**Ebola, disease-control and the Security Council: from securitization to securing circulation**

**Abstract**

In 2014 the United Nations Security Council (UNSC) described the Ebola outbreak then ongoing in West Africa as ‘a threat to international peace and security’ (Resolution 2177). It was the first time a disease outbreak of natural origin had attracted language ordinarily applied to political violence. This article assesses the significance of Resolution 2177 as an instrument of health governance, with particular regard to the Council’s primary aim in the resolution: to bring about the lifting of state-imposed bans on travel to and from West Africa. As travel bans were arguably a harmful move to securitize a disease at the national level, the UNSC’s response might at first appear to have been an international-level attempt to remove Ebola from the realm of security policy for the sake of public health. However, the use of threat language in Resolution 2177, and the rapid mobilization of disease-control resources by some governments represented on the Council, suggests that some kind of security logic was driving the international response to Ebola. It was not the logic of securitization which some other governments, intent upon using borders as barriers to contagion, were apparently applying. Rather, to counteract this, the UNSC appears to have acted according to the security logic of governmentality whereby the health of populations (within and beyond West Africa) would be secured by facilitating cross-border circulation of people with medical expertise. The Council’s contribution to health governance on this occasion was to support a shift in security logic: from securitization to securing circulation.

**Keywords**

Africa, Ebola, governmentality, health, securitization, United Nations Security Council

**Introduction**

In late March 2016 the World Health Organization (WHO) reported that an outbreak of Ebola in West Africa (occurring mainly in Guinea, Liberia and Sierra Leone) had been brought under control. At that stage a total of 11,323 deaths had occurred among 28,646 reported cases of disease (WHO 2016b), yet governments around the world had earlier been concerned that the human toll from the outbreak would end up being much heavier.[[1]](#footnote-1) During 2014, when Ebola was still out-of-control, this public health challenge came to be framed also as a security issue, and in this article the assessment of that framing focuses on the role that the United Nations Security Council (UNSC) played as a contributor to health governance.

On 18 September 2014 the UNSC determined that the Ebola outbreak then ongoing in West Africa constituted ‘a threat to international peace and security’ (UN 2014d: 1). Although the Council had twice previously issued resolutions addressing HIV/AIDS (UN 2000; UN 2011b), Resolution 2177 on Ebola was unprecedented. It was the first instance of the UNSC describing a naturally-occurring disease outbreak using language ordinarily applied to problems of violence in international affairs.[[2]](#footnote-2) Moreover, the resolution (which passed unanimously) was endorsed by a record number of other UN member states, and it coincided with large-scale mobilization of resources by governments outside West Africa (including some represented on the UNSC) to resist the Ebola outbreak there. Resolution 2177 might thus appear to signify a new high-point in the ongoing political practice of affording security status to selected public-health issues and thereafter regarding disease-control as serving a security end. However, in the context of other political responses to Ebola in 2014, the UNSC’s framing of this disease in security terms is arguably more significant for what it revealed about the way security manifested as a political practice. Of particular interest in this regard is the Council’s primary aim in Resolution 2177: to bring about the lifting of state-imposed bans (implemented in an attempt to thwart the spread of disease) on travel to and from West Africa.

The proposition to be explored here is that, on this occasion, the UNSC was not moving merely to frame a health issue in security terms. Beyond this, and in the context of other political responses to Ebola, Resolution 2177 appears to have been an attempt by the Council to replace one kind of security logic with another as a basis for remedial action. The logic of securitization that was being brought to bear against Ebola at the national level in 2014 (for example, in the form of strict border controls) was to be overridden by the logic of governmentality at the international level. That is, for the sake of public health in and beyond West Africa, the UNSC was apparently promoting a form of security oriented not toward the securing of bordered territories but rather toward the securing of systems of cross-border circulation that generally support population welfare. Specifically, against the threat of Ebola, population health was to be secured by facilitating the cross-border circulation of people with medical expertise into and out of West Africa. In using threat language to emphasize this need for good circulation, the UNSC was arguably moving not to securitize a disease but to help governmentalize security in the context of a health crisis.

An analysis of political responses to the Ebola outbreak in West Africa contributes to an expanding academic literature on the linking of health and security concerns arising at the national, international and/or global level. For more than a decade, numerous scholars of International Relations have sought to discern, explain and assess elements of security in the governance of public health. Some have explored the ways in which security agendas have expanded to include infectious disease risks (Peterson 2002; Enemark 2007; Price-Smith 2009), and others have assessed the advantages and disadvantages of adopting security-oriented approaches to public health policy in general (McInnes and Lee 2006; Rushton 2011; Nunes 2014). There is also a subset of literature on the health–security nexus which examines ways in which security practice manifests as the management of human bodies and wellbeing (Braun 2007; Dillon and Lobo-Guerrero 2008; Elbe 2009). The political and practical implications of linking health and security have been examined with regard to particular institutions, such as the WHO (Davies 2008; Hanrieder and Kreuder-Sonnen 2014; Kamradt-Scott 2015). And further insights have been gained from studies of specific diseases: for example, SARS (Curley and Thomas 2004; Caballero-Anthony 2005), HIV/AIDS (Ostergard 2002; Elbe 2006) and pandemic influenza (Kamradt-Scott and McInnes 2012; Huang 2015). Ebola, by contrast, has attracted little attention from scholars of security, and there has hitherto been only limited consideration (in the context of HIV/AIDS) of the UNSC as a contributor to health governance. Hence the recent and largest-ever outbreak of Ebola, and the high-level political concern it generated, is new empirical terrain that presents an opportunity to consider anew the relationship between health and security.

One perspective on that relationship might be that a health issue (e.g. the spread of a deadly virus) counts as a security issue only if it directly affects military operations (see Smallman-Raynor and Cliff 2004), but this does not suffice for present purposes. In the case of Ebola in West Africa, there was certainly a military dimension to the outbreak and the response to it in 2014. UN-mandated peacekeeping troops were deployed inside Liberia at the time and, in Resolution 2176 (passed on 15 September 2014), the UNSC expressed concern for the risk that Ebola posed to those personnel and their overall mission (UN 2014b). In addition, the response to the outbreak by some governments outside West Africa (including UNSC members France, the United Kingdom and the United States) involved using their militaries’ logistical capabilities to deliver healthcare resources to the three worst-affected countries (Tisdall 2014). Such use was not, however, akin to a military operation in the sense that the (potential) use of armed force (e.g. during an invasion or a peacekeeping mission) was of critical importance. And, although the threat of Ebola to UN peacekeepers in particular was of concern to the UNSC, the scope of its concern for international peace and security eventually extended beyond immediate military matters. As of 18 September 2014, when the Council passed Resolution 2177, the threat in contemplation was the Ebola outbreak’s impact on ‘West Africa, in particular Liberia, Guinea and Sierra Leone, as well as Nigeria *and beyond*’ (UN 2014d: 1, emphasis added). Thus the situation in 2014 is distinguishable from that in January 2000 when, in Resolution 1308, the UNSC focused narrowly upon HIV/AIDS in Africa as potentially rendering UN peacekeeping missions there non-viable (UN 2000). In neither case, moreover, was the Council using a resolution to authorize or even foreshadow the use of external military force for disease-control purposes.

Thinking beyond the military paradigm of security, then, an alternative perspective is that the security status of Ebola in 2014 was constructed through a process of securitization. According to securitization theory (as first conceived by Barry Buzan and his colleagues), ‘security issues’ are distinguished from ‘the normal run of the merely political’ and, to count as the former, ‘[t]hreats and vulnerabilities’ have to be ‘staged as existential threats to a referent object by a securitizing actor who thereby generates endorsement of emergency measures beyond rules that would otherwise bind’ (Buzan et al. 1998: 5).[[3]](#footnote-3) As this article will show, however, securitization theory does not well explain the UNSC’s 2014 framing of a non-military threat (Ebola) as a security concern. Specifically, Resolution 2177 is difficult to characterize as a securitizing move because it envisaged no extraordinary (rule-breaking) measures. On the contrary, the UNSC’s primary political aim in the resolution was to bring about the lifting of unilaterally-imposed travel bans which, because the WHO had declared them to be unnecessary, probably contravened the 2005 International Health Regulations (IHR) principle against ‘unnecessary interference with international travel and trade’ (WHO 2008). In Resolution 2177, the UNSC was essentially calling for a move back toward normal arrangements of cross-border travel (so that medical expertise could flow into Ebola-stricken West Africa) for the sake of public health. And yet, because threat language was used (Ebola was deemed a threat to international peace and security), the UNSC’s move still had an unmistakable security quality about it. Resolution 2177 thus presents a puzzle in the way it links health and security concerns, at least according to securitization theory which envisages threat language accompanying a call for action ‘*beyond* rules that would otherwise bind’ (Buzan et al. 1998: 5, emphasis added).

A better explanation, arguably, is that the UNSC was in this instance engaged in an altogether different kind of security practice: the securing of circulation. In contrast to extraordinary, rule-breaking political practices that are driven by the logic of securitization, securing circulation is a practice driven by the logic of governmentality. In the era of governmentality, which according to Michel Foucault had emerged in Europe by the 18th century, populations rather than states are the referent object of political rule, and population welfare is ruled by recourse to three types of power: sovereignty, discipline and governmental management (Foucault 2007: 108-9). The latter is the newer and purportedly dominant form of power, and in Foucauldian understandings of security there tends to be an assumption that security involves more than just the surviving of threats and the safeguarding of sovereignty (Aradau and van Munster 2010: 74). It can also involve the management of human bodies and wellbeing at the level of entire populations and, as such, security can be seen as a routinized and facilitative practice rather than an exceptional and obstructive one. Beyond the protection of bordered territories, then, security becomes the business of protecting the cross-border ‘circulation of populations, goods and services’ (Aradau and van Munster 2010: 76). And, in this way, security driven by governmentality logic—security *qua* securing circulation—serves to ‘improve the condition of the population, to increase its wealth, its longevity, and its health’ (Foucault 2007: 105).

Among International Relations scholars who examine the health–security nexus by reference to infectious disease risks, Stefan Elbe has been a leading exponent of the governmentality perspective. He has argued that the ‘task of security’ in the era of governmentality has become one of managing bad circulation so as to prevent it causing a crisis of circulation in general (Elbe 2009: 74). Such management can occur, for example, with regard to various deadly ‘viruses circulating upon the planet’ (Elbe 2009: 1), and Elbe has observed the way in which HIV/AIDS in particular has been problematized in security terms ‘precisely as a *circulatory* threat’ on account of its ability to transcend national borders (Elbe 2009: 80, original emphasis). This convergence of health- and security-based concerns about that disease has not, however, been an instance of securitization (as envisaged by securitization theory). Rather, according to Elbe (2009: 11), it has been a manifestation of the governmentalization of security. Whereas securitization logic would see disease-control practices being undertaken in service to security, the security logic of governmentality instead involves the appropriation of security (its language and institutions) for a public health purpose. That is, in the latter mode of political practice, securing systems of circulation is the means and population wellbeing is the end.

During the recent Ebola outbreak in West Africa, as this article will show, both of these logics of security (securitization and governmentality) came into contention. To contextualise the UNSC’s unprecedented characterization of the outbreak as a ‘threat to international peace and security’ (UN 2014d: 1), the next section of the article begins by providing a brief account of the spread of Ebola in 2014. This is followed by a discussion of how some governments moved to securitize the disease by severely restricting the movement of people (as potential carriers of Ebola virus) within and across national borders. The article then assesses the significance of Resolution 2177 in which the UNSC used security language, alongside an attempt to delegitimize travel bans, to usher in a different form of security practice for the sake of public health within and beyond West Africa. The picture that emerges is that, in this instance, the UNSC was not moving to securitize Ebola but rather, in the context of a health crisis, helping to governmentalize security.

**The spread of Ebola and securitization**

For contextualization purposes, it is important at the outset to acknowledge that Ebola is, by its nature, a frightening disease. The symptoms of illness (including high fever, diarrhea, and profuse internal and external bleeding) are horrific, and recorded case-fatality rates have historically been as high as 90 percent (WHO 2016a). After the Ebola virus was first discovered in 1976, outbreaks of disease were rare and small-scale, mainly because the virus is not easily transmitted between humans.[[4]](#footnote-4) Until 2014, fewer than 2400 Ebola cases had ever been reported, and the largest outbreak (in Uganda in 2000-01) had resulted in 224 deaths out of 425 cases (CDC 2015). In December 2013, though, a case of Ebola in a two-year-old child in the rural southeast of Guinea sparked an outbreak of unprecedented scale. After the disease started spreading, local health officials misdiagnosed initial cases, and so Ebola was not confirmed in Guinea until 21 March 2014 (Gostin and Friedman 2015: 1902). Soon afterwards, laboratory tests showed that at least 70 people had died of Ebola there, and neighboring Liberia notified the WHO that it had two laboratory-confirmed cases of Ebola (Green 2014; McNeil 2014). Sierra Leone quickly became the third of three adjoining West African countries within which the Ebola virus mainly proliferated, but small numbers of cases were later also reported in Mali, Nigeria, Senegal, Spain, the United Kingdom (UK) and the United States (WHO 2016b).

In early April 2014 a WHO spokesperson offered the assurance: ‘The fortunate thing with Ebola is, it’s quite difficult to transmit. You have to touch someone. Fortunately for the greater population, the risks are quite small.’ (Nossiter 2014a). By late June, however, nearly 400 people had died in the Ebola outbreak, by then the largest ever in terms of cases, deaths and geographical spread. The WHO’s regional director for Africa, Luis Sambo, declared: ‘WHO is gravely concerned of the on-going cross-border transmission into neighbouring countries as well as the potential for further international spread. There is an urgent need to intensify response efforts ...’ (Gallagher 2014). A month later, when WHO director-general Margaret Chan told a summit of government leaders in West Africa that the Ebola outbreak was spreading faster than efforts to control it, she also announced a US$100 million plan by the Organization to send more experts and supplies to the region (BBC 2014b; Nossiter and Grady 2014). Then, on 8 August 2014, Chan used her authority under the IHR to declare the Ebola epidemic to be a Public Health Emergency of International Concern (PHEIC). Her advice to states with active Ebola transmission (Guinea, Liberia and Sierra Leone) was to declare a national emergency and activate disaster management plans (WHO 2014a). A week later, after WHO staff at outbreak sites reported that the magnitude of the outbreak vastly exceeded the number of reported cases and deaths, the Organization warned: ‘extraordinary measures [are] needed, on a massive scale, to contain the outbreak in settings characterized by extreme poverty, dysfunctional health systems, a severe shortage of doctors, and rampant fear’ (WHO 2014b).

Even taking into account the probably large number of unreported Ebola cases, the disease was at that time causing illness and death on a very small scale compared to other diseases prevalent in West Africa (such as HIV/AIDS, malaria and tuberculosis). The high degree of political concern about Ebola—vastly disproportionate to the immediate health burden of the disease—was mainly attributable to fear, and this fear inevitably informed governments’ responses. For although Ebola is a disease that historically kills far fewer people than does HIV/AIDS, the former not only kills more quickly but also has a fearsome ability to spread more quickly. During a fast-unfolding outbreak of a dreaded disease, when time is of the essence and governments are more likely to govern with haste and zeal, there is an increased danger that emergency disease-control measures will be ineffective, counterproductive and/or unjust (Enemark 2009). In August 2014, when Margaret Chan described the Ebola virus as ‘lethal and deeply dreaded’, she observed also that ‘fear remains the most difficult barrier to overcome’ and that ‘[f]ear and anxiety have spread well beyond West Africa to engulf the world’ (Chan 2014: 1183, 1184). Her use of the term ‘barrier’ was apt because some governments were at that time erecting physical obstacles to the geographical spread of Ebola. Within West Africa, large-scale quarantine zones were established inside Liberia and Sierra Leone. And, beyond West Africa, bans on travel to and from Ebola-affected states were unilaterally imposed by some governments. In both instances, the political practice of bordering—implemented as an emergency measure—transgressed rules and expectations in favor of a basic human right: freedom of movement. And, to the extent that these practices were counterproductive to public health, this was arguably a manifestation of negative securitization of Ebola taking place at the level of national policy.

Inside the three West African countries worst-affected by Ebola, which had only recently emerged from years of civil conflict, fear of the disease generated further pressure toward social tension and distrust of authority. In late August 2014, for example, riots broke out in the Guinean city of Nzerekore over rumors that health workers there had deliberately infected local people with the Ebola virus (Samb et al. 2014). At that stage, the total human toll from the outbreak had grown to 1841 deaths out of 3685 probable, confirmed or suspected cases (WHO 2014d). When the director of the US Centers for Disease Control and Prevention (CDC), Tom Frieden, returned home from a visit to the worst-affected countries on 2 September 2014, he declared: ‘There's … a real risk to the stability and security of societies as governments are increasingly challenged to not only control Ebola but provide basic health services, security services, and keep the government running…’ (CDC 2014). The Liberian defense minister agreed, telling representatives on the UNSC: ‘Liberia is facing a serious threat to its national existence. The deadly Ebola virus has caused a disruption of the normal functioning of our state’ (BBC 2014g). And, earlier, the president of Sierra Leone had warned: ‘The very essence of our nation is at stake.’ (Nossiter 2014b).

Matching words to actions, in late July 2014 Sierra Leone’s president ordered the quarantine of ‘all epicenters of the disease’ and of ‘localities and homes where the disease is identified’ for a period of 60 to 90 days (Nossiter and Grady 2014). Soon afterwards, around 750 military personnel deployed to establish and maintain a *cordon sanitaire* (‘sanitary barrier’) based on roadblocks. In the east of the country, where the density of Ebola cases was highest, one area designated as a quarantine zone contained around one million people. A serious downside of this large-scale and indiscriminate quarantine, however, was that access restrictions pushed up food prices, and this in turn prompted local concerns that starvation would soon pose more of a danger than Ebola itself (Nossiter 2014c). In neighboring Liberia, when President Ellen Johnson-Sirleaf announced a 90-day state of emergency in early August, she declared that ‘extraordinary measures’ were required ‘for the very survival of our state’ (Paye-Layleh 2014a). These measures included military blockades to stop people from Ebola-affected regions in the west of Liberia from entering the capital, Monrovia (BBC 2014c). More extraordinary still, though, was the sudden imposition and violent enforcement of a *cordon sanitaire* inside the city. On 20 August 2014, residents of West Point (a slum area of Monrovia) awoke to find riot police, under orders from President Sirleaf, blocking roads into and out of the area with barbed-wire barricades. Amid fears of food shortages among the more than 60,000 people forcibly contained within the quarantine zone, angry crowds clashed with soldiers at the barricades and a local teenager died after being shot (Onishi 2014). Later, President Sirleaf acknowledged that her decision to quarantine West Point ‘did not work’ and ‘created more tensions in the society’ (MacDougall 2015).

By infringing in this severe way upon people’s freedom of movement, the political leaders of Sierra Leone and Liberia were probably attempting sincerely to protect the greater part of their citizenry. However, as the West Point example well demonstrates, if disease-control efforts provoke anxiety and violence, they can end up being deleterious to both public health and public safety. Indeed, popular outrage at mass quarantine is understandable given that, in addition to restricting liberty, this imprecise measure can expose people who are not infected to a higher risk of becoming so if groups of people are quarantined together and disease is transmitted among them (Gainotti et al. 2008: 469). At the same time, it is important to acknowledge that a government might be justified in resorting to the implementation of non-pharmaceutical disease-control measures when, as was the case during the Ebola outbreak in 2014, vaccines and/or antiviral drugs are not available. In the absence of effective pharmaceutical resources, the governments of Liberia and Sierra Leone might have determined in good faith that there was no alternative but to try blocking the transmission of a deadly virus simply by blockading the people who might carry it. Unfortunately, the emergency measure of geographical quarantine turned out to be counterproductive. The Ebola virus is not highly contagious, so it is relatively easy to contain using basic infection-control measures, and supportive medical care such as rehydrating patients who have diarrhea and vomiting can improve their chances of surviving the disease. Therefore, as WHO officials had argued persistently, the better approach to Ebola relief in West Africa was to insert a large number of capable, well-supplied medical personnel into the situation to treat illness and prevent infection. Such an approach was stymied, however, by externally-imposed prohibitions on travel to and from the worst-affected countries.

When the WHO declared the Ebola outbreak to be a PHEIC on 8 August 2014, its advice to all states was that there should be no general ban on international travel (WHO 2014a). In Nigeria, the most populous country in West Africa, the president responded by declaring a national emergency even though only two people there had died of Ebola (BBC 2014d). One victim had been a man who travelled by airplane from Liberia to Lagos (the former Nigerian capital), and popular fear had erupted over the notion that Ebola might spread through that huge city (Cocks 2014). For this reason, the Nigerian Government had already acted in a way that soon set a trend for establishing international *cordons sanitaires* against Ebola. In late July 2014 the Nigerian airline Arik Air suspended all flights to Liberia and Sierra Leone (BBC 2014a), and Nigeria’s health minister afterwards warned that ‘everyone in the world is at risk’ because of air travel (Paye-Layleh 2014a). The following month, several other West African countries, including Ivory Coast and Senegal, banned all travel to and from Guinea, Liberia and Sierra Leone (BBC 2014f). The Kenyan Government announced that Kenya was also closing its borders to travelers from those three countries, describing its decision as ‘in line with the recognition of the extraordinary measures urgently required to contain the Ebola outbreak in West Africa’ (Paye-Layleh 2014b). Air France suspended flights to Freetown (in Sierra Leone) at the direction of the French Government, and the South African Government announced that non-citizens arriving from Ebola-affected areas of West Africa would not be allowed into South Africa (Wall 2014; BBC 2014e).

The justification for travel bans seemed to be that, if *some* people travelling from West Africa *might* be carrying the Ebola virus, the prevention of inward travel by *all* such people would reduce the Ebola importation risk (possibly to zero). However, there was no scientific basis for adopting this extremely risk-averse approach, and this is why the WHO repeatedly advised against travel bans (WHO 2014a; WHO 2014c). Such bans, when they were implemented anyway, were arguably contrary to the IHR, a fundamental purpose of which is:

to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid *unnecessary* interference with international traffic and trade (WHO 2008, emphasis added).

Acting to ban international traffic against WHO advice, and without a scientific rationale, is readily deemed ‘unnecessary’. Thus, in the terms of securitization theory, travel bans imposed in an effort to reduce the risk of Ebola transmission can be characterized as ‘emergency measures beyond rules that would otherwise bind’ (Buzan et al. 1998: 5). And, because these bans were counterproductive to public health (in West Africa, at least), they arguably constituted negative securitization. The placing of restrictions on the insertion of medical personnel and supplies into Ebola-affected countries increased the risk that local people would try to leave those countries in search of safety and/or treatment. In turn, this increased the risk of the disease spreading to other countries ill-equipped to cope with Ebola (Nuzzo et al. 2014: 307). As Liberia’s foreign minister observed at the time: ‘There is a panicked reaction across the globe, but disproportionate actions [travel bans] will only compound the problem here and limit our ability to contain the virus.’ (Hogan 2014).

By the end of August 2014, and despite an evident appetite for *cordons sanitaires* within their own territory, the presidents of Guinea, Liberia and Sierra Leone were pleading for international travel bans to be lifted. They were supported by Ghanaian president John Mahama who warned: ‘Excessive restrictions of travel and border closures will adversely affect the economies of the [West Africa] sub-region’ (BBC 2014f). And on 8 September the African Union issued a statement on the Ebola outbreak, urging member states ‘to respect the principle of free movement, and to ensure that all restrictions are in line with recommendations from the relevant international organisations’ (African Union 2014). A week later, the UN Secretary-General transmitted to the UNSC a letter (dated 29 August 2014) he had received from the presidents of Guinea, Liberia and Sierra Leone. The three presidents jointly complained therein about ‘virtual economic sanctions and trade embargoes that will end up aggravating the effect of the outbreak on our economies and stifling attempts to control the [Ebola] epidemic’. The ‘blanket travel bans’ implemented by some other states would, they argued, make it ‘impossible to bring in the international expertise and supplies required to end the outbreak’. The presidents therefore urgently requested, in the form of a ‘resolution’, the ‘intervention of the United Nations with our neighbours far and near to end the sanctions’ (UN 2014a). In September 2014 it happened to be the turn of the United States to hold the month-long presidency of the UNSC, and the US Government responded to this request by proposing a resolution aimed at unblocking the flow of medical assistance into Ebola-stricken West Africa.

**Resolution 2177 and the securing of circulation**

When the Council convened on 18 September 2014, the US representative described the essential problem with travel bans:

Precisely at the moment when a robust, united intervention was needed, some countries started to seal their borders. This reaction, driven by a mix of fear and the desire to protect one’s own citizens from the virus’s spread, was understandable. The problem is that while isolation is effective and indeed necessary for dealing with individuals who may have been exposed to Ebola, it is utterly counterproductive when applied to entire countries. It deprives them of the very resources they need to bring the virus under control (UN 2014c: 8).

Fear-driven political concern was at that time still evident in a Nigerian diplomat’s description of Ebola as an ‘apocalyptic virus’ that posed a threat ‘to the entire globe’ (UN 2014c: 9). However, as the debate in the UNSC proceeded, other state representatives emphasized the need for some allegedly panic-stricken governments to abandon their counterproductive response practices. The Guinean foreign minister argued that ‘border closures, flight restrictions, stigmatization of victims, isolation of affected countries and repatriation of their citizens constitute a weapon that is more dangerous than the scourge being combatted’ (UN 2014c: 24). And the foreign minister of Sierra Leone declared: ‘To those countries that, through panicked reactions, have closed their borders and cancelled flights and shipping arrangements, I want to join my colleagues from Liberia and Guinea to plead for a return to normalcy.’ (UN 2014c: 27). The UK representative agreed, stating:

It is important to remember that Ebola is a preventable and containable disease, but only if we all work together to stop it and confront the fear and stigma associated with the disease. We must not let fear dictate the response; instead, we must act (UN 2014c: 17).

The intended catalyst for such action was the subsequent passage of Resolution 2177 (18 September 2014) in which the UNSC expressed concern about ‘the detrimental effect of the isolation of the affected countries as a result of trade and travel restrictions imposed on and to the affected countries’ (UN 2014d: 4). Accordingly, the Council also called on UN member states to ‘lift general travel and border restrictions … that contribute to the further isolation of the affected countries and undermine their efforts to respond to the Ebola outbreak’, and to ‘facilitate the delivery of assistance, including qualified, specialized and trained personnel and supplies, in response to the Ebola outbreak to the affected countries’ (UN 2014d: 4). In so doing, the UNSC effectively denounced travel bans as unnecessary (and, by implication, a contravention of the IHR). And, by encouraging increased international provision of medical resources, the Council was moving to reduce the pressure felt by governments in West Africa to resort to the draconian public-health instrument of mass quarantine. From the perspective of securitization theory, however, it is not clear what contribution the UNSC was thus making (as a security actor) to the management of a problem situated *prima facie* in the sphere of health policy. In the context of other political responses to the Ebola outbreak in West Africa in 2014, is Resolution 2177 better characterized as a securitizing move, a desecuritising move, or as some other kind of security practice?

In their 1998 book *Security: a New Framework for Analysis*, Buzan and his colleagues theorized the political process by which an issue acquires security status. They argued that, to count as security issues, ‘[t]hreats and vulnerabilities’ have to be ‘staged as existential threats to a referent object by a securitizing actor who thereby generates endorsement of emergency measures beyond rules that would otherwise bind’ (Buzan et al. 1998: 5). In the case of UNSC Resolution 2177, its resemblance to a securitizing move begins with the Council’s use of language that is ordinarily applied only to problems of political violence: ‘the unprecedented extent of the Ebola outbreak in Africa constitutes *a threat to international peace and security*’ (UN 2014d: 1, emphasis added). It is clear that a naturally-occurring infectious disease risk was on this occasion being staged as a threat to a referent object by a securitizing actor (the UNSC). However, it is clear also that the Council was not ‘*thereby*’ seeking to generate ‘endorsement of emergency measures beyond rules that would otherwise bind’ (Buzan et al. 1998: 5, emphasis added).

Resolution 2177 certainly received a high degree of international political endorsement. It was adopted unanimously by the 15 members of the UNSC, and it attracted a record 130 co-sponsors from among UN member states (BBC 2014i). Moreover, apart from Brazil and Columbia, no state objected to the characterization of the Ebola outbreak in West Africa as a threat to international peace and security (UN 2014c: 28, 45). Even so, a plausible explanation for this abundant support is that in Resolution 2177 the Council was not acting under Chapter VII (‘Action with respect to threats to the peace, breaches of the peace, and acts of aggression’) of the UN Charter. That is, the resolution may have been popular precisely because the UNSC was *not* seeking to wield its power to authorize (in September 2014 or at a later time) the use of violence. A core provision in the Charter is that states ‘shall refrain in their international relations from the threat or use of force against the territorial integrity or political independence of any state…’ (Article 2.4). However, if the Council (acting under Chapter VII) determines that a threat to peace exists, it is empowered under Article 42 to authorize ‘action by air, sea or land forces as may be necessary to maintain or restore international peace and security’ (UN 1945). In 2011, for example, Resolution 1973 authorized UN member states ‘to take all necessary measures … to protect civilians and civilian populated areas under threat of attack’ in Libya (UN 2011a: 3). In 2014, by contrast, no authority for a force-based response—an emergency measure ‘beyond’ the Article 2.4 rule ‘that would otherwise bind’ (see Buzan et al. 1998: 5)—to the Ebola outbreak in West Africa was even foreshadowed by Resolution 2177. As such, notwithstanding the UNSC’s use of threat language, the resolution as a whole was not a securitizing move (as envisaged by securitization theory).

An alternative characterization of Resolution 2177 might be that, on the contrary, it was an international-level move by the UNSC to *de*securitise a disease that was being harmfully securitized at the national level. That is, if making Ebola a (national) security issue meant it was transferred to ‘the agenda of panic politics’, perhaps the Council was signaling that the disease would be ‘better handled within normal politics’ (Buzan et al. 1998: 34). During the UNSC debate that took place on 18 September 2014, a preference for the latter approach prevailed, and governments which had unilaterally imposed travel bans were indeed accused by others of panicking and of thereby jeopardizing public health within and beyond West Africa. Arguably, securitization of Ebola by those governments had involved transgressing the IHR principle against unnecessary interference with international travel. In which case, when Resolution 2177 called forth a return to ‘normal’ (IHR-compliant) arrangements of cross-border travel (unimpeded by unnecessary restrictions), with a view to facilitating the provision of healthcare resources to Ebola-affected countries, it appeared to be a deliberate rejection by the UNSC of security *qua* ‘panic politics’.

And yet, the UNSC (a self-conscious security actor) was clearly not rejecting ‘security’ *per se* on this occasion, and its use of threat language makes it difficult to characterize Resolution 2177 as essentially a desecuritising move. If, as Lene Hansen has observed, desecuritisation stems from a conviction that an issue is ‘better dealt with if we conceive of it in less fearful terms’ (Hansen 2012: 546), it is hard to reconcile this with the Council’s use of the alarming term ‘threat to international peace and security’. And, as such, Resolution 2177 presents a puzzle for securitization theory: here is a case in which utterances of ‘threat’ accompanied a move to *remove* an issue from the grip of an exclusionary, rule-breaking logic of security. With regard to the Ebola outbreak in West Africa in 2014, the UNSC’s threat language did not evacuate normal politics. Rather, inasmuch as Resolution 2177 was a reaction to harmful securitization occurring at the national level, such language was an integral, attention-grabbing element of a move to return international travel arrangements to a condition of normality (*within* ‘rules that would otherwise bind’). Thus, if securitization theory is applied in consideration of Resolution 2177, the distinction between securitization and desecuritization appears to collapse, and so this instance of a disease being framed in security terms is left unexplained.

The explanation posited here is that the UNSC, when calling forth security to facilitate effective disease-control efforts, was moving to promote a different kind of security logic. Threat language conferred an undeniable ‘security-ness’ upon the Council’s response to the Ebola outbreak in West Africa, but this was arguably the ‘security’ of governmentality rather than securitization. In the context of other international responses to the outbreak, including rapid and large-scale mobilization of military capabilities by foreign governments, it is more plausible to characterize Resolution 2177 as a contribution to the securing of circulation. The broader ‘task of security’ (Elbe 2009: 74) on this occasion was circulation-management: only by enabling greater cross-border circulation of medical expertise and resources into and out of West Africa could the damaging circulation of the Ebola virus itself be stopped.

A concern for systems of circulation can be contrasted with the traditional concern for sovereign power that is fixed upon a particular territory (see Foucault 2007: 64-65). In a Foucauldian vision of political rule, the governance of those systems is done for the sake of population welfare and prosperity, and it essentially involves facilitating the wide-scale movement of capital, people and goods. The political importance of circulation is reflected, for example, in the IHR principle that there should be no ‘unnecessary interference with international traffic and trade’ (WHO 2008). However, the implication therein that such interference can sometimes be necessary indicates that associated security practice (*qua* the securing of circulation) is not simply about maintaining circulation always, everywhere and at all costs. Rather, when practiced according to the logic of governmentality, security becomes a matter of discerning, separating and managing ‘good’ and ‘bad’ circulation, and the human-to-human transmission of a deadly disease is a prime example of the latter. This task is an inherently difficult one and, as Sonja Kittelsen has observed, the dilemma in responding to the risk of transnational contagion rests in ‘the need to prevent, control and mitigate the spread of infectious disease while continuing to enable … cross-border circulation’ (Kittelsen 2007: 124) of people who can carry pathogenic microorganisms inside their bodies. For this reason, other authors too have suggested that a better way to address the challenge of infectious diseases is to move beyond thinking only about territorially-bounded space and toward an understanding of interdependent systems of circulation (Braun 2007; Bingham and Hinchliffe 2008; Elbe 2008).

Elbe and his colleagues have previously identified pandemic influenza as a dangerous system of circulation the social effect of which is ‘to abruptly cancel out all the other systems of circulation crucial to maintaining population welfare – such as the movement of goods, of people, of services, and so forth’ (Elbe et al. 2014: 449). The response of some governments to pandemic influenza, in order to avoid the political pressure created by this disease to introduce travel restrictions and other social-distancing measures, has been instead to avail themselves of pharmaceutical means (stockpiles of antiviral drugs) to secure circulation (Elbe et al. 2014: 442). By contrast, a ‘pharmaceuticalized’ process of securing populations (and the circulatory systems that support them) was not available with respect to the Ebola outbreak in West Africa in 2014. At that time, no safe and effective Ebola vaccine existed, and antiviral drugs had not been developed beyond the experimental stage. Nevertheless, another alternative to social-distancing was still available to secure populations against the circulation of Ebola which, though more deadly than influenza, is much less contagious. This alternative approach—recommended by the WHO and supported by the UNSC’s call (in Resolution 2177) for the lifting of travel bans—was to enable the (good) cross-border circulation of medical expertise and resources into and out of West Africa in order to stop the (bad) circulation of Ebola. Resolution 2177 could thus be characterized as contributing to a security process which involved releasing a remedial free-flow that would smother the cause of a crisis of circulation.

The greater part of that process involved a more general harnessing of the language and institutions of security in service to a public-health objective. As such, the international response to Ebola exhibited elements of what Elbe has termed the ‘governmentalization of security’ (see Elbe 2009: 11-13). In this instance, as previously discussed, security practice became oriented toward a wider concern about population welfare rather than a narrower concern about military operations (e.g. the UN peacekeeping operation in Liberia). The phenomenon categorized as a ‘threat’ to population welfare (a deadly contagion) was feared because of its potential to *circulate* and so imperil systems of good circulation. And, as a further indication that security became driven by governmentality logic in the context of the Ebola outbreak, the practitioners of security broadened beyond traditional (military and intelligence) institutions to include ‘wider assemblages of state and non-state actors’ (Elbe 2009: 13). In early September 2014, for example, the humanitarian organization Médecins Sans Frontières (MSF) issued a public plea for national military capabilities—logistics, engineering, and supply-chain management—to be used for disease-control purposes (MSF 2014). Soon afterwards, virologist Professor Peter Piot (from the London School of Hygiene and Tropical Medicine) challenged the UK prime minister to support a ‘quasi-military intervention’ in West Africa to stop Ebola (O’Carroll 2014). And, in her contribution to the subsequent UNSC debate on Ebola, WHO director-general Margaret Chan bought into the security narrative too, describing the disease as ‘a threat to national security well beyond the outbreak zones’ (UN 2014c: 5).

Resolution 2177, in which the UNSC described Ebola as a threat to international peace and security, probably helped further to whip up political enthusiasm for re-orienting security practice toward public health. In practice, though, the extraordinariness of the broader international response to the outbreak in West Africa was not about breaking rules and making exceptions, even though this is what some governments (driven by the security logic of securitization) had apparently done by imposing travel bans against WHO advice. Rather, the extraordinariness of that response appeared to be driven by the facilitative security logic of governmentality, and it lay in the scale and speed of international efforts to control Ebola using infection-control and treatment measures that were known to be effective. These much-needed measures were themselves quite ordinary, as reflected in the Guinean foreign minister’s declaration during the UNSC meeting of 18 September 2014: ‘We need essential equipment: protection and hygiene kits, medicines, mobile hospitals, thermoflashes, stretchers, hospital beds, et cetera.’ (UN 2014c: 25). The provision thereof by governments outside West Africa was to be made easier by Resolution 2177 with its call for a lifting of travel bans. And, although the resolution itself did not expressly authorize or foreshadow the use of force as a disease-control measure, it coincided and was consistent with individual undertakings by some Council members (France, the UK and the United States) to engage in rapid and large-scale mobilization of military resources. Two days previously, US president Barack Obama had announced plans to send as many as 3000 US military personnel, with headquarters in Liberia, to build up to 17 Ebola treatment centers (each with 100 beds) in affected areas of West Africa (Cooper et al. 2014). Against the Ebola outbreak, which Obama described as ‘a potential threat to global security’ (BBC 2014h), US forces were to bring ‘expertise in command and control, in logistics, in engineering’, and the president boasted: ‘our Armed Services are better at that than any organization on Earth’ (Lamothe 2014). The UK and French governments soon followed, making similar commitments to Sierra Leone and Guinea respectively (Higgins 2014).

In addition, on the same day that the UNSC passed Resolution 2177, UN Secretary-General Ban Ki-moon announced his decision to establish a UN Mission for Ebola Emergency Response (UNMEER), claiming: ‘This unprecedented situation requires unprecedented steps to save lives and safeguard peace and security.’ (UN 2014c: 3). The establishment of UNMEER was unanimously endorsed by the UN General Assembly (UN 2014e: 2), and the Mission’s core objectives were to scale up the on-the-ground response to Ebola in West Africa and establish a consistent approach among all international responders in support of locally-led disease-control efforts. To that end, UNMEER channeled financial, logistical and human resources to Guinea, Liberia and Sierra Leone with a view to achieving zero cases of Ebola there (UN 2015). The circulatory threat posed by Ebola was to be met, it seems, with a counter-circulation of remedial resources and expertise. The scale and swiftness of this enterprise, its instigation by the UN Secretary-General (rather than the WHO Director-General), and the fact that it was called a ‘mission’ (a UN term that normally refers to peacekeeping operations) were all extraordinary characteristics of the international response to Ebola in West Africa in 2014. Even so, this extraordinariness was not like that which might have manifested in accordance with the exclusionary and exceptionalizing logic of securitization. Whereas that logic could have disposed disease-control practices toward being means to a (national) security end, the alternative security logic that emerged on this occasion was that of governmentality. In the UNSC and beyond, the mobilizing power of ‘security’ had been drafted in service to the public-health goal of defeating Ebola, and this practice worked in contrast to the static defensiveness of those governments which had sought to shut down international movement in the face of contagion. At a time when moving to securitize a particular disease was unnecessary and counterproductive, a move toward the securing of circulation promised to be better for public health.

**Conclusion**

In 2014, as the dreaded Ebola virus spread further and killed more people than ever before, exclusionary political responses generated a crisis of circulation. Some political responses to the outbreak were informed by either of two distinct logics of security—securitization or governmentality—and the UNSC played a role in championing the latter when, in Resolution 2177, it made a rare contribution to health governance. Initially, in the absence of pharmaceutical resources for preventing and treating Ebola, the governments of the worst-affected states in West Africa plausibly framed the disease as a threat to national survival, and this became a basis for implementing draconian measures that limited freedom of movement. As a disease-control instrument used for the sake of national security, the *cordon sanitaire* was as blunt in principle as it was sometimes brutal in practice, and yet the resort to this measure was at least partly attributable to a deficit of external medical assistance. WHO officials had argued that a better way to defeat Ebola in West Africa was to send in large numbers of medical personnel to treat illness and prevent infection. However, such an approach was stymied from without by another exclusionary practice: unnecessary bans, imposed by foreign governments, on cross-border travel into and out of the outbreak zone. Thus there arose the problem, within and beyond West Africa, that Ebola was being harmfully securitized at the level of national policy.

As a matter of international-level policy, then, there seemed to be a public-health imperative to override security practice driven by the logic of securitization with a different and more helpful version of security practice. The idea emerged that, rather than attempting individually to thwart the progress of Ebola by severely curtailing people’s freedom of movement, governments could act collectively to facilitate the necessary influx of remedial capabilities. UNSC Resolution 2177, which called for the lifting of travel bans, was a political move to that effect. Even so, the resolution’s characterization of Ebola as a threat to international peace and security should not be regarded as a *securitizing* move. In characterising the disease thus, the Council was arguably only contributing to a broader process (involving non-state actors, the WHO, individual UNSC member states and the UN Secretary General) of placing security (its language and institutions) in the service of public health. Far from legitimizing the extraordinary, rule-breaking anti-Ebola measures that some governments had implemented according to the logic of securitization, Resolution 2177 rather worked to delegitimize any extraordinariness that was counterproductive to public health within and beyond West Africa.

From the perspective of securitization theory, this is puzzling because securitization is supposed to be a process whereby the framing of an issue as a threat is done in order to legitimise extraordinary measures ‘going beyond rules that would otherwise bind’ (Buzan et al. 1998: 5). And yet, in Resolution 2177, threat language was used in the course of ushering in an ‘ordinary’ (albeit large-scale) response; a response of the kind that the WHO had advised was necessary to contain and defeat Ebola in West Africa. As such, a better explanation of Resolution 2177, seen in the context of other international responses to Ebola, is that it was a move driven by the security logic of governmentality; a move toward governmentalizing the practice of security itself. Health was the end to which security would be the means. And systems of circulation supporting population welfare, more than the bordered territories of sovereign states, would become the object of security against the circulatory threat posed by Ebola. On this occasion, the UNSC’s positive contribution to health governance was to support a shift in security logic: from securitization to securing circulation.

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1. In September 2014, for example, a senior US health official warned that as many as 1.4 million people worldwide might be infected with Ebola by January 2015 (Glenza 2014). [↑](#footnote-ref-1)
2. The UNSC has on numerous occasions concerned itself with the possibility of non-natural disease outbreaks (caused by the use of biological weapons). [↑](#footnote-ref-2)
3. Such staging is a ‘securitizing move’, which these authors distinguish from a ‘successful securitization’ (Buzan et al. 1998: 25). Other authors, seeking to develop and extend securitization theory, have argued that the exercise of framing an issue in security terms can itself generate a variety of political effects (see, for example, Balzacq 2005), and this stands in contrast to the more narrow view of securitization as the business of justifying extraordinary measures. [↑](#footnote-ref-3)
4. Ebola is spread by contact with the bodily fluids (such as urine, sweat and blood) of infected people or animals (WHO 2016a). [↑](#footnote-ref-4)