

**Global Health Crises and International Cooperation:  
A Comparative Framing Analysis of Narratives Told  
During Cholera Outbreaks in 1851 and 2017**

**by  
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# Approval

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## **Abstract**

This thesis explores the following questions: can global health crises provide effective opportunities for international cooperation? More specifically, what is the relationship between how a crisis is framed, and policy responses? To answer these questions, this thesis conducted a comparative case study and framing analysis of narratives told during two cholera outbreaks: the 1829 second cholera pandemic; and 2017 cholera outbreak in Yemen. This entailed analyzing proceedings of the 1851 International Sanitary Conference, 2017 Security Council meeting records, and Global Task Force for Cholera Control documents. Documents were analysed using two techniques: (1) narrative analysis to identify narratives constructed around the two cases; and (2) framing analysis to identify which global health frames actors used in narratives. This thesis argues that health crises can provide opportunities for cooperation, if cooperation is framed as a global public good and if actors refer to existing norms and laws governing state behaviour.

**Keywords:** International cooperation; cholera outbreaks; narratives; frames; global public goods; international law

To Irin and Syed, with all my love

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## List of Acronyms

GTFCC	The Global Task Force on Cholera Control
ICRC	International Committee of the Red Cross
IHL	International Humanitarian Law
OCV	Oral Cholera Vaccine
SDGs	Sustainable Development Goals
S/PV	Security Council Verbatim Records of Meetings
S/PRST	Security Council Presidential Statement
UN	United Nations
WASH	Water, Sanitation, and Health
WHO	World Health Organization



# Chapter 1.

## Introduction

This thesis explores the following research questions: can global health crises provide effective opportunities for international cooperation? More specifically, what is the relationship between how a global health crisis is framed, and policy responses? To answer these questions, I conducted a comparative case study and framing analysis of narratives of cholera outbreaks. I focused on policy responses to outbreaks, the context in which responses emerged, and the subsequent development of norms regarding international cooperation on health problems. I analysed the similarities, differences, and patterns across two different cases: the second cholera pandemic in 1829; and the cholera outbreak in Yemen in 2017. I explored how actors involved in responding to cholera outbreaks framed the outbreaks in different ways in narratives they told, as well as how their values and interests shaped both the framings and policy responses. To help me answer the research questions, I draw on historical and contemporary scholarship on international crises, cooperation, and global health. Based on my investigation, I argue that health crises can provide opportunities for cooperation, if cooperation over a crisis is framed as a global public good, and if actors refer to existing norms and laws governing state behaviour.

## Background

Health crises can present opportunities for state-to-state interactions that fall outside the bounds of normal interests and interactions. For example, severe polio epidemics in Hungary during the Cold War created unique instances of cooperation, an “improbable relationship”, between Soviet and American scientists to develop polio vaccines (Vargha, 2014, p. 320). Vargha (2014) explains, “the story of the two vaccines, one arriving from the West, the other from the East, shows how, for the sake of polio prevention, holes in the Iron Curtain opened and closed” (p. 321), showing how collaboration and cooperation amongst actors to address global health crises can reveal new dimensions of interactions beyond those driving high politics and security studies.

Health crises are a frequented topic within the United Nations (UN), and many health programmes, initiatives, and sub-organizations have been founded within the UN system. Health crises have also triggered a number of public-private partnerships such as The Global Fund to Fight AIDS, Tuberculosis and Malaria and Gavi, the Vaccine Alliance.

Some researchers suggest health crises can act as a stimulus for change, driving cooperation (Nickerson, 2014; Marceau, 2011). Scholars studying international crises and cooperation suggest crises can drive cooperation by highlighting gaps and challenges in crisis response. For Marceau (2011), the event of crisis provokes positive action, forcing intergovernmental organizations and states to collaborate and find creative solutions to problems. Marceau states, “if we look back at our most successful international organizations’ innovations, many followed crisis” (p. 2). Examples of such action include the approval of the new International Health Regulations following the 2003 severe acute-respiratory syndrome (SARS) and 2004-2005 avian influenza outbreak (Marceau, 2011). With a similar, however more pessimistic view, Nickerson (2014) argues cooperation often only occurs when health problems are brought to international attention after the situation becomes a crisis beyond repair, reaching “a humanitarian tipping point” (p. 267).

Although health crises can present opportunities, some scholars have also identified a number of barriers to achieving effective cooperation. The multiple (state and non-state) actors involved in responding to health crises can make it difficult to achieve coordination, set priorities and goals, and enforce rules because of competing interests and differences in willingness to cooperate (Olsson, 2015; Ney, 2012). In health cooperation, the national context of each state and institutional mandate of each organization influences crisis response and decision-making (Christensen et al., 2016; Ney, 2012). Alternatively, Rhinard (2009) has explained cooperation problems using collective action and public goods theory, which states that public goods can be produced through cooperation. Public goods are non-excludable (benefits all members) and non-rival (can be consumed by all without reducing the benefit for others). Rhinard treats the control of communicable disease as a public good, however the high cost of producing public goods and fear that all members will not contribute to producing them can lead actors to fail to take collective action. In addition, some argue that a lack of clear definitions and enforcement mechanisms can prevent collective action (Boulden, 2004; Rhinard, 2009). Legally binding measures with clear definition of terms (such as crisis, emergency) invoke action and responsibilities on the part of states (Boulden, 2004). Although more

effective, states are often reluctant to cooperate if measures are legally binding (Rhinard, 2009; Boulden, 2004). Boulden (2004) offers the example of states' reluctance to use the word "genocide" during Rwanda's 1994 crisis to avoid invoking state responsibilities.

Despite listing some barriers to achieving effective cooperation during health crises, literature on international crises and cooperation emphasises the necessity of cooperation in the 21<sup>st</sup> century. Contemporary research highlights new and complex problems facing states, such as pandemics, infectious disease outbreaks, terrorism, and climate change, and suggests that the transboundary nature of modern crises requires international cooperation (Boin & Rhinard, 2008, Boulden, 2004; Christensen et al., 2016; Hampson & Heinbecker, 2011). Contemporary research identifies globalization, or "the interconnectedness of states and societies" (Boulden, 2004, p. 803), and the unique and complex challenges presented by globalization, as major forces driving international cooperation. In addition, contemporary research suggests that international cooperation takes place within a system of organized multilateralism, or "new multilateralism" of the 21<sup>st</sup> century, which follows formal patterns of diplomatic engagement through treaties, organizations, and conferences (Hampson & Heinbecker, 2011; Gorman, 2017). However, historical research on international cooperation shows that a system of organized multilateralism of the 21<sup>st</sup> century developed earlier, in the 19<sup>th</sup> and early 20<sup>th</sup> centuries (Gorman, 2017). More specifically, historians argue that international cooperation on health matters developed as a response to globalization, and technological, political and economic transformations of the 19<sup>th</sup> and 20<sup>th</sup> centuries (Fidler, 2001; Gorman, 2017; Iriye, 2002; Huber, 2006; Harrison, 2006). Examining historical examples of health cooperation can be useful to understand how the 19<sup>th</sup> and 20<sup>th</sup> centuries contributed to the development of norms and laid the foundation for state-to-state cooperation on health.

The following section presents a review of literature on international cooperation and health crises, starting with research on cooperation in the 19<sup>th</sup> and 20<sup>th</sup> centuries, and then the 21<sup>st</sup> century. A number of authors agree that the 19<sup>th</sup> century was a turning point for international cooperation, especially due to globalization, which led to an increased interest in global health issues because of interconnected trade, travel, and communications (Gorman, 2017; McInnes & Roemer-Mahler, 2017; Fidler, 2001). Technological transformations of the 19<sup>th</sup> and 20<sup>th</sup> century helped bring states and societies in closer contact with each other, but also raised concerns about the adverse

effects of industrialization on health (Fidler, 2001; Gorman, 2017; Iriye, 2002). Political and economic transformations, such as European imperial expansion and the expansion of international trade also brought states and societies in closer contact with each other, while raising fears and risks about the spread of disease worldwide (Fidler, 2001; Gorman, 2017; Huber, 2006; Harrison, 2006). Some scholars suggest that globalization, and technological, political and economic transformations drove international cooperation by signalling the need for standardization to facilitate global interactions (Iriye, 2002; Huber, 2006; Gorman, 2017). Some scholars also suggest that international cooperation in the 19<sup>th</sup> and early 20<sup>th</sup> centuries was influenced and shaped by norms of multilateral diplomacy initiated at the 1815 Congress of Vienna, as well as xenophobic sentiments in Europe (Harrison, 2006; Gorman, 2017; Huber, 2006; Fidler, 2001). Research also highlights changes in international cooperation by the 21<sup>st</sup> century, such as the inclusion of more non-Western states, and new and complex transboundary threats facing states (Hampson & Heinbecker, 2011; Iriye, 2001; Boin & Rhinard, 2008, Boulden, 2004; Christensen et al., 2016).

### ***Globalizing forces: technological, economic, and political transformations***

Some scholars suggest that globalization and the resulting transformations in communication, travel, social and political integration in the 19<sup>th</sup> century contributed to greater cooperation between states. Historians such as Gorman (2017) regard the 19<sup>th</sup> century as a turning point for global interactions, stating “it was nonetheless in the nineteenth century when global integration deepened, providing more opportunities for international cooperation, and the possibilities for international cooperation on a much larger and wider scale than in the past” (p. 3). Fidler (2001) argues that international cooperation on health matters began specifically in the mid-19<sup>th</sup> century, in response to infectious disease outbreaks and awareness that health problems in one part of the world could have an effect elsewhere, even in faraway places. Increased trade, travel, interconnected finance and economics between nations therefore led to an increased interest in global health issues in the mid-19<sup>th</sup> century (McInnes & Roemer-Mahler, 2017; Fidler, 2001). In addition to globalization, the factors related to and facilitating globalization in the 19<sup>th</sup> century, such as technological, economic, and political developments, contributed to international cooperation.

Researchers have examined how technological advancements of the 19<sup>th</sup> and early 20<sup>th</sup> centuries facilitated globalization and cooperation by connecting societies and markets with each other (Gorman, 2017). Technological advances “provided the means by which international cooperation expanded” (Gorman, 2017, p. 10). Developments in telegraph, telephone, steamship, and locomotive technologies helped create what Iriye (2002) labels a “global consciousness” (p. 11), meaning that there was growing awareness “of a wider world over and above separate states and national societies, and that individuals and groups, no matter where they are, share certain interests and concerns in that wider world” (p. 8). For example, Huber (2006) explains how international responses to health crises were triggered by the realization that the development of new technologies in steam and rail meant that disease could travel rapidly, shifting perceptions of time and space as unlimited and borderless. As an example of the impact of technology on health cooperation, Fidler reports that technological improvements in sail allowed expansion of the opium trade in the 19<sup>th</sup> century, “solidifying the economic links between Europe, the Americas, and Asia” (Fidler, 2001, p. 843). The expansion of the opium trade raised international concerns over the adverse health effects of opium in the 20<sup>th</sup> century, causing states to convene the first International Opium Commission in 1909, followed by nine treaties on the control of narcotic drugs from 1912 to 1953 (Fidler, 2001). Additionally, scholars highlight the importance of the Industrial Revolution in stimulating health cooperation between states. International concerns over occupational safety and health began in the 19<sup>th</sup> century and continued well into the 20<sup>th</sup> century, over issues such as the industrial use of white phosphorus and poor working conditions in factories (Fidler, 2001; Gorman, 2017). These concerns over occupational safety and health drove cooperation over creating international labour standards and the creation of the International Labour Organisation (ILO) in 1919 (Fidler, 2001; Gorman, 2017).

Along with technology, some scholars note that political and economic transformations aided by Europe’s expansion of its overseas empires in the 19<sup>th</sup> century “brought people around the world into ever-greater direct and indirect contact with each other”, allowing “long-distance international relations” (Gorman, 2017, p. 2; p. 8). Iriye states that the 19<sup>th</sup> century marks the period when imperialism “became truly global, covering all corners of the earth” (p. 18). As a result, international cooperation on health matters in this period were often motivated by factors relating to international trade and commerce, especially by European nations. This is because political leaders realised that

traditional methods of containing infectious disease, such as quarantines and *cordons sanitaires*, were impractical and detrimental for navigation and trade (Fidler, 2001; Huber, 2006; Harrison, 2006; Liverani & Coker, 2012). For example, scholars note that both commercial and imperial interests motivated countries such as Britain and France to reform or find alternative solutions to traditional quarantine measures, as they hampered with trade and travel (Harrison, 2006; Fidler, 2001; Liverani & Coker, 2012). Traditional quarantines in the Mediterranean were inconvenient for both people travelling between colonies and metropolises (such as between Britain and India), and governments seeking trade in the Mediterranean (such as the French in Algeria) (Harrison, 2006). Some historians therefore argue that international cooperation over health matters in the 19<sup>th</sup> century was largely driven by political and economic interests, mostly by European nations. Huber (2006) states, “many Europeans profited from this growing unification of the globe and therefore in favour of dismantling travel restrictions” since “larger sums of money depended on rapid passages across borders” (p. 456).

In addition to motivating cooperation, scholars also suggest political and economic transformations contributed to the spread of disease globally. Gorman uses the example of the 1918-1920 Influenza pandemic to show how political transformations brought people from around the globe in greater contact with each other. Gorman suggests the Influenza pandemic began in China, but “was transmitted globally by Chinese labourers who were sent by the Chinese government via North America to aid the Allies in Europe” during the First World War (p. 202). Gorman explains that states were unable to deal with the influenza outbreak on their own, “which made them more willing to participate in international control and research efforts” (p. 202). Through this example, and the example of quarantine reforms above, historians demonstrate how political and economic transformations of the 19<sup>th</sup> and 20<sup>th</sup> century were globalizing forces, driving both cooperation and the spread of disease.

### ***Influencing forces: desires for uniformity, harmony and protection***

Some scholars suggest that globalizing forces of the 19<sup>th</sup> and 20<sup>th</sup> centuries brought states and societies in closer contact with each other, and as a result, the mid-19<sup>th</sup> century became a period of increased interest in standardization. From the mid-19<sup>th</sup> century onwards, there has been a proliferation of international conventions, cooperative

agreements, and organizations interested in standardization, monitoring, establishing rules and order in a number of different areas, including health (Huber, 2006; Gorman, 2017; Liverani & Coker, 2012). Between 1851 and 1899, Huber (2006) reports that 1390 international meetings with different agendas were convened, many of them scientific congresses focused on the standardization of weight and measurements. Cooperation between states on health matters during the 19<sup>th</sup> century took place in the form of international conferences, such as the International Sanitary Conferences (1851-1938), in the context of other attempts at international cooperation for standardization, such as the International Telegraph Union and the Universal Postal Union (Iriye, 2002; Huber, 2006). Such attempts at cooperation were fuelled by perceptions of “the potential benefits of universalization and standardization.” (Gorman, 2017, p. 10). The growing “global consciousness” (Iriye, 2002), or “ideas of international and universal order” as Gorman describes (p. 10), of the 19<sup>th</sup> century proved to states that if they were to engage in international communications, travel, and commerce, standardization was not only something that could make global interactions more efficient, but was a necessity.

Although some scholars suggest that globalizing forces of the 19<sup>th</sup> century were crucial in driving international cooperation through standardization, Harrison (2006) argues that these factors alone do not explain the radical shift in thought required for collaboration on health issues. Huber suggests that increase in the number of international conferences, conventions, and agreements since the 19<sup>th</sup> century is not simply a result of globalization, but due to wider changes in diplomatic engagement. Health cooperation in the 19<sup>th</sup> century was influenced by the 1815 Congress of Vienna and Concert of Europe, created by European powers following the Napoleonic wars, “in which states perceived international equilibrium as preferable to war” (Gorman, 2017, p. 17). Although the Congress of Vienna ended by the mid-19<sup>th</sup> century, the Congress was an attempt to deal with issues peacefully, before turning to armed conflict, through multilateral diplomacy, which continued in the form of smaller conferences. Harrison explains, “the system of diplomacy inaugurated at Vienna recognized the existence of different national interests but sought agreements that transcended them” (p. 198). The motivations for health conferences were influenced by the Congress of Vienna, as agreement over quarantine reforms, for example, was also driven by “the desire to remove potential sources of tension between nations” (Harrison, 2006, p. 209). Other international conventions and conferences taking place after the Congress of Vienna were also convened with similar

intentions to achieve harmonious relations between states, focusing on specific issues, such as infectious disease, rather than large topics such as the prevention of wars. By the 20<sup>th</sup> century, Gorman argues that “formalized patterns of multilateral interaction” and “regularized diplomatic relations” had developed (p. 8).

Although changes in diplomatic relations and the emergence of “global consciousness” in the 19<sup>th</sup> century motivated cooperation, some researchers note that cooperation was also influenced by heightened fears and suspicions over foreigners, and desiring protection from “external threats” in Europe (Liverani & Coker, 2012, p. 916). Globalization and the resulting interconnectedness of states and societies made crises and problems far away seem threatening (Boulden, 2004). In terms of health, European leaders’ recognition of the benefits of globalization was accompanied by the belief that globalization increased Europe’s exposure and vulnerability to new diseases, a phenomenon which Huber labels “a broader tension of the period” (p. 453).

While more efficient global interactions motivated state cooperation for standardization and universalisation, some scholars also note how such efforts were influenced by xenophobic sentiments in Europe. For example, collaboration in controlling the spread of diseases, such as cholera, through quarantine and travel regulations were framed by European actors as defending Europe against Asian evils at the International Sanitary Conferences 1851-1938 (Huber, 2006). Specifically, the International Sanitary Convention (1892) regulating quarantines in Asia and Europe, reflected xenophobic sentiments through “exaggerated European fears that pilgrims making the Hajj [Islamic pilgrimage] could translate cholera”, (Gorman, 2017, p. 200) “despite its limited role in bringing cholera into Europe” (Huber, 2006, p. 476). Delegates at health conferences of the late 19<sup>th</sup> century pushed for greater use of identification measures, such as passports, to track cross-border travel for certain groups of people. Certain categories of travelers, such as pilgrims, but also “transmigrants, gypsies, or itinerant people became increasingly targeted as potential contagion bearers” (Huber, 2006, p. 474). Huber argues, “while some types of mobility – connected with European expansion and trade – became a marker of modernity, other types came to be seen as a symbol of the Orient and its lack of civilization” (Huber, 2006, p. 474).

Historians also cite examples from regulation over the trade of alcohol in the 19<sup>th</sup> and 20<sup>th</sup> centuries as evidence of how cooperation over health matters were at times



tainted with hypocrisy and racism. Western states cooperated in creating a number of regional and bilateral treaties to regulate the trade of alcohol in their colonies, such as the 1890 General Act of the Brussels Conference Relating to the African Slave Trade and the 1899 Convention Respecting Liquor Traffic in Africa (Gorman, 2017; Fidler, 2001). To justify prohibiting the distribution of alcohol in colonies, countries such as the United States (US) and Great Britain cited “protection of the indigenous peoples of the Pacific Ocean” and because alcohol was considered by state parties to be “especially dangerous to the native populations by the nature of the products” (Fidler, 2001, p. 843). In addition to the regulation over alcohol, regulations for certain travelers despite European imperial expansion, and regulation over opium despite the lucrative opium trade mentioned above, “seem hypocritical when one considers the exploitation of Asians and Africans at the hands of [Western] countries” (Fidler, 2001, p. 847).

### ***Modern crises and cooperation: diverse states and transboundary problems***

By the late 20<sup>th</sup> century, some scholars note that there were significant changes in the states engaging in multilateral relations. Specifically, researchers report that by the end of the 20<sup>th</sup> century, the states engaged in international cooperation had diversified to include non-Western states, whereas previously cooperation was limited mostly between European states. For example, the International Sanitary Regulations adopted by the World Health Organization (WHO) in 1951 was based on a universal perspective, “unlike the Eurocentric standpoint of the [1892] sanitary conventions” (Liverani & Coker, 2012). Some scholars attribute the expanding membership of non-Western states in international cooperation by referencing changing meanings of the concept of multilateralism, which “centers on the collectively agreed norms, rules, and principles that guide and govern interstate behavior” (Hampson & Heinbecker, 2011, p. 299). Changes in multilateral engagement to include non-western states are what Hampson and Heinbecker label, the “new multilateralism” of the 21<sup>st</sup> century (p. 299).

Others attribute the inclusion of non-Western states in international cooperation directly to decolonization (Gorman, 2017; Iriye, 2001). In the mid-20<sup>th</sup> century, many nationalists in colonial countries were inspired by Wilsonian and Leninist discourses of self-determination and independence which emerged in the West after the First World War (Gorman, 2017). Gorman suggests that the West’s domination in the international system

had declined and been undermined especially after the Second World War, and former colonies of Western states in Asia and Africa began to decolonize during the 1950s Cold War period (Iriye, 2001). Hampson and Heinbecker use the term “the awakening of the South” (p. 301), arguing that “diplomacy will have to be sensitive to the needs and wishes of emerging economies and the interests of new global powers.” (Hampson & Heinbecker, 2011, p. 299). In the 21<sup>st</sup> century, Hampson and Heinbecker (2011) refer to emerging powers and economies such as India, China, and Brazil wanting to see “a better representation of Southern values and interests” in multilateral diplomacy (p. 299). The “new multilateralism” of the 21<sup>st</sup> century, some researchers argue, have made international cooperation more global, whereas cooperation in the 19<sup>th</sup> and early 20<sup>th</sup> centuries was heavily shaped by Western, or more specifically, European states.

Not only have the states engaging in cooperation become more global in composition by the 21<sup>st</sup> century, some scholars also argue that crises which require international cooperation have become more global. In contemporary research about cooperation and crises, researchers emphasize the newness of problems facing states. Scholars highlight issues such as pandemics, infectious disease outbreaks, terrorism, climate change and water security, as examples of new challenges faced by “the modern nation-state” (Boin & Rhinard, 2008, p. 3). In her discussion about contemporary international crisis response, Boulden (2004) references the UN secretary-general’s 1992 report, *Agenda for Peace*, in which the secretary-general writes about entering a time of “global transition”, a period of increased cooperation between states and new challenges faced by threats because of blurred national boundaries due to global trade, commerce, and communications. Scholars argue that in the 21<sup>st</sup> century, “the interconnectedness of states and societies” (Boulden, 2004, p. 803) presents unanticipated global challenges and forces states to think about how to manage and respond to global problems.

To describe problems transcending political borders in the 21<sup>st</sup> century, Boin and Rhinard (2008) use the terms “transboundary threats” and “transboundary crises”. Christensen et al., (2016) also argue that crises are “increasingly transboundary, crossing geographical, administrative, infrastructural and cultural borders” (p. 316). Rhinard (2009) argues that it is the transboundary nature of modern crises which motivates cooperation between states. Contemporary scholarship defines ‘crisis’ as a situation where there is a serious and unexpected threat to the main values, norms, and structures of a system, and requires urgent response by actors (Christensen et al., 2016; Boin & Rhinard, 2004;

Boulden, 2004). Based on this definition, scholars identify states as the primary actors responsible for responding to crises. Boin and Rhinard note that while crisis management is “traditionally the responsibility of the nation-state” and a “national government responsibility” (p. 1; 4), they argue that transboundary crisis management requires individual states to cooperate with each other.

Including pandemics, outbreaks, and infectious disease in lists of transboundary crises associates health problems with security threats. As a result, scholars have frequently turned to global security, national security, and foreign policy to explain international cooperation around health crises. Labonté and Gagnon (2010) argue that the underlying logic behind securitization is that there is a threat (to someone or something) that requires defensive measures against it, providing a rationale for intervening in epidemics in states. Communicable diseases have dominated the global health security agenda, and as a result have been thought of frequently as a security issue (McInnes & Roemer-Mahler, 2017). The emergence of disease outbreaks such as severe acute-respiratory syndrome (SARS), Middle East respiratory syndrome (MERS), Ebola, Zika, and recurrent pandemic influenza have remained on global health agenda because of the perceived threat communicable diseases pose to state and regional stability (McInnes & Roemer-Mahler, 2017). For example, Rhinard attributes coordination and cooperation within states in the European Union (EU) to transnational networks of people, movement of goods and services, weak internal border controls, interconnected infrastructure, and cross-border supply chains in Europe. Following the identification of H5N1 avian influenza virus in Turkey and Romania within this context in Europe, EU member state leaders cooperated to organize a number of meetings for pandemic preparedness, citing safety and security as a main concern (Rhinard, 2009).

Contemporary research shows how characterizing health problems as a “transboundary crisis”, as in transcending political boundaries and posing a serious and unexpected threat to systems, motivates international cooperation. However, as the beginning of this literature review demonstrates, historians have documented cooperation over health problems since the 19<sup>th</sup> century over a number of reasons along with security. Among historical and contemporary research about international cooperation, there is consensus that globalization drives international cooperation. Historical research emphasises the importance of technological, political, and economic transformations in driving cooperation in the 19<sup>th</sup> and early 20<sup>th</sup> centuries. Contemporary research focuses

on the global reach of modern crises. Historians and contemporary researchers also agree on the diversification of both the issues and states engaging in international cooperation. Historical research reveals how the patterns and norms guiding international cooperation in the 21<sup>st</sup> century developed in the context of, and were influenced by changes in diplomatic engagement and desires of protection of European space in 19<sup>th</sup> and early 20<sup>th</sup> centuries.

### ***Framing narratives in global health***

To make sense of the multitude of explanations for why states cooperate, global health scholars suggest that the way health issues are presented, or framed, can shape cooperation and collective action (McInnes & Lee, 2012). When framing an issue, actors connect the issue to “a set of deeper paradigms”<sup>1</sup> which influences how “actors think and talk about global health problems” (Rushton & Williams, 2012, p. 148). Frames are employed by actors, often strategically, to portray health problems in certain ways to generate or legitimize different policy responses (McInnes et al, 2012; McInnes & Roemer-Mahler, 2017). Powerful actors, in particular, can frame health problems to influence how different interests (e.g. national vs international) will be privileged (McInnes et al, 2012). Scholars have identified six frequently used frames in global health: evidence-based medicine; security; development; global public goods; human rights; and commodities (Labonté, 2008; Rushton & Williams, 2012; McInnes et al., 2012; McInnes & Lee, 2012).

Many scholars have pointed out that frames are linked to narratives or “stories” that actors tell. Spencer (2017) explains that “humans think about the world and themselves in a narrative form” (p. 31). Indeed, actors use frames to create narratives that interpret their own actions. (Liu and Kim, 2011; Ney, 2012). Ney (2012) suggests that narratives are not only stories about what occurred, but are also “political arguments for or against a particular course of action” (p. 257). In discussing the relationship between narratives and framing, Olsen (2014) asserts that frames can help validate narratives: “frames make narratives coherent by linking personal accounts to dominant political and legal discourses” (p 249).

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<sup>1</sup> In addition to “paradigms” (Rushton & Williams, 2012), others use the terms “discourse” (Labonté, 2008; Lee, 2009) and “worldview” (Lee, 2009) to describe actors’ perspectives.

Despite scholars' acknowledgment that framing takes place within narratives told by actors, few studies<sup>2</sup> in global health have examined both frames and narratives together in their analyses. In this thesis, I combine framing analysis and narrative analysis to explore the following research questions: can global health crises provide effective opportunities for international cooperation; and what is the relationship between how a global health crisis is framed, and policy responses?

## Structure of the thesis

Historical and contemporary research about international crisis and cooperation have identified a number of reasons why states cooperate over health matters. To better understand the nuance and relevance of explanations offered by literature, I conducted a qualitative comparative case study and framing analysis of narratives used by actors during two cases: 1) the second cholera pandemic of 1829; and 2) the cholera outbreak in Yemen in 2017.

Chapter 2 outlines the research design and methods used in this thesis. In chapter 2, I begin by introducing the background of the two cholera cases used in this study. Then, I explain the steps involved in carrying out a framing analysis of narratives, which includes conducting a narrative analysis of public speeches and texts, and then applying dominant frames identified by scholars to analyze these texts. In this section, I also address some of the potential limitations of the study.

Chapter 3 presents the findings from carrying out the framing analysis of narratives told during the two cholera outbreaks. Chapter 3 begins with the findings from conducting the narrative analysis. To analyze the frames present in the narratives, I begin by with a deeper description of the six dominant frames scholars have identified in global health literature. I then apply these frames to the narratives.

Chapter 4 presents a discussion of what shaped cooperation during the second cholera pandemic and cholera outbreak in Yemen in 2017. I begin by summarising and

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<sup>2</sup> For example: Johnson, C. (2010). Framing and the politics of public health: An examination of competing health narratives in Honduras. *Global Public Health*, 5(1), 1-14.

comparing the frames used in each of the narratives told by actors in both cholera cases. Then, I discuss the findings in relation to literature on international cooperation, crises, and global health to argue that cooperation was facilitated by framing cooperation as a global public good and by referring to existing norms and laws governing state behaviour.

## **Chapter 2.**

### **Research Design and Methods**

The objective of this thesis was to explore whether global health crises can provide opportunities for international cooperation and how the framing of a crisis can impact policy response. To do so, this thesis conducts a qualitative comparative case study and framing analysis of narratives told by actors during the second cholera pandemic of 1829 and the cholera outbreak in Yemen in 2017. The purpose of this chapter is to outline the research design and methods used in this thesis. First, I present and discuss the two cases used for the comparative case study. Then, I explain the steps involved in carrying out a framing analysis of narratives. First, I found texts that I would rely on to identify the narratives constructed around the two cases. Next, I examined the texts for narrative elements, which combined, produce narratives for each case. Once constructed, I reviewed these narratives to see which dominant global health frames actors were using. I conclude by addressing some of the potential limitations of the study.

#### **Case comparison**

Comparative case study analysis involves analysing the similarities, differences and patterns in the relationship between the outcome and factors leading to the outcome across two or more cases (Roselle & Spray, 2016). Choosing two cases with similar outcomes makes a stronger comparison for highlighting specific factors that may have played similar roles in the outcome of both cases (Roselle & Spray, 2016). I have chosen to analyse two cases of international cooperation that have been spurred by cholera outbreaks. The first is the second cholera pandemic of 1829. The second case is the cholera outbreak that occurred in Yemen in 2017. Each of the two cases are presented below.

## ***Second cholera pandemic of 1829***

For the first case, I have chosen the second cholera pandemic of 1829 because it is a “critical case”, a case which is considered historically important by scholars (Roselle & Spray, 2016; p. 36). The second cholera pandemic is significant because of the large number of deaths it caused, its scale and geographic reach (Imperato, Imperato & Imperato, 2015). This cholera pandemic is also significant because it is representative of a particular moment where states began to collaborate on health matters in the mid-19<sup>th</sup> century (Fidler, 2001; Liverani & Coker, 2012). The second cholera pandemic was a key focus of the International Sanitary Conferences, which were the first attempts to tackle the spread of disease through international cooperation and influenced the modern framework of international health governance today (Huber, 2006; Harrison, 2006; Liverani & Coker, 2012; Youde, 2017; Lee, 2001). The International Sanitary Conferences were a series of 14 conferences which took place beginning in the 19<sup>th</sup> century (Howard-Jones, 1975). Although the WHO was founded in 1948, it “represents the culmination of efforts at international health cooperation that started almost a century before” (Howard-Jones, 1975, p. 9).

In 1817, cholera became endemic in South Asia, in part due to European colonial expansion as it led to restructuring of communities, changes in land use patterns, and mass migration (Lee, 2001). In 1829, cholera from South Asia began to reach the continent of Europe, the first cases of which broke out in Orenburg, Russia, and then Moscow (Howard-Jones, 1975). From Russia, cholera spread to Poland, and later England and France (Imperato, Imperato & Imperato, 2015). Cholera thrived in Europe due to ongoing social and economic transformations such as urbanization, poor water and sanitation (Liverani & Coker, 2012; Lee, 2001).

Previously, quarantine regulations were applied to prevent the spread of cholera, but were seen by states as inconvenient because of the costs and delays it caused to maritime travel (Howard-Jones, 1975). To tackle these challenges, the French Government convened the first International Sanitary Conference in Paris, starting on 23<sup>rd</sup> July 1851. The goal was to draft a convention regulating sanitary measures in each of the attending countries, and more specifically, to discuss whether or not cholera should be included in quarantine regulations (Howard-Jones, 1975). Although the first Conference did not produce many concrete results, (a draft convention was agreed upon, but not



ratified by all states) it still “provided a unique forum for the international exchange of ideas between medical administrators and medical scientists of different nations and cultures” (Howard-Jones, 1975, p. 9). Therefore, the second cholera pandemic, and more specifically, the first International Sanitary Conference is important to my study as it is a historically important example of international health cooperation.

### ***Cholera outbreak in Yemen in 2017***

The second case I have chosen is the 2017 cholera outbreak in Yemen. Since 2017, Yemen faces the world’s largest cholera outbreak and has received significant international attention; the UN has labelled it the “world’s worst cholera outbreak in the context of the world’s worst humanitarian crisis” (The Lancet, 2017). In response, the WHO scaled up interventions to contain the outbreak and partners of the Global Task Force on Cholera Control (GTFCC) brought together stakeholders to develop a Global Roadmap to end cholera by 2030 (The Lancet, 2017).

In October 2016, the WHO issued a statement saying that the Ministry of Public Health and Population in Yemen had confirmed additional cases of cholera in Yemen (WHO EMRO, 2016). In June 2017, the WHO reported that the number of cases of cholera in Yemen had continued to rise, attributing the rise and difficulty in containing outbreaks to Yemen’s nearly destroyed health system due to two years of conflict (WHO, 2017a). Only half of the health systems were reported as fully functional, while conflict and violence led to the damage of infrastructure and blockage of medical supplies flowing into the country, leaving 14.5 million people without regular access to medical facilities, clean water and sanitation (WHO, 2017a). The WHO announced that Yemen was “facing the worst cholera outbreak in the world”, as it had spread almost all over the country (WHO, 2017b). By August 2017, Yemen’s cholera epidemic was still considered the “largest in the world”, as the case count reached 500 000 (WHO, 2017c) and in December 2017, the total number of cholera cases exceeded one million (UN, 2017). During 2017, the number of cholera cases also increased in other parts of the world, such as Somalia, South Sudan and northeastern Nigeria (WHO, 2017d).

In response to the cholera outbreaks in 2017, the Global Task Force for Cholera Control (GTFCC), a group of countries, non-profit organizations, public-private

partnerships, academic institutions, the WHO and other UN agencies, launched a new plan to reduce deaths from cholera by 90%, titled, *Ending Cholera: A Global Roadmap to 2030* (henceforth Global Roadmap) (WHO, 2017e). The GTFCC was previously revitalized in 2014 in response to the cholera outbreak in Haiti, and in parts of Africa (WHO, 2018). The 2017 Global Roadmap “aims to align resources, share best practice and strengthen partnerships between affected countries, donors and international agencies”, through a coordinated, multi-sector approach (WHO, 2017e).

The other international response generated by the 2017 cholera outbreak in Yemen was in the UN Security Council. The Security Council invoked rules 37<sup>3</sup> and 39<sup>4</sup> of the Provisional Rules of Procedure, to invite the representative of Yemen, and other representatives involved in the humanitarian response in Yemen to brief the Security Council a number of times. In June 2017, the Security Council also adopted a presidential statement expressing concern at the humanitarian situation and cholera outbreak in Yemen. Therefore, the 2017 cholera outbreak in Yemen, specifically, the GTFCC and Security Council responses are important to my study as they provide examples of international health cooperation brought about by significant cholera outbreaks.

Although the second cholera pandemic and 2017 cholera outbreak take place within very different contexts, they are a good comparison because they share similar outcomes. Both were cases of significant cholera outbreaks, resulting in significant international cooperation between states and non-state actors in an attempt to coordinate and standardize responses. The second cholera pandemic led to a large number of deaths worldwide and an unprecedented outcome: the creation of an international health conference. The only other comparable cholera outbreak to the second cholera pandemic is the 2017 outbreak. Health issues are not usually discussed at the Security Council, unless they raise serious concerns about international peace and security. Prior to 2017, only two health issues have been discussed at length at the Security Council: HIV/AIDS; and the 2014 Ebola outbreak. Discussing the 2017 outbreak during multiple Security

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<sup>3</sup> Rule 37 of the “Provisional Rules of Procedure of the Security Council” allows the Security Council to invite any UN members who are not members of the Security Council to participate in meetings without vote

<sup>4</sup> Rule 39 allows the Security Council to invite members of the Secretariat to brief or assist the Security Council

Council meetings, in addition to the GTFCC, demonstrates the 2017 cholera outbreak's significance.

Methodologically, I try to remain aware of the advantages and critique of comparative work from both idiographic and nomothetic camps, while my own approach tries to walk a middle ground between them. Comparing international cases has been criticized by historians and constructivists, who instead emphasise the singularity of events, places and actors (Lindemann, 2017). This approach, the idiographic approach, focuses on exploring how and what actors "make of reality". (Lindemann, 2017, p. 20). On the other hand, the nomothetic approach, guided by positivist epistemology, pays less attention to the context of events and focuses on objective scientific research (Lindemann, 2017). In this approach, the quantification of variables is not embedded in context, rather it is generalized across cases (Lindemann, 2017). This is problematic when an element has different meanings in each case.

In my analysis I try to generalize across cases, while still paying close attention to the context of each and recognizing this impact. A potential question which illustrates this tension is how to compare across different time periods. Although the two cases I explore are set in different time periods, Haydu (1998) suggests that this can be a strength in that "comparison of time periods serves to tease out differences and highlight shifts that might otherwise have gone unnoticed" (Haydu, 1998, p. 346). By comparing cases across time periods, it is possible to construct a trajectory to see how previous events and responses shaped subsequent responses (Haydu, 1998). In other words, comparison can help us understand the development of norms in international health cooperation.

## **Framing analysis of narratives**

To conduct my case comparison, I combine two different techniques, narrative analysis and framing analysis, to highlight factors that can promote international cooperation during health crises. As discussed in Chapter 1, actors use frames, a system of values and ideas, to guide decision-making in policy challenges (Ney, 2012). Frames are employed by actors to portray events in certain ways to generate or legitimize different policy responses (McInnes et al, 2012; McInnes & Roemer-Mahler, 2017). Kuypers (2009)

explains framing as the “process whereby communicators act—consciously or not—to construct a particular point of view that encourages the facts of a given situation to be viewed in a particular manner” (p. 182). Dan (2017) expands this definition to include both visual and verbal interpretations of people and events. Frames are used by actors as a guide to organize their ideas within narratives (Kuypers, 2009; Ney, 2012). Narratives, or storytelling, are important in constructing identities and explanations for events (Olsen, 2014; Spencer, 2017). In discussing the relationship between narratives and framing, Olsen (2014) explains that frames can help validate narratives; “frames make narratives coherent by linking personal accounts to dominant political and legal discourses” (p 249). Therefore, looking at frames used in narratives is useful for answering my research questions because it provides a sense of how actors understand the world and situations, provides insight into how policy decisions are made, and how different policy actions become dominant or legitimate since actors use frames to legitimize particular courses of action (Rushton & Williams, 2012).

### ***Step One: Narrative analysis: production of narratives from cases***

The narrative analysis method used for data collection in this thesis was guided by Spencer (2017). In his paper, Spencer applies narrative analysis to conflict in Libya in 2011, and compares stories told by the British media and politicians about the conflict. In doing so, Spencer finds the stories told about the conflict legitimized certain policy actions, while silencing or marginalizing other narratives, showing how narrative analysis can “contribute to the understanding and criticism of dominant political perceptions in world politics” (p. 43). In what follows, I apply Spencer’s techniques to structuring the analysis and retelling the stories that emerged.

The first step in narrative analysis was to delimit the primary documents I would seek for my analysis (Spencer, 2017). For my first case, the second cholera pandemic, I focused on the meeting minutes of the twenty-five meetings held during the first International Sanitary Conference in 1851. These minutes are important to my study as they “constitute a living history of the different conceptions of the nature of epidemic diseases” (Howard-Jones, 1975, p. 9). In other words, they could reveal the different narratives actors created about disease, to argue for different policy actions. I translated the meeting minutes from French to English, from the records of the Conference digitized

and held by Harvard Law School Library. For my second case, given that the cholera outbreak in Yemen worsened in 2017, I focused on responses by the GTFCC and the Security Council to the crisis during that year. The documents selected for study consisted of ten Security Council verbatim minutes, one statement by the president of the Security Council, as well as the meeting minutes for the Fourth Annual Meeting of the GTFCC, GTFCC Declaration to Ending Cholera (henceforth GTFCC Declaration), and the Global Roadmap to ending cholera by 2030. The GTFCC documents were found from the WHO's information page for GTFCC, limiting the documents to those published in 2017. The Security Council documents were found using the United Nations Official Document System (UN ODS). To find documents, I searched for Security Council documents containing the key words "cholera" and "Yemen", limiting the search to documents published in 2017.

Once my texts had been found, the second step in carrying out a narrative analysis was examining the text for words and phrases which fit into the categories of elements of narratives (Spencer, 2017). Spencer identifies three different narrative elements, which combined, create a narrative: (1) setting; (2) characterization; and (3) emplotment. The setting, the background and context in which actors place the event "give us a clue of the kind of story we are about to indulge in" (Spencer, 2017, p. 34). Characterization involves naming and describing the agents or actors' relational, physical, and behavioural attributes (Spencer, 2017). Emplotment involves assembling the series of events into a narrative by bringing together all elements into a meaningful story (Spencer, 2017). To identify narrative elements, I reviewed all the selected documents through close reading, and recorded and organized the words and phrases into the three narrative elements using a Microsoft Excel spreadsheet.

The third step in carrying out a narrative analysis was to identify the dominant narrative elements and to "retell the story using quotes as a collage" (Spencer, 2017, p. 37). Once the narrative elements were found and sorted, I summarised and retold each of the narratives which emerged from documents related to each of the two cases. These narratives are presented in Chapter 3.

## ***Step Two: Framing Analysis: Applying frames to narratives***

The framing analysis used in this thesis was guided by techniques described by Dan (2017). I first reviewed the narratives for framing devices, which include key words, concepts, and metaphors (Kuypers, 2009). I then reviewed these devices to identify which of the six frames identified in the literature review in chapter 1: ((1) evidence-based medicine; (2) security; (3) development; (4) human rights; (5) global public goods; or (6) commodities)) were used by actors in their narratives to guide different policy responses.

## **Limitations**

As noted above, a potential limitation of this method is the gap in time periods between the two cases, which make it difficult to compare them exactly. However, doing so can help trace the development of norms in health cooperation. Another possible limitation which arises when using a deductive approach (using frames from literature) is that I may limit the number of frames in my study and “overlook unanticipated frames” (Dan, 2017, p. 16). However, given this issue, Dan argues that deductive “framing studies contribute to theory building in a unique way, given that they allow scholars to build on others’ work” (p. 16). Finally, the documents related to the second cholera pandemic have been translated from French to English which may result in misunderstanding or misinterpretation.

## **Chapter 3.**

### **Framing Analysis of Narratives**

This chapter applies the methods of narrative analysis and framing analysis outlined in the previous chapter and presents the findings from conducting the analysis for the two cases. First, I present the findings from conducting the narrative analysis, structured around narrative elements (setting, characterization, and emplotment). Then I use these elements to construct narratives from each case. I use these narratives to conduct my framing analysis. I begin by expanding upon and defining the six dominant frames from global health. Finally, I apply these frames to the narratives I constructed.

#### **Narrative Analysis**

This section presents the narratives identified from the narrative analysis of primary documents, first for the second cholera pandemic and then the cholera outbreak in Yemen in 2017. The section is structured using the narrative elements, setting, characterization, and emplotment. I compiled the words and phrases used by actors to describe the setting of each document, which includes both the purpose and context, the characterization of cholera and states, and emplotment of events by actors. I conclude by presenting two narratives which emerged from analysing each of the two cholera cases.

##### ***Second Cholera Pandemic***

The documents analysed in this section are the verbatim records of the twenty-five meetings which took place during the first International Sanitary Conference. The first International Sanitary Conference took place in Paris, 1851, between twelve states. The states which took part in the conference were Austria, the Two Sicilies, the Papal States, Spain, France, Great Britain, Greece, Portugal, Russia, Sardinia, Tuscany, and the Sublime Port (now Turkey). Each country was represented by two delegates: one physician; and one diplomat.

## **Setting**

### *Purpose*

The formally declared goal for this conference was to draft a convention regulating the sanitary measures in each of the attending countries (Meeting 4). Members of the conference expressed two reasons for drafting a sanitary convention: the protection of public health; and the protection of commerce. The primary goal was to draft a sanitary convention in order to achieve uniformity and standardize responses to diseases in different countries, to “put an end to the inequalities between the measures prescribed in different countries to prevent the importation of diseases” (Méliér, Meeting 4). This was to achieve harmony and mediation between attending nations, since members cited “conciliation” and “rapprochement” as the “spirit” governing the formation of the conference (Méliér, Grande, Perrier, Meeting 11).

One of the reasons members cited for drafting a sanitary convention was the protection of public health. In their speeches, members repeatedly referred to the “public health interest” (Meeting 9), “the defense of public health against the dangers of which it could be destroyed” (French Minister of Foreign Affairs, Meeting 2), and the “safeguarding of public health” (David, Meeting 1; French Minister of Foreign Affairs, Meeting 2; Betti, Meeting 10). The second reason mentioned was the protection of trade and navigation in the Mediterranean. The multitude of different, competing sanitary regulations were said to be a “detriment of the commerce of the different nations” (French Minister of Foreign Affairs, Meeting 2). “Time is money”, stated the French Minister of Agriculture and Trade (Meeting 2), giving a sense of the urgency and importance of commerce driving this conference.

### *Context*

Members placed this conference within the wider context of growing internationalism, and regarded the conference as a symbol of modernity and progress. The speeches show that members acknowledged that this conference was something important and unprecedented which, if successful, would be a “remarkable work of this century, so fruitful in new and great things” (French Minister of Foreign Affairs, Meeting 2). David, the president of the conference, stated: “we are going to somehow take the first



step, perhaps the most important step” (Meeting 5). Monlau, the Spanish delegate, distanced this conference from older methods of sanitary regulation by saying:

we do not intend to support quarantine in the etymological rigor of the word, any more than the old quarantine and the fearsome *lazarets* of old time, with all the fanaticism of their origin, with their errors and their superstitions too long respected, with their fiscal demands, their obsolete, ridiculous and vexatious practices: no (Meeting 11).

In the penultimate meeting, David also emphasised that this was a starting point to using conference diplomacy as a tool to address global health issues, by reminding members to focus on general matters for now rather than the details, since “the Conference will later have to deal with the composition of health administrations” (Meeting 24). Others also indicated that this conference was a new method to dealing with international health issues, by referring to global changes, such as technological advancements bringing together faraway nations for matters which had previously divided them (French Minister of Foreign Affairs, Meeting 2).

## **Characterization**

### *Cholera*

Delegates characterised cholera in different ways throughout the conference: as an intruder; as a foreign disease; as international; and as powerful and frightening. Delegates spoke about cholera as an unwelcome intrusion and in terms of military imagery. The spread of cholera in Europe was repeatedly described as an “invasion” (Ménis, Meeting 5; Meeting 10; Mélier, Monlau, Perrier, Grande, Meeting 11; Rosenberger, Meeting 12; Bartoletti, Meeting 14), as well as that Europe had been “attacked” (Carbonaro, Meeting 5; Meeting 9; Rosenberger, Meeting 12) and “penetrated” (Lavison, Meeting 5; Ménis, Meeting 10). In addition, speakers alluded to political borders of countries, stating the need to “prevent the entry” (Mélier, Meeting 9), “block the passage” (Betti, Meeting 9) and “importation” (Sutherland, Carbonaro, Cappello, Meeting 10; Bô, Meeting 5) of cholera since it could “easily escape barriers” (Ménis, Meeting 10). By doing so, they suggested that disease is something that citizens need protection against. Cholera was referred to as “evil” (Halphen, Meeting 12), the “enemy” (Rosenberger, Meeting 12), and delegates discussed the need for “defending” (Betti, Meeting 10), “securing” (Betti, Meeting 10), “protect[ing]” (Grande, Meeting 11)

themselves and for governments to “preserve the populations” against cholera (Ménis, Meeting 5).

Tied to these characterizations was the image of cholera as a foreign disease. Cholera was referred to in different ways throughout the conference. Participants referred to the disease as just cholera, cholera morbus (Bô, Carbonaro, Meeting 10; Bartoletti, Meeting 14), but often also attached it to locations as “Asiatic” or “Asian cholera” (Sutherland, Betti, Bô, Meeting 10; Monlau, Meeting, 11; Carbonaro, Meeting 12; Grande, Meeting 16), and “Indian Cholera” (Betti, Cappello, Meeting 10; Grande, Cappello, Meeting 12; Grande, Meeting 11). Speakers shifted between the multiple ways of referring to cholera, while asserting that it was a “disease of the Indies” (Carbonaro, Meeting 10), “has been brought from India” (Bô, Meeting 5) and that India was “his native country” (Perrier, Meeting 11). Cholera was also referred to as an “import” and “importable” disease (Méliier, Grande, Meeting 11). Delegates therefore saw cholera as a foreign, “exotic” (Carbonaro, Meeting 10; Méliier, Meeting 11; Monlau, Meeting 24), disease which had “threatened to invade the states of the Empire” (Ménis, Meeting 5) and “invaded several European states” (Bô, Meeting 10; Carbonaro, Meeting 5).

Despite emphasizing the otherness of cholera, members of the conference also highlighted cholera’s global presence. Méliier, the French delegate, stated, “cholera is now a widespread, widely dispersed disease, reaching most continents and islands” (Meeting, 11). Others also referred to the familiarity of cholera among many countries in their speeches, as a “cosmopolitan disease” (Ménis, Meeting 10) which “exists almost everywhere now” (Halphen, Meeting 12) and an “exotic disease [that] tends to become native in Europe” (Grande, Meeting 11).

In addition to this, cholera was described as a powerful and uncontrollable disease, while being mysterious and frightening. It was repeatedly described as “ravaging” (Sutherland, Meeting 10), “ravages” (Ménis, Meeting 5; Betti, Meeting 10; Monlau, Méliier, Meeting 11; Rosenberger, Ménis, Meeting 12) and a “scourge” (Perrier, Grande, Meeting 11; Halphen, Rosenberger, Ménis, Meeting 12). Participants also stated that cholera was a “cruel disease” (Méliier, Meeting 11) which displayed “great violence” (Bartoletti, Meeting 14; Sutherland, Meeting 24), using words such as “raging” (Carbonaro, Meeting 10) and “perils” (French Minister of Foreign Affairs, Meeting 2) to describe its impact in countries. Cholera was described as more powerful than humans, as Lavison, the Austrian delegate,

stated, "where is the human power that would stop a disease like that" (Meeting 5). It was regarded as a disease unstoppable by sanitary regulations as illustrated by these quotes, "for the disease to which you forbid entry by sea will enter your house by land or by any other means" (Bô, Meeting 5), or "quarantine measures adopted against cholera have never preserved any country from this disease" (Bô, Meeting 5).

Furthermore, participants characterised cholera as puzzling and frightening, because it "often passed without immediate contact from one city to another" (Lavison, Meeting 5). Grande, the Portuguese delegate, labelled cholera "a mysterious disease" (Meeting 11), and others mentioned that it was "a disease which alarms doctors and peoples more than the plague" (Ménis, Meeting 10) and that "the name of cholera...is feared more than the plague itself" (Ménis, Meeting 12).

### *States*

It is clear that the states invited to this conference considered themselves superior to other extant states. The conference was said to include "the most enlightened powers of Europe" (David, Meeting 1; Meeting 2; Ménis, Meeting 12). The delegates repeatedly referred to themselves as "enlightened" (David, Meeting 1; Cappello, Meeting 10, Meeting 5), of "the civilized world" and as "high powers" (David, meeting 1). They were confident that they would accomplish what they set out to do, given that they were rational and competent, possessing "knowledge" and "experience" (French Minister of Agriculture and Trade, Meeting 2). Therefore, they felt the goals and subject of the conference were "worthy of [them]" (French Minister of Foreign Affairs, Meeting 2) to discuss.

### **Emplotment**

#### *Narratives in favour of regulation*

Some of the delegates created a narrative to argue for sanitary regulations, by following the characterization of cholera as foreign and fearsome, and as regulations would be a better option than doing nothing, and successful from experience. These members argued that regulations would be "fruitful" and "effective" (French Minister of Foreign Affairs, Meeting 2). They cited the necessity of regulations, stating that good hygienic measures alone could "make the disease less deadly" (Carbonaro, Meeting 9), that prevention was better than hopes of "stifling it afterwards" (Rosenberger, Meeting 9),

and that “it is better to close a door to the enemy than to leave it open to both of them” (Rosenberger, Meeting 12). Méliér, the French delegate, summarised the position in favour of regulations by stating:

cholera is essentially an import disease; it is introduced from one country to another, from a place to another place, by things and by men; stop things and men, submit them to a good system of precautions and measures, and the disease will not go further; restrained by the barriers you have opposed, it will stop and you will be preserved (Meeting 11).

Others used evidence of previous success with quarantines and sanitary cordons against other diseases to argue this narrative. For example, members mentioned that the successful use of quarantines in Russia “prevented sickness from invading the rest of the empire” (Meeting 9). Betti, the Tuscan delegate, also reminded participants “that if our ancestors succeeded in driving the scourge of plague out of Europe, this benefit was due only to the great development of quarantine and sanitary measures” (Meeting 10). The story presented here was that regulations are necessary and doable from experience.

#### *Narratives against regulations*

Other delegates created a narrative to argue against regulations, by following the characterization of cholera as powerful and uncontrollable, unstoppable by any measures. The Austrian delegate reported that he was instructed by his government to discuss only yellow fever and plague, and not cholera because “[Austria] has been convinced by the practice of the complete uselessness of the most severe measures against the invasion of this disease” (Ménis, Meeting 5). Similarly, others argued that any measures taken would be powerless against cholera due to the difficulty of enforcement. Sutherland, the British delegate contended that “an army of 500,000 men would not be sufficient”, because cholera would still be carried by animals, smugglers and the wind (Meeting 9). Others emphasised that from previous experience, “quarantines are powerless to stop the march of the terrible scourge” (Bartoletti, Meeting 14).

In explaining why cholera should not be included in the sanitary regulations, these actors emphasized the singularity of cholera, which they argued could not be likened to plague, yellow fever, or other diseases (Lavison, Bô, Meeting 5, Sutherland, Meeting 10). Sutherland, the British delegate, claimed that smallpox and syphilis “ravaged Europe for

12 centuries” but cholera has only been known for 20 years (Meeting 10) and therefore the response to all diseases could not be the same.

Instead, these actors argued, regulations against cholera would only make it “more frightening and more fatal to humanity” (Ménis, Meeting 5). They suggested that regulations would have adverse effects on public health by “inspiring a false security to populations and neglecting the hygienic precautions” (Sutherland, Meeting 9). Additionally, they emphasised that regulations would only make it more difficult for growing international travel, commerce and navigation (Lavison, Meeting 5), creating an “an impossible system with that network of railways which is expanding its arms day by day” (Sutherland, Meeting 9). The story presented here was that cholera is uncontrollable and powerful, and that any regulations against it would be useless and inconvenient.

In sum, two narratives emerged from the narrative analysis of texts from the first International Sanitary Conference during the second cholera pandemic. The first, understood cholera as something deadly and in need of protection against through regulations. Proponents of this narrative included delegates from Spain, Greece, Tuscany, the Papal States, the Two Sicilies, Russia, and Portugal. The second, saw cholera as unstoppable, which no regulations can control. Proponents of this second narrative included delegates from Great Britain, Sardinia, Austria, and France.

### ***Cholera Outbreak in Yemen in 2017***

The documents analysed in this section can be separated into two types: Security Council documents; and GTFCC documents. The Security Council documents analysed in this section are the verbatim records of ten Security Council meetings and one presidential statement. The meetings took place over 2017, including both Security Council members and non-members. The GTFCC documents include meeting minutes of the Fourth Annual Meeting of the GTFCC, GTFCC Declaration to Ending Cholera, and the Global Roadmap to ending cholera by 2030. The Fourth Annual Meeting of the GTFCC took place in June 2017 in South Africa, and was attended by forty members of the GTFCC, including representatives from the ministries of health of Zambia, Zimbabwe, Malawi, and Zanzibar, representatives from WHO regional offices from South Sudan and

Somalia, representatives from educational institutions, and representatives from non-profit organizations.

## **Setting**

### *Purpose*

The formally declared purpose of the Security Council meetings and statement by the President was to discuss the humanitarian situation in Yemen. The formally declared purpose of the GTFCC meetings, declaration and roadmap were to launch a new campaign for cholera control. In both Security Council and GTFCC documents, actors expressed two reasons for wanting to discuss Yemen and launch a new campaign: to raise the profile of the issues discussed; and to mobilize resources for action towards the issue.

The agenda of the Security Council meetings were set in different ways. One of the meetings had the agenda set as “protection of civilians in armed conflict” (S/PV.7951) and another as “children in armed conflict” (S/PV.8082). Discussions in these meetings focused on the impact of conflict on civilians and civilian infrastructure, in particular, medical facilities, in Yemen, Syria, and South Sudan. Two of the meetings had the agenda set as “the maintenance of international peace and security” (S/PV.8069; S/PV.8144), which focused on current dangers and challenges to maintaining international peace and security, using the examples of Yemen, Democratic Republic of the Congo (DRC), Syria, Nigeria, Somalia, and South Sudan as “hotspots”. Another meeting had the agenda set as “briefing by the Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator” (S/PV.7897), to brief the Council about famine in Yemen, South Sudan, and Somalia, and food insecurity in Ethiopia and northern Kenya. Five of the meetings had the agenda set as “the situation in the Middle East” (S/PV.7871; S/PV.7954; S/PV.7999; S/PV.8027; S/PV.8066), although these meetings focused exclusively on the conflict situation in Yemen.

In discussions pertaining to Yemen in these meetings, participants stated that the goal was not just to discuss the conflict in Yemen, but specifically, to “shed light on the cruel reality that the country is suffering and provide an opportunity to express to the thousands of Yemeni men, women and children that they have not been forgotten.” (Rosselli, S/PV.7954, p. 10). The president stated at the beginning of his statement that

the Security Council “expresses grave concern about the devastating humanitarian impact of the conflict on civilians” and “expresses deep concern about the recent outbreak of cholera” (Solíz, S/PRST/2017/7). This was an effort to establish the position of the Security Council on Yemen—that they acknowledged the conflict and its consequences, and to raise the issue to the attention of the Security Council. Secondly, the Security Council documents urged and instructed actors to action. In his statement, the president listed a number of calls to action for parties to the Yemen conflict, using the words “calls upon” and “calls on” (Solíz, S/PRST/2017/7).

The GTFCC documents aimed to launch a new strategy for cholera control, a global cholera roadmap, with the objective of “eliminating predictable cholera epidemics” (Legros, GTFCC Meeting, Session 2.1) and ensuring “large-scale outbreaks do not occur in humanitarian and crisis settings” (Jones, GTFCC Meeting, Session 2.2), with a “target of a 90 percent reduction in cholera deaths by 2030” (GTFCC Declaration). One of reasons cited for doing so was to increase the visibility of cholera, to “bring attention to an old, neglected issue, inspire action and mobilize resources” (Jones, GTFCC Meeting, Session 2.2) and to “raise the profile of cholera on the global public health agenda” (Legros, GTFCC Meeting, Session 2.1). Secondly, the GTFCC documents listed many calls to action, while stating that the GTFCC would play an organizational role, by ensuring “strategic leadership and coordination among partners” (Legros, GTFCC Meeting, Session 2.1). The GTFCC would help to “mobilize development donors”, and “encourage the development of large-scale cholera control programmes at the country level” (Legros, GTFCC Meeting, Session 2.1).

### *Context*

The Security Council and GTFCC documents were set in the context of continued challenges and gaps in response to cholera outbreaks. In the Security Council documents, participants placed the cholera outbreak in the wider context of war in Yemen, describing the cholera outbreak as inseparable from the conflict. Participants repeatedly mentioned three interrelated issues, labelling the situation a “triple tragedy” (O’Brien, S/PV.8027, p. 2), a “triple threat” (Vitrenko, S/PV.8069, p. 12; O’Brien, S/PV.7954, p. 7), and a “triangle of death” (Al-Mikhlaifi, S/PV.8027, p. 10). Participants declared that the combination of three elements, famine, the world’s worst cholera outbreak, and armed conflict, made the case of Yemen a “tragic humanitarian situation” (Ahmed, S/PV.7999, p. 2). Ahmed, the

Special Envoy of the Secretary-General for Yemen, explained the complexity of the problem: “those who survive the fighting face death by famine or disease” (S/PV.8027, p. 5), and “the country is not suffering from a single emergency, but from a number of complex emergencies” (S/PV.7999, p. 2). Alyemany, the representative for Yemen, also emphasised: “my country is currently dealing with an extremely serious and complex health and humanitarian situation.” (S/PV.7999, p. 10). Haley, the US representative, described the situation in terms of “the most vicious of vicious spirals, where conflict compounds food and health-care shortages, which in turn compound the risk of disease” (S/PV.8069, p. 6).

Participants also stressed that the situation was deteriorating, while facing a significant lack of financial resources to respond to the crisis. In his statement, the president of the Security Council stated that the cholera outbreak in Yemen was the “latest indicator of the gravity of the humanitarian crisis” (S/PRST/2017/7). The problems in Yemen were referred to as an “appalling” (Ahmed, S/PV.7999, p. 2), “alarming” (Jinga, S/PV.7951, p. 47), and “worsening crisis” (Solíz, S/PRST/2017/7). Participants highlighted that the “intensity of the conflict is increasing daily, and the tragic humanitarian situation continues to worsen.” (Ahmed, S/PV.7999, p. 2). In the face of continued challenges, actors mentioned that they had “limited funding and, worse, limited assets” (Da Silva, S/PV.7999, p. 7). O’Brien, the Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator, emphasised the gravity of this issue further by stating: “humanitarian workers have had to use resources programmed for food security or malnutrition to combat the unprecedented cholera outbreak, which has surged beyond initial estimates” (S/PV.7999, p. 5). He also highlighted the degrading health system: “health-care workers have not been paid in nearly a year, and no funding has been provided to keep basic infrastructure, such as hospitals and water-pumping and sanitation stations, operating” (O’Brien, S/PV.7999, p. 4).

In the GTFCC documents, participants placed cholera outbreaks in the context of ongoing challenges encountered in global public health. The repeated references to the need for “a renewed strategy” (Global Roadmap; Legros, Jones, GTFCC Meeting, Session 1.8; 2.1; 2.2; 3.2) for cholera control indicates that cholera outbreaks were still a problem that required more attention using different approaches. While acknowledging that Yemen faced “the world’s largest cholera outbreak”, the GTFCC documents also noted the continued impact of cholera in Somalia, the DRC, and Haiti in 2017 (Global Roadmap; p.



6). As in the Security Council documents, participants in the GTFCC documents suggested a worsening situation, as illustrated by these quotes: “there is a growing burden of cholera” (Jones, GTFCC Meeting; 2.2); “there is no sign of a decline in the number of cholera cases reported globally, and cholera remains endemic in many settings” (Legros, GTFCC Meeting, 2.1); and “major outbreaks are still occurring, and the difficulties still faced in counteracting the disease” (Sack, GTFCC Meeting, para. 5).

Given the continued challenges, GTFCC documents also mentioned gaps in cholera outbreak response, mainly in organization and planning. To highlight this, Benson, the Chief Director for Communicable Diseases in South Africa, explained: “challenges continue to be faced in coordinating regional action to combat disease”, (GTFCC Meeting, para. 4) using the examples of lack of coordination during the 2014-16 Ebola virus outbreak in West Africa and the 2008-09 cholera outbreaks in southern Africa. Additionally, one of the points listed in the GTFCC Declaration was, “we avow that cholera outbreaks like the one in Yemen should not happen again”. GTFCC participants also expressed concern over future challenges that would impact cholera outbreaks, citing climate change, urbanization, increasing population density and widening social inequality, as reasons to act on cholera control.

## **Characterization**

### *Cholera*

In both Security Council and GTFCC documents, participants chose to describe cholera in three ways: quantified in numbers; using military imagery; and as controllable and preventable. Predominantly, actors chose to describe cholera in numbers. Descriptions such as “the world’s largest cholera outbreak” (Global Roadmap; p. 6) and “a cholera outbreak of unprecedented scale” (Ghebreyesus, S/PV.7999, p. 5) were supplemented with presentation of numerical data such as “more than 320,000 suspected cholera cases have been reported...at least 1,740 people already are known to have died” (O’Brien, S/PV.7999, p. 4) and “over 600,000 suspected cases...more than 2,000 deaths reported” (Global Roadmap; p. 6). Participants used statistical data to strengthen general descriptions such as “an outbreak of cholera that has killed hundreds of Yemenis” (Alyemany, S/PV.7999, p. 10) and “rapid spread of cholera to all of Yemen’s governorates” (Skoog, S/PV.7999, p. 9).

Actors used numbers to demonstrate the scale and intensity of the “devastating cholera outbreaks” (Haley, S/PV.8069, p. 6), as illustrated by these quotes: “more than 1,700 deaths...300,000 suspected cases” (Ghebreyesus, S/PV.7999, p. 6); and “more than 313,000 people are suspected to be ill with cholera, ...more than 1,700 people have lost their lives” (Solíz, S/PV.7999, p. 8). Solíz, the Bolivian representative, emphasized the magnitude of the outbreak: “the number of those who have succumbed to cholera in Yemen alone...is greater than the total number of deaths resulting from the disease in the entire world in 2015” and “the statistics...have surpassed projections to an alarming extent” (S/PV.7999, p. 8).

Numerical evidence was also used by actors to track changes and trends in the disease over the period of the conflict as illustrated by these quotes: “55,000 suspected cases, and it has now surged to over 300,000. That increase is as much as 15,000 to 20,000 per day with more than 1,700 associated deaths in just 75 days.” (Skoog, S/PV.7999, p. 9); “over 2,000 deaths and possibly infecting 750,000 people, a one third increase over the number reported at our previous briefing” (Solíz, S/PV.8066, p. 5); and “since the month of April, when we were cautioned about the outbreak, the death toll has increased fivefold” (Solíz, S/PV.8027, p. 8).

Cholera was also spoken about using military imagery. The approaches described to respond to cholera were frequently described as needing to “combat” (Jones, GTFCC Meeting, Session 2.2; O’Brien, S/PV.7999, p. 5; Alyemany, S/PV.7954, p. 12) and “combating” cholera (Legros, Benson, GTFCC Meeting, Session 2.1; para. 4). Others also described responses to cholera in terms of warfare, by stating the need to “fight the disease” (Legros, GTFCC Meeting, Session 2.1), “fight cholera” (Skoog, S/PV.7999, p. 9), and to “overcome the cholera epidemic” (Alyemany, S/PV.7999, p. 10) as if it were an enemy. In addition, cholera was characterized as dangerous. The GTFCC documents in particular, argued for ending cholera from being a “threat to public health” (Global Roadmap, p. 4; 6; 13) and wanting to see “a world free from the threat of cholera” (GTFCC Declaration).

Despite speaking about cholera as a dangerous enemy, participants in both Security Council and GTFCC documents spoke about cholera as something that could be tamed, gained dominance over. Many participants referred to “cholera control” (Legros, GTFCC Meeting, Session 2.1; Global Roadmap; p. 7) and “controlling cholera” (Global

Roadmap; p. 13). Moreover, launching the Global Roadmap as a “cholera control strategy” (GTFCC declaration) and using “cholera control” in the name of the Global Task Force indicates that control was considered achievable and feasible. Alyemany, the representative for Yemen, lumped cholera, famine, and violence together as “controllable crises” (S/PV.8027, p. 6). O’Brien, the Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator, explained: “we will not cease our efforts until the scourge of cholera is contained” (S/PV.7954, p. 6). By this he indicated that cholera control is an achievable goal.

The characterization of cholera as controllable was further demonstrated by participants’ descriptions of cholera as entirely preventable. Participants emphasised that the outbreak was not a natural phenomenon, rather “an entirely man-made humanitarian catastrophe” (Ahmed, S/PV.8066, p. 2), which made it “depressingly predictable” (O’Brien, S/PV.7954, p. 5-6). Others also claimed that cholera was an “entirely preventable disease” (O’Brien, S/PV.7999, p. 4), “preventable” (Global Roadmap, p. 7; GTFCC Declaration), “treatable” (Sison, S/PV.7951, p. 22), and “curable” (Al-Mikhlaifi, S/PV.8027, p. 10). The cholera outbreak in Yemen, as well as famine and conflict, were considered “all totally preventable, avoidable and treatable” and also “stoppable” by participants (O’Brien, S/PV.8027, p. 2).

### *States*

In Security Council documents, states were characterized as indifferent, self-interested and failing to fulfill state responsibilities. Actors emphasised these traits by using non-governmental organizations (NGOs), civil society and Yemeni civilians as foil characters. They praised NGOs, inter-governmental, and humanitarian organizations and Yemeni civil society while highlighting the vulnerability of civilians, in particular children, in contrast to the irresponsibility of states. The GTFCC documents on the other hand, chose to emphasise the importance and key role played by states in successful cholera control.

NGOs, inter-governmental and humanitarian organizations were praised continually throughout the Security Council documents. Participants reported the work that organizations, such as the WHO, UNICEF, UN Office for the Coordination of Humanitarian Affairs (OCHA), and other partners, have been doing on the ground, and noted the impact

of their work. Ghebreyesus, the Director-General of the WHO, explained the extent of the WHO's efforts, and resulting success:

WHO and UNICEF are supporting more than 600 cholera treatment centres and oral-rehydration therapy sites in the most affected districts across the nation, and we plan to open another 500 centres...More than 400 tons of critical lifesaving supplies have been delivered, including intravenous fluids and treatment kits, and more than 5 million people have been supported to access safe water (S/PV.7999, p. 6).

Others listed similar achievements, "the cholera response has established 222 treatment centres and 926 oral rehydration points across the country" (O'Brien, S/PV.8027, p. 4), and "some 1.6 million people have already been supported through those interventions" (O'Brien, S/PV.7954, p. 6), all thanks to "the swift intervention by humanitarian partners" (O'Brien, S/PV.7871, p. 6). Many participants praised their efforts: "we pay tribute to the United Nations and all humanitarian actors present on the ground, who continue to deliver live-saving support to all those in need in what are very challenging circumstances." (Skoog, S/PV.7999, p. 9).

While organizations were commended for doing "admirable work" (Delattre, S/PV.7897, p. 6), "selfless, brave work" (Safronkov, S/PV.7897, p. 5), "working tirelessly", with "extraordinary speed and courage" and "doing all they can" (O'Brien, S/PV.7954, p. 6), on the other hand, participants criticized "all parties to the conflict" for their "continued inability to put the genuine needs of the Yemeni people first" (O'Brien, S/PV.7954, p.5). Participants expressed concern over organizations having to shoulder state responsibilities, such as the payment of health workers and their incentives, travel costs, and overtime payments in the short term, as it is "not a sustainable solution." (Ghebreyesus, S/PV.7999, p. 6). States, on the other hand, were described as neglecting their duties to citizens, "at what point will the parties shoulder their responsibilities to protect civilians and civilian infrastructure...and to provide basic services for the population?" (O'Brien, S/PV.7999, p. 4).

In addition to organizations, Yemeni citizens and civil society were praised by participants for their "courageous efforts", "spirit of compromise", and "commitment and dedication" (Ahmed, S/PV.7999, p. 4). Also, Yemeni civil society was characterized as rational and intelligent. To demonstrate these points, Ahmed, the Special Envoy of the Secretary-General for Yemen, described a meeting he had with Yemeni youth activists:

We discussed the political and security challenges facing Yemen, as well as the cholera outbreak. In my discussions with those members of civil society, women and youth groups proposed very practical ideas...The demands of those young people are just, logical, inspiring and practical (S/PV.7954, p. 4).

By contrast, parties to the conflict were characterized as unwise and stubborn. Alyemany, the representative for Yemen, criticized warring parties by labelling the conflict a “foolish war” (S/PV.7999, p. 11) and stating that “war is the choice of fools and peace the choice of the brave.” (S/PV.7999, p. 10). While civil society’s willingness to produce solutions was commended, participants expressed discontent with the “reluctance of the key parties to embrace the concessions needed for peace, or even discuss them” (Ahmed, S/PV.7954, p. 2).

Whereas Yemeni civil society was characterized as patriotic, “their drive and sense of nationalism carries with it a great deal of hope” (Ahmed, S/PV.7999, p. 4), political leaders were not, “I wish that the political leaders would mirror these activists’ love of their nation and its people” (Ahmed, S/PV.7999, p. 4). O’Brien, the Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator, applauded Yemeni citizens for fulfilling their duties, while being impartial, by saying, “I salute the local health and sanitation workers, who are trying to support all and taking no sides regardless of the warring parties’ contemptible attempts to get them to do so” (S/PV.7954, p. 6). Ahmed, the Special Envoy of the Secretary-General for Yemen, agreed with the sentiments of impartiality by stating, “these [civil society] groups are the true voices of Yemen, far removed from personal concerns and considerations” (S/PV.7999, p. 4).

Participants used different methods to refer to the victims of “unfathomable pain and suffering” (O’Brien, S/PV.7999; p. 4) in the conflict. In addition to labelling victims “ordinary people” (O’Brien, S/PV.7954; p.5), and “Yemeni people” (Ahmed, S/PV.8066; p. 3), participants repeatedly invoked the image of a child to represent the suffering of Yemeni people. O’Brien, the Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator, presented the “heart-breaking story” of an “innocent” six-year-old child:

her family spent six months sleeping in a hole in the ground at night in order to avoid air strikes near their home. This little girl was already suffering from malnutrition, and her condition became severe while hiding with her family. After several rounds of treatment, she was recovering, only to contract and

die of acute watery diarrhoea shortly after her release from hospital (S/PV.8027; p. 2).

Other participants also chose to appeal to Security Council members by describing the impact of the conflict on children, as illustrated by these quotes: “children in Yemen spend their childhood in the midst of poverty, hunger, disease and indiscriminate attacks committed against them by all parties to the armed conflict” (Bermúdez, S/PV.8027; p. 6); “children in particular are the main victims” (Skoog, S/PV.7999; p. 9); and “by the time I finish my statement to the Council today, another child in Yemen will have died from a preventable disease” (O’Brien, S/PV.7954; p.5).

While emphasising the innocence and suffering of civilians, participants criticized the self-interest of political leaders refusing to solve problems so as to not “lose their power and control” (Ahmed, S/PV.8066, p. 3). Ahmed, the Special Envoy of the Secretary-General for Yemen, warned about the consequences of shifting the burden of war on civilians, “history will not judge kindly those Yemeni leaders who have used the war to increase their influence or profit from public finances (S/PV.7999, p. 4). Others criticized the international community in general, for their “inaction, due to inability or indifference” (O’Brien, S/PV.7954, p. 4).

While Security Council documents characterized states by pointing out their shortcomings, GTFCC documents highlighted the responsibilities and importance of state participation in successful cholera response. One of the differences the GTFCC documents cited between the 2014 revitalization of the GTFCC and the 2017 renewed strategy was that the new global roadmap has a “much stronger focus on implementation at the country level” (Global roadmap, p.15). To rationalize this, the Global Roadmap outlined the problems with conventional cholera response:

Cholera has been a neglected issue within national, regional, and global health agendas despite its high burden and the continued risk of emergence and re-emergence. As an issue which cuts across multiple sectors, controlling cholera sustainably requires the highest level of political commitment within governments (p.18).

As a result, “lack of political will or commitment” was labelled as one on the “risks” that “can compromise progress towards ending cholera” by the GTFCC (Global Roadmap, p.19). Instead, “political engagement and committed leadership” was named as more important to successful cholera control than funding, “funding is important, but perhaps

more important is the political will and leverage to include cholera in national budgeting and overall priorities.” (Legros, GTFCC Meeting, Session 2.1).

## **Emplotment**

### *Narratives in favour of a political solution*

Some of the participants created a narrative to argue for a political solution, by arguing that the cholera outbreak in Yemen was inextricably tied to the man-made conflict, and therefore required a political solution. The cholera outbreak and humanitarian crisis was repeatedly, on multiple occasions labelled by participants as “man-made” (Sinirlioğlu, S/PV.7951, p. 58; O’Brien, S/PV.7954, p. 4; S/PV.7999, p. 5; S/PV.8027, p. 2; Ahmed, S/PV.7954, p. 4; S/PV.8066, p. 2; Ging, S/PV.8066, p. 3; Skoog, S/PV.7999, p. 9; Bermúdez, S/PV.8027, p. 7). O’Brien, the Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator, cautioned against seeing the crisis through too much of a statistical lens, “with numbers of this scale, there is a pernicious risk that we may become mired in a statistical fog or that we may begin to take an overly technical view of this crisis, almost as if it were a natural phenomenon. It is not.” (O’Brien, S/PV.8027, p. 2). Similarly, Haley, the US representative, emphasised that cholera outbreaks “are not the result of the wrath of God but of the acts of men” (S/PV.8069, p. 6).

A number of actors attributed the outbreak to the effects of conflict on the health system by saying: “war led to the collapse of the health system” (Al-Mutawakel, S/PV.7954, p. 7); and “because of the crisis approximately 15 million people lack adequate access to clean drinking water, sanitation and hygiene, or health services” (Ging, S/PV.8066, p. 3). Others blamed the conflict directly for the health crisis, as illustrated by these quotes: “the scale of the latest outbreak is a direct consequence of the conflict” (O’Brien, S/PV.7954, p. 5-6); “if there were no conflict in Yemen, there would be no descent into famine, misery, disease and death”(O’Brien, S/PV.7954, p.5); and the “coup d’état...has caused the spread of cholera” (Alyemany, S/PV.8066, p. 7).

Actors arguing this narrative saw the outbreak as a political issue which demanded a political solution. They blamed the parties to the conflict for creating and prolonging the crisis, both local and international, “conflicting parties and those beyond Yemen’s borders who are leading, supplying, fighting and perpetuating the fear and the fighting.” (O’Brien, S/PV.7999; p. 4); and “it is a direct result of the deliberate policies, tactics and actions of

the parties and their powerful proxies to the conflict” (O’Brien, S/PV.8027; p. 2-3). Rosselli, the representative for Uruguay, explained the relation between crises and conflict by saying, “the common denominator linking humanitarian crises, which is that they take place within the context of conflicts. It is therefore essential to find a solution to those conflicts.” (S/PV.7879, p. 7). Beerli, representative of the International Committee of the Red Cross (ICRC), labelled the actions by state and non-state parties to the conflict “violence against health care” (S/PV.7951, p. 5).

Participants argued that Yemeni civilians suffered not just from cholera but from “political cholera” (Ahmed, S/PV.8027, p. 6) and not just “human tragedy” but also “political tragedy” (O’Brien, S/PV.8027, p. 2). Thus, they advocated a “political process to bring an immediate end to the conflict” (Ghebreyesus, S/PV.7999, p. 6), so that humans do not “continue to lose out to politics.” (O’Brien, S/PV.7999, p. 5). In his statement, the president of the Security Council emphasised the necessity of a political solution, “the humanitarian situation will deteriorate in the absence of a political solution” (Solíz, S/PRST/2017/7). Others agreed, stating that “there is no military solution” (Bessho, S/PV.7897, p. 9; Haley, S/PV.8069, p. 7; O’Brien, S/PV.8027, p. 5), instead, “only a political solution can end the war and suffering of the Yemeni people”. (Ahmed, S/PV.7999, p. 4), and “resolving the conflict in Yemen can be done only through political means” (Safronkov, S/PV.7897, p. 5). The story presented was that cholera is preventable, controllable and treatable, however since the outbreak was a direct result of conflict due to political issues, it required a political solution.

#### *Narratives in favour of a technical and political solution*

Others created a narrative which argued for both a political and technical solution, by following the characterization of cholera as controllable and preventable. They saw the outbreak as a technical problem which required a technical solution. The solutions proposed in this narrative were less concerned about the “why” and current situation, and more focused on future responses.

Actors arguing this view drew links between the “near-absent health, water and sanitation services and the unprecedented cholera outbreak” (Ging, S/PV.8066; p. 4). The focus of this narrative was on safeguarding against future cholera outbreaks, “rebuild[ing] the country’s health and sanitation systems so that we can prevent and better contain



future health risks.” (Ghebreyesus, S/PV.7999; p. 6). The GTFCC documents outlined two “strategic pillars” of action required for achieving cholera control and prevention: at the political level, to “increase political and financial commitments to cholera”; and at the technical level, to “strengthen multisectoral prevention, preparedness and control” (Jones, GTFCC Meeting; Session 2.2). To these actors, cholera was seen as controllable and preventable.

Participants rationalised their confidence by arguing that they had the means to prevent and control cholera because of modern scientific knowledge. The GTFCC documents in particular, made repeated references to being able to prevent and control cholera “with the tools we have today” (Global Roadmap; p. 7; p. 25; GTFCC Declaration). They further demonstrated this using evidence, stating that the measures and knowledge of measures to control and prevent cholera, such as the use of Oral Cholera Vaccine (OCV), and promotion of sanitation and safe water access are “well known” (Legros, GTFCC Meeting, Session 2.1; Global Roadmap, p. 25) and “readily available to us” (Global Roadmap; p. 25). The Global Roadmap summarised the position in favour of technical solutions by explaining:

OCV is a game-changer in the fight against cholera. It takes effect immediately and also works to prevent cholera locally for two to three years, effectively bridging emergency response and longer-term cholera control with a WASH [water, sanitation, and hygiene] focus, demonstrating that cholera is not inevitable and that cholera control is not beyond reach (p. 10).

At the political level, they argued that “political engagement and committed leadership” (Legros, GTFCC Meeting; Session 2.1) were important to implement the Global Roadmap to reduce deaths from cholera by 90 percent. State responsibilities outlined were to ensure effective surveillance and reporting of outbreaks, devote financial resources for cholera control and ensure cholera control strategies are implemented at the country-level (GTFCC Meeting). The story presented was that cholera control and prevention for the future is desirable and achievable, through synergy between political engagement and technical solutions.

In sum, two narratives emerged from the narrative analysis of texts from Security Council and GTFCC documents during the cholera outbreak in Yemen in 2017. The first, understood cholera as inextricably tied to the conflict in Yemen, a preventable and

resolvable political problem which required political solutions. This narrative was mostly argued by participants in the Security Council documents. The second, saw cholera outbreaks as controllable and a preventable disease, requiring action at both technical and political levels. This second narrative was mostly argued in the GTFCC documents.

## **Framing analysis**

This section presents the framing of cholera outbreaks by actors in their narratives for both cases. I begin by reviewing and defining the six dominant frames in global health. I then analyze the frames evoked by actors in the two narratives I constructed from my first case: (1) narrative in favour of regulations; and (2) narrative against regulations. Then, I repeat the analysis for the two narratives constructed for my second case: (1) narrative in favour of a political solution; and (2) narrative in favour of technical and political solutions.

### ***Dominant Frames in Global Health***

As discussed in chapter 1, scholars in global health have identified six dominant frames that emerge from the literature: evidence-based medicine; security; development; human rights; global public goods; and commodities.

#### **Evidence-based medicine**

One of the major frames used in global health is evidence-based medicine, or biomedicine, which relies on rationalist, positivist epistemology to argue that the world can be observed and analysed using epidemiological tools to inform policy-making (McInnes et al., 2012; Lee, 2009). McInnes et al. state that use of the evidence-based medicine frame “is often identifiable by reference to ‘evidence’ to support decision-making” (p. 89). Actors using this frame rely heavily on quantitative scientific evidence to make and validate decisions, and may regard other forms of evidence as inferior (McInnes et al., 2012; Rushton & Williams, 2012).

## **Security**

The security frame identifies dangers, risks, and threats to the state (McInnes et al., 2012). Labonté (2008) labels security “the most dominant discourse of recent years” (p. 468). The goal guiding decision-making in this frame is defence against threats (Ruston & Williams, 2012). The security frame relies on the institutionalization of fear, which makes certain global health issues more prominent than others (Lee, 2009). Associating health issues to security ties it directly to national security and states’ “duties to protect their citizens from foreign risk by guarding their borders, whether the ‘invaders’ are pathogens or people” (Labonté, 2008, p. 468). Using the security frame provides health problems more political leverage, significance, and financial resources (Labonté, 2008; Lee, 2009).

## **Development**

Improved health is one of the desired outcomes in development discourse, and has been featured prominently in the Millennium Development Goals (MDGs) and Sustainable Development Goals (SDGs) (Labonté, 2008). Actors using this frame argue for improving living conditions, focusing mostly on developing countries (McInnes et al., 2012). This frame follows a narrative that improving and investing in health can lead to higher economic returns (Labonté, 2008). Improved health plays a dual role in this frame: as both fuelling economic growth and a positive outcome of economic growth (Labonté, 2008).

## **Human rights**

Actors framing health issues as human rights issues use a “moral-legal rhetoric to argue that moral values should guide health policy decisions” (McInnes et al., 2012, p. 89). The human rights frame is embedded in international treaties and declarations as “the right to the highest attainable standard of physical and mental health” (Labonté, 2008, p. 476; Lee, 2009). Understanding for this frame comes mostly from Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which obligates state parties to provide key public health services (Labonté, 2008; McInnes, et al., 2012; Lee, 2009). The human rights frame has become more prominent over the years, made important by actors such as the WHO and civil society organizations (Ruston & Williams, 2012; Lee, 2009; McInnes et al., 2012).

## **Global public goods**

The global public goods frame uses health economics as a way to determine how to best use and distribute scarce resources which the free-market cannot provide (McInnes, et al. 2012). Labonté (2008) explains: “a global public good is one whose benefits extend to all countries, people, and generations” (p. 473). This view is based upon underlying assumptions that health is a scarce resource, since there are always free-riders who benefit from the good without contributing to its production, and that demand for health is inelastic, meaning that demand does not vary with wealth or price (Rushton & Williams, 2012; McInnes et al., 2012; Labonté, 2008). Actors using this frame frequently promote community and collective benefits over individual benefits (Labonté, 2008).

## **Commodities**

Another frame which uses an economic perspective is health as a commodity. In this discourse, health is reduced to tradeable goods in the form of drugs and technologies, and services in the form of insurance and health facilities (Labonté, 2008). It is used to rationalize spending or lack of spending on health resources (Lee, 2009). Economic and trade interests guide health policy decisions, where health resources flow through borders and free-market for profit rather than in the interest of improved health (Labonté, 2008).

## ***Frames present in narratives from the second cholera pandemic***

This study found that five frames, evidence-based medicine, security, development, global public goods, and human rights, were employed by actors in their narratives to argue, for and against regulations during the second cholera pandemic.

## **Evidence-based medicine**

Both narratives from the second cholera pandemic used evidence-based medicine to argue their positions. However, actors arguing against regulations also rejected evidence-based medicine to argue their position. In general, delegates used the evidence-based medicine frame to explain the formation of the conference, mentioning “the double aspect of science and practice” (Bô, Meeting 10). The French Minister of Foreign Affairs declared at the outset at of the conference that “these are problems very difficult to solve;

and that's why we used the 'meeting of lights, science, practical experience that shines in this conference'" (Meeting 2). Science was also used to rationalize decisions, such as figuring out how long incubation periods for cholera cases should be if regulations were imposed, for example, "as the germ of cholera evaporates more rapidly than the one of the other two diseases, it is right that the delay is shorter" (Betti, Meeting 24). Science was also used to discredit and argue against each other, "M. Monlau has said that plague, yellow fever, and cholera are three identical diseases. Scientifically and practically, this principle can not be accepted" (Bô, Meeting 24).

The narrative for regulations also used the evidence-based medicine frame to argue quarantine measures should be established "only on the basis of the observations of science" (Carbonaro, Meeting 8). Actors arguing this narrative also mentioned "science and experience" (Cappello, Meeting 10) together. The argument of "experience" was also used by Russian delegates to argue for regulations, explaining how when strict quarantine regulations were in place from 1829-32, 290 000 people died (Howard-Jones, 1975). However, from 1846-49, no regulations were in place due to an apparent previous failure with regulations, and 880 000 people died (Howard-Jones, 1975). The dramatic change in statistics with and without regulations forced participants to rethink their preconceptions regarding regulations. Grande, the Spanish delegate, cited observations to argue for regulations:

[Cholera's] appearance is almost always preceded by changes and disturbances of weather, very pronounced sometimes. Unusual variations have been observed in the temperature and density of the air, in the electrical and magnetic state of the atmosphere...Finally, there is, in the sudden and overwhelming invasion of the disease, in its diffusion, in its insidious progress, and in its termination, almost always fatal, all the characters of an eminently epidemic disease (Meeting 11).

In the narrative against regulations, delegates argued this position by saying that cholera was "epidemic", which in the 19<sup>th</sup> century, was understood that diseases did not spread from sick to healthy persons, but large cases of disease occurred when people were exposed to the same atmospheric and climatic conditions (Howard-Jones, 1975). Sutherland, the British delegate, argued that cholera was "purely epidemic; that quarantine measures have had no effect against it, and have not prevented the progress of the disease, while hygienic measures have often succeeded" (Meeting 5), and "epidemic diseases, their progress being due, as we now know, to atmospheric conditions from

which nothing could stop the march” (Meeting 9), claiming this knowledge came from “the most elementary notions of science and the system of contagions” (Meeting 10). Some also used observations to express doubt about the effectiveness of regulations, “the Neapolitan Government, like all other governments, has employed these measures, and yet cholera has spread its ravages everywhere” (Carbonaro, Meeting 9). In addition to science, actors mentioned experience as evidence for their arguments, “experience has shown that a simple wall or the distance of a few meters is enough to prevent the transmission of cholera in a large number of circumstances” (Sutherland, Meeting 10). Science, experience, and observations were not only used as arguments for and against regulations, but guided how actors understood disease, “indeed, what good are lazarets and quarantines, if these diseases come...on the wings of the winds?” (Carbonaro, Meeting 12).

While using evidence-based medicine to argue their position, actors arguing against regulations simultaneously rejected the evidence-based medicine frame. These actors regarded scientific evidence as complicated and unimportant to the Conference. These actors argued that scientific understandings should help guide decisions but should not be the main focus of the Conference. Méliér, the French delegate, argued that the Conference should not “proceed as an academy...certainly, it must take into account science, but only from a practical point of view” (Meeting 8). Science was seen by actors as unnecessarily complicating and lengthening discussions, “if we treat the questions proposed to the Conference only from the scientific point of view, we shall be here again next year at such a time” (Bô, Meeting 8). Sutherland, the British delegate, also conveyed the unimportance of science by stating, “I do not want to forget that we are not a scientific academy, and we must recognize that we must take account of rations other than those of science” (Meeting 10). Additionally, Sutherland expressed disinterest in scientific evidence, as he did not mention British physician’s (John Snow and William Budd) hypotheses regarding cholera’s transmission through contaminated water, even though it was suggested two years before the Conference took place (Howard-Jones, 1975, p. 12).

## **Security**

Both of the narratives during the second cholera pandemic invoked the security frame, particularly through the characterization of cholera. Actors in both narratives characterized cholera in terms of national security threats to states, repeatedly labelling

cholera an “invasion” (Rosenberger, Meeting 12; Bartoletti, Meeting 14), and a foreign “disease of the Indies” (Carbonaro, Meeting 10), which had “threatened to invade the states of the Empire” (Ménis, Meeting 5). In the narrative arguing for regulations, participants especially emphasised these traits to argue the necessity of regulations to control cholera, likening regulations to “clos[ing] a door the enemy” (Rosenberger, Meeting 12).

## **Development**

Actors arguing the narrative against regulations for cholera invoked the development frame. In arguing in favour of improved living conditions instead of regulations, Sutherland, the British delegate, used a combination of both the evidence-based medicine and development frame:

It has been proven that cholera never decimates populations living in good hygienic conditions; but, on the contrary, it always breaks out in places where there are favorable conditions for its propagation: such as the great agglomerations of men, the poor quality of water, the uncleanliness of streets and houses, the lack of proper sewage to dry the soil, excessive moisture from the ground, an atmosphere contaminated by organic matter and other similar conditions. It has also been proved that by the improvements of towns and houses, as I have indicated, the population can be protected against cholera as well as against all other epidemics (Meeting 12).

In arguing against regulations, Ménis, the Austrian delegate, presented a similar argument, although arguing for the improvement of society in general, rather than living conditions:

Cholera, on the contrary, attacks only the rejection of the population. The intemperants, the drinkers especially, the debauchees, the old decrepits, the languishing due to long illnesses, the insane, the reckless and the timorous become mainly his victims: he has more respect for women than for men; and the young population, which is the hope of future generations, is almost constantly spared. His object in this respect, therefore, is only to punish and correct (Meeting 12).

On the other hand, actors arguing the narrative for regulations invoked the development frame, only to reject it. Actors argued for regulations by stating that cholera “acquired the right of middle class among us” (Monlau, Meeting, 11) and “acquired the right of the bourgeoisie” (Méliér, Meeting 11). They argued that regulations were needed because cholera attacked individuals regardless of social class, “cholera is like death, it

knocks on the door of the cottage and of the chateau” (Carbonaro, Meeting 10), or progress and civilization, “it has been said that the plague was destroyed in Europe by civilization; but Europe, before cholera, was more civilized than at the time when the plague ceased to show itself, and the hygienic measures were not forgotten” (Carbonaro, Meeting 9).

### **Global public goods**

Both narratives from the second cholera pandemic emphasised that the purpose of the conference, discussing and drafting a sanitary convention, was for the good of public health. Actors arguing both narratives made repeated references to the “public health interest” (Meeting 9) and the “safeguarding of public health” (David, Meeting 1; French Minister of Foreign Affairs, Meeting 2; Betti, Meeting 10). The work of the conference was described as something “really useful” (David, Meeting 1), and “essential to the progress of civilization and the welfare of peoples” (French minister of Agriculture and Trade, Meeting 2). In saying so, they indicated that the interest was collective benefit over individual gain. Mouzinho da Silveira, the Portuguese delegate, stated this clearly by saying:

although our Conferences are exclusively Mediterranean, it is certain that if we succeed in solving the difficult problem of sanitary measures, taking into account, on the one hand, commercial requirements and, on the other, those of public health, we will have made a useful work, beautiful, almost holy; and later, Europe, perhaps the whole world (Meeting 12).

Here, he argues that the benefits from the success of this conference would extend to other countries and people, fitting in with global public goods theory.

### **Human rights**

Although not expressed in terms of legal rhetoric, both narratives from the second cholera pandemic invoked the human rights frame to argue their positions. The Conference was described as a “truly philanthropic enterprise” (David, Meeting 5) and “useful and truly philanthropic work” (French Minister of Foreign Affairs, Meeting 2). In fact, the activities of the conference were framed by actors as a moral obligation, “it is our obligation to safeguard public health with all our might” (Betti, Meeting 10). The delegates had characterized themselves and their representing states as enlightened and superior to other extant states, and used this to argue that the work they were doing would serve



“civilization” and “humanity as a whole” (French Minister of Foreign Affairs, Meeting 2). The president of the Conference, David, urged participants to “open [their] enlightened zeal for the public good” (Meeting 5), essentially combining the human rights and global public goods frame. Again, without invoking any specific treaties, actors brought up the obligation of states, “every government knows very well what it is to do, and what are the hygienic measures which must be adopted, without failing in the duties of humanity, in the case of dangerous diseases imported into their States” (Ménis, Meeting 15). In particular, the narrative in favour of regulations invoked the human rights frame by saying that making cholera a part of the sanitary regulations would be an “eminently humanitarian act” (Betti, Meeting 10).

### ***Frames present in narratives from the 2017 cholera outbreak in Yemen***

This study found that five frames, evidence-based medicine, security, development, global public goods, and human rights, were employed by actors in their narratives to argue for political solutions and for both technical and political solutions during the 2017 cholera outbreak.

#### **Evidence-based medicine**

During the 2017 cholera outbreak, both narratives used the evidence-based medicine frame in their characterization of cholera to argue their positions. In the narrative arguing for political solutions, Security Council meeting participants used numerical evidence to justify appeals for political intervention in the Yemen conflict, as evidence of the scale and gravity of the cholera outbreak. Participants used statistical evidence of the devastation brought on by cholera such as, “approximately 500,000 persons have been stricken by the illness. One person dies of cholera every hour in Yemen,” (Bermúdez, S/PV.8027; p. 6) to strengthen requests for a political solution in Yemen.

In the narrative arguing for both political and technical solutions, GTFCC documents used numerical evidence to justify requests for more political and technical engagement in cholera control. To show that cholera is still an important issue requiring attention and resources, Legros, the GTFCC Secretariat, reported the number of recorded cholera cases around the world before using this as evidence to say, “there is no sign of

a decline in the number of cholera cases reported globally, and cholera remains endemic in many settings” (GTFCC Meeting; Session 2.1). GTFCC documents also used evidence-based medicine to rationalize their argument in favour of technical solutions, by explaining the effectiveness of OCV using evidence from research, such as “a systematic review and meta-analysis of protection against cholera from killed whole-cell oral cholera vaccines (kOCV) (Qifang, Azman et al.) found an average two-dose efficacy of about 58%” (Sack, GTFCC Meeting, Session 1.2). Scientific explanations for disease transmission, such as “the disease is usually transmitted through faecally contaminated water or food...Worldwide, 844 million people still lack access to even a basic drinking water source, more than 2 billion drink water from sources that are faecally contaminated” (Global Roadmap, p. 7), were employed to argue for water, sanitation and hygiene (WASH) interventions. Jones, the representative for WaterAid, summarised the role of evidence in formulating the Global Roadmap by stating, “the roadmap supports a coordinated, multisectoral and comprehensive approach to cholera control in different settings, realized through an evidence-based action plan” (GTFCC Meeting, Session 2.2).

## **Security**

During the 2017 cholera outbreak, the narrative arguing for political solutions in Security Council documents invoked the security frame. Most participants did not explicitly label cholera outbreaks a security issue; only one representative associated cholera with national security directly by saying, “epidemics, like cholera, can spread across borders” (Haley, S/PV.8069, p. 6). However, including the cholera outbreak in Yemen in Security Council meetings, whose main mandate is “the maintenance of international peace and security” (UN Charter, Article 23), automatically framed cholera as a security issue. Additionally, participants framed global health crises in general as security issues, by mentioning health crises as part of “contemporary, non-traditional sources of complex challenges” to international peace and security, that have “transcended geographical boundaries with severe ramifications” (Kafle, S/PV.8144, p. 62). In the list of contemporary challenges to international peace and security in these discussions, many participants included “infectious diseases” (Pobee, S/PV.8144, p. 51), “the spread of disease” (Sapag Muñoz de la Peña, S/PV.8144, p. 53), and “pandemics” (Sinirlioğlu, S/PV.8144, p. 28; Pobee, p. 51; Álvarez, p. 14; Kafle, p. 62; Amaral, p. 65; Bessho, p. 3; Hattrem, p. 31; Heusgen, p. 33; Djani, p. 35; Akbaruddin, p. 36) in addition to issues such as terrorism, cyberattacks, nuclear proliferation, violent extremism, climate change, human, drug, and

weapons trafficking, transnational organized crime, human rights violations, food and water insecurity. Others framed humanitarian crises caused by conflicts as security issues, as illustrated by these quotes: “that kind of trend — a conflict-exacerbating, climate-induced humanitarian crisis — poses serious threats to global peace and security and to development agendas” (Guadey, S/PV.8069, p. 10); and “those conflicts threaten us all. People without access to food, water, basic services and economic opportunities are more likely to turn to armed and extremist groups” (Haley, S/PV.8069, p. 6).

## **Development**

During the 2017 cholera outbreak, the narrative in favour of both technical and political solutions used the development frame. Actors arguing this narrative invoked the development frame by using cholera outbreaks as a proxy measure for development and progress. GTFCC documents argued that cholera control required both technical and political solutions by stating that cholera is a disease which mostly affects developing, rather than developed countries, or even more specifically, is a disease of the global South.

Participants of the GTFCC meeting described cholera as “very noticeably a disease of developing rather than developed countries” (Benson, GTFCC meeting, para. 4). GTFCC documents also asserted that the global cholera burden is disproportionately borne by low-income countries in the global South, by saying “safe drinking water and advanced sanitation systems have made Europe and North America cholera free for decades” (Global Roadmap, p. 7) and “it has been 150 years since the world’s high-income countries achieved control of cholera, thanks to the implementation of safe piped water, sewerage systems, and basic hygiene principles” (Global Roadmap, p. 25).

By contrast, they argued that the risk of cholera remains with the “the world’s poorest” (Global Roadmap, p. 25). All of the GTFCC documents in this narrative used the development frame to argue that cholera is connected to poverty, as illustrated by these quotes: “the map of cholera is essentially the same as a map of poverty” (Global Roadmap, p. 6); “cholera is a stark marker of inequality” (Global Roadmap, p. 7); “cholera disproportionately affects the poorest and most marginalized” (Jones, GTFCC meeting, Session 2.2); and “cholera is a disease of inequity” (GTFCC Declaration). The GTFCC declaration further characterised cholera as something affecting only underdeveloped

nations by characterising cholera as “an ancient illness that today sickens and kills only the poorest and most vulnerable people on Earth” (GTFCC declaration). By characterising cholera as an ancient illness, the suggestion is that cholera control is a step towards modernity and progress.

By characterising cholera as ancient, and a disease of poor and underdeveloped countries, GTFCC documents using this narrative argued that cholera control is a matter of development. Actors used the development frame by linking cholera control to global development agenda. Actors mentioned meeting the SDGs to argue for more engagement at technical and political levels. Some actors referred to specific SDGs, “progress on cholera prevention is a proxy for progress in attaining SDGs 3, 6 and 10” (Jones, GTFCC Meeting, Session 2.2); and “cholera serving as a proxy measure for progress across a number of [SDG] goals.” (Global Roadmap; p. 8). Others referenced the SDGs more generally, stating “controlling cholera is a...critical step to achieving the [SDGs], which call for the reduction of inequality, and good health and wellbeing for all” (GTFCC Declaration). The Global Roadmap summarised their stance on the connections between cholera and poverty:

the proposed long-term cholera control investments will also significantly reduce the impact of all water-related diseases, while contributing to improvements in poverty, malnutrition, and education, thereby representing a significant step toward the achievement of the Sustainable Development Goals (SDGs) for the world’s poorest people and toward a world free from the threat of cholera (p. 5).

### **Global public goods**

During the 2017 cholera outbreak, the global public goods frame was invoked by the narrative arguing for both technical and political solutions in the GTFCC documents. GTFCC documents rationalized arguing for more technical and political engagement in cholera control by referencing the global economic burden of cholera, “which costs an estimated \$2 billion per year globally in health care costs and lost productivity” (Global Roadmap; p. 5). The economic burden was labelled “significant” (Global Roadmap; p. 5), and actors argued for investing in the prevention of cholera as it is “not only affordable, but will ultimately allow significant cost savings compared with the average yearly cost of continuously responding to cholera outbreaks” (GTFCC Declaration). By pointing out the substantial global burden of cholera, and emphasising what “cholera costs the world”

(GTFCC Declaration), GTFCC documents showed how achieving cholera control would be a global public good that offers collective benefits, extending to all countries.

## **Human rights**

Both narratives during the 2017 outbreak invoked the human rights frame through international legal rhetoric. International human rights laws and international humanitarian laws (IHL) are both “concerned with the protection of life, health and dignity of individuals” (ICRC, 2010). International human rights law applies at all times, in both times of peace and war to protect fundamental human rights, while IHL applies during armed conflict, to protect civilians and restrict the means and methods of war (ICRC, 2010). During armed conflict, both international human rights laws and IHL apply (ICRC, 2010).

In the narrative arguing for both technical and political solutions, GTFCC documents invoked the human rights frame by referring to international human rights law. Proponents of this narrative argued that the measures outlined in the Global Roadmap would help fulfill international human rights law. Actors argued that one of the reasons cholera remains a global health problem is because some human rights are not being fulfilled, “access to safe water, sanitation, and hygiene (WASH) has been recognized by the United Nations as a human right, yet over 2 billion people still lack access to safe water, putting them at risk for cholera” (GTFCC Declaration).” According to these actors, achieving cholera control means addressing human rights issues, such as fulfilling “the human right to access to water and sanitation” (Global Roadmap, p. 9).

In the narrative arguing for political solutions, actors in Security Council documents invoked the human rights frame, to state that parties to the conflict were not adhering to international human rights law and IHL. Security Council participants argued that the humanitarian situation in Yemen is a result of parties to the conflict committing “serious” (O’Brien, S/PV.7999, p. 5), “grave” (Al-Mutawakel, S/PV.7954, p. 8), and “widespread” (Rosselli, S/PV.7999, p. 8) violations of international human rights law and IHL. Laws were also generalised together and labelled collectively as “international law” (Al-Mutawakel, S/PV.7954, p. 8; O’Brien, S/PV.7999, p. 5; Solíz, S/PRST/2017/7), “international legal norms” (Ahmed, S/PV.7999; p. 2) and “international norms” (O’Brien, S/PV.7871, p. 5). In particular, actors mentioned the fact that “warring parties” (Ahmed, S/PV.7999, p. 2) and “all parties” (Solíz, S/PRST/2017/7; O’Brien, S/PV.7871, p. 5) had either targeted or failed

to take precautions to avoid targeting and minimising harm to civilians and civilian infrastructure, such as medical facilities and schools. To rationalize the argument for political intervention, this narrative argued that the situation in Yemen is a matter of state and international responsibility, “the people of Yemen look to the international community to ensure accountability for these serious violations of international law” (Al-Mutawakel, S/PV.7954; p. 8), and in particular, the responsibility of the Security Council, “the international community must do more — words are insufficient — to ensure that the parties are upholding their obligations under international humanitarian law. The Council has a primary responsibility for this” (O’Brien, S/PV.7999, p. 5).

In sum, five frames, evidence-based medicine, security, development, global public goods, and human rights, were employed by actors in their narratives to argue for political and both political and technical solutions during the 2017 outbreak. The same five frames were used by actors in their narratives to argue for and against regulations during the second cholera pandemic. The next chapter discusses these findings from the framing analysis of narratives in relation to literature on international cooperation, crises, and global health.

## Chapter 4.

### Discussion and Conclusion

This chapter presents a discussion of what shaped cooperation during the second cholera pandemic and 2017 cholera outbreak in Yemen. First, I summarise and compare the frames used in each of the narratives told by actors in both cholera cases. Then, I discuss the findings in relation to literature on international cooperation, crises, and global health to argue that cooperation was facilitated by framing cooperation as a global public good and referring to existing norms and laws governing state behaviour.

#### Summary and comparison

##### *Multiple narratives and frames*

This study found that during the 2017 cholera outbreak, there was less disagreement and conflict between actors, compared to the second cholera pandemic. During the 2017 outbreak, one narrative emerged within each set of documents, whereas two narratives emerged during the first International Sanitary Conference of 1851. During the 2017 outbreak, there was consensus among actors in the Security Council documents regarding the cause, consequences, and solutions to the cholera outbreak, and conflict in general. In their statements, actors echoed, and often repeated each other without disagreement. Actors agreed that the conflict, and subsequent cholera outbreak, was man-made, led to a devastating humanitarian situation and demanded a political solution to end the conflict. Similarly, GTFCC documents demonstrated shared understandings about the cause and solutions to cholera outbreaks. They agreed upon the epidemiological explanations of cholera and agreed that cholera control could be achieved through cooperation at political and technical levels. A single narrative emerged within each set of documents during the 2017 outbreak, facilitating cooperation as actors were working towards a unified goal.

On the other hand, discussions at first International Sanitary Conference during the second cholera pandemic were dominated by debates and disagreements about what

to prioritise, the understanding of cholera, and which solutions to advocate for. Actors disputed over whether public health or international trade and commerce should take precedence over the other when making decisions. Actors also argued about understandings over the transmission of cholera, which led to disagreement over whether or not cholera should be included in sanitary regulations. One narrative argued for regulations over cholera, understanding cholera as something deadly, dangerous, and in need of protection against through regulations. A second narrative argued against regulations, understanding cholera as unstoppable, which no regulations could control. Two competing narratives emerged during the first International Sanitary Conference, hindering cooperation as actors were no longer working towards the same goal.

This study found that five frames, evidence-based medicine, security, development, global public goods, and human rights, were employed by actors in their narratives to argue for and against regulations during the second cholera pandemic. I also found that the same five frames were employed by actors in their narratives to argue for political solutions and for both political and technical solutions during the 2017 cholera outbreak. No single frame dominated the narratives told by actors in either of the cases. Table 1 below presents a summary of the ways actors used frames in their narratives.

**Table 1 Use of frames in narratives**

<b>Frame</b>	<b>Second cholera pandemic</b>	<b>2017 Cholera outbreak</b>
EBM	N1 & 2: science as guiding the formation of the Conference N1: observations and previous experience using regulations show success in controlling cholera N2: differing understandings of cholera transmission; scientific discussions not part of the agenda of the Conference	N1 & 2: characterization of cholera using statistical evidence N2: confidence in the effectiveness of cholera control methods based on scientific evidence
S	N1 & 2: characterization of cholera as a national security threat and requiring defence against	N1: cholera / health crises as part of new and complex challenges to international peace and security
D	N1: cholera as a disease affecting all societal classes N2: improving living conditions and society would help prevent outbreaks instead of regulations	N2: cholera as a disease affecting underdeveloped countries and cholera control as a proxy measure for SDGs
GPG	N1 & 2: conference was convened in the interest of public health and benefit of all countries	N2: cholera control could reduce the global economic burden of cholera



HR	N1 & 2: conference and conference activities as a moral obligation and for the good of humanity	N1: humanitarian situation indicates violations of international human rights law and IHL N2: cholera control measures would also fulfill international human rights law
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Key: evidence-based medicine (E); security (S); development (D); global public goods (GPG); human rights (HR); narrative (N)

## Discussion

### *Global public goods as an overarching frame*

No single frame dominated the narratives told by actors in either of the cholera cases. All of the narratives invoked five frames, evidence-based medicine, security, development, global public goods, and human rights. I argue that while no frame can be credited with driving cooperation singlehandedly, global public goods as a general and overarching frame best captures the motivations behind cooperation in both cholera cases. Labonté (2008) describes two ways to understand global public goods: in economics; and more generally. In economics, “a global public good is one whose benefits extend to all countries, people, and generations” (Labonté, 2008, p. 473). From an economic perspective, health is a scarce resource under-supplied by the free market (McInnes et al., 2012; Rushton & Williams, 2012; Labonté, 2008).

In general, global public goods refer to things which prioritise collective benefit over individual gain, with the “underlying premise...that shared interests are the key rationale for collective action” (Labonté, 2008, p. 474). While competing interests can make cooperation difficult, Olsson (2015) argues cooperation is “facilitated by joint problem framings, mutual dependencies and incentives to improve cooperation” (p. 93). In describing the difference between the two definitions of global public goods, Labonté states that “definitional boundaries remain vague, however, and identifying such goods remains more a matter of public policy, and hence politics, than of economic theory alone” (p. 473). Within each narrative told in the two cholera outbreak cases I have studied, actors tended to use the global public goods frame in a general manner, while simultaneously using other frames.

During the second cholera pandemic, actors suggested that by cooperating over cholera, collective benefit could be derived from the protection of public health and the

protection of international commerce and communications. Some actors were keen on considering both commercial and health interests equally, emphasising the importance of both: “we are here to establish a fair compensation between sanitary interest and commercial interest” (Carbonaro, Meeting 10). In other cases, commerce and communications took precedence over health, suggesting the collective benefits from promoting commerce were more important than public health. Actors argued that the main reason for cooperating over this conference was to reform regulations in a way that was “least fatal possible to the commerce and the free communication of the peoples between them” and “to establish the least ruinous sanitary system possible for commerce” (Bô, Meeting 10; Meeting 25). These actors also mentioned they were “united in a very precise and well-understood aim of promoting, as far as possible, international communications” (David, Meeting 12). The protection of public health was suggested as being less important for collective benefit, and attached as an aside to the main goal of promoting commerce and communications. Actors emphasised the promotion of commerce and communications, “while safeguarding, as we must, public health” (David, Meeting 12), “while safeguarding public health (Bô, Meeting 10; David, Meeting 8), and “while bearing in mind the sacred interest of public health” (Vitalis, Meeting 12).

In other cases, public health took precedence over the promotion of international communications and commerce. Monlau, the Spanish delegate, stated that on one hand, “quarantines waste time, and time is money”, but on the other hand, “time is money, but public health is gold” (Meeting 11). Grande, the Portuguese delegate emphasised how the protection of public health provides more collective benefit to society than the promotion of commerce, when proposing longer incubation periods in quarantine:

I am very sorry, gentlemen, to propose these delays; I would like to break all the commercial obstacles: in commerce as in nature, movement is life; and the ease of movement is welfare. Industry means civilization, and civilization means commercial freedom: I know it. But public health has been put under our guard; and this health is the first condition of our happiness and the prosperity of commerce itself. Well! that commerce, to which society has sacrificed a great deal, sacrifices in its turn to society a little time, a few days only (Meeting 25).

Throughout the narratives, different actors sought to reconcile both commercial and health interests, as both commerce and public health were seen as providing collective benefits.

During the 2017 cholera outbreak, actors in Security Council meetings and GTFCC documents suggested that by cooperating over cholera, collective benefit could be derived from addressing threats to international peace and security and reducing the burden of disease worldwide. Although discussing cholera at Security Council meetings most immediately connects cholera to the security frame, cooperation over a political solution in Yemen was framed in terms of global public goods. Actors arguing this narrative suggested that cooperating over a political solution to end the conflict in Yemen would not only alleviate humanitarian suffering, but put an end to the “man-made” cholera problem. Including infectious disease outbreaks in the list of new and complex threats to international peace and security also framed cholera as a security issue. However, actors argued that cooperating over a political solution in Yemen would provide collective benefits, because the alternative (no cooperation) would create collective disadvantages. Actors mentioned that ongoing conflicts “threaten us all” (Haley, S/PV.8069, p. 6) and “pose a challenge to the international community as a whole” (Sinirlioğlu, S/PV.8144, 28). The absence of cooperation over a political solution, they argued, would create collective disadvantages because of new threats to international peace and security, “since the factors affecting one country quickly take on regional and transnational overtones and have the effect of destabilizing adjoining countries and regions” (Pobee, S/PV.8144, 51), “destabilize countries” (Hattrem, S/PV.8144, p. 31; Bessho, S/PV.8144, p. 3), and “spread insecurity and distress to surrounding regions” (Amaral, S/PV.8144, p. 65). Actors emphasised that because of globalization and interdependence, the best solution to avoiding collective disadvantages is to cooperate, “given their transnational nature, those [new] types of challenges can be overcome only through the cooperation and effective action on the part of the entire international community” (Amaral, S/PV.8144, p. 65).

In GTFCC documents, the general global public goods frame was used to emphasise the collective benefit of cooperating over technical and political solutions in controlling cholera. The documents argued that the collective benefits would be a lowered global economic burden imposed by cholera. GTFCC documents reported that cholera costs the world “an estimated \$2 billion per year globally in health care costs and lost productivity” (Global Roadmap; p. 5), and that cooperation over cholera control is needed to reduce these costs.

During the second cholera pandemic, promoting commerce and communications, and protecting public health were both regarded by actors as providing collective benefits.

Because of this, actors generally agreed that both international commerce and communications, and public health would be considered in the Conference, although the balance shifted from time to time. During the 2017 cholera outbreak, each narrative emphasised the collective disadvantages from lack of cooperation. In the Security Council documents, actors emphasised the collective disadvantage of lack of cooperation in the Yemen conflict. They argued that continuation of the conflict would lead to worsening of the outbreak and humanitarian situation, destabilize regions, and pose threats to international peace and security. GTFCC documents emphasised the collective disadvantage of lack of cooperation over cholera control. They argued that continued cholera outbreaks create significant global costs. The second cholera pandemic and 2017 cholera outbreak demonstrate how appealing to shared interests and mutual dependencies provides incentives to cooperate (Olsson, 2015; Labonté 2008). Using global public goods as a general and overarching frame, where the goal is to prioritise collective benefit over individual gain, can be used to facilitate cooperation for a unified goal.

### ***International law and norms as facilitating cooperation***

There was more agreement and harmony between actors within each narrative during the 2017 outbreak, which facilitated cooperation. During the second cholera pandemic however, actors used two competing narratives which hindered cooperation. The most obvious explanation for this difference lies in the difference in time period between the two cases. During the second cholera pandemic, all of the delegates at the 1851 Conference lacked knowledge of the etiology and modes of transmission of cholera (Howard-Jones, 1975). Whereas in 2017, the etiology and modes of transmission of cholera have been well explored and accepted by the medical field. As a result, rather than questioning science, actors in the Security Council and GTFCC documents displayed confidence in scientific and technical knowledge in controlling cholera, concentrating instead on quantifying disease and eliminating factors relating to outbreaks such as sanitation and access to medical facilities.

In addition to the establishment of widely accepted scientific knowledge about cholera in 2017, I argue that the establishment of international laws and norms facilitated cooperation during the 2017 outbreak. During the 2017 outbreak, there was widespread

agreement among actors that the devastating humanitarian situation should appeal to “collective conscience” (Ciss, S/PV.7897, p. 15), and “human conscience of Council members,” (Alyemany, S/PV.7954; p. 12). Many actors agreed that the humanitarian situation in Yemen was indicative of apathy and “indifference of the international community” (Solíz, S/PV.8027; p. 8). Alyemany, the representative for Yemen, expressed this sentiment:

And yet the conscience of the international community has not yet driven it to raise its voice in protest at such violations of human rights, and the deafening silence continues, as if it were normal to consider that international humanitarian law does not apply in Yemen and that the international community does not care about Yemenis (S/PV.7999; p. 11).

Others echoed this sentiment by saying, “Yemen has been forgotten...Yemen today is one of the greatest failures of the Council and of our Organization” (Solíz, S/PV.7954; p. 10). Actors agreed that not only is cooperation over the cholera outbreak a solution, but it is also a “moral obligation” (Global Roadmap; p. 6). Additionally, one of the points listed in the GTFCC declaration were “we avow that cholera outbreaks like the one in Yemen should not happen again”. Actors called for the international community to work together, as illustrated by these quotes: “instead of fighting over Yemen, let us cooperate for the best interests of Yemen” (Ahmed, S/PV.8066; p. 3); and “collaborate in the pursuit of a peaceful solution to the conflict.” (Rosselli, S/PV.7954; p. 11).

While actors described moral obligations, Labonté (2008) argues that moral language is insufficient, instead “legal language is also needed and remains best provided in human rights covenants” (p. 478). During the 2017 outbreak, actors were able to create a shared narrative by referring to international laws and norms. They referred to state responsibilities and obligations, such as “all parties must comply with their responsibilities under international humanitarian law and human rights law, and all States must exert their influence to ensure the parties do so” (O’Brien, S/PV.7999; p. 5), and “the Government and the parties to a conflict are duty-bound to protect the civilians. National Governments bear the primary responsibility when it comes to the protection of their civilians. Parties to conflict must respect international humanitarian law” (Rycroft, S/PV.7951, p. 15). By referring to existing laws, international human rights laws and IHL, there is less disagreement among actors.

Since international human rights laws and IHL became formalized in the mid 20<sup>th</sup> century, this explains why there was less agreement during the 1851 Conference, since there were fewer legally binding rules governing state behaviour. ‘Human rights’ as a concept has long existed throughout history, but ‘international human rights law’ to protect fundamental human rights were formalized and codified in documents such as the 1948 Universal Declaration of Human Rights (ICRC, 2010). Similarly, there have been customs and rules governing warfare throughout history, however IHL to limit the effect of armed conflict on civilians was formalized and codified within in a number of conventions in the 20<sup>th</sup> century, such as the 1949 Geneva Conventions and 1977 Additional Protocols (ICRC, 2010).

During the second cholera pandemic, the human rights frame was invoked using moral language rather than legal rhetoric. Actors described the work of the Conference using moral language such as “philanthropic” (David, Meeting 5; French Minister of Foreign Affairs, Meeting 2), “duties of humanity” (Ménis, Meeting 15), and a “humanitarian act” (Betti, Meeting 10). Moral reasoning was less sufficient in facilitating cooperation towards the same goals during the second cholera pandemic. However, during the 2017 outbreak, actors’ use of moral arguments was strengthened by referring to widely accepted international laws and norms as they invoke action and responsibilities on the part of states (Boulden, 2004).

## **Conclusion**

This thesis explored the following research questions: can global health crises provide effective opportunities for international cooperation; and more specifically, what is the relationship between how a global health crisis is framed, and policy responses? Based on a comparative case study and framing analysis of narratives told during the second cholera pandemic and cholera outbreak in Yemen in 2017, this thesis argues that crises can indeed provide opportunities for cooperation, if cooperation over a crisis is framed as a global public good and if actors refer to existing norms and laws governing state behaviour.

The analysis in this thesis reveals that global public goods, as a general and overarching frame, can provide an alternative way to understand factors motivating international health cooperation beyond security. Explanations for contemporary interest over health tend to focus on the security aspect of transboundary crises (Boin & Rhinard, 2008; Rhinard, 2009; McInnes & Roemer-Mahler, 2017). However, as the two cholera cases in this study demonstrate, global public goods—appealing to shared interests and collective benefits over individual gain—can facilitate cooperation towards a unified goal. This means that any factor, from security threats to trade inconvenience, could potentially provide incentives for cooperation as long as a health crisis creates collective benefits or collective disadvantages to actor's involved.

Secondly, the analysis in this thesis reveals the importance of norms and laws in helping to mitigate some of the barriers to achieving effective cooperation. Factors which prevent effective coordination and collective action include multiple actors, competing interests, and differences in willingness to cooperate (Olsson, 2015; Rhinard, 2009; Christensen et al., 2016; Ney, 2012, Boulden, 2004). While using moral language and reasoning can promote agreement among actors, cooperation towards a unified goal is strengthened by reference to widely accepted international norms and laws, as it reduces the number of competing narratives emerging in policy discussions.

Additionally, the analysis in this thesis demonstrates how comparing cases across time periods can be valuable for understanding the development of norms. As noted previously, the large gap in time periods between the second cholera pandemic and 2017 cholera outbreak makes it difficult to compare them exactly and is a potential source of limitation in this study. However, in doing so, this thesis reveals the important role of international laws and norms, reflected in the extent to which international cooperation has become an expectation during global health crises. As Haydu (1998) explains, “comparison of time periods serves to tease out differences and highlight shifts that might otherwise have gone unnoticed” (p. 346). Although the context of the two cases used in this study differed greatly, the importance of the development of norms and laws in guiding health cooperation become clear only through comparison of cooperation in 2017 and 1851. This factor may have been overlooked by comparing cases with similar contexts.

The power of the global public goods frame and the importance of international norms and laws in influencing cooperation raise a number of concerns and areas for

further research, such as: the role of non-state actors; and international laws in practice. If cooperation over health crises depends on identifying shared interests, then, the actors involved play a key role in defining which health problems become prioritised in global health policy-making. Actors set the agenda, determine the issues to be discussed, the types of solutions proposed, and ultimately determine what is the 'global public good'. Rushton and Williams (2012) argue that policy debates take place on an "uneven playing field" (p. 149). They are referring to the fact that certain actors hold more power and authority than others (McInnes & Lee, 2012). Although actors with moral authority (such as civil society organizations), institutional authority (such as the WHO or World Bank), or professional expertise (such as medical professionals) hold power, in health policy discussions, most of the time political actors are seen as the most powerful (McInnes & Lee, 2012; Labonté, 2008; Rushton & Williams, 2012). Non-state actors may possess influence, however as Labonté (2008) suggests, non-state actors "remain largely creations of or dependent upon nation-states for their existence" (p. 468). Cooperation over health crises therefore, remains largely dependent upon the interests of states. If interests guide cooperation, this limits the number of health problems brought to international attention, prioritising issues which can secure political buy-in. This calls into question, for example, whether cholera would have been a main concern at the first International Sanitary Conference, had traditional quarantine methods not been hampering with international trade and commerce? Or if the 2017 cholera outbreak would have been discussed at the Security Council, had the outbreak not been tied to the conflict in Yemen?

Given the scope of this thesis, I have focused on health cooperation through narratives told by state and non-state actors at the multilateral level. Therefore, this thesis has not explored narratives told by non-state actors outside of the system of multilateral diplomacy. It would be worthwhile to examine such narratives to understand the influence of non-states actors in international health cooperation. Exploring narratives outside of the system of multilateral diplomacy could provide insight into how non-state actors frame, and raise the profile of health issues to the multilateral level.

Additionally, while international laws are "a central instrument in the crafting of a common approach" (Fidler, 2001, p. 844), invoking them does not necessarily indicate whether it will translate into successful cooperation in practice. This is because many international legal regimes, such as international human rights treaties, often lack enforcement mechanisms (Labonté, 2008). Although this study has focused on



discussions surrounding a health issue, in future studies, it would be useful to explore international health cooperation in practice. Tracking the development of a health issue from policy discussions, to policy-making, to action, could help provide a better understanding of the influence of narratives which use laws and norms to justify and advocate for cooperation, in practice.

This also raises a question about the value of discourse in diplomacy as an instrument for cooperation. Is cooperation through discussion enough to achieve the stated goals of cooperation, or does it generate empty dialogue for the sake of maintaining diplomatic relations between states? This was evident during the second cholera pandemic, where by the end of the first International Sanitary Conference, participating states finally agreed upon a draft convention to include cholera in sanitary regulations. However, the convention did not come into force as it was not ratified by all states (Howard-Jones, 1975). Despite its apparent failure, the 1851 Conference sparked international cooperation over health and eventually led to a series of fourteen health conferences by 1938. WHO historian, Howard-Jones, describes the positive, albeit delayed, impact of the Conference:

The French Government of the time had planted a seed that was not to germinate for some forty years and then, after a complicated cycle of development, to blossom more than half a century later into the World Health Organization (p. 16).

The extent to which cooperation through discussion can accomplish stated goals remains an issue in the case of the 2017 cholera outbreak. As of 2018, a political solution to end the conflict in Yemen remains out of reach. And although OCV was used for the first time in Yemen in 2018—demonstrating success at the technical level, access to and protection of health services continues to be limited without political solutions (WHO EMRO, 2018). These problems continue to be present, despite relative consensus demonstrated by actors in Security Council meetings and GTFCC documents in 2017. This brings the value of discourse as an instrument into question, an area that would be beneficial to explore in future studies. However, lessons from the second cholera pandemic show not only the benefits, but also the importance of cooperation through discussion.

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