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A Shift in Global Thought and Practice: Assessing the Impacts of the Human Security Paradigm on Global Public Health

An Honors Thesis submitted in partial fulfillment of the requirements for Honors in International Studies.

By

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Under the mentorship of Dr. William Biebuyck

ABSTRACT

With the increasing emphasis on health through human security since the 1990s by the United Nations, scholars have debated how human security has influenced public health. I examine how the idea of human security has become a paradigm and if this paradigm has adopted in public health programs. I argue that the rise of human security has led to an emphasis on the role of global actors, preventative care and health education when states adopt the paradigm. This adoption should in turn improve public health in Ghana and the Ivory Coast.

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Introduction

In "A Tale of Two Africas," Cesar Chelala (2018) writes that even with the economic progress happening in sub-Saharan Africa, health is still a pertinent issue where 23,000 healthcare workers leaving annually. Chelala (2018) calls on global actors to assist African countries technically and fiscally by increasing access to primary health care along with "health promotion, disease prevention and improved health education activities." There is an emphasis on preventative rather than reactive care. In West Africa previously, epidemics of HIV/AIDS and Ebola have led to national crisis. The unforeseen outbreak of disease placed strains on the public health systems of countries that did not have policies or systems in place to defend against a disease spreading so quickly. This is yet another call on states and global actors to put health at the forefront of the world's agenda as it is the backbone for sustainable communities, states and populations.

The reference that Chelala (2018) is making is not a new one. These have been addressed for years by the United Nations (UN), an intergovernmental organization tasked to maintain peace and security by developing cooperation among nations. The UN has been instrumental in setting the global tenants of rights and security which have emerged as an important discourse after the Second World War and the Cold War.

The atrocities of the concentration camps in Germany abhorred many people and nations who declared that diminishing people's rights as humans should never happen again. This belief was the basis for what the UN defines as human rights, which they formally institutionalized in their publication of the Universal Declaration of Human Rights (UDHR). This landmark document articulates thirty articles that cover the basic rights a person is entitled to from birth (1948).

From this landmark article to the Cold War, the opposing powers of the United States and the USSR split human rights into two categories. The United States focused on civil and political rights, those that ensure protection from discrimination and of natural justice in law, for example the right to a fair trial and the right to vote. The second half of human rights includes economic, social, and cultural rights as advocated for by the USSR. These emphasize the socioeconomic human rights such as the right to education, housing, and health. These rights make up the basis for the study on why public health is important to individuals, states and global actors.

Collectively, these rights create the basis of human rights, and later, human security. As a universal concern, they are made up of economics, food, health, the environment, personal, community, and political aspects that envelope every person at every level of life. Human rights suggest a more legalistic approach of these issues in which global actors simply identify that there are risks that individuals face in their everyday lives.

Since the release of the UDHR, the global emphasis on human rights has been overshadowed by the idea of human security. Both human rights and human security are widely held beliefs on the claims and freedoms that people are innately born with. They also focus on a people-centered view where individuals are prioritized over the state, an inward rather than outward view of security. However, human security goes one step further by focusing on operationalizing the ideas and policies put forth by the human rights movement to create tangible change in addressing risks that individuals face in their daily lives. In doing so, human security is stating that these individual risks are the most important for state security. The Human Development Report (HDR) (UN, 1994)

equates human security with the security of people rather than territories, with development rather than military forces. While threats to security may differ, the report suggests that human security is about human welfare, viability, and ensuring basic opportunities, freedoms, and socioeconomic rights while limiting the risks that threaten these.

The HDR also proposes that these problems of hunger, disease, crime, job insecurity, and environmental threats be identified and dealt with earlier rather than later - a preventative, not reactive response. The report concludes that "human security is a child who did not die, a disease that did not spread, a job that was not cut, an ethnic tension that did not explode in violence, a dissident who was not silenced" (UN, 1994). This concept of human life and dignity is the foundation of human security. From this foundation, a child who did not die or a dissident who was not silenced is seen as the basis of national security over that of power and military.

In the realm of health, human security includes a person's physical and biological health attributes to the state's overall security. State security has been directly linked to public health (Chen 2003). For example, without healthy citizens, a state has an unstable support system for any internal issues. This includes a person's physical and mental health that makes up the state's overall public health. Public health leads to more order, stability, and prosperity in a state's security and with the collective populations' health being supported, they are able to contribute their time and efforts to society. If an individual is sick, she is not able to work at their full capacity, decreasing the efficiency and prosperity of herself, the state, and the globe.

Human security has become a common discourse in the global arena. While it focuses down to the security of the state based on the security of populations, the idea has stemmed from global actors such as the United Nations (UN) and the World Health Organization (WHO) and the United States Agency for International Development (USAID). States were the primary caretakers of their inhabitants, but as the world becomes more globalized, states are no longer the sole primary actors in attributing to their own programs. While states are still important actors in both giving security to its people and protecting them from outside forces, non-governmental organizations (NGOs) and inter-governmental organizations (IGOs) have raised awareness of many issues, one of them being human security. NGOs and IGOs have become more prominent in addressing human security risks when national governments cannot or will not.

The foundational thematic concept of this research is that of a paradigm. Paradigms are a distinct set of concepts or ideas relative to a specific area of policy-making that have shifted over a period of time. Not only must this shift happen but the new set of ideas must then be adopted by actors at a large level. Ideas and paradigms matter as agents of socialization as they are causal actors that focus ideas in a policy making domain. This shift in thoughts and practices is essential to understanding how policies change and affect individuals, states, and global actors because ideas shape how actors interpret and construct their social reality.

Paradigms are linked to the rise of constructivist thought, which also came about after the Cold War. In bridging international relations with sociological theory, constructivists are interested in the bidirectional links of how agents produce structures and structures produce agents. Constructivists believe that knowledge shapes how actors

interpret and create their social reality. Ideas shape actors' identities and interests. While actors are shaped by their underlying cultures, the meanings to their actions are not static and fixed. This is a bidirectional relationship between global actors and ideas where each of them influences the other. However, in terms of this paper, I will be looking more closely at how one paradigm that constitutes a set of ideas, can be adopted and formulate change.

In regard to paradigms, NGOs and IGOs hold important roles in the global arena. With globalization, governments have less control over the flow of information across borders. Information is one of the main ways in which NGOs and IGOs facilitate change. The influx of knowledge and ideas from outside sources, such as the UN, has the power to broadly change how ideas are thought about. This has greatly affected how human security discourse has morphed into a paradigm of "human security," and I argue that human security in and of itself has also become a paradigm.

Human security is, first, a paradigm about putting into practice human rights as it is based upon the same belief that there are necessary rights each individual is entitled to. The shift is how those rights are impacted. Human security operationalizes human rights issues. Human rights may state that there is an epidemic and that people's rights to health are at stake, but human security goes one step further by stating how this is a problem for the state and pinpoints in what ways the epidemic could be dealt with through state and global actors by intervening at the level of the population.

In the paradigm of human security, the cooperation between the state's government and global actors should lead to generating policy and delivering programs. Along with this, global actors now have a greater obligation to address human security

when national governments cannot or will not, calling on increased technical policy support and education to be implemented. I argue that this change in how human security is thought about and implemented at a global level by state and global actors constitutes it as a paradigm because it is internalized and put into practice by multitudes of global actors.

The global governance of human security also has policy implications in the public health sector. With this thesis, I am interested in the adoption of the human security paradigm in public health programs in the sub-Saharan African countries of Ghana and the Ivory Coast. When and under what conditions did human security emerge as an important concept within global governance? How has human security become a paradigm? How has the human security paradigm impacted the practice of global public health? More specifically, under what conditions has the human security paradigm been adopted into the public health programs in Ghana and the Ivory Coast and what is the evidence for this interpretation? I argue that the inclusion of human security in public health programs will be shown through increased number of global actors, emphasis on preventative care and educational initiatives because these have been pushed forth by global actors. I seek to find the ways in which Ghana and the Ivory Coast have adopted the human security paradigm into their public health programs to improve citizen's health and longevity of those programs.

Literature Review

In this paper, I aim to identify links between paradigms, human security, and public health across select pieces of literature. The literature creates a basis for how I will examine the relationships between the human security paradigm and public health. Specifically, they help define when and how human security emerged in global governance and how human security has become a paradigm, impacting the practice of global public health. I will build upon their analysis of these connections through the policies of public health programs in Ghana and the Ivory Coast.

The Paradigm

Beland (2003) and Beland and Cox (2013) discuss the foundations of paradigmatic thinking. Beland (2003) goes more in depth to describe the basics of policy paradigms that Beland and Cox (2013) seem to gloss over. Both describe how policy is shaped by paradigms, or the analysis of policy issues that lead to a greater consensus in how to respond through policy (Beland and Cox 2013). A policy paradigm is the struggle of competing ideas to best address a policy problem (Beland and Cox 2013).

Beland (2005) pays greater attention to the processes of ideas, or how ideas are created and shared, without abandoning how structures can impact political institutions and policy. This shows the bidirectional linkages between ideas and structures as policy change moves between ideas and institutions and how these ideas can be understood through the construction and content of policy that is set forth or adopted by these institutions (Beland 2005).

Beland emphasizes that ideas are important for three reasons: problems, policy streams and political streams (2005). Problems refer to the agendas that are set by different actors. This is a selection of issues that are considered significant social and economic problems (Beland 2005). It is important to note that the types of problems deemed significant depends on the ideas that create society and that are upheld by different structures. Beland (2005) defines the policy stream as alternatives and paradigms. He argues that policy change occurs when the public and private thought adopt a new set of ideas. We can see this in the creation of think tanks and research institutes whose main goal is to identify and advocate for new ideas. Beland (2005) also mentions that these policy ideas often transcend national boundaries and allow alternatives and paradigms to spread internationally. This could be through the networks of IOs and NGOs along with news, the internet, and globalization as actors in sharing information widely.

Beland (2005) emphasizes how issues are framed and the entrepreneurs who back the policies that address those issues. He argues that proposals for policy agenda will only be reached if backed by a major political advocate (2005). Today this could be seen as states, but also includes global actors such as the UN and other NGOs and IGOs, whose global presence infiltrates how policies are viewed and implemented. This political stream is crucial in determining the policy outcomes (Beland 2005).

Beland (2005) and Beland and Cox (2013) give a clear description of what paradigms are at a basic level. They do this by describing how the components of a paradigm, the problems, policy streams and political streams, combine to put forward a

more comprehensive theoretical perspective concerning the relationship between ideas, institutions and policy making (Beland 2005).

Human Security and Public Health: The Connections

According to Periago (2012) and Lisk et al. (2015) human security has shifted in meaning: from terms of state and nuclear powers to a more people-centered focus. Before this shift, issues that only threatened a fraction of the population were not viewed as threats to the states security. Risks affecting groups such as women, children and ethnic identities had little influence how the state perceives its strength. There was a greater focus on problems between states rather than within states. The shift to human security led states to reevaluate how they interacted externally with other states and more importantly, internally with the inhabitants of its own state. As an aspect of human security, the health of individuals in a state then became important to the security of that state. Lisk et al. (2015) discusses how health and human security are intertwined, focusing on the individual and their right to health as agreed upon by the United Nations (UN). Periago (2012) also mentions the *Human Development Report* (1994), which laid the foundation in the shift of human security and healthcare that was brought forth by the UN from state-centered to citizen-centered ideas of security.

Periago (2012) states that poverty is the main cause of health and human insecurity and stresses the need to alleviate poverty as basic needs of physical health and well-being stem from it. Lisk et al.'s (2015) research focuses on funding, or economic status. Both authors conclude that healthcare is a right to individual humans, with Lisk et al. (2015) explaining the importance of increasing technical support for the state to

improve overall health, and Periago (2012) calling for a well-defined system of global health and human security with needs on all levels to be met. Policy growth is supported by both authors, yet Periago (2012) stresses the needs of the community over the individual as "all members of a society are stakeholders and have a level of accountability," calling for equity over equality regarding health plans and government policies.

Paivansalo (2015) discusses a different point of view on the linkages between human security and the "right to health". Paivansalo (2015) explains that there are two different approaches to health as a right, health-in-itself or "welfarism" and standard-of-living or "resourcism" (p. 190). The health-in-itself approach is defined by the World Health Organization (WHO) in which every person can achieve the highest attainable standard of physical, mental, and social well-being. The standard-of-living approach is defined by the Universal Declaration of Human Rights (UDHR) where every person has the right to security of a standard of living with positive health benefits. These two approaches define the differences between human rights and human security. Welfarism takes its stance from human rights as it declares that each person should have "the enjoyment of the highest attainable standard of health [as] one of the fundamental rights of every human being" (Paivansalo 2015 p. 190). Resourcism also emphasizes the right to health but extends to say there should be a "right to security in the event of… sickness [and] disability" (Paivansalo 2015 p. 191). Through the descriptions of the broad approaches, resourcism reflects that of human security. Paivansalo (2015) goes further to combine these two branches of health into the "dialogical capabilities approach (DCA)" where rights are promoted by states in partnership with global actors (p. 191). Unlike

Periago (2012) and Lisk et al. (2015), Paivansalo (2015) explains the dichotomy in relation to human security and health. Overall, Periago (2012), and Lisk et al. (2015) give a historic overview of the shift of human security out of human rights and into the realm of public health. Paivansalo (2015) goes further by defining two viewpoints of health in human security.

Questioning Human Security and Health

Roznai (2014), Lautensach (2015) and Aduloju and Pratt (2014) delve into shortcomings of connections between human security and health. Roznai (2014) presents a conceptual analysis of human security, arguing that the idea of human security is appealing, but focuses too much on policies rather than using that energy to implement human rights protections. The concept of human security is overused and holds the same idea of human rights, but with a different name (Roznai, 2014).

Lautensach (2015) also criticizes the idea that there is a right to health based on human security. He takes a stance against the right to health stating that it is not sustainable with the resources needed and is therefore ungrantable. Unlike Roznai (2014), Lautensach (2015) identifies circumstances in which some policy could be made to further health and human security. He explains the causal connections between health and the environment, what he calls an "ecocentric" view. Along with scholars who deem health as a human security issue, he pushes preventative measures with the enforcement of healthy lifestyle choices and a decrease in human reproduction but explains that if states were to put these policies in place, there would be much backlash from private healthcare providers and the curtailing of democratic and individual rights.

Aduloju and Pratt (2014) take this connection one step further by investigating the human security concerns of health in contemporary West Africa. Like Roznai (2014) and Lautensach (2015), the authors emphasize the ambiguity of human security will lead to instability if operationalized in the sub-region. Aduloju and Pratt (2014) mention conflicts and their developmental consequences on the regions health, referring to the human development index from 1980 to 2013. The authors note that human insecurity and developmental crisis are interchangeable and revolve around the state and the people. They conclude that while the paradigm of human security is broad and not fully defined, human insecurity in West Africa should be addressed by identifying and challenging the developmental crisis in the region (Aduloju and Pratt, 2014). This prioritization of the developmental crisis in the region shows one emphasis on how human security can be operationalized.

Overall Roznai (2014), Lautensach (2015) and Aduloju and Pratt (2014) argue that the right to health as a facet of human security is too broad and undirected, and therefore becomes more of an aspirational ideal than policy that can be operationalized.

Human Security in Global Governance

With increasing globalization, scholars have questioned the role of global leadership and how human security should be conceptualized and practiced. Leucea (2014), Šehović (2015), Shriwise and Stuckler (2015) all comment on the unidirectional awareness of human security globally. Leucea (2015) places emphasis on accepting human security in its broad definition in that defining human security restrictively might perpetuate human insecurity. Leucea (2015) comments on how global powers are

offensive, in that they are proactive rather than reactive, by interfering with the "rightful" state on matters of human security, stating that sovereignty is an outdated principle and negatively impacts human security promotion.

Shriwise and Stuckler (2015) developed a slightly different route creating a conceptual framework of the bidirectional linkages between health and social protection, or human security. They conducted a semi-structured review of different global organizations, namely the World Health Organization, the International Labour Organization (ILO), the World Bank, the International Monetary Fund (IMF), the Organization for Economic Co-operation and Development (OECD) and the European Union (EU), to identify social protection regarding health. The vast list of international organizations shows the importance of health to human security. Shriwise and Stuckler (2015) connect the links between health and social protection through these global actors.

Šehović (2015) takes a step inward and focuses on the centrality of the state and its role in upholding health on the level of human security. Her study regards the HIV/AIDS epidemic in South Africa and the Ebola epidemic in West Africa where pressures concerning health not only falls on the states, but also on the world in terms of NGOs and IGOs (Šehović, 2015). Concerning globalization, Šehović (2015) calls for a multilateral framework that can assure responsibility and accountability in terms of global health.

West Africa: Programs, Health and Human Security

Kosia (2011) and Sagoe-Moses (2011) identify examples of improvement in public health programs in West Africa. Kosia (2011) writes on the growing access and

improvement in quality care that comes along with the inclusion of the medical eligibility criteria wheel for contraceptive use in Ghana. This wheel made it easier for health care providers to better diagnose patients with different types of contraceptive use. Questioning the medical providers in the state, Kosia (2011) concludes through a quantitative analysis that the wheel should be expanded to other health care providers across Ghana. Sagoe-Moses (2011) discusses how the global strategy for infant and young child feeding has been implemented since the 1990s into the African region to address the lack of infant breastfeeding, finding that increased communication, national capacity building plans and counselling are needed to further improve the plan. Published by WHO journal, Kosia (2011) along with Sagoe-Moses (2011) both demonstrate the broad and global aspect of health.

Munodawafa, Sookram, and Nganda (2013) and Munodawafa and Sookram (2013) both address public health in the African region. Munodawafa and Sookram (2013) demonstrate the prioritization of health promotion in the region through their progress report of the 2001 Regional Health Promotion Strategy implementation. The guidelines focused on health promotion planning, implementation and capacity building, specifically for maternal and child health and HIV/AIDS prevention and control (Munodawafa and Sookram, 2013). Weaknesses of the program were identified and the next steps are planned where they call on leadership to strengthen, the promotion of good health governance through collaboration across other sectors, monitoring progress, establishing a financial basis, and building a group of practitioners who promote health (Munodawafa and Sookram, 2013).

Munodawafa, Sookram, and Nganda (2013) follow a similar guideline in the commitment to greater health equity per recommendations from the WHO. However, they focus on the social determinants of health, or the conditions a person is born into and the context they presently live in. To improve these conditions, they prioritize ameliorating day-to-day living conditions, addressing the inequitable distribution of power, money and resources and understand the problem of inequity in health and assess the impacts of action (Munodawafa, Sookram, and Nganda, 2013). These four articles were all contributed to by the WHO in the regional office for Africa. Based on the WHO's emphasis on social protection and human security, these authors address specific programs of health and the idea of health as a right in West Africa.

Conclusion

The aforementioned scholars have discussed the connections between human security and public health, and how paradigmatic thinking emphasizes health as a concrete right and how this shift in thought can change policy (Chen and Narasimhan, 2003; Quinn et al., 2017). The WHO has also led programs in West Africa that have introduced the idea of human security to public health.

In my study, I plan to investigate to what extent the human security paradigm has or has not been adopted by public health programs in Ghana and the Ivory Coast. While human security can be seen in the programs that the WHO has implemented and through the global governance of health programs worldwide, I will be addressing the specific linkages between human security and the policies of public health programs in Ghana and

the Ivory Coast. The goal of this paper is to identify how the adoption of the human security paradigm affects states public health programs.

Theory

I argue that if the human security paradigm is adopted by a state, then the density of activity by NGOs and IGOs will increase, preventionary measures will increase, and educational initiatives will increase across a state's public health programs policies. This paradigm defines the values, norms, and beliefs that people, and institutions hold, constructing identities, or how one views themselves. Because identities are not assigned at birth, they are shaped by ideas. The paradigm focuses on how these identities develop and how they change. The value of the paradigm is in understanding the actors and how they are motivated. I argue that human security is a paradigm and if adopted by states, the increase of NGOs and IGOs, preventionary measurers and educational efforts will be found in those states.

Human security focuses on addressing the risks individuals face in their daily lives. Human security is the physical and biological security of each person that is prioritized within state policy. The human security paradigm then represents how these principle ideas have shifted in the past twenty years from human security's inception after the Cold War. The human security discourse in the 1990s emphasized individual socioeconomic rights and was heavily influenced by global actors such as the United Nations and other prominent NGOs and IGOs. The ideas behind human security were also supported by states in the Global North, which includes North America and Europe, and the Global South, consisting of South America, the Caribbean, Africa and Asia. The

discourse also emphasized a particular understanding of national security, that the responsibility fell on states to 'care' for the needs of their inhabitants.

The idea of human security spans beyond each individual state to global institutions in how it reflects into the greater policies of the UN and other major global actors. Since the 1990s, this paradigm has taken on new meanings and identities as it has been more widely integrated and accepted at a global level. While still founded on valuing the individual's daily life and how this amounts to national security, there have been shifts in how human security is approached and implemented. It is believed that now states, NGOs and IGOs, should cooperate in generating policy and delivering programs that benefit a state's inhabitants. These global actors of NGOs and IGOs are now seen as having an obligation to address human security when national governments will not or cannot. Before, states held the power to allow NGOs and IGOs into their countries. This power has created offensive global actors when they assist with human security issues. Being offensive, global actors take charge in addressing certain human security dilemmas in a preventative manner rather than reactive. They are not necessarily waiting on countries to green light them in setting up programs or creating change. Scholars have especially called for change in increased technical policy support and education.

There is also an increased bias towards material equity over political equality. Equity is defined by addressing problems and giving different solutions based on people's different needs so that they have similar outcomes, unlike equality where people are given the same solution and have different outcomes. An example of equality is giving people in different countries with different cultures the same care and them reacting to it

differently, such as all women being treated by male doctors when some cultures may find this uncomfortable. Women may not disclose certain symptoms to male doctors which could lead to misdiagnosis or mistreatment. An equitable approach would be understanding each culture that a program would be installed in and tailoring the care to each, minimizing the risks and leading to similarly positive outcomes in how the women would be cared for. This material equity should be prioritized over political equality, or the assessment of how politics plays into what and how programs are implemented in different countries. This represents the increased operationalization of the human security discourse. The aforementioned points comprise the paradigm of human security. While human security is still founded on the tenets of addressing individual's everyday risks and how that affects the national security of a state, the ideas that surround human security have shifted and become more widely adopted not only by global actors and states, but also in the lives of individuals.

First, I argue that if the human security paradigm is adopted by a state, then the density of activity by global actors in the global public health sector will increase. Global actors here include NGOs and IGOs. Density is distinguished by the number of global actors present and the amount of monetary resources put forth in program efforts. I define a state's public health programs as programs addressing public health located in a state's borders.

Although some authors stress the importance of states being the main actors in their public health programs (Lisk *et al.* 2015), I argue that the human security paradigm will lead to a greater amount of involvement from global actors. I agree with Leucea's (2014) argument that sovereignty or the "rightful" state has become an outdated principle

and thereby an obstacle in promoting the human security paradigm. The "rightful" state is a state that takes responsibility for the rights of its inhabitants and has the power to devise and execute programs at its discretion (Leucea 2014). This allows for states to perpetrate human insecurity by capitalizing on the inequalities of its inhabitants. For example, a state may prioritize economics over public health. The state could be choosing not to have certain health care benefits because they would be more of a hassle economically. Many times, these insecurities cannot be dealt with by global actors unless they are invited by the state to intervene, except in terms of direct and violent conflicts (Leucea 2014). If a state's policies do not provide adequate health infrastructure to its inhabitants, then the human security paradigm calls for global actors to confront the inequalities. I argue that the acceptance of the human security paradigm has led to more global actors being active in their means of addressing human security needs, meaning their presence has grown over the years that human security has become a paradigm. I also argue that this paradigm has led to an increase in monetary resources put forth by global actors in public health programs.

In all, I argue that the human security paradigm produces an increase in global actors in a state's public health programs. This follows my argument that the human security paradigm has partially displaced the sovereignty of a state in attending to a state's public health programs. Through an analysis of public health program cases, I argue that the paradigm of human security will lead to increasing density of global actors in a state's public health programs.

H1: If the human security paradigm is adopted by a state, then the presence of global actors will increase in a state's public health programs.

Next, I argue that if the human security paradigm is adopted by a state, then there will be a greater emphasis on preventionary measures in a state's public health programs. I define preventionary measures as initiatives that give resources meant to stave off the occurrence of public health issues rather than using reactionary measures. These measures would help prevent the recurrence of public health epidemics which are understood as a sudden and severe outbreak of disease in a given region.

With the presence of the human security paradigm, I argue that there will be a greater emphasis on preventionary measures in public health programs. The human security paradigm focuses on the daily lives of the individuals of a state and whether those aspects of a person's life are secure. For example, by human security, I mean that a person has access to the necessary resources that produces an adequate degree of health and wellness. Preventative measures call for using resources to hinder a greater number of health issues from arising. Preventative measures could possibly include nutritional and vaccination programs, for example. Nutritional programs address the importance of food to a person's health. If a person only has access to non-nutritional foods, they may be at a higher risk for disease as they are not receiving the best quality of food. These could include making healthy vaccination programs account for preventionary health measures as they are a large part of averting diseases from occurring. Preventative health measures align with the human security paradigm in that the measures are thought of proactively.

In terms of maternal and child public health programs, proactive measures could include the usage of contraceptive care such as birth control, prenatal care, checkups for the mother and child, among others. The mother and child programs will be focused on women who are of fertile age and their children under the age of five, as this population can be insecure. The preventative care is focused on keeping the women and children's health secure so that they are able to obtain a greater amount of freedom and opportunity. If a mother or child is sick, they automatically lose are losing security of their health and are at a higher risk for more diseases and death.

The human security paradigm has led scholars to call on preventionary measures to combat public health concerns. These preventionary measures can be seen through nutritional efforts, vaccinations, and continuous checkups in clinics such as prenatal care through maternal and infant programs. I argue that the human security paradigm will inherently lead to an emphasis on preventative care in a state's public health programs.

H2: If the human security paradigm is adopted by a state, then preventative care techniques will increase in a state's public health programs.

Further, I argue that if the human security paradigm is adopted by a state, then there will be an increase in educational initiatives in a state's public health care programs. Educational initiatives follow the same line as preventative measures in that they teach the general public about health issues, and educational initiatives also follow a preventative care pattern in which the public is taught how to utilize their resources to prevent diseases and promote positive lifestyles. For example, the individual who is

taught to wash their hands after she urinates is less likely to spread disease. Educational initiatives could possibly include teachings on sanitation, nutrition and other instructional lessons regarding a person's health and her living conditions.

The human security paradigm, as previously stated, focuses on the daily aspects of a person's life. I argue that educational initiatives would positively affect a person's daily life in that she is given knowledge about her personal health and health at a large scale, or public health, which is the health of the country. Once given this information, an individual has the knowledge to utilize the tools in her life to improve her health.

In summary, I argue that the human security paradigm leads to an increase in educational initiatives in a state's public health programs. This follows the argument that an individual's knowledge affects her daily life, which is a pillar of the human security paradigm.

H3: If the human security paradigm is adopted by a state, then educational initiatives will increase in a state's public health programs.

Research Design

I conduct an interpretive analysis using qualitative text and quantitative data to determine if and how the paradigm of human security has been transformative in public health programs. I specifically assess this change in three ways: through the density of global actors, the inclusion of preventionary measures and the development and reinforcement of educational initiatives. This analysis derives from evidence that includes

public health program texts and quantitative data sets in Ghana and the Ivory Coast from the years of 1993-2013.

The paradigm of human security serves as my independent variable. I have traced the history of the idea of human security and how it has transformed into a paradigm. This includes examining the texts, geopolitical shifts, and the role of global actors that have normalized this paradigm in contemporary governance and thus cemented its status as an independent variable. I am measuring the presence or absence of the human security paradigm in public health policies in whether this has created a tangible impact. In the qualitative texts, this could include references to human security as well as human rights, as human security is a particular extension of human rights.

The overall indicators in public health programs is the dependent variable. I am measuring these changes in three ways: the density of global actors, the emphasis on preventionary measures, and the increase of educational initiatives. The density of global actors refers to the number of NGOs and IGOs present in the states and their monetary or financial commitment to public health programs. These indicators demonstrate whether or not there is a change in the approach and implementation of public health policy in the states of Ghana and the Ivory Coast. The emphasis on preventionary measures and educational initiatives is interpreted through an examination of policies from the World Health Organization (WHO) and the United States Agency for International Development (USAID), among other sites. Quantitative data is also evidence of how the paradigm of human security has been implemented into public health programs. Evidence would include data sets portraying the allocation of money to certain public health programs as well as the increase of data available in the public health sector.

Focusing on public health programs in Ghana and the Ivory Coast is ideal for my study. Both countries are in West Africa where health epidemics have been present and where the states have some type of public health program policies in place. Ghana and the Ivory Coast are also located in a region that I have previously studied and have data available through their own governmental websites and through sources such as the WHO and USAID.

By focusing on cases in Ghana and the Ivory Coast, I also control for location including factors such as climates, geography, and urbanization rates. I also control for similar gross domestic product (GDP), birth rate, median age, and degree of risk for major infectious diseases. There are slightly different population sizes with roughly 27,5000 people in Ghana and 24,000 people in the Ivory Coast. However, both countries having the median ages around 21 years and population growths around 2% per year. Urbanization rates are around 3% for both countries. GDP is slightly different between the countries with Ghana having a household consumption of around 80% and the Ivory Coast closer to 60% of the GDP composition. There is also a very high degree of risk for major infectious diseases. Another major control is the reach that global actors have had in the governments of Ghana and the Ivory Coast since their respective independence. By this, I mean that global actors have policies and programs in place regionally that have been accepted by these two states in regard to health. This creates a more equal field on which to compare how the human security paradigm affects public health program policies.

The programs I research also vary. I do not control for the reach of the programs, meaning how many people fall under their coverage. However, the reach is significant

because human security initiatives are normally population focused since they are focused on public health. I do not think this will have any effect on the human security paradigm being present or not. I predict that this will not affect my research because of the presence of globalization. I am assuming that states will be well versed in the human security paradigm such as global actors, where human security is implemented into their policies. Programs may be run by the countries' governments and outside actors such as the UN, WHO, USAID, or CDC where these usually represent partnerships or networks.

In Ghana and the Ivory Coast, I examine three different cases. The first is maternal and infant programs, accompanied by preventative measures and educational initiatives. These programs allow me to measure whether the human security paradigm has created changes in the overall public health policies of the states. I define mother and child centered programs as those targeting women who are in their fertile years, whether they are mothers, and children who are under the age of 5 who often depend solely on the mother for nutrients and care. These programs could possibly overlap with preventative and educational programs which could also include nutritional and vaccination programs among maternal and infant programs as many public health programs in Ghana and the Ivory Coast are directed to these sub-populations.

In this interpretive analysis, there is qualitative and quantitative data sets that the study will analyze. For the qualitative text I rely on documents that span throughout the twenty-year range of 1993-2013. I compare the presence or absence of the human security paradigm in the two countries based on the different versions of the policies over the span of twenty years. I look at an article on the implementation of international code on the marketing of breastmilk substitutes and specifically sites its changes in Ghana and

the Ivory Coast. I also look at the quantitative data from USAID by country of the current

and constant dollars throughout the time span of 1993-2013. In analyzing these data sets,

I explore the overall monetary flow to these countries. I also compare how each country

distributes the USAID money to its programs from 2001-2013, looking at the years of

2001, 2007, and 2013 to get an overall comparison over these thirteen years. This

qualitative text and quantitative data provides evidence for my analysis of how the human

security paradigm may be found in public health program policies.

I analyze these policies based on the presence of the human security paradigm. As

my unit of analysis is the state, I am looking at the density of global actors, preventative

measures, and educational initiatives throughout the state. These may present themselves

in the same programs, such as mother and children programs giving vaccinations and

classes that would register as preventative and educational measures.

Analysis

It is imperative to know the impacts that paradigms such as human security have

as states presently because it affects future policies. I am curious as to their direct impacts

on public health programs through how policies are shaped. If these impacts are not

effective, not only will the security of the state decrease, but it could also affect public

health globally. More generally, it is also important to understand the impact

contemporary global governance and to what extent it has emerged. I evaluate how the

human security paradigm is adopted by states through its public health programs. I

measure this in three ways, through analyzing the density of state and global actors in the

public health programs and the types of initiatives they have put forth, specifically preventative care and educational programs.

By analyzing policies and data on the public health programs in Ghana and the Ivory Coast, I evaluate a trend that suggests to what extent the human security paradigm has been adopted by the states. Between the policy texts and the dataset analysis, I find that there is a greater adoption and implementation of the human security paradigm in Ghana than the Ivory Coast. However, there is an increase in the presence of the human security paradigm across both case studies that are analyzed.

The presence or absence of the human security paradigm in transforming public health program policies is the focus of this analysis. While I will be comparing the differences between Ghana and the Ivory Coast, I am not looking into what it means for one country to have a greater adoption of this paradigm as it is outside the immediate scope of this study. This analysis takes what it means to see human security as a paradigm, how it emerges and what it is defined as and looks at how this has created transformations in the overall priorities of public health programs for the purpose of seeing how international discourse affects policies.

Data

Following the data, there is strong support for my hypothesis that the human security paradigm is present in both countries during my time frame. Specifically, the document on international code on the marketing of breastmilk substitute gives background on both countries and their compliance with the international code. This document follows the marketing of breastmilk substitutes in West and Central Africa

from the 1960's when these substitutes were heavily pushed, often decreasing the number of infants that were exclusively breastfed in the first six months. This caused large health problems for infants and mothers alike to the extent that the UN and the WHO held a conference in the early 1990's with thirty countries of West and Central Africa to discuss the importance of exclusive breastfeeding. This paired with the other data sets shows trends of increasing funds and initiatives in both Ghana and the Ivory Coast. The differences stem from the policies created and the acceptance of the governments in order to implement them.

I define density as the number of global actors present in the state's public health programs and their influence as such, specifically in finances. From USAID, there is a steady increase of finances in the constant and current amounts given to Ghana over the course of twenty years, with a jump in funds during 2007 that can be seen in the appendix. Disregarding this jump, funds stay steadily increasing. In comparison to the Ivory Coast, funds increase over the twenty years with minor dips every three to four years which can be seen in the appendix. However, the overall trend is steadily increasing. USAID is but one example of the global actors that are present in the human security paradigm. The increase in funding and outreach by global actors is a main theory of the human security paradigm. Human security is intertwined globally, and this can be seen through the increase in global actors being present in state public health programs, as well as in providing funds for these programs.

Trends from the WHO also show an overall increase in initiatives for mother and child programs as well as preventative measures with immunizations for diseases like the measles over the twenty-year period. In Ghana, both these programs steadily increase for

both male and female children from 1993-2008 for the mother and child programs and 1993 and 1998 respectively to 2011 for the immunizations. In the Ivory Coast these trends are slightly different. They steadily increase from 1994 to 2006 and take a dip in the 2011 statistics. In regard to mother and child initiatives, there does not seem to be as strong of an emphasis between an increase from 1994 and 1998 to 2011. This demonstrates the increase in preventative care that is a tenant of the human security paradigm. While Ghana has a clear connection of increases over the past 20 years, the Ivory Coast followed a different path in steadily increasing over a period and then dropping off after 2006, probably due to the economic housing crash that happened in the late 2000's. Either way, both countries show increases in preventative care, a core tenant of the human security paradigm based on the idea of being proactive to ensure health.

The international code on the marketing of breastmilk substitutes clearly states the acceptance of the international code by many West African countries, including Ghana and the Ivory Coast. In the 1960's, exclusive breastfeeding was often discouraged, and the use of formula rose. This created health problems, especially for infants under six months who were not being fed exclusively with breastmilk. As a response to this, UNICEF and WHO called on all government to protect, promote and support breastfeeding specifically in those first six months of infancy. From this, both Ghana and the Ivory Coast along with a multitude of other countries in West and Central Africa signed the *Innocenti Declaration* to affirm that breastfeeding lowered infant morbidity and mortality and contributed positively to mother's health, along with social and economic benefits since children are often born farther apart. Since this affirmation by Ghana and the Ivory Coast, Ghana has implemented most of the provisions of the

international code that is set forth while the Ivory Coast has had legislative issues getting their measure drafted. Ghana's success came from many years of information, advocacy and consultation before the Breastfeeding Promotion Regulation was adopted in 2000 whereas the Ivory Coast has had issues due to lack of information to policy makers, leading them to believe it would create negative economic impacts on the country. The issue with the Ivory Coast may have also stemmed from political instability and continuous changes in government.

In mentioning these two countries, the article goes into depth on the successes and lessons learned in each. From knowing Ghana has been a relatively peaceful country since its independence, I am not surprised that the article calls Ghana a true success story. Not only was the code adopted early on, but great strides were made in governmental policies to where the regulations were adopted in 2000. There were also clear connections between the government and global actors through the Ghana Infant Nutrition Action Network (GINAN) and UNICEF. The two worked as steady and active players during the entire process which was an important partnership between the state and global actors. Not only are these two actors working together in the maternal and child sector, but they are also utilizing the tenant of nutrition, or a preventative measure, in their programs. Overall, Ghana shows strength in informing officials of the issues surrounding the marketing of breastmilk substitutes and how the international code relates to them. Ghana also established an independent monitoring body that submits findings and recommendations to government enforcement agency.

The Ivory Coast was a bit different in their story with the implementation of the international code. The country was just as accepting of the code and quickly brought it

to legislation for the purpose of creating policy. The Ivory Coast was one of the first countries to participate in the pilot program for Baby Friendly Hospital Initiative in 1991 and one of the first to adopt the decree to end the practice of free and low-cost supplies of breastmilk substitutes to health care facilities. However, the country had issues with this being implemented too quickly because not enough background was given on the topic. In 1994 the Ministry of Health proposed a draft decree that did not advance. This was due to the rush with information to the government such that they viewed the regulations of breastmilk substitutes as bad for the economy. This along with other endogenous factors such as political instability left this policy untouched and not yet adopted by national law. Even though the country has a long history of acting to improve infant and young child feeding, the legislation remains unadopted. Lessons to be learned from the Ivory Coast's experience includes making sure there is proper communication as a lack of information can be confusing or misleading, especially among government officials.

For future references, it is noted that exclusive breastfeeding should be protected, promoted and supported along with health feeding practices and providing guidance to breastfeeding mothers. These are the three tenants of the human security paradigm. First that these international codes are endorsed and implemented into state public health programs through policy changes as well as the emphasis on preventative care of breastfeeding infants for their health as well as the health of the mothers. Along with this, education is encouraged through emphasizing the importance of guidance to breastfeeding, specifically with HIV-positive mothers. These three points match my theories of the human security paradigm. They are important tenants for advancing what is the human security paradigm.

Conclusion

The human security paradigm is a set of ideas that have been adopted at a global level through its inclusion in policies put forth by global actors. It is necessary to evaluate to what extent this paradigm has been adopted in public health programs because the paradigm puts forth policies that are active in their role of preventing public health dilemmas through partnerships with global actors, preventionary measures and educational initiatives.

Through reviewing data sets on the monetary amounts that global actors such as USAID put forth along with an overview of the marketing policies for breastmilk substitutes in West and Central Africa, both countries seem to have adopted the human security paradigm in its essence. Ghana and the Ivory Coast both have increases in funding throughout 1993-2013 through USAID, however, the Ivory Coast seems to vary a bit. Regarding the policies surrounding the marketing of breastmilk substitutes, Ghana and Ivory Coast both adopted the principle of the human security paradigm. In this they were in agreeance at the 1990 meeting with the UN over the *Innocenti Declaration* that these breastfeeding substitutes had negative health consequences on infants and mothers. Both countries made strides to create legislation to diminish the marketing of these substitutes. However, in not conveying information about the marketing strategies well to legislature, the Ivory Coast has not done well in approving a policy because legislatures were more concerned about the negative economic downfalls the policies might exhibit.

The collaboration between the UN and Ghana and the Ivory Coast is clear through the ability of the countries to agree and adopt the policy ideas and create legislature that carry out the policies in their countries. The document puts forth an emphasis on

preventative measures and educational initiatives for mothers and children. The preventative care is seen through the policies themselves, hindering the marketing of breastfeeding substitutes in Ghana and the Ivory Coast, among other West and Central Africa countries, is how these countries are combating the issue of negative health consequences on infants and mothers. There is also an emphasis on the education of mothers, specifically those who are HIV positive as this affects if they should breastfeed their infants.

These two countries both show signs of adopting the human security paradigm in their public health programs. This can be seen through the three theories that have been previously laid out such as the increase in partnerships between the states and global actors and especially in increases in preventative care and educational initiatives that have been put forth by the states in their legislature.

This connection between the human security paradigm and the public health programs of Ghana and the Ivory Coast are just two examples of how the world has become globalized to the point that whole shifts in idea sets have been adopted globally. We have followed the timeline of how human security came out of human rights and how it has developed into a specific paradigm based on the ideas that the human rights of a state's inhabitants need to be fulfilled for the state to be secure, an internal and preventative emphasis over external and reactive emphasis. This change can be seen specifically through increases in partnerships between global actors that push forth the paradigm and individual states through preventative measures and educational initiatives. These can be reiterated throughout other public health programs and any of the other tenants that are shared by human rights and human security.

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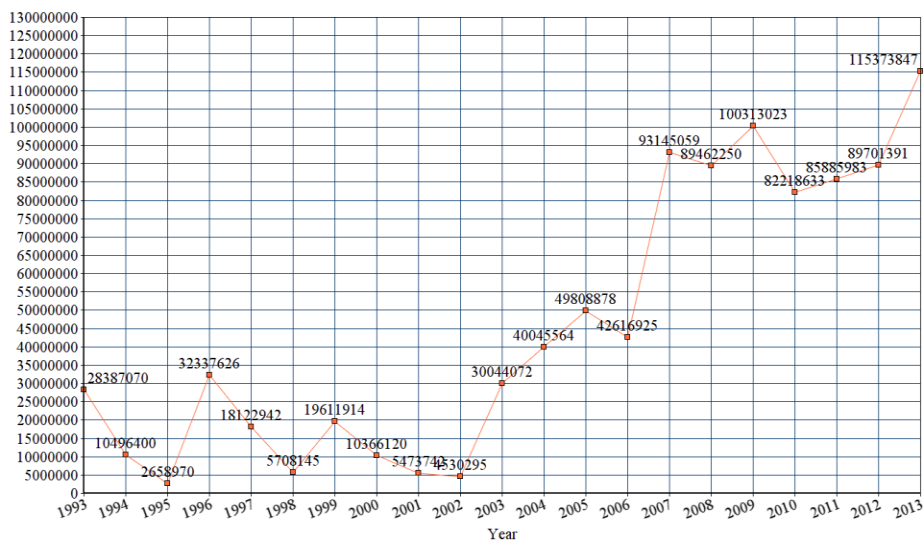
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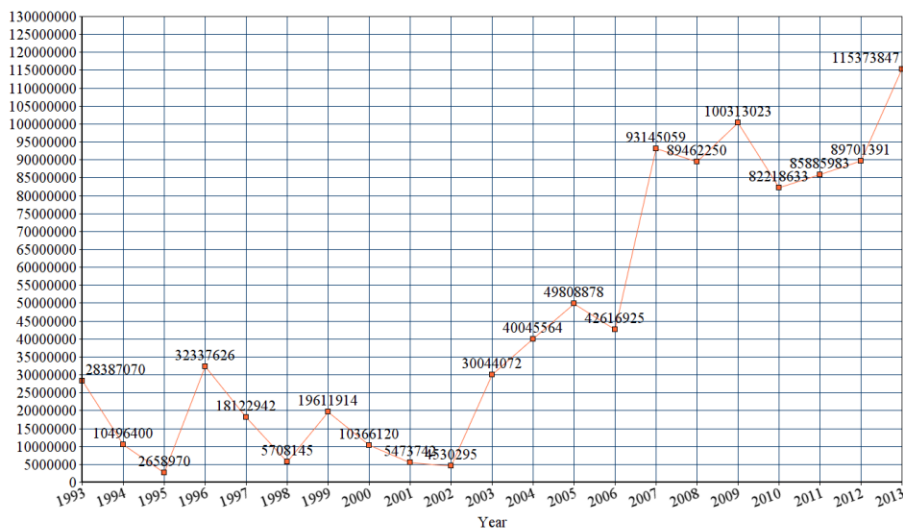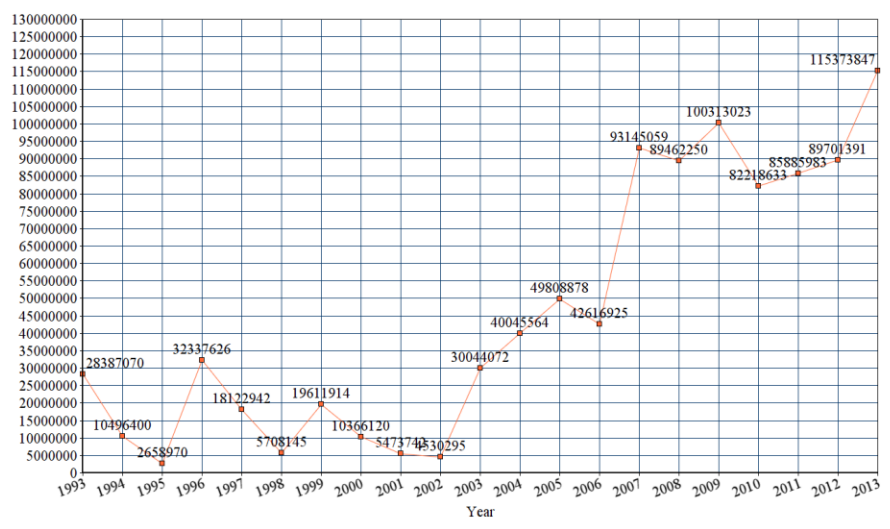
Appendix

Cote d'Ivoire Constant Amount

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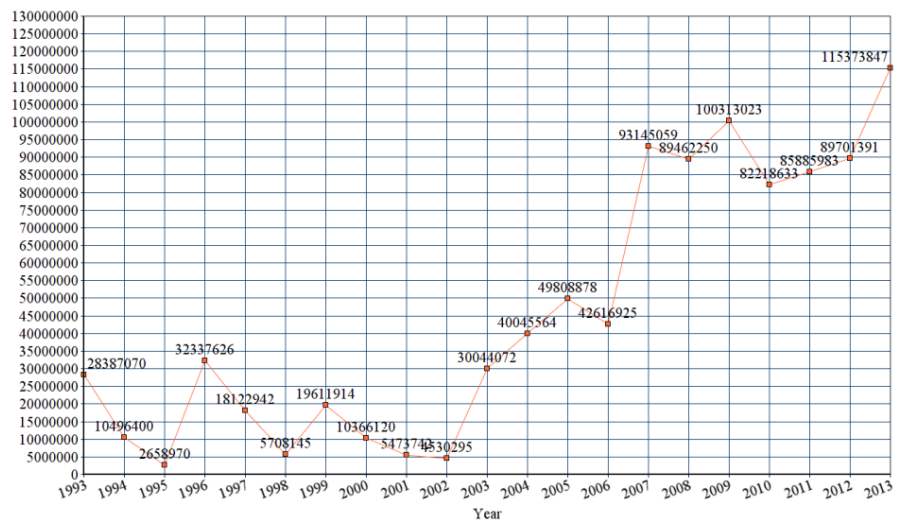
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