Securitization and the Merger of Great Power Management and Global Governance: The Ebola Crisis*

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Abstract

Within the discipline of International Relations (IR), the literatures on global governance (GG) and great power management (GPM) at best ignore each other, and at worst treat the other as a rival or enemy. On the one hand, the GPM literature, like both realism in all its forms, and neoliberalism, takes for granted the ongoing, disproportionate influence of the great powers in the management of the international system/society, and does not look much beyond that. On the other hand, the GG literature emphasizes the roles of smaller states, non-state actors and intergovernmental organizations (IGOs), and tends to see great powers more as part of the problem than as part of the solution. This paper argues that the rise to prominence of a non-traditional security agenda, and particularly of human security, has triggered a *de facto* merger of GPM and GG that the IR literature usually treated as separate and often opposed theories. We use the Ebola crisis of 2014-15 to show how an issue framed as human security brought about a multi-actor response that combined the key elements of GPM and GG. The security framing overrode many of the usual inhibitions between great powers and non-state actors in humanitarian crises, including even the involvement of great power military forces.

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Through examining broadly the way in which the Ebola crisis is tackled, we argue that in an age of growing human security challenges, GPM and GG are necessarily and fruitfully merging. The role of great powers in this new human security environment is moving away from the simple means and ends of traditional GPM. Now, great powers require the ability to cooperate and coordinate with multiple-level actors to make the GG/GPM nexus more effective and sustainable. In doing so they can both provide crucial resources quickly, and earn respect and status as responsible great powers. IGOs provide legitimation and coordination to the GPM/GG package, and non-state actors (NSAs) provide information, specialist knowledge and personnel, and links into public engagement. In this way, the unique features of the Ebola crisis provide a model for how the merger of GPM and GG might be taken forward on other shared-fate threats facing global international society.

Keywords
Great Power Management, Global Governance, the Ebola Crisis, Human Security, Global International Society

Ⅰ. Introduction

It has been argued (Cui and Buzan, 2016), that the English School's idea of great power management (GPM) as an institution of global international society, is closely linked to the agenda of international security. This link meant that the practice of GPM was being transformed by the opening up of that agenda to include not just traditional great power military/political issues, but also a wider range of non-traditional security (NTS) issues. The widening and deepening of the security agenda is well documented as a practical fact (Buzan, Wæver and deWilde, 1998; Buzan and Hansen, 2009). But the implications of this for the management of global international society (GIS) have not really been explored. Cui and Buzan's (2016) work has noted that as the process of securitization spread to an ever-wider range of issues — economy, environment, human rights, identity, the internet, migration, public health — it has expanded the functions of GPM from regulating great power relations and keeping interstate order, to managing complex global governance challenges. As a consequence, and quite unintentionally, the agendas of GPM and global governance (GG) have increasingly been overlapping, and have now arguably reached a point of *de facto* merger.

The irony here is that within the discipline of International Relations (IR), the literatures on GG and GPM at best ignore each other, and at worst treat the other as a rival or enemy. The GPM literature, like both realism in all its forms, and neoliberalism, takes for granted the ongoing, disproportionate influence of the great powers in the management of the international system/society, and does not look much beyond that (for

example: Bull, 1977; Gilpin, 1981; Simpson, 2004; Buzan, 2004; Goh, 2013). The GG literature emphasizes the roles of smaller states, non-state actors and intergovernmental organizations (IGOs), and tends to see great powers more as part of the problem than as part of the solution (Rosenau, 1992; Weiss, 2013). A key driver behind the merger is the increasing prominence of shared-fate issues and the inability even of great powers to address these by themselves (Karns and Mingst, 2010: 3). Bukovansky et al.(2012) show how special responsibilities have diffused away from great powers to a variety of other actors. The general image is one of states of all types and levels of power being not only entangled in a web of non-state actors (NSAs) and IGOs, but also being constrained, and in some ways hollowed out, by global laws, norms, and transnational networks (Weiss, 2013, locs. 459, 1202). The result of these ships passing in the night is that the GG literature underplays the need to take the great powers into account in the process of global governance (Hurrell, 2005: 33), while the GPM literature loses legitimacy because it neglects the fact that other kinds of actors are playing major roles in the issues encompassed by the wider security agenda.

This academic literature needs to catch up with the real-world practice, in which the securitization of a wide range of non-military issues provides foundations for the merger of GPM and GG. In this paper, we use the case of the Ebola crisis to show what this securitization-driven merger looks like, and how far it has developed. The Ebola case suggests that GPM remains both a legitimate institution of GIS, and a practical necessity for getting things done. At the same time, it validates the GG view that IGOs, NSAs and the corporate world are also key players, necessary to the legitimacy and function of global governance in the wider security

agenda. Perhaps most importantly, the Ebola case shows that unlike in the academic literature, where the two schools of thought remain remote from each other, in the real world, great powers and NSAs are able to work together and acknowledge a division of labour.[1)]

An additional twist of interest is provided by the fact that the Ebola case involves China as one of the responsible great powers. We feature China's role a bit here because it supports the argument that China is not just oppositional to contemporary GIS (Larson and Shevchenko, 2010; Callahan and Barabantseva, 2012; Fontaine and Rapp-Hooper, 2016), but in some significant ways a supporter of it (Zhang, 2016: 796; Suzuki, 2008: 60). A case can be made that China is in some respects behaving as a responsible great power in managing GG issues, including its participation in the UN peace keeping, and its more cooperative role in environmental stewardship (Gill and Huang, 2009; Suzuki, 2008, 2009; Lanteigne and Hirono, 2014; Falkner, 2016; Zhang, 2016; *China Daily,* 30 May 2016; Buzan, 2018; Cui, 2018b). The Ebola case shows both the strengths and limitations of China as a responsible great power participating in, and contributing to, global health governance (Cui, 2018a).

The next section looks at the securitization of international public health issues leading up to the Ebola crisis. The following two focus on the Ebola crisis, looking first through the GPM lens at the responses of the great powers, and then through the GG lens at the responses of IGOs and a range of NSAs. The conclusions assess the Ebola crisis both

1) We are aware that the Ebola case could be approached using other theoretical framings, but we confine ourselves to GPM and GG, both because the Ebola case is a particularly good one to expose the unhelpful estrangement between these two important theories, and because of length constraints.

as an example of how GPM and GG have merged, and as a model for how this merger might be applied to other securitized shared-threat issues.

II. The Securitization of International Public Health Issues

The background to the international response to the Ebola crisis is the securitization of public health that took place within the institutionalization of human security. This securitization is the key to showing how the barriers separating the practices of GPM and GG were surmounted. Since the concept of human security was introduced in 1994 (UNDP, 1994), the idea has increasingly been reflected in both GG and in many countries' foreign and aid policies. As with the longstanding controversy about human rights, human security has also been divided between those supporting a more political and civil perspective, and those emphasizing economic and social rights (among others see, Acharya, 2001; James, 2012; Cui, 2014; Zhang and Buzan, forthcoming). However, it is increasingly a broader definition of human security that has gained wider acceptance. The UNDP (1994) defined it as freedom from fear and freedom from want, and identified seven components of human security, including economic, food, health, environment, personal, community and political. In its 2003 report, the Commission on Human Security (CHS) also took a broad view, defining it as protecting 'the vital core of all human lives in ways that enhance human freedoms and human fulfillment' (CHS: 2003: 4). This line of conceptual development was endorsed by the UN Resolution A/RES/66/290 in 2012, which describing human security as 'the right of people to live in freedom and dignity, free from poverty

and despair' (UNGA, 2012). A broader definition of human security is thus now accepted widely in academic and policy-making circles (James, 2012). It is also widely accepted among most East Asian countries, where human security and human development are now closely linked (Hernandez, et al. 2018). This linkage suits China well because it has been a long-standing promoter of a developmental approach to human rights and human security (Zhang and Buzan, forthcoming).

This commitment to a broad view of human security has brought public health issues into the GPM/GG nexus. Diseases and pandemic have long been considered as issues in GIS, but mainly as technocratic health issues. Increasingly, however, they have become human security issues. The first time that the UN Security Council (UNSC) acknowledged explicitly the link between health and security was in 2000, when it recognised the HIV/AIDS pandemic as 'a risk to security and stability' in Resolution 1308 (UNSC, 2000). Although this resolution was mainly concerned with 'regional effects' in Africa (Deloffre, 2014), it is important in terms of human security, because it was the first time in the UNSC's history that its members had formally debated a non-mandated issue, and added the issue into its international peace keeping operation agenda (Poku, 2013: 529). Following this precedent, when the UNSC adopted Resolution 2177 on 18 September 2014, declaring that the outbreak of Ebola in Africa constitutes 'a threat to international peace and security', it pushed the scale and depth of securitization of health to an unprecedented level, bringing the securitization processes into close alignment with human security frameworks (Snyder, 2014). Since the UNSC is the key legitimizing forum for GPM, this action put public health squarely onto the great power security agenda.

Public health, like other NTS threats, spills over territorial borders and creates a wide range of security threats and sources of instability (Thakur and Newman, 2004: 4). Since no single country can address these threats on its own, both greater interstate cooperation and the engagement of non-state actors are required, and *a multi-stakeholder* response has thus become an important trend (Jones, Pascual and Stedman, 2009; Caballero-Anthony and Cook, 2013: 2, 3). Greater cooperation among multi-stakeholders in responding to infectious diseases, reached global scale when the US government launched the Global Health Security Agenda (GHSA) in February 2014 with more than 25 nations and major IGOs including the World Health Organization(WHO). Now the number has expanded into 44 countries including China.[2] The rationale behind the creation of GHSA was that infectious diseases, just as with nuclear, chemical, or cyber security attacks, posed security challenges rather than just *health challenges*. They qualify as security issues because they can cause enormous damage in terms of lives lost, economic impact, and difficulty of recovering. Since these threats know no borders, even the US cannot address them alone, and so the GHSA takes both a 'multi-partners' approach, bringing together international partners both public and private, and an 'across sectors' approach including agriculture, health, defence, and development sectors. In this sense, the GHSA is 'an international effort to enhance our ability to prevent, detect, and respond to outbreaks of infectious disease threats' (Monaco, 2014).

The securitization of public health underlines the link to development within the human security framing. As Hurrell and Woods (1999: 259)

2) About GHSA, see its web at: https://www.ghsagenda.org/index.html

note, much of the NTS agenda has emerged 'not from state strength, military power, and geopolitical ambition, but rather from state weakness'. This was particularly true in the 2014 Ebola crisis. Guinea, Liberia and Sierra Leone, the three hardest hit countries, are all weak states, have high poverty rates, high rates of maternal and child mortality, limited educational attainment, weak infrastructure, and inadequate public services (UNDP, 2014a: 3). The Ebola crisis thus revealed the strong link between poverty, underdevelopment and infectious-disease-driven threats (Poku, 2013; Bonnel, 2000).

The Ebola virus disease in West Africa broke out in December 2013, and was first alerted by WHO in March 2014. It turned out to be the largest, longest and most severe and complex outbreak of the virus since it was discovered in 1976. When the crisis was at its peak in September 2014, weekly cases reached almost 1000 (WHO, 31 December 2014). Until WHO officially declared it over on 14 January 2016, the crisis lasted about two years, during which more than 28,600 people were infected with the virus and more than 11,300 died, mostly in Guinea, Liberia, and Sierra Leone (WHO, 14 January 2016). The global effort to fight against the Ebola crisis in 2014-15, provides an ideal case through which we can investigate the interplay of GG and GPM in an era of complex NTS challenges with a strong human security content. In the next section we survey the great power response, and in the one following, the response at the level of GG.

Ⅲ. Great Power Management in the Ebola Crisis

Great power participation in the Ebola crisis was motivated not just by the sense of threat about the disease spreading out of Africa, but also by wanting to be seen as responsible actors, and competing with each other for status. All the states that think of themselves in some sense as great powers, participated actively, especially after the declaration of emergency by the WHO and the UNSC in August and September 2014, and were eager to show how valuable and significant their contributions were to the global efforts to stop Ebola spread. Among the countries playing leading roles were the traditional donors, such as the US and the UK. As a new player, China was especially interested in using the crisis to both enhance its soft power and to use its military in humanitarian missions to improve its global image (Guo, 2014; Tiezzi, 2015).

On 16 September 2014, President Obama announced a major increase in the US response to fight Ebola in Africa, including up to 3,000 troops and materials to build field hospitals (*New York Times*, 16 September 2014). This commitment included the establishment of a central command centre in Liberia and 17 new treatment facilities. Speaking at the UN on 25 September 2014, Obama told world leaders that the Ebola outbreak had gone beyond a health crisis and is a 'growing threat to regional and global security' (*The Washington Post*, 25 September 2014). By the end of 2014 the US government had contributed about $850 million in aid, ranked the largest donor, followed by the UK with about $330 million (Grépin, 2015: 5). Over the course of the crisis, the US deployed more than 3,500 personnel to the affected region, from including the Department

of Defense, the Center for Disease Control, and the Public Health Service. As the sole superpower, and as a longstanding traditional donor country, the US played an indispensable role in this humanitarian crisis.

The United Kingdom (UK) also played leading role to combat Ebola, particularly in Sierra Leone. A £427 million ($568 million) package of direct support was committed in addition to supporting various international agencies, such as the World Bank and the UN's Central Emergency Response Fund. The UK's direct contributions included, among other things, financial support, sending medical experts, supporting treatment centres and beds, and training frontline workers. Six Ebola treatment centres were built in Sierra Leone and more than 1,400 treatment and isolation beds were supported. More importantly, about 750 troops were sent in order to help build treatment centres, provide logistical support, engineering expertise and hands-on help. Hundreds of NHS staff volunteered to travel to West Africa and help those affected by Ebola. The UK also trained over 4,000 healthcare workers, logisticians and hygienists including Sierra Leonean Army and Prison staff.[3)]

Over the course of 2014 and 2015, France mobilised over €200 million ($235 million) to combat Ebola, and over 200 French workers, including staff from the health-care sector and the Ministry of Defence were sent on various missions to Guinea.[4)] Germany provided €161 million ($190 million) financial assistance, and supported many Ebola-

3) See, 'How the UK government is responding to Ebola', at the UK government website, https://www.gov.uk/government/topical-events/ebola-virus-government-response/about#response-in-africa (accessed 2 October 2017)

4) 'Ebola: The Response of France.' The Government of Republic of France, 10 April 2015. Available at: https://hongkong.consulfrance.org/Ebola-The-response-of-France (accessed 3 October 2017)

related activities of German and international non-governmental organizations. For example, more than 500 tonnes of aid supplies were transported to Monrovia, Conakry and Freetown; and 400 special motorbikes were provided for the transport of blood samples.[5)]

In addition to the individual responses of its member states, the European Union (EU) also made significant contributions to fighting the epidemic. Its total financial contribution was over €1 billion (about $1.17 billion), which included funding from the Member States and the European Commission. The EU also sent emergency supplies and experts, and EU humanitarian experts, including specialists in hazardous diseases, to the three most affected countries (European Commission, 2014).

Japan is a longstanding supporter and promoter of human security oriented foreign policy. Although it did not make great personnel contributions (it sent a total of 20 experts), over the course, Japan provided approximately $173 million financial support (which includes funds provided through WHO, the World Bank and other international organizations). Japan also made important in-kind contributions, such as providing 720,000 sets of personal protective equipment (PPE), a total of 42 vehicles including ambulances, and 95 beds donated by local governments and private companies (Japan Kantei, 2015).

More importantly, the strength of Japan's deep-rooted philanthropic culture and non-governmental organizations (NGOs) also shows the combination of GPM and GG. Coordination between Japanese NGOs and Direct Relief, a US based international humanitarian aid organization,

5) See, 'Germany's Contribution to fighting Ebola', accessed at the Permanent Mission of the Federal Republic of Germany to the UN website, http://www.new-york-un.diplo.de/Vertretung/newyorkvn/en/02-what-we-do/german-contribution-ebola.html (accessed 9 December 2017)

provides an excellent example. Direct Relief began its support to partners in West Africa with resources for Ebola response, including critical medicines and PPE. As Ebola spread across borders, quality PPE was in high demand, and became difficult to find. Thanks to the good relationship it built with the Japan NGO Center for International Cooperation (JANIC), Direct Relief was quickly able to approach Japan through JANIC. In response to the urgent request for PPE, JANIC mobilized its network resources, and soon found several government entities that had acquired stores of PPE in 2009, when the Avian flu was a major threat. Many of these PPEs were donated to the West African countries through Direct Relief (Hutain, 2015).

India, not a traditional donor country, but liking to think of itself as a great power, contributed about $12.5 million in response, and Russia about $60 million (Nundy, 2014). Russian public health official Anna Popova particularly emphasized the fact that 'Irrespective of economic difficulties, Russia has been honoring its commitments as a leading partner to the resolution of global healthcare problems' (*Russia Beyond*, 17 April 2015). Russia also offered some humanitarian assistance and dispatched medical groups to the affected countries.

Among the emerging great powers, China gained particular attention. It was one of the first countries to participate in the fight against Ebola, marking the first time for China to offer such aid to combat a foreign health crisis (Cui, 2018a; Tiezzi, 2015). China's role in fighting Ebola was particularly important in the earlier stage, and contrasted well with the slowness of international responses. After the initial WHO alert in March 2014, in April Médecins Sans Frontières (MSF) warned that Ebola was getting out of control, and in June the spread and scale of

the epidemic was obvious to many experts. Yet, not until 8 August did WHO declare a public health emergency, and the international response generated much criticism for being both too small and too slow (*Independent*, 20 October 2014; Grépin, 2015). In comparison, China's participation in fighting Ebola was swift, mainly for two reasons. First, given China's long-term medical cooperation with African countries, there were already Chinese doctors and medical staff in the places where the outbreak occurred. Second, the experience of severe acute respiratory syndrome (SARS) in 2003, and China's struggle to stop the spread of SARS, made Chinese officials and medical experts particularly alert to pandemic. Immediately in April 2014, China announced its first emergency assistance plan, which would send about 4 million RMB ($600,000) worth of medical supplies to West Africa, which arrived in May (NHFPC, 2015a).

By the end of 2014, through four consecutive phases in April, August, September and October 2014, the Chinese government contributed about $123 million emergency aid (750 million RMB). China also provided other in-kind contributions including medical equipment and prevention care packages. More importantly, China sent more than 1200 people, including medical teams, and public health teams into West Africa to combat Ebola. As with many other major powers' responses, the Chinese military joined the government's efforts, and within three months it had sent some 300 medical personnel and specialists to West Africa to help control the epidemic (Xinhua, 21 March 2015). It was the largest-ever medical aid program so far implemented by China (NHFPC, 2015b). Yet in comparison with many traditional donor countries, China had less experience in coordinating with NSAs, and the Ebola crisis, in a sense, revealed the shortcomings of China's private sector participation and

philanthropy (Rajagopalan, 2014). Even though at the government level China contributed over $120 million to fight Ebola, at the level of private sector it donated little to the cause. Many firms and business people in China still assume that the Chinese government should take the lead on international aid. In a deeper sense, this philanthropic shortfall results from China's international aid tradition, which has been predominantly bilateral and government-to-government (Chan, 2011: 95-122; Xu, 2012). Thus, the Ebola case revealed China's new role as a significant contributor to the global health governance for the purpose of human security provision. China demonstrated its 'growing position within the international community as a global actor in humanitarian aid' (UNDP, 2014b). Yet, because China's response lacked any significant engagement by its civil society its engagement in the Ebola crisis was all GPM and no GG.

This unprecedented level of great power involvement in a global health crisis, confirms how the acceptance of human security has both expanded the agenda of GPM, and confirmed it as a primary institution of GIS.

Ⅳ. Global Governance in the Ebola Crisis

These contributions from great powers were accompanied by, and interwoven with, significant roles for the key actors in GG: middle powers, IGOs and NSAs.

Among the middle powers, Canada, Norway, Sweden and Denmark can stand as illustrative examples. Canada, along with Norway a long-

standing promoter of human security diplomacy, committed more than $110 million to address the spread of the disease. It also made an interesting military cooperation with the UK. The Canadian Armed Forces' (CAF) Operation SIRONA, augmented the UK Operation, focusing their work in Kerry Town to treat local and international healthcare workers who were exposed to Ebola. Three rotations were carried out with total of 79 CAF healthcare and support staff participations until the mission was ended on 30 June 2015.[6)]

Canada also made major additional contribution by supporting a Phase 3 clinical trial of Ebola vaccine (the Canadian VSV-EBOV vaccine) in Guinea, which was led by WHO in collaboration with the Health Ministry of Guinea, MSF, Epicentre and the Norwegian Institute of Public Health. Testing through 2015-16 proved the VSV-EBOV vaccine to be safe and highly effective; and it is now licensed to the U.S.-based Merck & Co (*National Post*, 3 December 2016). As Marie-Paule Kieny, a WHO assistant director-general and the lead author of the study, notes, the success of the made-in-Canada vaccine was 'an unprecedented development in what has been an unprecedented public health disaster' (Yang, 2015). The success also demonstrated how the public-private partnerships (PPP) model has been successfully implemented in Ebola emergency.[7)] In addition, Norway provided $60 million to the efforts to fight Ebola in West Africa, and more than 300 Norwegian health workers volunteered to join the efforts in Sierra Leone.[8)] Sweden donated $28.7 million to support

6) See, 'Operation SIRONA', at the CAF website, http://www.forces.gc.ca/en/operations-abroad/op-sirona.page (accessed 2 October 2017)

7) See, 'Public-private partnerships: An Innovative Solution against Ebola', Oleg Deripaska official website, https://www.deripaska.com/initiative/Fighting-Ebola/ (accessed 9 December 2017)

8) 'Norway adjusts its Ebola response'. Government of Norway, 26 March 2015. Available at:

various UN efforts to combat Ebola, and sent some health workers.[9] Demark donated $32.3 million, and sent four medical teams to West Africa (*CPH Post*, 16 March 2015).

As already suggested, IGOs both alerted and legitimized the securitization of Ebola. Although criticized for acting too slowly, their declarations nonetheless imposed upon great powers the responsibility and obligation to take decisive actions to halt the outbreak. The UNSC's declaration was followed on 19 September by the formation of the UN Mission for Ebola Emergency Response (UNMEER), the first-ever UN emergency health mission, after the unanimous adoption of General Assembly resolution 69/1, and the adoption of Security Council resolution 2177 (2014) on the Ebola outbreak. It was in this crisis atmosphere that many countries pledged more aid and manpower to help. UNMEER brought together the full range of UN actors and expertise under the leadership of a special representative of the secretary general. The WHO also took responsibility for overall health strategy and advice within the Mission. Without the leadership role played by these organizations it is difficult to imagine how diverse actors could take coordinated actions in such a complex situation.

The contribution of NSAs was also significant. It was NGOs, such as MSF, that fought in the forefront and warned early that Ebola was getting out of control. MSF responded in all three worst affected countries from the very beginning of the epidemic, by setting up Ebola management

https://www.regjeringen.no/en/aktuelt/ebola-response/id2403173/ (accessed 19 December 2017).

9) 'Sweden contributes medical care efforts in the fight against Ebola in West Africa'. Government Offices of Sweden, 16 October 2014. Available at: http://www.government.se/press-releases/2014/10/sweden-contributes-medical-care-efforts-in-the-fight-against-ebola-in-west-africa/ (accessed 19 December 2017)

centres and providing services. During the first five months, it handled more than 85% of all hospitalised cases in the affected countries. At its peak, MSF employed nearly 4,000 national staff and over 325 international staff to combat the epidemic across the three countries.[10] Between March 2014 and December 2015, MSF admitted 10,310 patients to its Ebola management centres of which 5,201 were confirmed Ebola cases. This number represents one-third of all WHO-confirmed cases. In the same period, the organisation spent nearly €104million ($810million) in total to tackle the epidemic (MSF, 2016).

Hundreds of millions of dollars were contributed by individuals, companies, and non-profits, to complement governments' efforts in the response Ebola. Particularly, companies with unique competencies and capabilities emerged as significant players and received much attention and praise. Among others, the Bill and Melinda Gates Foundation alone donated $55 million to fight Ebola, and the South African MTN Group contributed $10 million. Wealthy entrepreneurs also donated large sums: $25 million from Facebook CEO Mark Zuckerberg, $15 million from Google CEO Larry Page, and $100million from co-founder of Microsoft Paul Allen (Hillier, Mhlanga and Zweben, 2014; *The Huffington Post*, 11 November 2014). This made it the largest scale public response since the 2004 Indian Ocean tsunami, demonstrating that in an internet age, NSAs are becoming an 'indispensable force in global health governance' (Xu, 2015). These contributions greatly enhanced public awareness of, and participation in, the campaign against Ebola.

Beyond financial generosity, as Faure, Kaja, and Weintraub (2014)

10) See, 'Ebola: MSF activities ', at MSF website, http://www.msf.org/en/diseases/ebola (accessed 4 October 2017)

observe, pharmaceutical companies made significant steps in developing vaccines and treatments for the Ebola virus. GlaxoSmithKline (GSK), for example, by working closely with regulators, governments and the WHO, became the frontrunner of vaccine development. Meanwhile, Johnson & Johnson (J&J) also pledged $200 million to accelerate Ebola vaccine development. Importantly, its vaccine regimen was developed as part of a public-private partnership (PPP) with the US National Institutes of Health and with another vaccine developed by Bavarian Nordic (a Swedish biotech company). Furthermore, GSK and J&J also pledged to work together to accelerate vaccine development, and Pfizer (an American global pharmaceutical corporation) offered its production facilities to ensure that supply could meet demand (Roland, 2014). Thus, Faure, Kaja, and Weintraub (2014) argue that 'This level of cooperation is extraordinary, not least because it is between companies who otherwise are competitors, but also because the speed and scale of planned development, testing and production are far greater than industry standards'.

One of the unique and significant developments concerning private sector contribution to Ebola response was the creation of the Ebola Private Sector Mobilisation Group (EPSMG). It is a coalition of more than 48 companies with major assets and operations in West Africa. Established in early August 2014, EPSMG was aimed to facilitate a mobilised and coordinated private sector response to the disease, and did a commendable job in this crisis (EPSMG, 2014; Hillier, Mhlanga and Zweben, 2014). As Alan Knight chairman of EPSMG notes, the greatest success of EPSMG was 'the ability to help get things done on the ground' (Knight, 2015). Contributions made by private sector were early and agile. At the onset of the outbreak, many companies focused first on

their responsibilities to protect their employees, their families and surrounding communities, only then quickly moving to help mobilise a broader national, regional and global response (EPSMG, 2014). They provided direct support through donating funding, personnel, equipment, and through building infrastructure, as well as lending expertise in construction, logistics, and distribution services. Thus, EPSMG (2014) claims that 'we must change the mentality of looking at the private sector solely as a source of funding', because they can add their distinctive resources, skills and competencies.

V. Epilogue

The effectiveness of the combined GPM/GG response to Ebola was shown by the response to a subsequent flare-up of the virus in the Democratic Republic of Congo (DRC) between 8 May and 24 July 2018. The outbreak struck four areas of the DRC, including Mbandaka, a major port city, which resulted in 54 confirmed cases and killed 33 people (WHO, 24 July 2018). Officials feared at first that the virus would travel up and down the Congo River to neighboring capital cities. Yet, compared to the 2014-2015 outbreak, the response to the latest flare-up was considered a clear success (AFP, 24 July 2018; *The Washington Times*, 24 July 2018).

As Mike Ryan, WHO's deputy chief for emergency response, notes, there was a'fast local and international response as well as "painful lessons" learnt' from the handling of the earlier West African epidemic

(AFP, 24 July 2018). WHO moved particularly quickly and efficiently this time, so that within hours of the Ebola outbreak being declared in Congo, it released $2 million from its contingency fund for emergencies, and deployed a team and activated an emergency incident management system (CNN, 24 July 2018). Importantly, WHO's rapid response was funded and supported by many countries, organizations, and relief groups, including the availability of the experimental vaccine from the pharmaceutical company Merck called rVSV-ZEBOV. During the outbreak, at least 3,300 people were vaccinated (WHO, 24 July 2018; CNN, 24 July 2018). It also demonstrated the improved capacity of the African region. Among the 360 people deployed to respond, more than three-quarters came from within the region. Dozens of experts from Guinea spent weeks leading Ebola vaccination efforts (AFP, 24 July 2018). Thus, WHO Director-General Dr. Tedros claimed that the outbreak was contained because of the 'efforts of local teams, the support of partners, the generosity of donors, and the effective leadership of the Ministry of Health' (WHO, 24 July 2018).

Ⅵ. Concluding Discussions: the Merger of Great Power Management and Global Governance

The Ebola crisis presented the GIS with both an unprecedented challenge and a unique opportunity. While it revealed serious flaws of national, regional and international public health mechanisms, it drew together a variety of actors to form different forms of working coalition. A key

insight from the Ebola case for academic IR is that it shows how GG and GPM have *de facto* already merged in relation to shared threats of a functional kind. The categorical divide between GPM and GG is based on the actors they feature: respectively, great powers on the one hand, with their global interests and large resources and capabilities; and on the other a variety of smaller states, IGOs and NSAs, using their specialised capabilities and political flexibility to offset and circumvent the political rivalries that often paralyze the great powers. Because of its security framing, the Ebola case was able to bridge the GPM/GG divide, and to demonstrate the value of cooperation among multiple level actors. Indeed, multi-level coordination became crucial to the success of the effort. Unlike many GG literatures that emphasize the state's failures in dealing with transnational challenges, the Ebola case highlights that states in general, and great powers in particular, were the indispensable actors with most resources in their hands. What we see in the Ebola crisis is a complex, and fairly coordinated, mix of actors from different domains: great powers, especially their militaries, smaller states, IGOs, INGOs, even companies, civil societies and individuals.

The Ebola crisis thus serves as possible indicator of, and model for, GPM and GG in the deeply pluralist international society that is emerging as Western dominance and leadership is replaced by more cultural and political diversity. Deep pluralism suggests a GIS that might be weaker because wealth and power are more diffused, and cultural authority has fragmented among several newly re-empowered civilizational cores. But despite its cultural and political diversity, this GIS shares not only a substrate of modernity, and a broad commitment to capitalism, but also a strong set of primary institutions including sovereignty, territoriality,

nationalism, diplomacy, human equality, international law, the market, and most recently environmental stewardship. This GIS is also increasingly challenged by shared fate threats ranging from the global economy and terrorism, through environmental disruptions, diseases and space rocks, to mass migrations and breakdowns of the internet (Buzan and Lawson, 2014, 2015). The Ebola crisis shows how shared threats can override not only differences amongst states, but also difference between states and NSAs.

Framing things in security terms seems to have been the key to overcoming the reluctance both of states to work with other states who they see as cultural and political rivals, and of NSA's to work alongside the great powers. Perhaps particularly significant in this regard was the way in which a NSA such as MSF overcame its taboo against working with state militaries. The Ebola crisis especially witnessed the armed forces of the great powers as an actor in public health crises, a novel and important part of the GPM/GG merger. Military engagement in humanitarian crises was not without concerns. As soon as Obama announced the deployment of AFRICOM, questions arose about whether a largely military response was appropriate for a public health epidemic (Dionne, Seay and McDaniel, 2014). The militarization of aid in a variety of global contexts has long been of concern to many humanitarian NSAs, who worry that use of the military violates important principles of ethical humanitarian aid: 'neutrality' (not taking sides in a conflict), 'impartiality' (not discriminating in aid provision) and 'independence' (working free of government interference). Hence some NGOs have renounced working with military forces to provide humanitarian relief (See, Deloffre, 2014; Dionne, Seay and McDaniel, 2014). The Ebola

crisis changed this conventional understanding. Because the outbreak of Ebola was constructed not only as a public health epidemic, but also as a public health emergency and a matter of international peace and security, it became a human security issue requiring a different kind of global response. Once the urgency associated with securitization had been accepted, concerns about non-neutrality were overridden by the need for immediate action for human security; and calls for a military response came directly from the affected countries, from the WHO, and even from NGOs.

In this sense, the Ebola crisis is a potential watershed moment, because it provides some models for future humanitarian interventions, in which, both NGOs and militaries can recognise their core comparative advantages and hence work together in partnership (Tambo, 2014; Worthington, 2014; Deloffre, 2014). In fact, it has been proven that with their adaptability, discipline, ability to operate in challenging environments, and logistical capabilities, militaries are particularly valuable during large-scale public health crises (Edelstein, Heymann and Angelides, 2015). Mobilized by human security considerations, MSF is now calling for military intervention as part of the outbreak response. During the Ebola crisis, there appeared to be a high level of cooperation between health actors and the militaries, and Deloffre (2014) is thus right to argue that defining the Ebola crisis as a human security issue was a 'game changer'. In this way, the great powers and their militaries have become crucial players in human security governance. Great powers no longer act as an exclusive privileged club, but in partnership with NSAs especially with IGOs and NGOs. Importantly, the US, as the most powerful state in the world, acknowledged that global health security is a 'shared responsibility'

that cannot be achieved by a single actor or sector of government.[11)]

Overall, the Ebola case points strongly to the conclusion that in an age of growing human security challenges, GPM and GG are necessarily and fruitfully merging. The role of great powers in this new human security environment is moving away from the simple means and ends of traditional GPM. Now, great powers require the ability to cooperate and coordinate with multiple-level actors to make the GG/GPM nexus more effective and sustainable. In doing so they can both provide crucial resources quickly, and earn respect and status as responsible great powers. IGOs provide legitimation and coordination to the GPM/GG package, and NSAs provide information, specialist knowledge and personnel, and links into public engagement.

11) 'Remarks by the President at Global Health Security Agenda Summit.' White House, 26 September 2014. Available at: https://www.whitehouse.gov/the-press-office/2014/09/26/remarks-president-global-health-security-agenda-summit (accessed 14 July 2015)

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