interview and other data protocols.

Organization of the Book

Chapter 2 provides a brief consideration of the global governance framework for infectious disease surveillance and response, a detailed discussion of the three case studies, and a look at a very recent effort to link these three regional networks and other similar networks together in an organization known as CHORDS (Connecting Health Organizations for Regional Disease Surveillance).

Chapter 3 draws from the empirical investigation to distill a unique theoretical explanation for the processes by which interests, institutions, and ideas can align to enable international cooperation even in difficult circumstances. This approach, I suggest, may have potentially broader relevance for appreciating, explaining, and encouraging other critically important but less visible forms of regional interstate cooperation, and it moves us away from what one scholar calls “the Olympian interpretation of relations among states,”⁶⁰ toward more meaningful understanding of real-world cooperation in a regional context.

Chapter 4 focuses on transnational problem-solving networks, in particular public-private partnerships. Here the emphasis is to generate working hypotheses about this new and important phenomenon in world politics. A growing list of polemical works on transnational networks casts them as everything from the answer to global problems to the scourge of democratic principles and the perpetuation of corporate control over the world’s poor.⁶¹ Most of these works are based on anecdotal evidence or single case studies collected in edited volumes. This study both sheds light on issues related to the effectiveness, legitimacy, and operation of transnational problem-solving networks and public-private partnerships and hones propositions about their operation and effects that scholars can use for further investigation and practitioners can refine for particular policy purposes. Developing workable hypotheses about the origins, operation, and factors that enhance or impede the success of transnational public-private networks is the goal of chapter 4.

60. I. William Zartman, “Dialog of the Deaf, Mutual Enlightenment or Doing One’s Own Thing?” paper presented at the Annual Conference of the International Studies Association, New Orleans, LA (February 18, 2010).

61. Compare Wolfgang H. Reinicke and Francis Deng, *Critical Choices: United Nations, Networks and the Future of Global Governance* (Ottawa: IDRC Publishers, 2000), with Jim Whitman, “Global Governance as the Friendly Face of Unaccountable Power,” *Security Dialogue* 33, no. 1 (2002): 45–57; Richter, “Public-Private Partnerships.”

Chapter 5 considers the impact and potential of national policies that can support ongoing regional and global efforts by focusing on U.S. global health diplomacy. Putatively, supporting foreign capacity in infectious disease surveillance and response is a policy initiative that could promote U.S. security and welfare interests by building health cooperation in troubled regions of the world as a frontline defense against pandemics and both fostering regional stability and promoting American humanitarian values worldwide. In addition to the national security implications of disease control that President Obama most recently noted, U.S. Secretary of State Hillary Clinton captured the relationship between infectious disease and the promotion of human rights in a 2009 speech: “Basic levels of well-being—food, shelter, health, and education—and of common goods—like environmental sustainability, protection against pandemic disease, and provisions for refugees—are necessary for people to exercise their rights.”⁶² Chapter 5 investigates existing U.S. foreign policy initiatives in strengthening infectious disease surveillance and response abroad. The goal of that chapter is to better understand this particular aspect of U.S. global health diplomacy and to consider how it might best complement transnational efforts in infectious disease control while furthering U.S. security and humanitarian interests.

Chapter 6 summarizes the volume’s conclusions and offers some suggestions for further research.

62. The White House, “Statement by the President on Global Health Initiative” (Washington, DC: Executive Office of the President, May 5, 2009); Hillary Rodham Clinton, “Remarks on Human Rights Agenda for the 21st Century” (speech, Georgetown University, Washington, DC, December 14, 2009).